

BEFORE THE STATE PERSONNEL BOARD OF THE STATE OF CALIFORNIA

In the Matter of the Appeal by) SPB Case No. 33538
)
 RICHARD MUGA) **BOARD DECISION**
) (Precedential)
)
 From dismissal from the position) **NO. 95-04**
 of Senior Psychiatric Technician)
 at the Patton State Hospital,)
 Department of Mental Health at)
 Patton) February 7-8, 1995

Appearances: Loren E. McMaster, Attorney, represented appellant, Richard Muga; William L. Summers, Executive Director of the Department of Mental Health represented respondent, Patton State Hospital.

Before: Richard Carpenter, President; Lorrie Ward, Vice President; Alice Stoner and Floss Bos, Members

DECISION

This case is before the State Personnel Board (SPB or Board) after the Board rejected the attached Proposed Decision of the Administrative Law Judge (ALJ) in the appeal of Richard Muga (appellant) who was dismissed from his position as a Senior Psychiatric Technician at the Patton State Hospital, Department of Mental Health (Department) at Patton. Appellant was dismissed for committing numerous acts of patient abuse and for making threats against his subordinate staff.

The ALJ who heard the appeal found that while there was insufficient evidence to support the majority of the Department's charges, two charges were proven by a preponderance of evidence. One incident involved appellant, in an effort to restrain a patient to his bed, placing his knee around the patient's neck

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area, covering the patient with a sheet and pushing the patient's face into the mattress so that the patient was choking and could not breathe. The other incident involved appellant's awakening a patient by tipping the sleeping patient's chair until the patient fell to the floor.

While finding sufficient evidence that these two incidents occurred, the ALJ modified appellant's dismissal to a 10-month suspension, based on his findings that: the former incident was more a serious error in judgment in restraining the patient than an intentional instance of patient abuse and the latter incident, while inexcusable conduct for a psychiatric technician, was in the nature of a childish prank.

The Board rejected the ALJ's Proposed Decision to review the record and receive arguments from the parties on the issue of what the appropriate penalty should be, if any, for appellant's misconduct. After reviewing the record, including the transcript, exhibits, and the written arguments of the parties¹, the Board adopts the ALJ's findings of fact, but further finds that each of the two above-referenced incidents constitutes intentional patient abuse and that appellant's dismissal is warranted.

¹ The parties did not request oral argument.

FACTUAL SUMMARY

After a review of the record, we find that the ALJ's findings of fact in the attached Proposed Decision are free from prejudicial error and thereby adopt these findings of fact as our own.²

ISSUE

What should be the appropriate penalty, if any, under the circumstances?

DISCUSSION

The allegations proven by a preponderance of evidence are that: 1) with both hands, appellant placed a sheet over a patient's face, and placed his knee in the patient's neck area while the patient lay resisting restraint to the bed face up, and pushed the patient's head into a mattress so that he could not breathe causing him to begin to choke, and, 2) appellant awakened a patient found sleeping in a chair by lifting the patient's chair into the air and tilting the chair forward until the patient fell to the floor. As the ALJ found in his determination of issues, these actions clearly constitute violations of

² We note that the ALJ states in Paragraph II of the attached Proposed Decision that the Department charged appellant with placing his knee on the patient's stomach and throat, but the ALJ found that appellant placed his knee around the patient's neck area. The testimony of witness Placencia at the administrative hearing was that appellant placed his knee around the patient's neck area. We find the difference between the Department's charged act and the findings of fact as adopted herein to be minor and inconsequential.

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Government Code section 19572, subdivisions (d) inexcusable neglect of duty, and (m) discourteous treatment of the public.

While finding the witness to the choking incident, Placencia, to be credible, the ALJ based his modification of the dismissal on testimony in the record that placing a sheet over a patient who is spitting is a proper procedure. The ALJ noted that the testimony was not conclusive as to whether or not the patient was actually spitting at appellant. The ALJ opined, however, that since it took two psychiatric technicians to subdue the hostile patient, and since the patient may indeed have been spitting, appellant's actions constituted more an error in judgment than intentional patient abuse. Relying on the Board's decision in Alejandro Nevarez (1994) SPB Dec. No. 94-04,³ the ALJ assessed a penalty less severe than dismissal.

The Board believes that appellant's conduct of placing a sheet over a patient's head and pushing the patient's face into a mattress so as to restrict the patient's breathing constitutes more than a serious error in judgment. Appellant's conduct constituted blatant physical abuse of a patient. Even assuming, arguendo, that the patient was actively resisting being placed in

³ In Alejandro Nevarez, SPB Dec. No. 94-04, the Board modified a psychiatric technician's dismissal to a ninety days' suspension on the grounds that a questionable procedure used to remove a recalcitrant patient from the floor where he lay in harm's way, while constituting an error in judgment, under the circumstances, did not constitute intentional patient abuse.

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restraints and was spitting in the appellant's face, such that appellant's placement of a sheet over the patient may have been justified, appellant's smothering of the patient so that he could not breathe was a thoroughly unjustified act of physical abuse which could have had serious, even fatal, results.

Similarly, we believe that appellant's action of awakening a patient by tipping over the patient's chair until he fell to the floor constitutes intentional physical abuse of a patient which the State cannot tolerate. While two childish coworkers engaging in mutual horseplay might justifiably receive an adverse action less severe than dismissal, appellant perpetrated his childish "prank" upon a vulnerable psychiatric patient, who was thoroughly dependent upon psychiatric technicians such as appellant for his welfare.

Appellant's action in tipping over the chair demonstrates that he has no business caring for persons with disabilities who are entrusted to the State's care. Appellant is charged with caring for patients in the hospital and, in particular, protecting patients from physical or emotional harm. It shocks the conscience to think that a person in such a position would engage in any conduct that would risk inflicting emotional and physical harm upon a patient who was sound asleep. As this Board stated in Paul Edward Johnson (1992) SPB Dec. No. 92-17:

[T]he State cannot afford to gamble with the care and safety of those who cannot care for themselves. The

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harm to the public service from physical abuse is sufficiently grave to merit the imposition of the ultimate penalty of dismissal. (Id at p. 10.)

Despite the appellant's long history of state service without formal disciplinary action, we believe that appellant's two intentional acts of patient abuse warrant his dismissal.

ORDER

Upon the foregoing findings of fact and conclusions of law and the entire record in this case, and pursuant to Government Code sections 19582, it is hereby ORDERED that:

1. The adverse action of dismissal taken against Richard Muga is hereby sustained.

2. This decision (along with the attached Proposed Decision) is certified for publication as a Precedential Decision pursuant to Government Code section 19582.5.

STATE PERSONNEL BOARD*

Richard Carpenter, President
Lorrie Ward, Vice President
Alice Stoner, Member
Floss Bos, Member

*Member Alfred Villalobos was not present when this decision was adopted and therefore did not participate in this decision.

* * * * *

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I hereby certify that the State Personnel Board made and adopted the foregoing Decision and Order at its meeting on February 7-8, 1995.

WALTER VAUGHN
Walter Vaughn, Acting Executive Officer
State Personnel Board

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BEFORE THE STATE PERSONNEL BOARD OF THE STATE OF CALIFORNIA

In the Matter of the Appeal By)	
)	
RICHARD MUGA)	Case No. 33563
)	
From dismissal from the position)	
of Senior Psychiatric Technician)	
at the Patton State Hospital,)	
Department of Mental Health at)	
Patton)	

PROPOSED DECISION

This matter came on regularly for hearing before Melvin R. Segal, Administrative Law Judge, State Personnel Board, on January 20, and March 28, 1994, at Patton, California.

The appellant, Richard Muga, was present and was represented by Loren E. McMaster, Attorney.

The respondent was represented by Michael M. Johnson, Labor Relations Analyst, Patton State Hospital.

Evidence having been received and duly considered, the Administrative Law Judge makes the following findings of fact and Proposed Decision:

I

The above dismissal effective July 1, 1993, and appellant's appeal therefrom comply with the procedural requirements of the State Civil Service Act.

II

Appellant entered state service as a Psychiatric Technician Student and has progressed through the classes of Pre-Licensed Psychiatric Technician, Psychiatric Technician, and Senior Psychiatric Technician. He has over 16 years of state service and no history of disciplinary action.

III

As cause for the dismissal, respondent alleged that

- 1) on November 27, 1992, appellant inappropriately assumed a one-to-one assignment with patient M. B. in order to taunt and intimidate the patient. In addition, it was alleged that on that date appellant maliciously cut M. B.'s beard off, twice slammed the patient's face into a wall, and slammed the patient into a door jamb. It was alleged that appellant failed to document the patient's injuries;
- 2) during August 1992, appellant placed a sheet over patient L. C's head while the patient was in restraints, and put his knee on the patient's stomach and throat and pushed the patient's face into a mattress;
- 3) during November 1992, appellant attempted to wake patient R. H. by tipping the chair the patient was sitting on and causing the patient to fall to the floor;
- 4) on October 26, 1992, appellant pulled patient D. P. off his bed by his feet, shoved him out of the dormitory, grabbed the patient from behind and attempted to place him in a head lock, and headbutted him in the stomach. It was alleged that appellant failed to summon sufficient staff to subdue the patient;
- 6) on November 29, 1992, appellant ordered all

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patients to attend a non-scheduled Therapeutic Community Meeting and threatened the patients; and 7) on or about December 21, 1991, appellant confined another employee, Mary Winget, in the Unit Supervisor's office for one and one-half hours, during which time appellant threatened her with personal injury if she reported this confinement.

Respondent alleged that this conduct constituted violations of Government Code section 19572, subdivisions (c) inefficiency, (d) inexcusable neglect of duty, (m) discourteous treatment of the public or other employees, (o) willful disobedience, (t) other failure of good behavior, and (x) unlawful retaliation.

IV

On November 27, 1992, appellant assumed a one-to-one assignment with patient M. B. Appellant denied that the assignment was inappropriate, that he taunted or abused the patient, or that he shaved the patient's beard without permission.

Appellant's testimony that his assumption of a one-to-one assignment with the patient was appropriate was not contradicted. Although there was testimony that such an assignment was unusual for a supervisor, it was not improper. Appellant testified that there was minimal staff that day.

The patient's medical record for November 26, 1992, contained an entry that the patient requested assistance in shaving, and staff shaved off his beard. Therefore, the allegation that on November 27 appellant "terrified" the

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patient "by deceiving him into believing that [appellant was] going to trim his beard" and that during the process appellant repeatedly stated, "You're not gonna hurt me are you?" was refuted by that document. Although there was testimony from Psychiatric Technician (PT) Mary Winget that in December 1992, she heard appellant make the quoted remark ten times while appellant shaved the patient's beard, she testified that the patient did not protest. The patient's medical record shows the patient is not bashful in making complaints and/or threats. Thus, even assuming that Winget described the shaving which took place on November 26, her testimony does not contradict the evidence that the shaving of the beard was requested by the patient. Considering the patient's back-ground, placing him in restraints appears to have been prudent, and appellant's comment about not being hurt was not threatening if taken in context with the patient's volatility.

The most serious part of this allegation is that while M. B. was in restraints, appellant slammed his face into a wall and pushed him into a door jamb. Winget testified that at about 2:30 she heard a commotion in the hallway and heard appellant say, "You want to play games, we'll play games," and observed appellant ram the patient's head into a wall. She testified appellant said, "if you mess with me you're going to go down hard," and he then slammed the patient's head into the wall three times.

Winget admitted that she did not file a Special Incident Report (SIR), did not check the patient for injuries, or call

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a doctor. She testified that several other staff members observed the incident and allowed the abuse to occur. She also testified that appellant positioned the patient so that the patient's shoulder was hurt as he was escorted into the Seclusion and Restraints (S & R) room.

Appellant testified that M. B., while in restraints, wildly attacked him, kicking at him. Appellant put the patient against the wall two times. Appellant testified that other staff assisted him in subduing the patient, and that Winget was not in the area. Appellant prepared a SIR.

Appellant testified that the patient resisted being placed in the S & R room, and the patient hit his shoulder against the door jamb on the way into the room. Appellant testified he checked the patient for injuries and did not observe any.

The other staff members who were present supported appellant's version. PT Orlando Chandler testified that appellant called for help and that he, Patsy Hardy, and Registered Nurse Allen Gregory responded. (Winget testified that appellant had said that he did not need help.) All three of these witnesses testified that they saw no abuse and no injuries, except to the patient's shoulder. They testified that M. B. had been resistant and appellant's actions to restrain him were proper. They agreed that it took several people to restrain M. B. and that M. B. hit his shoulder as

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he resisted going into the S & R room. They did not hear appellant threaten the patient. Several witnesses testified that Winget's reputation for veracity was not good.

The following day M. B. complained of an assault. A physical examination revealed a raised area to the left side of his scalp, a superficial abrasion to his left shoulder, and redness on the right side of his neck and jaw.

The version of appellant and the three staff witnesses is accepted. Although the patient was in restraints, he was aggressively resistant and it took several staff members to restrain him. It is not surprising that in the struggle the patient suffered some superficial abrasions. The charges were not established.

V

Appellant testified that he had no recollection of the August 1992, incident in which it was alleged that he placed a sheet over a patient's head and pushed the patient's face into a mattress. He admitted that he has, on occasion, placed a sheet over a patient's head to prevent the patient from spitting, and asserted, without contradiction, that was an appropriate procedure. He denied the allegations of abuse.

PT Robert Plasencia, testified that in November 1992, he assisted appellant in placing a difficult patient, L. C., into restraints while on his back in bed. Plasencia testified that appellant placed a sheet over L. C.'s head and pushed his face into the mattress to an extent that the patient was choking. He did not believe the patient was spitting. Plasencia

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testified that appellant put both of his hands on the patient's face, and that appellant placed his knee in the patient's neck area, until the patient said that he gave up.

Plasencia did not report this incident, or the one described in paragraph VI, during an interview conducted on December 7, 1992. In fact, he denied that he had ever seen abusive behavior committed by staff members. During an interview conducted on March 31, 1993, Plasencia related the incidents described here and in paragraph VI. He explained the discrepancy by stating that at the time of the first interview he was naive, he was on probation and in his first year as a Pre-Licensed Psychiatric Technician, appellant was more experienced, and was his supervisor. He admitted that he failed to write a SIR or report the incident to a doctor.

No credible reason for Plasencia to have committed perjury was presented, and, in fact, his testimony was credible. Appellant used excessive force in subduing patient L. C.

VI

Appellant denied the allegation that in November 1992 he attempted to wake patient R. H. by tipping forward the chair in which the patient was sitting.

Plasencia testified that in November 1992, R. H. was seated in restraints in a chair in the day hall of Unit 78. He testified that appellant tilted the chair until the patient fell on his face. Plasencia testified that he helped the

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patient up, and observed that he was not injured. He admitted that he did not, but should have, reported the incident. (He testified that he did not report the incident for the reasons stated in paragraph V.)

Placencia's testimony was persuasive and is believed.

VII

It was alleged that on October 26, 1992, appellant pulled patient D. P. off his bed by his feet, shoved him out of the dormitory and physically attacked him, and then failed to summon sufficient staff to control the patient.

Appellant testified that the patient got off his bed by himself and cussed at and threatened appellant. Appellant headed to the office for assistance and tapped on the office window to indicate he needed help. At about this time the patient hit him, and PT Rebecca Wheat came to his assistance, as PT Leslie Monroe activated the panic button. Appellant testified that the patient hit him several times and that to avoid being injured he lowered his head and moved in on the patient. PT Leslie Bently grabbed the patient's feet and they got the patient to the floor. Appellant documented the incident in the patient's medical file and in a SIR.

Winget's recollection of the incident differed. She agreed that the patient got out of bed, but testified that appellant pushed him out the dormitory door, appellant grabbed D. P. from behind, that D. P. wiggled free, and swung at

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appellant, who swung back. Winget testified that appellant ran into D. P. with his head, and they fell to the floor, falling on her. She testified that her shoulder and neck were hurt. She did not make a report of patient abuse.

PT Wheat, Rehabilitation Therapist Beverly Monroe and Unit Supervisor Leslie Bently observed the incident. Wheat heard a commotion and observed appellant tap on the window. She saw the patient swing at appellant, and rain blows on appellant's head. She came to appellant's assistance. She saw Winget grab the patient's left hand, and testified Winget was on the scene for ten seconds. Wheat testified that Bently took the patient to the floor. Wheat did not observe any patient abuse. Bently's version and Monroe's were in agreement with Wheat's.

The testimony of appellant, Wheat, Monroe and Bently is accepted. Appellant summoned assistance as soon as he saw D.P.'s aggression. He appropriately defended himself.

VIII

Only Winget testified that appellant called a Therapeutic Community Meeting for Sunday, November 29, 1992, where he threatened patients. Other staff who would have attended such a meeting were not called to support her recollection. Appellant denied the allegation. The charge was not proven.

IX

Winget testified that on December 21, 1991, appellant confined her in the Unit Supervisor's office for a counseling session which lasted for 45 minutes to one and one-half hours.

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She testified that he threatened her with personal injury if she reported the matter. Winget testified that she was so upset she went to a doctor whose record would support her allegations.

Winget testified the counseling session occurred after the incident with patient M. B. (see paragraph IV.) That incident occurred in November 1992 and therefore that testimony had to be incorrect. The institution's investigator obtained access to the medical records which were supposed to support Winget's testimony. Those records did not confirm her allegations, nor did anyone whom the investigator contacted. The charge was not established.

X

Appellant's performance appraisals show that he has consistently met or exceeded standards. Comments contained in letters of recommendation praised his knowledge, competence, and dedication.

* * * * *

PURSUANT TO THE FOREGOING FINDINGS OF FACT THE ADMINISTRATIVE LAW JUDGE MAKES THE FOLLOWING DETERMINATION OF ISSUES:

The allegations that appellant placed a sheet over a patient, placed his knee on the patient's neck, and pushed the patient into a mattress causing him to choke, (paragraph V) and that he awakened a patient by tipping the patient's chair and causing the patient to fall (paragraph VI)

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were proven. These acts constituted violations of Government Code section 19572, subdivisions (d) inexcusable neglect of duty, and (m) discourteous treatment of the public.

The Board held in *Paul Edward Johnson* (1992) SPB Prec. Dec. No. 92-17 that the Administrative Law Judge's modification of a dismissal to a six-month suspension where a Psychiatric Technician struck a patient in the stomach would be rejected, and the dismissal upheld.

The Board held:

"Working at a center for developmentally disabled adults poses stressful challenges everyday to hospital workers, particularly those who must deal with sometimes hostile, uncooperative clients. The likelihood of such physical confrontations reoccurring [sic] is, unfortunately, high given these working conditions. While the appellant may normally be a very caring person as the ALJ found, the State cannot afford to gamble with the care and safety of those who cannot care for themselves. The harm to the public service from physical abuse is sufficiently grave to merit the imposition of the ultimate penalty of dismissal."

(*Id.* p. 10.)

In a recent holding concerning patient abuse the Board modified a dismissal to a 90 days suspension. (*Alejandro Nevarez* (1994) SPB Prec. Dec. No. 94-04.) The Board reiterated its decision in *Johnson* that, "Certainly intentional, blatant patient abuse is intolerable and warrants

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an employee's dismissal from state service in the first instance." (*Id.* p. 9.) The Board, determined, however, that Nevarez' actions constituted an error in judgment, and not intentional harm to the patient. (*Id.* p. 10.)

Plasencia's testimony, though credible, discussed incidents which occurred in August and November 1992. In regard to the placing of a sheet over a patient (paragraph V), Plasencia testified that he did not believe the patient was spitting. That testimony was not conclusive. It took two Psychiatric Technicians to restrain the patient and it is concluded that appellant used excessive force. Nevertheless, in light of the effort needed to restrain the patient, it is believed appellant's actions constituted an error of judgment rather than intentional harm to the patient.

Likewise, appellant's manner of attempting to wake a patient (paragraph VI) by tipping a chair is reminiscent of a childish prank, but is inexcusable conduct for a Psychiatric Technician.

The misconduct could have caused serious injury to the patients and was more severe than in Nevarez. Appellant must realize that such conduct, even though not malicious, is unacceptable, inappropriate and must not be repeated.

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A ten-month suspension should convey the message.⁴

* * * * *

WHEREFORE IT IS DETERMINED that the dismissal taken by respondent against Richard Muga effective July 1, 1993, is hereby modified to a 10 months suspension. Said matter is hereby referred to the Administrative Law Judge and shall be set for hearing on written request of either party in the event the parties are unable to agree as to the salary, if any, due appellant under the provisions of Government Code Section 19584.

* * * * *

I hereby certify that the foregoing constitutes my Proposed Decision in the above-entitled matter and I recommend its adoption by the State Personnel Board as its decision in the case.

DATED: May 31, 1994.

MELVIN R. SEGAL
Melvin R. Segal, Administrative Law
Judge, State Personnel Board.

⁴Appellant's motion to dismiss, based upon the decision in *California Correctional Peace Officers Association v. California State Personnel Board* (March 31, 1994) 94 D.A.R. 4398, is denied. That decision is not final. If it becomes final in its present form, appellant will have adequate opportunity to argue its applicability in a petition for rehearing or petition for writ of mandate.