STATE OF MICHIGAN

COURT OF APPEALS

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS, Petitioner-Appellee,	UNPUBLISHED November 28, 2017
v	No. 335816 LARA Bureau of Professional Licensing
BILLY CHEVALIER WEITHERSPOON, R.N., Respondent-Appellant.	LC No. 15-037370

Before: O'CONNELL, P.J., and MURPHY and K. F. KELLY, JJ.

PER CURIAM.

Petitioner, Department of Licensing and Regulatory Affairs (LARA), filed an administrative complaint against respondent Billy Chevalier Weitherspoon, R.N., alleging a violation of MCL 333.16221(a) (negligence or failure to exercise due care) and MCL 333.16221(b)(*i*) (incompetence) that arose out of respondent's actions as a nurse in physically restraining a patient in the mental-health wing of a hospital. After an evidentiary hearing, a hearings examiner (HE) found that LARA had failed to establish the alleged violations by a preponderance of the evidence. The HE recommended that his proposed findings of fact and conclusions of law be adopted by the Board of Nursing Disciplinary Subcommittee (the subcommittee). The subcommittee, however, rejected the HE's proposed factual findings and legal conclusions, in their entirety, ruling instead that respondent violated MCL 333.16221(a) and (b)(*i*), as primarily evidenced by a surveillance video. The subcommittee then issued a final order, placing respondent on probation "for two years, not to exceed five years," subject to numerous probationary terms, and fining him $250. Respondent appeals the subcommittee's ruling as of right. See MCL 333.16237(6) ("A final decision of a disciplinary subcommittee rendered on or after January 1, 1995[,] may be appealed only to the court of appeals[,]" and the "appeal . . . is by right."); MCR 7.203(A)(2). Despite some errors, we hold that the subcommittee's findings were sufficiently supported by competent, material, and substantial evidence on the whole record and that its decision was authorized by law, Const 1963, art 6, § 28, such that reversal is unwarranted. Accordingly, we affirm.

I. BACKGROUND

In November 2014, LARA, by and through the Director of the Bureau of Health Care Services, filed the administrative complaint against respondent. LARA alleged that respondent was currently licensed to practice as a registered nurse and that at the time of the incident, he was employed as a registered nurse at St. Mary Mercy Hospital (the hospital). It was alleged in the complaint that on March 3, 2014, at 4:00 a.m., respondent "grabbed a patient by the neck in [a] headlock, wrestled him to the ground, and left him on the floor." (Quotation marks and ellipsis omitted.) The complaint contained two counts premised on this alleged misconduct, one asserting a violation of MCL 333.16221(a) and the second claiming a violation of MCL 333.16221(b)(*i*).

In respondent's answer to the administrative complaint, he presented the following defense:

> Respondent and fellow nurses were physically and verbally assaulted by the patient in question, including threats of unlawful force against [respondent]. The patient had serious mental health issues and came from a "high risk" population from an infectious disease standpoint. The patient in question spit on [respondent] and saliva from the patient landed on [respondent's] mouth and eyes. [Respondent] had an honest and reasonable belief that the patient would continue his threatening and assaultive conduct giving [respondent] a legitimate fear that he, or another nurse or patient in the ward would be subjected to great bodily harm. [Respondent] used the minimum force necessary to gain the patient's compliance and immediately called another aid and security to assist with the situation. . . . .

A hearing on the complaint was conducted over two days before two different HEs. LARA called to testify a recipient rights advisor, the hospital's director of security, an LPN who was working with respondent at the time of the incident and was an eyewitness, a department coordinator for the hospital, a registered nurse who testified as an expert, and respondent himself. Respondent also testified as part of his own defense, and he called another registered nurse to the stand. The evidence additionally included a video of the incident, which captured an image approximately once every three seconds; it was not a continuous-motion video. Also admitted into evidence was a crisis prevention intervention (CPI) training manual. In a 65-page proposal for decision, the HE who conducted the second day of the hearing set forth the case's procedural history, a summarization of the testimony, credibility assessments, recommended findings of fact and conclusions of law, and a proposed decision.

With respect to the alleged violation of MCL 333.16221(a), the HE ruled that LARA had not proven by a preponderance of the evidence that respondent specifically grabbed the patient

by the neck in a headlock, wrestled him to the ground, and left him on the floor; therefore, respondent could not be found in violation of MCL 333.16221(a).[1] However, the HE then stated:

> To the extent that the . . . [s]ubcommittee finds it appropriate to consider facts and law that are outside the scope of the matters pled in the . . . [c]omplaint, the evidence supports a conclusion that [r]espondent failed to follow the CPI training by 1) failing to disengage with the patient at the moment he realized that he did not have assistance to physically manage the patient, and 2) failing to properly perform the CPI Interim Control Position in a manner consistent with the CPI manual. . . . .
>
> Four witnesses trained to use CPI in their jobs testified that physical intervention was not called for, that further verbal de-escalation should have occurred, and that [r]espondent should have called for help rather than physically managing the patient on his own. These are judgments made in hindsight by individuals who did not witness the incident . . . and one eyewitness[, the LPN,] whose credibility has been effectively impeached . . . . Only one witness is a registered nurse. All of the witnesses are trained in CPI, which is the standard of care in this case. [Respondent] is the only person who truly knows what happened. His testimony regarding his thought processes and the split-second decisions he made is found to be credible. His motivation was to ensure the safety of himself, other staff and other patients by bringing the patient under control. He did not intend to put the patient on the floor. However, the failure to disengage and the failure to properly implement the CPI Interim Control Position each constitute a breach of a general duty consisting of "failure to exercise due care" within the meaning of MCL 333.16221(a).
>
> When considering the appropriate sanction, it is relevant to consider the mitigating circumstances discussed in this Report. Specifically, [r]espondent's initial intent when he came around the nurse's station was not to approach the patient alone (he called for assistance from [the LPN]) and it was only after the patient spit in his face that he attempted to implement a CPI Interim Control Position that is depicted in the CPI manual. These issues could likely be solved by supplemental training in CPI.

[1] The HE found that the video images, due to the momentary breaks in the flow of events, did not show respondent placing the patient in a headlock when both men were standing face to face, nor did it show respondent wrestling the patient down to the ground. The HE also determined that the testimony did not establish either of those two acts. Respondent had testified that when he moved to grab the patient, in response to threats and being spit at in the face, he and the patient fumbled around and unintentionally tumbled to the ground. Respondent denied ever placing the patient in a headlock. The HE also found that it was an inaccurate characterization to say that respondent simply "left [the patient] on the floor," where respondent merely backed away when the patient stopped struggling with respondent and became motionless.

With respect to the alleged violation of MCL 333.16221(b)(*i*), the HE ruled that LARA had not proven by a preponderance of the evidence that respondent specifically grabbed the patient by the neck in a headlock, wrestled him to the ground, and left him on the floor; therefore, respondent could not be found in violation of MCL 333.16221(b)(*i*). The HE also found as follows:

> Furthermore, none of the testimony or evidence proves that [r]espondent is unable to perform his job. To the contrary, notwithstanding the bad result of his effort to physically manage [the] patient, the evidence supports a conclusion that he is a competent, experienced registered nurse who was promoted to Clinical Leader in July of 2013, eight months before the incident . . . . He has never before been subject to professional discipline.

The HE concluded by stating that "[b]ased upon the findings of fact above, and the conclusions of law, it is recommended that the [subcommittee] adopt the findings of fact and conclusions of law above and issue sanctions against [r]espondent's license." Effectively, the HE determined that while there was insufficient evidence establishing that respondent placed the patient in a headlock, intentionally wrestled him to the ground, and left the patient on the floor, as specifically alleged in the complaint, which is why the complaint failed, respondent's conduct, going outside the four corners of the complaint, was nonetheless improper and justified sanctions.

Both parties filed exceptions to the HE's recommendations. The subcommittee subsequently issued its findings of fact and conclusions of law, ruling in full as follows:

> The . . . [s]ubcommittee rejects the [HE's] Findings of Fact and Conclusions of Law in the Proposal for Decision . . . .
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> The . . . [s]ubcommittee having viewed the surveillance video (Exhibit 1) finds that [r]espondent, in response to being approached by [the] patient . . ., who was agitated at the time, grabbed [the] patient . . . by the neck in a headlock, wrestled him to the ground, and left him on the floor, rather than de-escalating or disengaging from the situation.
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> * * *
>
> The . . . [s]ubcommittee rejects the [HE's] conclusion that [r]espondent's conduct did not violate sections 16221(a), for the conduct alleged in the . . . [complaint], and 16221(b)(*i*) . . . .
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> The . . . [s]ubcommittee concludes that when [r]espondent, in response to being approached by [the] patient, who was agitated at the time, grabbed [the] patient . . . by the neck in a headlock, wrestled him to the ground, and left him on the floor, rather than de-escalating or disengaging from the situation, [r]espondent was both negligent and incompetent, violating sections 16221(a) and 16221(b)(*i*) of the Public Health Code . . . .

> Respondent made no attempt to de-escalate the situation, and, instead, he approached and physically managed the patient on his own, which he admits is contrary to his training and "can be harmful to the patient and it can be harmful to the staff." . . . The Bureau's expert . . . credibly testified that the standard of care in dealing with a problem patient required de-escalation, physical management is used only as a last resort, and physical management is done only using safe techniques. . . . In [the] . . . expert['s] opinion, based on all the evidence, [r]espondent failed to meet the minimum standard of care and failed to exercise due care during the incident with [the] patient . . . .
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> * * *
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> Based on the above, the . . . [s]ubcommittee concludes that [r]espondent's conduct in this matter constitutes violations under section 16221(a) and 16221(b)(*i*) . . . as alleged in the . . . [complaint].

The subcommittee then issued a final order, placing respondent on probation "for two years, not to exceed five years," subject to numerous probationary terms, and fining him $250.

II. ANALYSIS

A. STANDARDS OF REVIEW

On appeal, respondent argues that the subcommittee's findings of fact and conclusions of law were not supported by competent, material, and substantial evidence on the whole record. Respondent additionally contends that he did not receive a fair hearing because he was denied his constitutional right to confront the patient. Rulings by disciplinary subcommittees are reviewed on appeal solely under Const 1963, art 6, § 28. *Dep't of Community Health v Anderson*, 299 Mich App 591, 597; 830 NW2d 814 (2013); *Dep't of Community Health v Risch*, 274 Mich App 365, 371; 733 NW2d 403 (2007). Const 1963, art 6, § 28, provides:

> All final decisions, findings, rulings and orders of any administrative officer or agency existing under the constitution or by law, which are judicial or quasi-judicial and affect private rights or licenses, shall be subject to direct review by the courts as provided by law. This review shall include, as a minimum, the determination whether such final decisions, findings, rulings and orders are authorized by law; and, in cases in which a hearing is required, whether the same are supported by competent, material and substantial evidence on the whole record.

A court must review the entire record, not just the portions that support an agency's findings, when assessing whether the agency's decision was supported by competent, material, and substantial evidence on the whole record. *Risch*, 274 Mich App at 372. "Substantial evidence" means evidence that a reasonable person would find acceptably sufficient to support a conclusion. *Id.* This may be substantially less than a preponderance of evidence, but does require more than a scintilla of evidence. *Id.* The *Risch* panel further observed:

> Moreover, if the administrative findings of fact and conclusions of law are based primarily on credibility determinations, such findings generally will not be disturbed because it is not the function of a reviewing court to assess witness credibility or resolve conflicts in the evidence. A reviewing court may not set aside factual findings supported by the evidence merely because alternative findings could also have been supported by evidence on the record or because the court might have reached a different result. [*Id.* at 372-373 (citations omitted).]

"Under th[e] test, it does not matter that the contrary position is supported by more evidence, that is, which way the evidence preponderates, but only whether the position adopted by the agency is supported by evidence from which legitimate and supportable inferences were drawn." *McBride v Pontiac Sch Dist (On Remand)*, 218 Mich App 113, 123; 553 NW2d 646 (1996). "[A]n appellate court must generally defer to an agency's administrative expertise." *Anderson*, 299 Mich App at 598.

For purposes of Const 1963, art 6, § 28, a decision is not "authorized by law" when it is in violation of a statute or a constitutional provision, in excess of an agency's statutory authority or jurisdiction, made upon unlawful procedure that results in material prejudice, or when it is arbitrary and capricious. *Northwestern Nat'l Cas Co v Comm'r of Ins*, 231 Mich App 483, 488-489; 586 NW2d 563 (1998).

With respect to respondent's Confrontation Clause argument, it presents a question of constitutional law that we review de novo. *People v Nunley*, 491 Mich 686, 696-697; 821 NW2d 642 (2012).

B. GOVERNING LAW

LARA filed the administrative complaint against respondent on the basis of the following provisions in MCL 333.16221:

> The department may investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The department may hold hearings, administer oaths, and order the taking of relevant testimony and shall report its findings to the appropriate disciplinary subcommittee. The disciplinary subcommittee shall proceed under section 16226 if it finds that 1 or more of the following grounds exist:
>
> (a) A violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition that impairs, or may impair, the ability to safely and skillfully practice the health profession.
>
> (b) Personal disqualifications, consisting of 1 or more of the following:
>
> (*i*) Incompetence.

"Incompetence" is statutorily defined as "a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, whether or not actual injury to an individual occurs." MCL 333.16106(1).

MCL 333.16231 authorizes the issuance of a complaint against a licensee for an alleged violation of MCL 333.16221. And MCL 333.16231a provides for a hearing on the complaint before an HE. At the hearing, the licensee "may be represented . . . by legal counsel," and LARA "shall be represented . . . by an assistant attorney general[.]" MCL 333.16231a(4). The HE "shall determine if there are grounds for disciplinary action under section 16221 . . . ." MCL 333.16231a(2). The HE must "prepare recommended findings of fact and conclusions of law for transmittal to the appropriate disciplinary subcommittee." *Id.* "In imposing a penalty . . ., a disciplinary subcommittee shall review the recommended findings of fact and conclusions of law of the hearings examiner." MCL 333.16237(1). Under MCL 333.16237(3), "[i]n reviewing the recommended findings of fact and conclusions of law of the hearings examiner and the record of the hearing, a disciplinary subcommittee may request the hearings examiner to take additional testimony or evidence on a specific issue or may revise the recommended findings of fact and conclusions of law as determined necessary by the disciplinary subcommittee, or both." A disciplinary subcommittee is not permitted to conduct its own investigation or to take its own additional testimony or evidence. *Id.* MCL 333.16237(4) provides:

> If a disciplinary subcommittee finds that a preponderance of the evidence supports the recommended findings of fact and conclusions of law of the hearings examiner indicating that grounds exist for disciplinary action, the disciplinary subcommittee shall impose an appropriate sanction . . . . If the disciplinary subcommittee finds that a preponderance of the evidence does not support the findings of fact and conclusions of law of the hearings examiner indicating that grounds exist for disciplinary action, the disciplinary subcommittee shall dismiss the complaint. A disciplinary subcommittee shall report final action taken by it in writing to the appropriate board or task force.

When a disciplinary subcommittee finds the existence of one or more of the grounds set forth in MCL 333.16221, the subcommittee is authorized under MCL 333.16226 to impose various sanctions against the licensee. And MCL 333.16226(2) provides:

> Determination of sanctions for violations under this section shall be made by a disciplinary subcommittee. If, during judicial review, the court of appeals determines that a final decision or order of a disciplinary subcommittee prejudices substantial rights of the petitioner for 1 or more of the grounds listed in section 106 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.306, and holds that the final decision or order is unlawful and is to be set aside, the court shall state on the record the reasons for the holding and may remand the case to the disciplinary subcommittee for further consideration.

C. DISCUSSION AND HOLDING

We hold that, despite some errors, the record reflects that the subcommittee's findings and rulings were sufficiently supported by competent, material, and substantial evidence on the whole record and that its decision was authorized by law, such that reversal is unwarranted. In the video, the patient is seen standing at the nurse's station, with at least one hand, and perhaps both hands, resting on the counter; respondent is standing near the other end of the nurse's station. We cannot tell from the video whether, at that point, the patient spit at respondent, nor can we discern, given the video's lack of audio, whether the patient was voicing threats. Respondent claimed that just before the video started rolling, the patient had made physical threats against staff members, pounded his fist on the counter, and spit at respondent, missing him when respondent jumped back. There does not appear to be anyone directly near or within the potential grasp of the patient, nor does the patient appear to be physically readying himself to lunge at anyone. The video depicts respondent moving from his position across the nurse's station to a face-to-face stance next to the patient. Respondent claimed that he approached the patient in response to the verbal threats and because the patient had spit at respondent, which act respondent viewed as a physical assault; there was testimony by LARA's witnesses that spitting at others constituted a "strike" that might require forced placement of a spit mask on the offending patient.[2] The patient continues to have at least one hand resting on the counter, and he does not move his arms or legs upon respondent moving toward and positioning himself directly adjacent to the patient. Respondent testified that when he began walking toward the patient, he called for the LPN to assist him in dealing with the patient; however, she failed to provide any help, and respondent continued on his own. The LPN testified that respondent did not ask for her assistance at that time. At this point, the LPN is yet to be seen in the video. Respondent stated that the patient's shouting created a problematic situation in the environment of the mental-health unit, where it could potentially result in agitating and upsetting other patients. Respondent informed the patient that the patient would not be allowed to take control of the mental-health wing.

We cannot tell from the video, at the stage that respondent and the patient were standing right next to each other, whether the patient spit at respondent and struck him with saliva in the face, as claimed by respondent, or whether the patient was speaking in a threatening manner, as claimed by respondent. The video certainly does not rule out those possibilities. The LPN

[2] The LPN, who was also in the area of the nurse's station but somewhat away from respondent and the patient when the incident occurred, testified that the patient had come up to the station demanding food several times that night, pounding his fist on the counter, that he was told that nothing was available, that he told the LPN and another employee that they would be sorry for not giving him food, which she did not perceive to be truly threatening, and that each time the patient eventually walked away. The LPN indicated that the same scenario was playing out once again that night, but this time respondent was present at the nurse's station and the physical altercation then transpired. The LPN testified that she did not see the patient spit at respondent, nor did she hear the patient make threats to respondent, when the two men were at different ends of the nurse's station.

testified that she did not see the patient spit at respondent or hear the patient threaten respondent when the two men were face to face. Shortly after respondent moved into close proximity to the patient, respondent's right hand can be seen, albeit very briefly, reaching under the patient's left armpit from the front, with respondent's left hand possibly reaching for the patient's left armpit from behind. It appears that respondent was attempting to lock up the patient's left arm or shoulder area. The next frame of the video cuts to respondent and the patient rolling and wrestling on the floor, so it cannot be determined from the video whether respondent had placed the patient in an actual headlock while both men were standing, nor can it be positively discerned whether respondent wrestled the patient to the floor. As mentioned earlier in this opinion, respondent testified that he grabbed the patient in an attempt to gain control of him. Respondent asserted that he was trying to lock up the patient's arm for purposes of placing him in a CPI-acceptable "interim control position." Respondent denied putting the patient in a headlock, or even attempting to do so, and he testified that the ensuing struggle resulted in the men falling to the floor, absent an intent by respondent to pull the patient to the floor. The LPN testified that she believed the patient was backing down and had frozen when respondent stood toe-to-toe with the patient. According to the LPN, respondent angrily told the patient that the patient "was no longer dealing with the women."[3]

The LPN is seen in the video for the first time when respondent and the patient are wrestling on the floor; she watches for a moment and then walks away. The LPN testified that she went for assistance on respondent's request, which, according to her, was the first point during the incident in which respondent asked her for help.[4] With respect to respondent's actions upon squaring off with the patient, the LPN testified that respondent "grabbed the patient and then they both went down to the floor." She later explained that respondent "grabbed him so quick and put him down [on] the floor[.]"

In the video, respondent does appear to employ a headlock on the patient when the two men are wrestling on the floor. Respondent testified, however, that the patient was using an arm and hand to clasp one of respondent's arms, making it appear that respondent was using a headlock, which was not the case. The video does not rule out that possibility. As depicted in the video, the patient is finally subdued by respondent and is seen motionless on the floor, at which time respondent stands up and watches the patient lying motionless. As further revealed in the video, assistance soon arrives, and the patient remains motionless on the floor, but he subsequently stands up and bolts down the hall, where he is quickly subdued by respondent and others in a manner that is not in question in this case.

[3] Respondent testified about two earlier events that night in which the patient allegedly touched a female patient in an inappropriate manner, massaging her stomach and inner thigh, before being stopped by respondent.

[4] The LPN opined that respondent's actions in physically restraining the patient were not necessary or appropriate and that the patient was not a physical threat. The HE did not find her to be a credible witness.

In its written ruling, the subcommittee mentioned twice that respondent was approached by the patient; however, as established by the video and the testimony, it was respondent who approached the patient, which the subcommittee acknowledged later in its ruling.[5] Next, the subcommittee found that, when the two men were standing next to each other, respondent grabbed the patient by the neck in a headlock. There is no evidence whatsoever that respondent grabbed the patient by the neck and placed him in a headlock at that point in the confrontation. The video and testimony do not support even an inference of such an act by respondent. We are troubled by the subcommittee's apparent ignorance of the record on this point. That said, the video does provide adequate evidence that respondent used a headlock on the patient when they were wrestling on the ground, notwithstanding respondent's testimony to the contrary, and there was evidence that employing a headlock on a patient violated CPI techniques and protocol and the standard of care, given the danger of positional asphyxiation. The subcommittee then found that respondent "wrestled [the patient] to the ground." Because there was evidence showing that respondent initiated the physical struggle by grabbing the patient, that the men ended up on the ground, and that, according to the LPN, the patient essentially froze and respondent "put him down [on] the floor," one could reasonably infer and find that respondent wrestled the patient to the ground. We cannot conclude that this finding by the subcommittee was unsupported by competent, material, and substantial evidence on the whole record. Also, there was sufficient evidence supporting the subcommittee's finding that respondent "left [the patient] on the floor," although it was of fairly short duration.

The subcommittee additionally found that respondent physically managed the patient on his own without assistance and failed to attempt to verbally deescalate or disengage from the situation, contrary to the applicable standards of care. We hold that there was competent, material, and substantial evidence supporting these conclusions. It is beyond dispute that respondent physically managed the patient absent assistance, and the evidence showed that respondent had an opportunity to engage in verbal de-escalation, but failed to do so. The evidence revealed that CPI techniques and the standards of care require staff, if at all possible under the circumstances, to attempt to verbally deescalate a situation in which a patient is acting inappropriately and to obtain assistance from a second person when physical management of a patient becomes absolutely necessary. There was testimony that physical management of a patient is a step of last resort. Assuming that, initially, the patient was speaking in a threatening manner and spit at respondent, missing him, as claimed by respondent, there was adequate distance, at that point, between the patient and respondent or others, such that respondent, instead of charging up to the patient, could have attempted to verbally deescalate the situation.[6] One of LARA's witnesses, a registered nurse recognized as an expert in behavioral health, testified that respondent improperly invaded the patient's space in a confrontational manner that was not justified under the circumstances. She testified as follows:

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[5] Perhaps the subcommittee was alluding to the patient approaching the nurse's station. The video does not show the patient directly approaching respondent at the nurse's station.

[6] Respondent conceded that he did not attempt verbal de-escalation, believing the circumstances to be such that talking was no longer a viable option and that physical management was necessary.

Q. Is there any set of facts under which what [respondent] did was appropriate?

A. No. The coming out from behind the desk invading the patient, going toe-to-toe and grabbing him and taking him down, no. The patient at that time was not trying to physically harm anybody else. He was not physically harming himself and he was not destroying property.

Q. Based on the testimony and evidence presented, who appears to be the aggressor in this case?

A. [Respondent] does.

Moreover, when respondent moved toward the patient and, assuming the truthfulness of respondent's testimony, the LPN did not step forward to provide assistance as requested, respondent had the opportunity to retreat, but chose to proceed in a confrontational manner on his own, leading to the physical altercation. And even if the patient spit in respondent's face when the two stood next to each other, respondent, given the evidence that the patient was not moving in any meaningful manner and essentially froze in place, could have backed away and waited for assistance from other hospital personnel, consistent with CPI training and the standards of care, instead of grabbing the patient.

Although alternative findings might also have been supported by the evidence, and regardless of whether this panel may have reached a different result, there was sufficient evidence in support of the subcommittee's findings and conclusions on these matters. See *Risch*, 274 Mich App at 372-373. Considering the evidence that respondent employed a headlock, that he failed to attempt verbal de-escalation despite having an opportunity to do so, that respondent physically managed the patient when it was not absolutely necessary, and that the physical management occurred absent assistance, even though respondent had the chance to await help, there was adequate evidence that respondent failed to exercise due care, MCL 333.16221(a), and that he acted incompetently, MCL 333.16221(b)(*i*), i.e., that he departed from, or failed to conform to, "minimal standards of acceptable and prevailing practice for a health profession," MCL 333.16106(1) (defining "incompetence"). Accordingly, the subcommittee's ruling was authorized by law. See Const 1963, art 6, § 28.

The HE's recommendations were based on a very narrow construction of the administrative complaint, focusing on the specific physical acts alleged in the complaint and their sequence, with the HE indicating that respondent's conduct was improper only if one looked beyond the scope of the allegations in the complaint. The HE was correct in his determination that respondent did not initially place the patient in a headlock, but there was evidence, contrary to the HE's findings, that respondent wrestled the patient to the ground and then left him on the floor. We cannot conclude that the complaint failed simply because there was no evidence that respondent utilized a headlock when he and the patient were standing together. There was evidence that a headlock was later used by respondent. Additionally, viewed a bit more broadly yet still accurately, the complaint alleged that respondent engaged in a

physical altercation with the patient, violating MCL 333.16221(a) and (b)(*i*). And the evidence adequately supported these allegations. Reversal is unwarranted.

Respondent, focusing on the LPN's testimony that the HE found was not credible, argues that the subcommittee was required to defer to the HE's credibility assessments. The caselaw cited by respondent, however, stands for the proposition that *this Court* defers to an agency's determinations regarding the credibility of witnesses. See, e.g., *Butcher v Dep't of Natural Resources*, 158 Mich App 704, 707; 405 NW2d 149 (1987). Regardless, as reflected in our analysis above, the subcommittee's findings of fact and conclusions of law sufficiently supported its ruling, even giving respondent the benefit of an assumption that his version of the events was true and not the LPN's account.

Finally, respondent contends that he did not receive a fair hearing because he was denied his constitutional right to confront the patient.[7] "Rudimentary due process demands that the defending party in an administrative proceeding be given a fair opportunity to confront and cross-examine adverse witnesses." *Sponick v Detroit Police Dep't*, 49 Mich App 162, 192; 211 NW2d 674 (1973). Assuming this legal proposition to be true in the context of this case, the fact is that no evidence was admitted regarding the patient's version of what transpired; LARA presented its case through the video, the CPI training manual, and witnesses other than the patient. The HE denied LARA's attempt to admit into evidence an investigative report that evidently included a statement by the patient. Respondent does not provide any citations to the record wherein a statement by the patient was successfully introduced against respondent. The patient was simply not an adverse witness. Moreover, assuming error, it was harmless, as respondent fails to show any resulting prejudice. See *People v Shepherd*, 472 Mich 343, 348; 697 NW2d 144 (2005). Reversal is unwarranted.

Affirmed.

/s/ Peter D. O'Connell
/s/ William B. Murphy
/s/ Kirsten Frank Kelly

[7] The HE ruled that respondent had failed to preserve the confrontation issue, given that it was not included in his written closing argument, even though respondent had raised the matter during the hearing. The HE also found that the argument lacked substantive merit.