

Issue: Group III Written Notice with 30-day suspension (less than alert while on duty); Hearing Date: 08/08/02; Decision Date: 08/12/02; Agency: Department of Mental Health, Mental Retardation and Substance Abuse Services; AHO: David J. Latham, Esq.; Case No.: 5474



COMMONWEALTH of VIRGINIA
Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 5474

Hearing Date: August 8, 2002
Decision Issued: August 12, 2002

PROCEDURAL ISSUE

Although the hearing was initially docketed within 30 days of appointment of the hearing officer, unavailability of representatives resulted in two postponements. Therefore, the hearing was conducted on the 51st day following appointment.¹

APPEARANCES

Grievant
Attorney for Grievant
Human Resource Manager
Legal Assistant Advocate for Agency

¹ § 5.1 of the *Grievance Procedure Manual* requires that a grievance hearing must be held and a written decision issued within 30 calendar days of the hearing officer's appointment unless just cause is shown to extend the time limit.

Three witnesses for Agency

ISSUES

Did the grievant's actions on March 5, 2002 warrant disciplinary action under the Commonwealth of Virginia Standards of Conduct? If so, what was the appropriate level of disciplinary action for the conduct at issue?

FINDINGS OF FACT

The grievant filed a timely appeal from a Group III Written Notice and a 30-day suspension issued because she was less than alert while on duty.² Following failure to resolve the grievance at the third resolution step, the agency head qualified the grievance for a hearing.³

The Department of Mental Health, Mental Retardation and Substance Abuse Services (MHMRSAS) (Hereinafter referred to as "agency") has employed the grievant for two years. She is a Forensic Mental Health Technician (MHT). The patients at this facility are mentally retarded, physically handicapped, mentally ill or some combination of these conditions.

Section 201-1 of MHMRSAS Departmental Instruction 201 on Reporting and Investigation Abuse and Neglect of Clients states, in pertinent part: "The Department has zero tolerance for acts of abuse or neglect." Neglect is defined as:

Neglect means failure by an individual, program or facility responsible for providing services to provide nourishment, treatment, care, goods or services necessary to the health, safety or welfare of a person receiving care or treatment for mental illness, mental retardation or substance abuse.⁴

The policy further states that "It is expected that a facility director will terminate an employee found to have abused or neglected a client."⁵

In January 2002, another supervisor advised grievant's supervisor that she had found the grievant asleep while on duty. She was able to awaken

² Exhibit 1. Written Notice, issued May 9, 2002. NOTE: The agency acknowledged during the hearing that a notation on the Written Notice regarding an active Group I Notice (Section IV) is erroneous. Grievant does not have an active discipline but had been counseled in January 2002. (See paragraph immediately above this footnote for detail)

³ Exhibit 1. Grievance Form A, filed May 10, 2002.

⁴ Exhibit 7. Section 201-3, Departmental Instruction 201(RTS)00, *Reporting and Investigating Abuse and Neglect of Clients*, April 17, 2000.

⁵ Exhibit 7. Section 201-8, *Ibid*.

grievant only after calling her four times. The supervisor spoke to grievant about remaining alert and awake because she was monitoring patients. Grievant's reaction was that she did not appreciate what the supervisor said. Grievant added that, "Everyone sleeps here in this building." The supervisor documented this incident by memorandum to grievant's supervisor and noted that grievant had been found asleep on other occasions.⁶ Grievant's supervisor subsequently verbally counseled grievant.

The agency recognizes that monitoring patients one-on-one can be tedious, particularly on the night shift. For that reason, staff assigned to one-on-one generally work no more than two continuous hours while on night shift in order to assure maximum safety and alertness.⁷ Grievant's supervisor frequently stresses the need to stay alert whenever staff is on a one-on-one assignment. In addition, staff is advised that they can deal with sleepiness by standing up, exercising, and if necessary, by asking the charge nurse for a temporary relief until they regain alertness.

Grievant was assigned to watch a patient one-on-one during a portion of the night shift (11:30 p.m. – 7:30 a.m.) on March 5-6, 2002. This patient is well known by staff to be aggressive and one who would utilize any opportunity to self-mutilate. He must be watched constantly because he will grab anything with a sharp or even rough edge to cut himself. Patients are housed in single rooms on either side of a hallway in the forensic ward. During the night shift, those assigned to night shift set a chair in the hallway just outside patient rooms where they observe the patient. Security cameras monitor the hall but do not monitor the inside of patient rooms. Because the rooms are dark (except for light from the hall), staff feel more secure sitting in the hall. Sitting in the hall is permissible providing the employee can see the patient from where they sit. Grievant had placed her chair in the doorway, half in the room and half in the hall. She sat facing into the room; the patient was lying in his bed on the left side of the room with his head closest to the hall wall.

The Department of Juvenile Justice provides security at the facility. At about 3:50 a.m., a corrections lieutenant entered the ward and walked down grievant's hall, approaching from grievant's left side. She observed grievant sitting in her chair, with her right shoulder and head leaning against the right doorjamb. Grievant's head was turned partially to her left in order to be facing the patient and grievant's eyes were closed. As the lieutenant approached, another staff person further down the hall said something to grievant but the grievant did not respond. When she again said something, grievant sat up straight. As the lieutenant walked past grievant, the lieutenant said hello but

⁶ Exhibit 4. Memorandum from another supervisor to grievant's supervisor, January 29, 2002.

⁷ Exhibit 6. Facility Policy P-5, *1:1 Staff Assignments*, February 17, 2000.

grievant did not respond. This encounter was recorded on the videotape surveillance camera.⁸ The lieutenant reported grievant for being less than alert.

Grievant did not see the lieutenant walk down the hall past her. Further grievant did not hear the lieutenant speak to her. Grievant recalls seeing only one person in uniform – a maintenance technician who came into the area to check thermostat settings. The maintenance technician is a white male about 5'6" tall. The lieutenant is a black female, is 4'11" tall, and wears her hair close-cropped, combed in a male style. Her physique is sufficiently female that a casual observer would not mistake her for a male. The lieutenant did not know who grievant was and had not had any prior interaction with grievant prior to March 5, 2002.

On this night, the lieutenant reported five employees including grievant who were either sleeping or less than alert. The agency investigated all five cases. Following investigation, the cases were referred to the central office for evaluation. Following some additional investigation, the central office concluded that the allegations were founded. The facility director waited until all five investigations had been completed before deciding upon discipline in order to assure that discipline was consistent and appropriate for each employee. Three of those found to be sleeping or less than alert, including grievant, are classified employees. Each of the three was given a Group III Written Notice and suspended from work for a period of time.⁹ The remaining two employees were temporary employees; both were discharged from employment.

APPLICABLE LAW AND OPINION

The General Assembly enacted the Virginia Personnel Act, Va. Code § 2.2-2900 et seq., establishing the procedures and policies applicable to employment within the Commonwealth. This comprehensive legislation includes procedures for hiring, promoting, compensating, discharging and training state employees. It also provides for a grievance procedure. The Act balances the need for orderly administration of state employment and personnel practices with the preservation of the employee's ability to protect his rights and to pursue legitimate grievances. These dual goals reflect a valid governmental interest in and responsibility to its employees and workplace. Murray v. Stokes, 237 Va. 653, 656 (1989).

⁸ The camera is at the end of a long hallway and the view of grievant's chair at the other end is very small. The date/time stamp on the videotape almost totally obscures even this small view of grievant. The resolution of the videotape is insufficient to identify details in the distance. Therefore, the videotape was of minimal value in assessing this incident.

⁹ One of the three served a smaller suspension because of extenuating circumstances. That employee had 16 years of service and an otherwise unblemished record. Further, he was taking medications that made him drowsy (and had reported this to his supervisor prior to March 5, 2002). He also demonstrated significant remorse for what had happened.

Code § 2.2-3000 sets forth the Commonwealth's grievance procedure and provides, in pertinent part:

It shall be the policy of the Commonwealth, as an employer, to encourage the resolution of employee problems and complaints . . . To the extent that such concerns cannot be resolved informally, the grievance procedure shall afford an immediate and fair method for the resolution of employment disputes which may arise between state agencies and those employees who have access to the procedure under § 2.2-3001.

In disciplinary actions, the agency must show by a preponderance of evidence that the disciplinary action was warranted and appropriate under the circumstances.¹⁰

To establish procedures on Standards of Conduct and Performance for employees of the Commonwealth of Virginia and pursuant to § 2.2-1201 of the Code of Virginia, the Department of Personnel and Training¹¹ promulgated Standards of Conduct Policy No. 1.60 effective September 16, 1993. The Standards of Conduct provide a set of rules governing the professional and personal conduct and acceptable standards for work performance of employees. The Standards serve to establish a fair and objective process for correcting or treating unacceptable conduct or work performance, to distinguish between less serious and more serious actions of misconduct and to provide appropriate corrective action. Section V.B.3 of the Commonwealth of Virginia's *Department of Personnel and Training Manual* Standards of Conduct Policy No. 1.60 provides that Group III offenses include acts and behavior of such a serious nature that a first occurrence normally should warrant removal [from employment].¹² One example of a Group III offense is sleeping during work hours.

The Standards of Conduct provides examples of the acts and behavior that constitute each level of offense. However, as the Standards further note:

The offenses set forth below are not all-inclusive, but are intended as examples of unacceptable behavior for which specific disciplinary actions may be warranted. Accordingly, any offense which, in the judgement of agency heads, undermines the effectiveness of agencies' activities may be considered unacceptable and treated in a manner consistent with the provisions of this section.¹³

¹⁰ § 5.8 Department of Employment Dispute Resolution *Grievance Procedure Manual*, effective July 1, 2001.

¹¹ Now known as the Department of Human Resource Management (DHRM).

¹² Exhibit 8. DHRM Policy No. 1.60, *Standards of Conduct*, September 16, 1993.

¹³ Exhibit 8. Section V.A, *Ibid*.

There can be no doubt that sleeping on the job is a serious offense and is appropriately categorized a Group III offense. In the case of health care technicians assigned to provide close one-on-one care of mentally ill patients, sleeping on the job is extremely serious because it involves the potential for injury or death of a patient. When a mental health technician is less than alert, the potential for injury or death of the patient increases. One can argue that sleeping involves snoring, or an inability to be aroused, or that some other criterion should be used. Similarly, one can debate various criteria for assessing whether an employee is "less than alert." However, when an employee is sitting in an easy chair, resting her head against a doorjamb, with her eyes closed, it must be concluded that she is, at the least, less than alert.

In the instant case, the testimony of an unbiased witness establishes that the grievant was resting her head and shoulder against the doorjamb and that her eyes were closed. Grievant avers that, while doing so, she had turned her head to the left so as to be able to see the patient. Since grievant's head was turned to the left, the lieutenant who was approaching from the left was able to see grievant's face sufficiently to observe that her eyes were closed. The lieutenant did not previously know who grievant was and had no reason not to truthfully report her observation. Grievant, on the other hand, has an obvious self-interest in denying that she was less than alert.

Grievant's own testimony provides further corroboration that she was less than alert. Grievant did not see the lieutenant when she walked within two feet of her and did not hear the lieutenant speak to her. This, in turn, corroborates the lieutenant's testimony that grievant's eyes were closed and that grievant failed to respond to the lieutenant's greeting. Accordingly, the agency has demonstrated, by a preponderance of the evidence, that grievant was less than alert, if not sleeping, during work hours. Her offense is even more egregious because she was doing so while assigned to one-on-one care of a patient she knew to be aggressive and a self-mutilator.

Contrary to her assertion, grievant has not shown that the lieutenant singled her out for reporting. The lieutenant had reported five people for being asleep or less than alert on the night of March 5, 2002. Grievant has not advanced any other credible reason to question the lieutenant's veracity or the accuracy of her observations. Therefore, the agency has demonstrated that grievant's failure to be alert on March 5, 2002 was a Group III offense.

Mitigation

The Standards of Conduct provide for the consideration of mitigating circumstances in the implementation of disciplinary actions. Department Instruction 201 provides that disciplinary action is based on criteria including but not limited to: a) seriousness of the neglect, b) circumstances surrounding the

incident and/or, c) the employee's work record. The Standards of Conduct states, in pertinent part:

While the disciplinary actions imposed shall not exceed those set forth in this policy for specific offenses, agencies may reduce the disciplinary action if there are mitigating circumstances, such as:

- a. conditions that would compel a reduction in the disciplinary action to promote the interests of fairness and objectivity; or
- b. an employee's long service or otherwise satisfactory work performance.¹⁴

The agency mitigated grievant's discipline notwithstanding the fact that she has only two years of service. After careful consideration of the evidence, it is concluded that retaining grievant in state employment, rather than discharging her, represents a considerable reduction in the discipline she could have been given. The evidence is sufficient to support the discipline administered by the agency.

DECISION

The disciplinary action of the agency is affirmed.

The Group III Written Notice and 30-day suspension issued to the grievant on May 9, 2002 are UPHELD. The Written Notice shall remain in grievant's personnel file for the length of time specified in Section VII.B.2.c of the Standards of Conduct.

APPEAL RIGHTS

You may file an administrative review request within **10 calendar** days from the date the decision was issued, if any of the following apply:

1. If you have new evidence that could not have been discovered before the hearing, or if you believe the decision contains an incorrect legal conclusion, you may request the hearing officer either to reopen the hearing or to reconsider the decision.
2. If you believe the hearing decision is inconsistent with state policy or agency policy, you may request the Director of the Department of Human Resource

¹⁴ Exhibit 14. Section VII.C.1, DHRM *Standards of Conduct Policy No: 1.60*, effective September 16, 1993.

Management to review the decision. You must state the specific policy and explain why you believe the decision is inconsistent with that policy.

3. If you believe that the hearing decision does not comply with the grievance procedure, you may request the Director of EDR to review the decision. You must state the specific portion of the grievance procedure with which you believe the decision does not comply.

You may request more than one type of review. Your request must be in writing and must be **received** by the reviewer within 10 calendar days of the date the decision was issued. You must give a copy of your appeal to the other party. The hearing officer's **decision becomes final** when the 10-calendar day period has expired, or when administrative requests for review have been decided.

You may request a judicial review if you believe the decision is contradictory to law. You must file a notice of appeal with the clerk of the circuit court in the jurisdiction in which the grievance arose within **30 days** of the date when the decision becomes final.¹⁵

[See Sections 7.1 through 7.3 of the Grievance Procedure Manual for a more detailed explanation, or call EDR's toll-free Advice Line at 888-232-3842 to learn more about appeal rights from an EDR Consultant]

David J. Latham, Esq.
Hearing Officer

¹⁵ Agencies must request and receive prior approval from the Director of EDR before filing a notice of appeal.