Issue: Group III Written Notice with termination (less than alert while on duty); Hearing Date: August 14, 2002; Decision Date: August 15, 2002; Agency: Department of Mental Health, Mental Retardation and Substance Abuse Services; AHO: David J. Latham, Esq.; Case No.: 5497

COMMONWEALTH of VIRGINIA
Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 5497

Hearing Date: August 14, 2002
Decision Issued: August 15, 2002

APPEARANCES

Grievant
One witness for Grievant
Human Resource Manager
Legal Assistant Advocate for Agency
Two witnesses for Agency

ISSUES

Did the grievant's actions 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 discharge from employment issued because he was less than alert while on duty.[1] Following failure to resolve the grievance at the third resolution step, the agency head qualified the grievance for a hearing.[2]

The Department of Mental Health, Mental Retardation and Substance Abuse Services (MHMRSAS) (Hereinafter referred to as "agency") has employed the grievant for 15 years. He was a Forensic Mental Health Technician (MHT). The patients at this facility are mentally retarded, physically handicapped, mentally ill or some combination of these conditions. At the time he was discharged grievant had three active disciplinary actions including two Group I Written Notices for unsatisfactory attendance, and one Group III Written Notice for threatening and intimidating a client.[3] Although no longer active, grievant had previously received a Group III Written Notice for sleeping during working hours.[4]

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.[5]

The policy further states that "It is expected that a facility director will terminate an employee found to have abused or neglected a client."[6]

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 April 30, 2002, and on May 1, 2002. The 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 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

---

[1] Exhibit 1. Written Notice, issued June 13, 2002.
[2] Exhibit 1. Grievance Form A, filed June 13, 2002.
[3] Exhibit 5. Written Notices, issued June 30, 2000, October 5, 2000, and June 11, 2001.
[4] Exhibit 6. Written Notice, issued August 23, 1991.
[5] Exhibit 7. Section 201-3, Departmental Instruction 201(RTS)00, *Reporting and Investigating Abuse and Neglect of Clients*, April 17, 2000.
[6] Exhibit 7. Section 201-8, *Ibid*.

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 did not work on April 29, 2002. On April 30, 2002, grievant worked his usual night shift from 11:00 p.m. to 7:30 a.m. The Department of Juvenile Justice provides security and safety at the facility. At about 4:45 a.m., a corrections lieutenant entered the ward, walked down grievant's hall, and approached grievant who was sitting in a chair in the hall. He observed grievant sitting with his head drooping down and his eyes closed. As the lieutenant approached within 10 feet of grievant, grievant raised his head. The lieutenant did not speak to grievant, and grievant did not speak to the lieutenant. This encounter was recorded on the videotape surveillance camera.[7] The lieutenant reported grievant for being less than alert.

On May 1, 2002, grievant again worked the normal night shift from 11:00 p.m. to 7:30 a.m. At about 3:55 a.m., the security lieutenant made his rounds and walked down grievant's hallway. On this occasion grievant was assigned to watch a patient one-on-one at the end of the 40-foot hallway. Grievant was sitting in a chair with his head tilted to the right and his eyes closed. When the lieutenant was within 10 feet of grievant, he stood and observed grievant for two minutes; grievant did not open his eyes or move. Neither the lieutenant nor grievant spoke to each other. The lieutenant then walked past grievant to the nurses' station. For four minutes, the lieutenant watched a television monitor that showed the hallway in which grievant was sitting. Grievant did not move his head or body during the four minutes.

The lieutenant reported his observations to the ward nurse.[8] The ward nurse (RN) advised the lieutenant that she had observed grievant about one hour earlier slumped in his chair, with head tilted to the right and eyes closed. She stomped her foot twice but grievant did not move. She spoke to him with no response; he then awoke the second time the nurse spoke to him. She relieved him and sent him on break to get refreshed.

An investigator was assigned to the case; he interviewed and obtained written statements from grievant, the lieutenant and the nurse. Following review of the case by central office, the charge of being less than alert was deemed founded. The facility director considered grievant's length of service and his generally good reputation in caring for patients. However, given the grievant's three other active disciplinary actions, it was concluded that the agency had no option but to terminate grievant's employment.

---

[7] 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 resolution of the videotape is insufficient to identify details in the distance. Therefore, the videotape was of minimal value in assessing this incident.

[8] The ward nurse was a temporary employee whose term of employment expired prior to this hearing.

Grievant had not had any previous problem or interaction with the security lieutenant. The lieutenant had never reported grievant prior to April 30, 2002. Grievant could offer no reason that the lieutenant would falsely report grievant for being less than alert. Similarly, grievant could not explain why the nurse would have any reason to make a false report. To the contrary, grievant testified that the nurse liked him.

Grievant had the day off on April 29, 2002. He did not work overtime on either April 30 or May 1, 2002.[9]

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).

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 Training[11] promulgated

[9] Exhibit 2, p. 9. Record of grievant's hours from April 25 through May 9, 2002.
[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).

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]

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 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 his head on his shoulder, with his eyes closed, it must be concluded that he is, at the least, less than alert.

The agency has demonstrated, by a preponderance of the evidence, that grievant was less than alert on three occasions – once on April 30, 2002 and twice during the night of May 1, 2002. The charge nurse on duty corroborated the testimony of the security lieutenant for the night of May 1, 2002. The burden of proof now shifts to the grievant.

Grievant denies being less than alert and contends that he saw the security lieutenant come down the hall both nights. He also says that he

observed the nurse approach him on May 1, 2002 and that she did not stomp her foot to arouse him. The grievant's denial is less credible than the testimony of the lieutenant and the nurse for three reasons. First, the lieutenant's testimony and the nurse's statement corroborate each other in all respects. Second, grievant can offer no reason that either the lieutenant or the nurse would fabricate their observations and reports. Neither had previously had any adverse interaction with grievant. In fact, grievant maintains that the nurse liked him.

Third, grievant offered as a defense that he should be excused because he was tired due to overtime he had been working, and due to being a single parent. Grievant submitted evidence to show that he had worked overtime hours on 14 occasions during the month of April 2002.[14] However, the record reflects, and grievant acknowledges, that he had a day off on April 29, 2002, and that he did not work overtime on either April 30 or May 1, 2002. Thus, even if grievant had worked some overtime hours earlier in April, he should have had adequate rest by the dates at issue herein. If grievant contends that he was less than alert because he was tired due to overtime, he is in effect, acknowledging the offense and offering as mitigation the fact that he was tired.

In cases involving employees who have long service with the agency, the length of service may be considered a mitigating circumstance. However, in this case there were aggravating circumstances that significantly outweighed grievant's length of service. First, grievant had accumulated two Group I Written Notices and one Group III Written Notice during the past two years; all were active when this Written Notice was issued. An accumulation of this many disciplinary actions virtually always results in termination of employment. Another aggravating circumstance is the fact that grievant had previously received another Group III Written Notice for sleeping while on duty. Therefore, grievant had more than adequate notice from previous discipline that he could be discharged for this offense.

DECISION

The disciplinary action of the agency is affirmed.

The Group III Written Notice and discharge from employment issued on June 13, 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

[14] Exhibit 9. Daily coverage sheets for April 2002.

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 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.