Issue: Group I Written Notice (unsatisfactory job performance); Hearing Date: 10/01/10; Decision Issued: 10/05/10; Agency: DBHDS; AHO: William S. Davidson, Esq.; Case No. 9396; Outcome: Full Relief.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EMPLOYMENT DISPUTE RESOLUTION
DIVISION OF HEARINGS
DECISION OF HEARING OFFICER
In Re: Case No: 9396

Hearing Date: October 1, 2010
Decision Issued: October 5, 2010

PROCEDURAL HISTORY

The Grievant was issued a Group I Written Notice on June 2, 2010 for:

> Unsatisfactory work performance as determined by investigation case #707-2010-006. [1]

Pursuant to the Group I Written Notice, no action was taken against the Grievant except for placing the Notice in her personnel file. On June 10, 2010, the Grievant timely filed a grievance to challenge the Agency's actions. [2] On August 24, 2010, the Department of Employment Dispute Resolution ("EDR") assigned this Appeal to a Hearing Officer. On October 1, 2010, a hearing was held at the Agency's location.

APPEARANCES

Agency Representative
Grievant
Witnesses

ISSUE

1. Was the Grievant's work performance unsatisfactory as determined by investigation case #707-2010-006?

AUTHORITY OF HEARING OFFICER

Code Section 2.2-3005 sets forth the powers and duties of a Hearing Officer who presides over a grievance hearing pursuant to the State Grievance Procedure. Code Section 2.2-3005.1 provides that the Hearing Officer may order appropriate remedies including alteration of the Agency's disciplinary action. Implicit in the Hearing Officer's statutory authority is the ability to independently determine whether the employee's alleged conduct, if otherwise properly before the Hearing Officer, justified termination. The Court of Appeals of Virginia in *Tatum v. VA Dept of Agriculture & Consumer Servs,* 41VA. App. 110, 123, 582 S.E. 2d 452, 458 (2003) held in part as follows:

[1] Agency Exhibit 1, Tab 1, Page 1
[2] Agency Exhibit 1, Tab 2, Page 1

> While the Hearing Officer is not a "super personnel officer" and shall give appropriate deference to actions in Agency management that are consistent with law and policy...the Hearing Officer reviews the facts de novo...as if no determinations had been made yet, to determine whether the cited actions occurred, whether they constituted misconduct, and whether there were mitigating circumstances to justify reduction or removal of the disciplinary action or aggravated circumstances to justify the disciplinary action. Thus the Hearing Officer may make a decision as to the appropriate sanction, independent of the Agency's decision.

BURDEN OF PROOF

The burden of proof is on the Agency to show by a preponderance of the evidence that its disciplinary action against the Grievant was warranted and appropriate under the circumstances. Grievance Procedure Manual ("GPM") §5.8. A preponderance of the evidence is sometimes characterized as requiring that facts to be established more probably than not occurred, or that they were more likely than not to have happened. [3] However, proof must go beyond conjecture. [4] In other words, there must be more than a possibility or a mere speculation. [5]

FINDINGS OF FACT

After reviewing the evidence presented and observing the demeanor of each witness, the Hearing Officer makes the following findings of fact:

The Agency provided the Hearing Officer with a notebook containing twenty (20) tabbed sections and that notebook was accepted in its entirety as Agency Exhibit 1.

The Grievant provided the Hearing Officer with several pages of documents which both parties agreed could be inserted into Agency Exhibit 1. Accordingly, behind Tab 3 of Agency Exhibit 1, eight (8) pages were inserted and designated as Grievant 1 through 8 and behind Tab 4 of Agency Exhibit 1, one (1) page was inserted and designated as Grievant 1. In all other respects, the Grievant chose to rely on documents contained in Agency Exhibit 1.

The relevant facts concerning this matter are contained in the Investigative Summary to case #707-2010-006. [6] This document was prepared for the Agency by its investigator. The investigation was completed and the summary was produced on or about March 9, 2010. [7] The relevant facts concerning this case are set forth at page 10 of this Report, in part as follows:

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[3] *Ross Laboratories v. Barbour*, 13 Va. App. 373, 377, 412 S.E. 2d 205, 208 1991
[4] *Southall, Adm'r v. Reams, Inc.*, 198 Va. 545, 95 S.E. 2d 145 (1956)
[5] *Humphries v. N.N.S.B., Etc., Co.*, 183 Va. 466, 32 S.E. 2d 689 (1945)
[6] Agency Exhibit 1, Tab 3, Page 3
[7] Agency Exhibit 1, Tab 3, Page 3

> On 2/20/10, staff reported to the weekend RN that Mr. T coughed up sputum with blood noted and he had nasal drainage. During her assessment, staff had showed her a small amount of red/brown blood with sputum in washcloth and also a tiny amount of brown blood when they wiped his nose. He was found to have no active bleeding from mouth, lungs clear and O2 SAT's were unable to obtain. His vital signs were Temperature 98.2, Pulse 120, Respirations 20 and Blood Pressure 120/98. She instructed staff to call the nurse of any further coughing up blood. (No Ill Flow Sheet was started and the nurse did not check the CVTC Nurse Report to follow-up.) Ms. G reported that she "did not have to recheck him during her shift and did not feel he needed to be rechecked by 2nd shift unless further problems occurred."
>
> Mr. T was not assessed again until his primary nurse did on 2/22/2010 and no further reports of coughing or blood noted. She notified the ANP and was instructed to continue to observe. The nurse instructed staff to continue to monitor also.
>
> On 2/22/2010, Mr. T was observed having "raspy" breathing by staff on 2nd shift at 5:45 p.m. Staff notified Ms. B, RN and she came to Mr. T's living area. She assessed him and "noted that his lungs were clear, eating and drinking fluids well, respirations even and non-labored. He appeared to her to be anxious." She instructed staff to observe and notify nurse of any change. [8]

On February 23, 2010 at 8:36 p.m., Mr. T was noted to have raspy and labored breathing. Thereafter, a set of events took place which ultimately led to Mr. T being transported to the hospital and his death at 10:47 a.m. on February 24, 2010. [9]

The Grievant worked a shift on February 22, 2010 that brought her to work at 7:45 a.m. and ended at 4:15 p.m. In the conclusions to her Investigative Report, the investigator found that Mr. T began to show signs of difficulty in breathing on February 22, 2010. [10] The exact time of that difficulty is set forth at page 12 of her Report and indicates that the raspy breathing was first noted at 5:45 p.m. on February 22, 2010. The investigator then concluded as follows:

> Base[d] (sic) on the preponderance of evidence, **I find neglect due to delay in care with serious** performance issues and systemic issues that the administration must correct. [11]

[8] Agency Exhibit 1, Tab 3, Page 12
[9] Agency Exhibit 1, Tab 3, Pages 12-14
[10] Agency Exhibit 1, Tab 3, Page 16
[11] Agency Exhibit 1, Tab 4, Page 16

When questioned by this Hearing Officer, this investigator clearly stated that she felt that the neglect to this patient began after 5:45 p.m. on February 22, 2010. This was after the Grievant had concluded her shift at work. The investigator stated that she found nothing in the Grievant's actions which would rise to the level of neglect. Indeed, this investigator, who had been a Registered Nurse for this Agency for more than thirty (30) years prior to becoming an investigator, stated that she probably would have acted in the exact same manner as the Grievant in this matter.

Following this Investigative Report, the Agency secured the services of an outside expert to render a second opinion. This Report is found at Agency Exhibit 1, Tab 4, Pages 1-4. The Grievant added an additional page to this Report, which was later filed by the outside expert, and it is marked as Grievant 1. The outside expert, in commenting on the three (3) Registered Nurses that cared for Mr. T, stated as follows:

> All of the Registered nurses in the assessment of [Mr. T] (Ms. G, [Grievant] and Ms. B) are neglectful in their duties to assess, plan and evaluate acute signs and symptoms of illness. They are neglectful in their responsibilities as Registered nurses to obtain medical care for Mr. T in a timely manner which is parallel to delay in treatment.
>
> ...It is the primary responsibility of registered nurses to perform comprehensive nursing assessments of the system/systems involved when individuals/patients present with unusual or abnormal sign or symptoms of illnesses. [12]

In short, this expert found all three (3) nurses to be guilty of neglect. The expert's findings regarding the Grievant in particular are found at Page 2 of her Report. [13] Unfortunately, there are numerous errors in the expert's Report. The first and most insignificant is that she incorrectly spells the Grievant's name. While one would think that she could get that correct, that amounts to only a scrivener's error. The more important error is in her total confusion regarding the date and time of events as they occurred in this matter. The expert states that Mr. T coughed up blood on February 22, 2010 and on February 20, 2010. The expert uses both of those dates interchangeably. Because she uses each date interchangeably, there is significant question as to whether or not she deemed that the Grievant was confronted with an urgent sign and symptom of coughing up blood. If in fact she deemed that Mr. T coughed up blood during the Grievant's shift on February 22, 2010, one could certainly make an argument that there was a need for that to be dealt with on an urgent basis. However, as the facts are set forth by the investigator and by the testimony of both witnesses for the Agency, the blood was coughed up on February 20, 2010. An evaluation was made at that time by the RN on duty. Two (2) days later, when the Grievant came to work, there had been no further reports of any such matter. This patient was on one-to-one status, which means he was constantly within arms reach of an employee of the Agency. None of these employees reported any further issues with this patient from February 20, 2010 to February 22, 2010, when the Grievant reported for work at 7:45 a.m. It is certainly arguable that, after the passage of 48 hours and no further repeat of the coughing up of blood and Mr. T was asymptomatic, then this matter was no longer urgent.

[12] Agency Exhibit 1, Tab 4, Page Grievant 1
[13] Agency Exhibit 1, Tab 4, Page 2

At Page 4 of her report, the expert sets forth nine (9) bullet points that are system issues. The bullet point that she devotes the most time to deals with Mr. T's weight issues that were taking place several months prior to the issue at hand. The witnesses for the Agency conceded that they did not know how or why the expert came upon this data and what relevance it had to the matter at hand. The expert talked about professional staff failing to assess a person for more than 24 hours when a symptom of raspy breathing was reported. All of the testimony before this Hearing Officer indicated that that assessment, to the extent that it applied to anyone, applied to nurses other than the Grievant. [14]

On April 22, 2010, the expert filed a Supplemental Clarification Note to her original documentation. The Hearing Officer was not made aware of why the expert felt the need to file this clarification, but it would appear that the expert deemed that she was in error in her original finding. In her original finding, the expert stated that:

> ...All the Registered nurses involved in the assessment of [Mr. T]... are neglectful in their duties to assess, plan and evaluate acute signs and symptoms of illness. They are neglectful in their responsibilities as Registered nurses to obtain medical care for [Mr. T] in a timely manner which is parallel to delay in treatment...[15]

In her clarification, the expert now states as follows:

> ...The term [neglect] as written in this document did not mean that the nurses neglected the patient.
>
> ...Neglect or negligence is not warranted for these three nurses' performances in the incident regarding the assessment of [Mr. T]...[16]

For whatever reason, this expert significantly, if not entirely, reversed her position.

This entire matter was also reviewed by Doctor B. The concluding paragraph of his Report states as follows:

> [Mr. T] was evaluated by the nurse on the morning of 2/20/10 and showed no signs of pneumonia so her impression was to closely follow-up. On 2/23/10 at 8:36 p.m. he started having clinical signs of pneumonia with the labored breathing and the nurse was informed. There was some delay by the nurse to come and see [Mr. T], not transporting him until almost 11:00 p.m. In my opinion, there was no neglect on the part of nursing staff, but there was a definite delay in administration of treatment which needs to be addressed as a

[14] Agency Exhibit 1, Tab 4, Page 4
[15] Agency Exhibit 1, Tab 4, Page 1
[16] Agency 1, Tab 4, Grievant 1

> performance problem. [17]

It is clear from the Doctor's Report that he found no neglect on the part of the nursing staff. He did find that there was a delay in the administration of treatment but that delay did not start until after 8:36 p.m. on February 23, 2010. This time frame was clearly outside of any time frame that would have implicated the Grievant

The Agency spent from April 10, 2010 until June 2, 2010 determining what they would do with the investigator's Report, the expert's Report, the Supplemental Clarification Report and the Doctor's Report. The end result of that review was that a Group I Written Notice would be issued. Under Section IV of that Written Notice, dealing with mitigation, the Agency set forth as follows:

> A review of the facts and circumstances of the violation resulted in a downward mitigation from a possible Group III for neglect. [18]

It is clear to this Hearing Officer from reviewing the documentary evidence by the Agency and listening to the Agency witnesses, that the Agency, based on the investigative Report and the original Report of the expert, deemed this to be neglect to Mr. T and therefore a Group III offense that could well have resulted in termination. Then the Agency was faced with the expert reversing her decision and clearly stating that this was not neglect. The Agency, faced with the death of Mr. T, felt that it had to do something. However, the documentary evidence and the oral testimony before the Hearing Officer points out that this Grievant violated no Agency standard. When the Grievant came to work on February 22, 2010, she reviewed the notes in the file, observed Mr. T, noted that he had had a normal weekend with no further recurrence of coughing up of blood and, consequently, found no further checks of him were required.

As stated earlier, the Agency's investigator testified that she probably would have treated Mr. T in the exact same fashion as the Grievant. Further, the Director of Nursing testified that, had the aura of neglect not been laid over this case as it was because of the Investigative Summary and the expert's Report, she would most likely have counseled the Grievant that she should have documented her files better.

This is clearly a case where the Agency was forced to react because a patient died. The problem is that the Agency immediately went into a mode of attempting to deal with an employee that was neglectful of a patient and having to shift into a mode of what should then happen when it became clear that neglect was not the issue.

MITIGATION

[17] Agency Exhibit 1, Tab 16, Page 1
[18] Agency Exhibit 1, Tab 1, Page 1

Va. Code § 2.2-3005.1 authorizes Hearing Officers to order appropriate remedies including "mitigation or reduction of the Agency disciplinary action." Mitigation must be "in accordance with rules established by the Department of Employment Dispute Resolution..." [19] Under the Rules for Conducting Grievance Hearings, "a Hearing Officer must give deference to the Agency's consideration and assessment of any mitigating and aggravating circumstances. Thus a Hearing Officer may mitigate the Agency's discipline only if, under the record evidence, the Agency's discipline exceeds the limits of reasonableness. If the Hearing Officer mitigates the Agency's discipline, the Hearing Officer shall state in the hearing decision the basis for mitigation." A non-exclusive list of examples includes whether (1) the employee received adequate notice of the existence of the rule that the employee is accused of violating, (2) the Agency has consistently applied disciplinary action among similarly situated employees, (3) the disciplinary action was free of improper motive, (4) the length of time that the Grievant has been employed by the Agency, and (5) whether or not the Grievant has been a valued employee during the time of his/her employment at the Agency.

Both of the Agency witnesses in their testimony before the Hearing Officer stated that the Grievant was a long time valued employee of the Agency. They both testified as to her excellent qualities as an employee. Even if the Hearing Officer is wrong and the Grievant somehow could be found to have been unsatisfactory in her work performance, the Hearing Officer would mitigate that to remove the Group I Written Notice. The Agency used mitigation to reduce a Group III Written Notice to a Group I Written Notice, when, in fact, there was no Group III offense, as the Agency's own evidence proves.

DECISION

For reasons stated herein, the Hearing Officer finds that the Agency has not bourne its burden of proof regarding this matter and orders that the Group I Written Notice be rescinded and removed from the Grievant's file.

APPEAL RIGHTS

You may file an administrative review request within **15 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. Please address your request to:

Director
Department of Human Resource Management

[19] Va. Code § 2.2-3005

101 North 14th Street, 12th Floor
Richmond, VA 23219

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. Please address your request to:

Director
Department of Employment Dispute Resolution
600 East Main Street, Suite 301
Richmond, VA 23219

You may request more than one type of review. Your request must be in writing and must be **received** by the reviewer within 15 calendar days of the date the decision was issued. You must give a copy of your appeal to the other party and to the EDR Director. The Hearing Officer's **decision becomes final** when the 15-calendar day period has expired, or when administrative requests for a review have been decided.

You may request a judicial review if you believe the decision is contradictory to law.[20] 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.[21]

[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]

_____
William S. Davidson
Hearing Officer

[20]An appeal to circuit court may be made only on the basis that the decision was contradictory to law, and must identify the specific constitutional provision, statute, regulation or judicial decision that the hearing decision purportedly contradicts. Virginia Department of State *Police v. Barton*, 39 Va. App. 439, 573 S.E.2d 319 (2002).

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