Issues: Group III Written Notice (failure to report patient neglect) and Demotion; Hearing Date: 04/19/11; Decision Issued: 04/28/11; Agency: DBHDS; AHO: Neil A.G. McPhie, Esq.; Case No. 9557; Outcome: No Relief – Agency Upheld.

In the matter of Case No. 9557

Hearing Date: April 19, 2011

Decision Issued: April 28, 2011

APPEARANCES

Grievant
Attorney for Grievant
Five witnesses for Grievant[1]
Representative for Agency
Two witnesses for Agency

ISSUE

Was the Virginia Department of Behavioral Health and Developmental Services (hereinafter the "Department" or "Agency") justified in demoting Grievant from a Shift Supervisor to a Medication Technician, in lieu of termination, for failure to report an allegation of patient neglect to the facility director. For the reasons that follow, I find in favor of the Agency.

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. In Tatum v. VA Dept. of Agriculture & Consumer Servs., 41VA. App. 110, 123, 582 S.E. 2d 452, 458 (2003), the Virginia Court of Appeals held, in part, as follows:

> *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*

[1] Grievant's witness list identified 8 witnesses in addition to the grievant. At the grievant's request, the Hearing Officer issued Witness Orders for four individuals who appeared and testified. One witness was excused by the grievant and two others did not show. Counsel for Grievant assured the HO that grievant's case was not prejudiced by the absence of these two witnesses.

removal of the disciplinary action or aggravated circumstances to justify the disciplinary action. Thus the Hearing Officer may make a decision as to 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 evidence which shows that what is sought to be proved is more probable than not. GPM §9.

RELEVANT POLICIES

1. DHRM Policy 1.60, effective April 16, 2008. Its purpose "is to set forth the Commonwealth's Standards of Conduct and the disciplinary process that agencies must utilize to address unacceptable behavior, conduct, and related employment problems in the workplace…when conduct impacts an employee's ability to do …her job and …influences the agency's overall effectiveness." The intent of the policy is "that agencies follow a course of progressive discipline" designed to help employees become fully contributing members of the organization …" and "to enable agencies to fairly and effectively discipline and … terminate employees whose conduct … does not improve or where the misconduct … is of such a serious nature that a first offense warrants termination". (Pol. at p. 1, Agency Ex. E)[2]

The progressive nature of the "disciplinary system typically involves the use of increasingly significant measures" in the form of counseling for minor offenses and written notices for more serious offenses. (Pol. at p. 6 -7). The Group III Written Notice that Grievant received in this case, is reserved for "acts of misconduct of such a severe nature that a first occurrence normally should warrant termination … unless there are mitigating circumstances" (Pol. at p. 9). Abuse or neglect of clients is specifically identified as a Group 111 offense. (Attachment A to Pol. 1.60)

2. Departmental Instruction 201 (RTS) 03 Reporting and investigating Abuse and Neglect of individuals Receiving Services in Department Facilities. (Rev. 8/31/2009) (Hereinafter DI 201) (Agency Ex. A; Grievant Ex. 3).

FINDINGS OF FACT

Grievant is an employee [at a facility of the agency], one of five regional residential training centers for individuals with intellectual disabilities operated by the Department of Behavioral Health and Developmental Services in the Commonwealth of Virginia. (hereinafter DBHDS or the Agency). [The facility] offers services to the citizens of four counties and two cities. To be eligible for services, an applicant must have intellectual disabilities, associated with sensory and physical disabilities and/or

[2] Grievant introduced six exhibits numbered 1-6. The Agency introduced seven exhibits numbered A – G. All exhibits were admitted into evidence as a block without objection at the start of the Hearing.

extreme maladaptive behaviors. To meet each individual's challenging requirements for care and training, a network of clinical and direct support professional staff are available on a 24-hour basis. Services are highly individualized and are provided in the least intrusive and non-restrictive manner for growth and development in an integrated, diverse environment. ([facility] public website.

[The facility] grounds cover 85 acres of woods and lawns. The Department of Residential Services (DRS) at [the facility] is responsible for managing, coordinating, and delivering a full range of administrative and programmatic services to the individuals who live at the Center. DRS staffs over 265 employees in its 24- hour direct support operation. (Id)

There are 11 residential homes at [the facility]. Each home provides a unique environment that enhances quality of life through a continuum of skilled, supportive, and compassionate care. For the individuals living on Home 5C, learning to live comfortably with their peers, promoting independence, socialization and community integration are major focal points. One side of the home is devoted to individuals with pica behaviors. (Id)[3]

The Department of Behavioral Health and Developmental Services has a duty to provide a safe and secure environment to individuals receiving services. The Department has developed and published a comprehensive policy for reporting and investigating allegations of patient abuse and neglect. Departmental Instruction 201 (RTS) 03 Reporting and investigating Abuse and Neglect of individuals Receiving Services in Department Facilities. (Hereinafter DI 201) (Agency Ex. A; Grievant Ex. 3).

According to the policy, "the Department … has a philosophy of zero tolerance for abuse and neglect. " 201 – 1

Neglect is defined, in pertinent part, as "the failure by a person responsible for providing services to do so, including … treatment, care,… or services necessary to the health, safety, or welfare of a person receiving care or treatment for mental illness…." 201 – 3

DI 201 explicitly states that "any workforce member who has any knowledge or reason to believe that an individual residing in a state facility may have been abused or neglected, or both, shall immediately report this information directly to the facility director, or designee, as appropriate… and cooperate fully in the investigation." Knowledge or reason to believe abuse or neglect has occurred may be based on, but not limited to…. [a] statement from another workforce member." 201 – 6

[The facility] has issued an "Instruction" to all staff reminding them of their obligation to follow DI 201. [facility] Instruction 5002, effective September 14, 2009, states that "In cases of suspected abuse, the Facility Director or designee **shall** be notified immediately. During non-duty hours, the Facility Director may be reached by contacting the Receptionist, TCOM or Security." (Grievant Ex. 2)

[3] Pica is a severe type of eating disorder commonly observed in people with developmental disabilities and mental retardation. People with pica frequently crave and consume nonfood items such as feces, dirt, cigarette ashes and butts, glue and hair. See, www://accessmylibrary.com-1G1-131198147/understanding – pica behavior – review.html

In [Facility] Instruction 2000, effective May 14, 2010, staff was reminded of the importance to personally and immediately contact the Facility Director to report allegations of abuse and neglect that occur after hours. "There are certain events or occurrences that require immediate, person-to-person communication with the Facility Director. The Training Center Operations Manager (TCOM), Security Officer, and/or Nurse-in-Charge can facilitate this communication. When allegations of abuse and neglect occur after normal business hours (Monday – Friday 8:15 a.m. – 5:00 p.m.), the Director should be notified immediately by the TCOM, Security Officer, and/or Nurse-1n-Charge, as appropriate…" (Grievant Ex. 1)

DI 201 applies to all employees of the [facility], including the grievant in this case. Under the policy, all [facility] employees have an individualized duty to immediately report allegations of patient abuse and neglect to the facility director or his designee.

All workers at [the facility]e trained on DI 201 before beginning employment and annually thereafter. The training is intense and lasts approximately three weeks. The Facility Director has, at times, during a training session, stressed the importance of contacting him personally to report allegations of abuse and neglect.

The preponderant evidence from exhibits and testimony is that employees are trained to immediately report allegations of patient abuse or neglect to the Facility Director. When suspected abuse or neglect occurs after normal business hours, employees are trained to get the Director's telephone number from various sources including Security, the Nurse-in-Charge or the TCOM.

The grievant received pre-service and in-service training on DI 201. (Agency Ex. F) As recently as April 7, 2010, grievant executed a "Statement of Commitment" certifying that she had been given a copy of DI 201; had been trained and understood the contents of DI 201; that she agreed to abide by the provisions of DI 201; agreed to cooperate fully in all [facility] investigations; and, **"agree to immediately report abuse or neglect to the Facility Director"** (Id) (emphasis added)

IH is a resident/client at [the facililty]. He is 66 years old and suffers from serious mental and medical issues. His diagnosis includes seizure disorders, osteopenia (fracture risk due to low bone density) and GERD, a gastro esophageal reflux disorder. He requires line of sight supervision when outside his bedroom. He has a history of falls due to fainting and seizures and has a heart condition that requires a cardiac recorder implanted under his skin. When travelling outside the facility, IH is required to be in a wheel chair. (Agency Ex. C)

Residents at [the facility] reside in "homes", divided into A and B sides separated by a Team station. IH resides in the B side of Home 5C and is well known by [the facility] treatment staff. On November 24, 2010, all but two of the residents on 5C were scheduled to go on a community outing to a local park. Approximately 12 residents and 12 staff members, in two vehicles, were scheduled to go on the trip. The grievant, who at that time was a shift supervisor, did not go on the trip. She remained at the facility conducting various supervisory functions, including providing support for one of the 5C residents who did not go on the trip.

A staff member was assigned the responsibility for supervising IH during the outing. When the two transport vehicles left the facility at approximately 11:20 a.m., IH was not with the group and was not missed. IH remained, by himself, on the B side of Home 5C unsupervised and unattended for approximately one hour and twenty minutes. A nurse who had not gone on the trip, found IH in a bathroom. He escorted him back to his room and determined that IH was not in medical distress. Upon the group's return to the facility, the nurse questioned a staff member as to whether IH was supposed to go on the trip. That staff member reported the incident to the grievant. The grievant reported it to the TCOM, but not to the facility director as required by DI 201. The TCOM failed to report the incident to the facility director as required by policy. The incident was reported five days later on November 29, 2010 to the Facility Director.

The incident was investigated by an employee who was trained in conducting patient abuse and neglect investigations. The investigator interviewed all employees who worked on home 5C on the date of the incident and reviewed all witness statements. The investigation concluded that there was a "[g]eneral lack of understanding/accountability for the potential health and safety risks for IH's emotional and physical well-being, from the Direct Support Professional (DSP) to the Training Center Operations Manager (TCOM)" The investigation concluded that all involved staff members failed to follow various policies and protocols. The grievant was determined to be one of nine employees who failed to follow DI 201 with regards to reporting neglect to the Facility Director (Agency Ex. B)

The grievant began working for the Agency in 2005 or 2006 as a Direct Care Professional. (Grievant Ex. 6; Agency Ex F). She subsequently held the position of Medical Technician and Shift Supervisor. She was a Shift Supervisor for approximately one or two years when the IH matter occurred. She performed her job well and received a number of awards. (Grievant Ex. 7). She had no prior disciplinary action taken against her.

The grievant described herself in documents and in testimony, as a caring and compassionate advocate for the residents under her charge. In asking the Facility Director for a second chance, she called the IH matter "a bad judgment call that if I have the opportunity to change, would have. **I followed the hierarchy system in reporting and unconsciously did not utilize the direct formal reporting system and for that I take full responsibility."** (Grievant Ex. 6)

Moved by the request, the Facility Director mitigated the discipline to a demotion. "I have reviewed the letter you presented me and your personnel file. I have also reviewed again the investigative report and relevant policies and procedures. In an effort to consider possible mitigation of the proposed Group 111 and termination, I have considered your length of employment and past performance evaluations. Based upon all available information I presented to the BDHDS Office of Human Resources, my request for mitigation of the Group 111 with termination was successful. Instead you will be issued a Group 111 written notice with a demotion from a Shift Supervisor to a Medication Assistant with a 7.0% loss of pay effective December 21, 2010." (Agency Ex. D)

Grievant filed a timely appeal pursuant to the expedited grievance procedure. Following failure to resolve the matter at the second resolution step, the grievance was qualified for a hearing.

ANALYSIS

The Agency was justified in issuing Grievant a Group 111 written notice with a demotion from a Shift Supervisor to a Medication Assistant with a 7.0% loss of pay effective December 21, 2010.

Grievant does not dispute the fact that IH was left unattended and unsupervised in Home 5C. She does not dispute that she was on duty November 24, 2010 in Home 5C; that she knew of the community outing for 5C residents; that she was informed by a subordinate that IH was left unattended and unsupervised in Home 5C; and, that she reported the incident to the TCOM but not to the Facility Director as required by DI 201. Grievant testified that the Facility Director was not at the Facility when the issue arose and that she was trained to report suspected abuse and neglect that occurred after normal business hours to the TCOM. This argument flies in the face of the exhibits and the preponderance of the testimony. DI 201 and [Facility] Instr. 5002 are clear in their requirement that each staff member has an independent duty to report suspected abuse or neglect directly to the Facility Director. The grievant received pre-service and in-service training on DI 201. (Agency Ex. F) As recently as April 7, 2010, grievant executed a "Statement of Commitment" certifying that she had been given a copy of DI 201; had been trained and understood the contents of DI 201; that she agreed to abide by the provisions of DI 201; agreed to cooperate fully in all [facility] investigations; and **"agree to immediately report abuse or neglect to the Facility Director"** (Id) (emphasis added). Grievant's reliance on Facility Instruction 2000 (Grievant Ex. 1) in support of her argument is misplaced. That Instruction makes it clear that the TCOM, Security Officer and/or the Nurse-in-Charge have a duty to facilitate abuse or neglect allegations to the Facility Director and to report such allegations themselves. It does not relieve the grievant or any other employee from reporting allegations directly to the Director.

Moreover, witnesses, including the trained investigator, the Director of Residential Services who has worked for [the facility] for approximately 20 years, the Training Coordinator who has trained [the facility] employees on reporting abuse or neglect since 1988, a Program Manager and a Medical Technician all attested to the independent reporting responsibility of all staff. These witnesses testified that Grievant should have called the TCOM for the Director's telephone number and called the Director herself. Grievant's admission that she **followed the hierarchy system in reporting and unconsciously did not utilize the direct formal reporting system and"** her willingness to **"take full responsibility,"** suggest that she knew she had failed to follow the direct report policy.

There is no basis to further mitigate the discipline imposed on Grievant

Grievant argues that the Agency could have and should have imposed a Group 11 written notice for failure to comply with policy. The choice of penalty is left to the sound discretion of the Agency. There is ample evidence in this case that the Agency exercised its discretion responsibly. A Group 111 is generally reserved for acts of misconduct of a most serious nature that severely impact agency operations. Abuse or neglect of clients is explicitly identified as a Group 111 offense. The range of penalties for a first offense includes Written Notice and discharge or demotion with loss of pay.

DECISION

For the reasons stated herein, the Agency's issuance to the Grievant of a Group 111 Written Notice and demotion from a Shift Supervisor to a Medical Technician is **affirmed.**

APPEAL RIGHTS

As the *Grievance Procedure Manual* sets forth in more detail, this hearing decision is subject to administrative and judicial review. Once the administrative review phase has concluded, the hearing decision becomes final and is subject to judicial review. **Administrative Review:** This decision is subject to three types of administrative review, depending upon the nature of the alleged defect of the decision:

1. A request to reconsider a decision or reopen a hearing is made to the hearing officer. This request must state the basis for such request; generally, newly discovered evidence or evidence of incorrect legal conclusions is the basis for such a request.
2. A challenge that the hearing decision is inconsistent with state or agency policy is made to the Director of the Department of Human Resources Management. This request must cite to a particular mandate in state or agency policy. The Director's authority is limited to ordering the hearing officer to revise the decision to conform it to written policy. Requests should be sent to the Director of the Department of Human Resources Management, 101 N. 14th Street, 12th Floor, Richmond, Virginia 23219 or faxed to (804) 371-7401.
3. A challenge that the hearing decision does not comply with grievance procedure is made to the Director of EDR. This request must state the specific requirement of the grievance procedure with which the decision is not in compliance. The Director's authority is limited to ordering the hearing officer to revise the decision so that it complies with the grievance procedure. Requests should be sent to the EDR Director, Main Street Center, Suite 301, Richmond, Virginia 23219 or faxed to (804) 786-0111.

A party may make more than one type of request for review. All requests for review must be made in writing, and received by the administrative reviewer, within **15 calendar** days of the **date of original hearing decision**. (Note: the 15-day period, in which the appeal must occur, begins with the date of **issuance** of the decision, **not receipt** of the decision. However, the date the decision is rendered does not count as one of the 15 days; the day following the issuance of the decision is the first of the 15 days.) A copy of each appeal must be provided to the other party.
A hearing officer's original decision becomes a **final hearing decision**, with no further possibility of an administrative review, when:

1. The 15 calendar day period for filing requests for administrative review has expired and neither party has filed such a request; or
2. All timely requests for administrative review have been decided and, if ordered by EDR or DHRM, the hearing officer has issued a revised decision.

Judicial Review of Final Hearing Decision: Within thirty days of a final decision, a party may appeal on the grounds that the determination is contradictory to law by filing a notice of appeal with the clerk of the circuit court in the jurisdiction in which the grievance arose. The agency shall request and receive prior approval of the Director before filing a notice of appeal.

ENTER:

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Neil A. G. McPhie, Hearing Officer
Cc by e-mail to the parties and their representatives
Cc by e-mail to the Department of Employment Dispute Resolution