Issue: Group III Written Notice (patient neglect); Hearing Date: 08/20/13; Decision Issued: 09/02/13; Agency: DBHDS; AHO: Lorin A. Costanzo, Esq.; Case No. 10149; Outcome: No Relief – Agency Upheld.

COMMONWEALTH OF VIRGINIA
OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In the matter of: Grievance Case No. 10149

Hearing Date: August 20, 2013
Decision Issued: September 2, 2013

PROCEDURAL HISTORY

Agency issued Grievant a Group III Written Notice on May 21, 2013 for violation of Departmental Instruction #201, *Reporting and Investigating Abuse and Neglect of Clients.* No disciplinary action was taken in addition to issuing the Group III Written Notice. The Written Notice, under *Nature of Offense and Evidence* stated:

> Violation of Departmental Instruction #201, *Reporting and Investigating Abuse and Neglect of Clients.* A facility investigation substantiated that on 04/12/13, you left individual *[Patient]* unattended on the day hall. You failed to notify anyone that you needed someone to sit with *(Patient]* while you departed the day hall to assist in the bathroom. Your actions created the ability for *[Patient]* to depart the suite unattended.[1]

Grievant timely grieved the issuance of the Group III Written Notice and the matter proceeded through the Resolution Steps. When matters were not resolved to Grievant's satisfaction, Grievant requested qualification of her grievance. On July 9, 2013 the matter was qualified for a hearing.[2] Effective August 5, 2013 a hearing officer was appointed by the Department of Human Resources Management.

A prehearing telephone conference was held with Grievant's Attorney, Agency Advocate, and Hearing Officer on August 13, 2013. A hearing was held on August 20, 2013. By agreement of the parties, all the exhibits exchanged were admitted into evidence *en masse.* Additionally, at hearing, Agreed Exhibits A, B, and C were admitted by agreement of the parties.

APPEARANCES

Agency's Presenter	(who was also the Agency's Party designee)
Witnesses:	Investigator
	Shift Supervisor #1
Grievant's Attorney	
Grievant	(who was also a witness)
Other Witnesses:	DSA
	Shift Supervisor #2
	DSP

[1] A. Tab 1, Written Notice.
[2] A. Tab 3.

ISSUES

Whether the issuance of a Group Ill Written Notice was warranted and appropriate under the circumstances?

BURDEN OF PROOF

As this is a disciplinary action, 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. A preponderance of the evidence is evidence which shows that what is intended to be proved is more likely than not; evidence more convincing than the opposing evidence.[3]

The employee has the burden of raising and establishing any affirmative defenses to discipline and any evidence of mitigating circumstances related to discipline.[4]

FINDINGS OF FACT

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

01. On May 21, 2013 Agency issued Grievant a Group Ill Written Notice (offense date April 12, 2013). The *Nature of Offense and Evidence* indicated:

> Violation of Departmental Instruction #201, Reporting and Investigating Abuse and Neglect of Clients. A facility investigation substantiated that on 04/12/13, you left individual ***[Patient]*** unattended in the day hall. You fail to notify anyone that you needed someone to sit with ***[Patient]*** while you departed the day hall to assist in the bathroom. Your actions created the ability for ***[Patient]*** to depart the suite unattended.

02. No disciplinary action was taken in addition to issuing the Group Ill Written Notice and the Written Notice indicated that, "Due to the fact that you have worked at facility for almost seven years with no prior disciplinary actions and your performance evaluations have consistently been rated you as "Exceeds Contributor", mitigation of termination is warranted in this case." [5]

03. Grievant has been employed by Agency since 2006 with a current job title of Direct Support Professional-11 (DSP II). On April 12, 2013 she worked at the Facility unit where Patient resided and she was responsible for Patient at the time matters relevant to this proceeding arose. [6]

04. Facility is operated by Agency and provides residential services and other services to individuals receiving with intellectual disabilities and other disabilities .[7]

---

[3] *Grievance Procedure Manual,* Office of Employment Dispute Resolution, Dept. of Human Resources Management, §5.8 and §9.

[4] *Grievance Procedure Manual,* Office of Employment Dispute Resolution, Dept. of Human Resources Management, §5.8.

[5] Agency Tab 1.

[6] Agency Tab 3 and Agency Tab 4.

[7] Agency Tab 4 and Testimony.

05. Patient is a 67-year-old male who resides at Facility and receives care and services for mental illness and mental retardation (intellectual disability) at Facility. Patient is intellectually disabled/mentally retarded and suffers with a number of matters including schizoaffective disorder, falls due to balance issues, episodes of persistent, repetitive self-injurious behaviors (rubbing his face raw), quick mood changes, not being connected with reality at times, and not being steady on his feet. [8]

06. Patient's resides on a unit housing nine adult males receiving residential services at Facility. Patient's unit is not considered a "secure living environment" wherein all of the entrances and exits require a key to enter and exit. The term, "Secure living environment" does not include a living area that is only secured at specific times, such as between dusk and dawn.[9]

07. Patient's unit has two doors via which persons could enter or exit the unit. Neither door was locked on April 12, 2013. At the time of the hearing Patient's unit had one of its two doors locked requiring a key to enter or exit the unit via this door. The other door was not locked from the inside at any time. This door allows anyone to exit the unit without a key at all times but is locked from the outside at certain times requiring a key to enter the unit at such times.[10]

08. On April 12, 2013 Grievant was responsible for providing services to Grievant. Patient was in Grievant's charge when she left him unattended in the unit day hall at approximately 5:40A.M. to assist another staff member in the bathroom. [11]

09. When Grievant left Patient unattended in the day hall she did not notify a supervisor or anyone that someone was needed to sit with Patient or assist with his care/supervision.[12]

10. After being left unattended by Grievant on April 12, 2013 at approximately 5:40A.M. Patient walked out of the unit and out of the building containing his unit. Patient walked/wandered outside unattended and unsupervised.[13]

11. At about 5:50A.M. on April 12, 2013 a Facility Food Services Technician was driving her car into a Facility parking lot and observed Patient unattended outside in the rain. Food Service Technician was not trained in direct care services. When she saw Patient he was about 537 feet from his unit. She did not know who he was or where he was assigned. She attempted to talk to Patient but was not able to determine his name or his residential unit. She took him to a nearby unit. A Security Officer was called and Patient was subsequently taken to Medical Clinic where it was determined he was not injured.[14]

12. A phone call was placed to Patient's unit (and another unit) at approximately 6:10A.M. on April 12, 2013 requesting staff to do a headcount to determine if anybody was missing. It was at this time that Grievant first determined Patient was not in his unit.[15]

---

[8] Agency Tab 4, Agency Tab 5 and Testimony.
[9] Testimony.
[10] Testimony.
[11] Agency Tab 4 and Testimony.
[12] Agency Tab 4 and Testimony.
[13] Agency Tab 4 and Testimony.
[14] Agency Tabs 4 & 5 and Testimony.
[15] Agency Tab 4.

13. On April12, 2013 the incident was reported to Facility Director/his designee at approximately 6:30A.M., the Department of Social Services at approximately 9:37A.M., and the Department of Health at approximately 1:00 P.M. [16]

14. Agency Investigator initiated an investigation pursuant to Dl-201 on April 12, 2013 to determine if abuse/neglect may have occurred.[17]

15. "Investigator's Summary" dated April 16, 2013 was filed upon completion of the investigation. The Investigator concluded Patient was found in the dark and rain several buildings over from his suite/unit unattended and Patient was estimated to be out of supervision for approximately ten minutes. It was further concluded that Grievant's actions rose to the level of "neglect" and concluded that "neglect" was substantiated.[18]

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 of Virginia. This comprehensive legislation includes procedures for hiring, promoting, compensating, discharging, and training state employees. It also provides for a grievance procedure. Code of Virginia, §2.2-3000 (A) sets forth the Virginia grievance procedure and provides, in 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 employee disputes which may arise between state agencies and those employees who have access to the procedure under §2.2-3001.

To establish procedures on *Standards of Conduct* and Performance for Employees of the Commonwealth of Virginia and pursuant to§ 2.2-1201of the Code of Virginia, the Department of Human Resource Management promulgated *Standards of Conduct* (Policy Number 1.60).

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 of Conduct* 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.

The *Standards of Conduct* provide that Group Ill offenses include acts of misconduct of such a severe nature that a first occurrence normally should warrant termination. "Abuse or neglect of clients" is indicated as an example of a Group Ill offense in *Attachment A* to Policy 1.60.[19]

---

[16] Agency Tab 4.
[17] Agency Tab 4 and Testimony.
[18] Agency Tab 4 and Testimony.
[19] Agreed Exhibit C.

Departmental Instruction 201 [20]

Departmental Instruction 201(RTS)03 ("DI 201")- "Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities" provides, in pertinent part, as follows:

> **201-1 Background**
>
> The ***{Department[*** has a duty to provide a safe and secure environment to individuals receiving services and has a philosophy of zero tolerance for abuse and neglect. The Department will, in all instances, investigate and act upon allegations of abuse or neglect….
>
> **201-3 Definitions**
>
> **Neglect** (Code of Virginia §37.2-100)
> This means that failure by a person, program, or facility operated, licensed, or funded by the department, responsible for providing services to do so, including 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.
>
> **201-05 Specific Guidance**
>
> **Rights of individuals**
> Each individual receiving services and a state facility has the right to:
> - be protected from harm including abuse, neglect, and exploitation (See§ 37.2AOO 12VAC35-115-50 (B) (2) and (D) (3); ...
>
> **Substantiating abuse and neglect**
>
> A finding of the abuse or neglect shall be substantiated by a preponderance of the evidence. The standards for substantiating abuse and neglect will be based on preponderance of the evidence gathered during the investigation process. See *"preponderance of the evidence"* in the definition section.

Policy entitled, "CLIENT OBSERVATIONS AND ACCOUNTABILITY" requires that that the physical location and whereabouts of all clients will be frequently determined, properly communicated and confirmed by direct care staff. All clients will be observed on a regular basis. Furthermore it is provided that staff need to know the physical whereabouts of clients assigned to their care at all times.[21]

Policy entitled, "INDIVIDUAL OUT OF NORMAL SUPERVISION" provides, in pertinent part:

> - Individuals residing at ***[Facility]*** have the right to be protected from harm at all times. To ensure that individuals are safe from harm, staff must know the physical whereabouts of individuals assigned to their supervision at all times….
>
> - Facility staff shall take appropriate action at all times to maintain accountability of the physical location of individuals under their care and supervision….[22]

Zero Tolerance:

Agency has a duty to provide a safe and secure environment to individuals receiving services and a philosophy of "zero tolerance" for abuse and neglect.

---

[20] Agreed Exhibit A.
[21] Agency Tab 11.
[22] Agency Tab 12.

Patient:

Patient is one of 9 adult intellectually disabled/mentally retarded males rece1vmg residential services a unit at Facility. Patient is a 67 year old male, with severe mental disabilities and profound mental retardation who was first admitted to Facility in 1954. He has a history of severe aggression (including choking staff) and inappropriate sexual behaviors. His "Behavior Support Plan" indicates that due to his history of engaging in inappropriate sexual behavior with peers, staff needs to closely monitor him to ensure that he does not have the opportunity to be alone with a peer(s).

The Diagnostic Assessment for the Severely Handicapped Revised (DASH II) completed in 2011 indicated Patient displays significant signs of psychopathology in the areas of Impulse, Organic, Mood, Mania, POD/Autism, and Schizophrenia. [23]

Facility additionally has concerns as to Patient's walking and falling due to balance issues. Patient has a Falls *Prevention Plan* which notes:

- Patient is not safe on steps;
- Avoid steps whenever possible;
- Gate belt should be on during all waking hours but staff do not need to offer assist unless unsteady;
- For long outings or if Patient is noticeable unsteady he should use the transport wheelchair; and
- If at any time Patient loses his balance staff should use the gait belt to support him whenever possible.

His *Falls Prevention Plan* also indicates he is to have available a Gait Belt, Transport Wheelchair, and Knee/elbow Pads/padding clothing. The Plan indicates "Assistance Needed" in areas of Toileting and Bathing, Transfers, Stairs, Ambulation, Navigating Curbs and Uneven Surfaces, Entering/Exiting Vehicles, Wheelchair Mobility, and Uneven Surfaces. [24]

Patient occasionally continues to display aggressive behavior but not the degree/intensity as in the past. In 1998 Patient was moved to a waiver funded home, however, in 2000 he was admitted to a Mental Health Institute on a Temporary Detention Order. It was determined he had profound mental retardation and that Patient's behavioral problems were related to his profound mental retardation, more than to his psychiatric problems.[25]

Timeline:

The approximate timeline of events occurring on April 12, 2013 include:

3:30 A.M.	Patient attempted to leave unit but was stopped.
5:20 A.M.	Medical issue with resident on other unit. That unit's staff to escort the resident to medical clinic.
5:30 A.M.	One staff to go from Patient's unit to other unit while the resident was at clinic.
5:40 A.M.	Patient left unattended in day hall and subsequently Patient left the unit and building.
5:50 A.M.	Food Service Technician found Patient unattended and walking/wandering in the rain.
6:00 A.M.	Normal wakeup time for Patient's unit and start of resident's A.M. care.
6:10 A.M.	Patient's unit called and requested to do a headcount. Patient found to be missing.
6:30 A.M.	Incident reported to Facility Director/designee.

At approximately 3:30A.M. on April12, 2013 Patient tried to leave the unit but was stopped by a member of unit's staff. The staff member who stopped Patient from leaving indicated to Investigator he believed the other staff on the unit knew Patient had been trying to leave.

---

[23] Agency Tab 6.
[24] Agency Tab 7.
[25] Agency Tab 6.

At approximately 5:20 A.M. on April 12, 2013 a medical issue with a resident on another unit occurred necessitating a staff member from that unit having to escort the resident to the medical clinic.

At about 5:30A.M. Supervisor pulled one of the five staff assigned to Patient's unit to go to the other unit which would be down to 3 staff members with the one staff required to be off the unit to escort the resident to the medical clinic. The staff member who previously stopped Patient from wandering off the unit was sent to the other unit. He reported to Investigator that, when he left the unit, he told Grievant that Patient needed to be watched.

Removing one staff from Patient's unit put the unit below its minimum coverage level of five staff members to four staff. Of the four remaining staff two were on 1:1 duties. The decision to pull one staff member from Patient's unit reflected considerations including:

- the other unit had 4 assigned staff which would be reduced to 3 while one staff took a resident to the medical clinic;
- pulling the one staff from Patient's unit to the other unit would result in each unit having 4 staff members;
- it was believed the staff member from Patient's unit would only be pulled off Patient's unit for a short time period; and
- residents on Patient's unit normally were not up for their morning activities until 6:00A.M.

Grievant contests the staff member who was pulled advised her she needed to watch Patient. However, Grievant was aware that Patient would not stay in his room and indicated this in her written statement of May 8, 2013. She also indicated when the staff member told her he was being pulled to another unit the first thing she asked him was where Patient was.[26]

The staff member who was pulled left Patient's unit at about 5:30A.M. At approximately 5:40AM Grievant left Patient unattended in his unit's day hall to go to the bathroom to assist another staff with a resident. At no time did Grievant request anyone assist with Patient, sit with Patient, or check on Patient. She did not notify a supervisor someone was needed to sit with Patient or assist with his care.

After being left unattended about 5:40A.M., and while unattended, Patient exited the unit and exited the building containing unit. Patient walked/wandered around outside until being observed outdoors in the rain at about 5:50A.M. at or near a parking lot. He was determined to be about 537 feet distance from his unit. Investigator found Patient was out supervision for approximately 10 minutes (from 5:40A.M. to 5:50A.M.).

At about 5:50 A.M. Food Service Technician was parking at Facility and saw Patient walking/wandering outside near the kitchen area. She described it as being dark and rainy when she saw Patient. Food Service Technician went to him, tried to talk to him, and tried to determine what unit he was from. However, Patient wasn't able answer. She took him to a nearby Facility unit, a security guard was called, and Patient was transported to the Medical Clinic for examination.

At about 6:10A.M. Patient's unit was called and asked to do a headcount determine if anyone was missing from the unit. Only at this time did Grievant realize that Patient was not on the unit and was missing.

[26] Agency Tab 3.

Grievant:

Grievant contends that she was not aware Patient tried to leave the unit earlier and was not told to watch Patient. She also contends she was required to assist the staff member in the bathroom and the unit should have been locked.

Not Aware: Grievant contends she was not aware Patient tried to leave unit earlier and was not told to watch Patient. However, the staff member pulled to go to the other unit indicated to Investigator he told Grievant that Patient needed to be watched. He also stated that the other staff on the unit knew Patient had been trying to leave.[27]

Grievant's May 8, 2013 written statement indicated that 4/12/13 Patient had to be redirected by her back to his room and he came back on the day hall and would not stay in his room. She also indicated that when the staff member told her he was being pulled to another unit the first thing she asked him was where Patient was.[28]

DSA testified she worked on Patient's unit but was off work on April 12, 2013. She was familiar with Patient and testified to his patterns of behavior including his trying to leave the unit. She was very aware of the need to watch Patient as he would often go to a door and try to leave if he thinks people were not paying attention to him. He would say he was going home. Based upon his often exhibited behaviors DSA knew to watch Patient very carefully. She was also aware Patient could generally be redirected verbally though when going through one of his episodes he was more difficult to direct.

Patient's Behavior Support Plan indicated a need to closely keep track of Patient due to some inappropriate behaviors of Patient. The Plan provided that staff will closely monitor him to ensure that he does not have the opportunity to be alone with a peer(s).[29]

Policy entitled, "CLIENT OBSERVATIONS AND ACCOUNTABILITY" requires that staff need to know the physical whereabouts of clients assigned to their care at all times. Additionally, the physical location and whereabouts of all clients will be frequently determined, properly communicated and confirmed by direct care staff. All clients will be observed on a regular basis . . .[30]

Facility Policy "INDIVIDUAL OUT OF NORMAL SUPERVISION" provides, in part, that individuals residing at Facility have the right to be protected from harm at all times. To ensure that individuals are safe from harm, staff must know the physical whereabouts of individuals assigned to their supervision at all times.

The evidence indicates that Grievant worked with Patient previously and was aware of or should have been aware of his behavior of trying to leave/going to the door and the need to closely monitor him. Patient has a well-known pattern of trying to leave, especially when he thinks he is not being paid attention to. Grievant was charged by Policy with knowing the physical whereabouts of Patient and to observe him on a regular basis. Patient's Behavior Support Plan indicated that staff will closely monitor him to ensure that he does not have the opportunity to be alone with a peer(s).

---

[27] Agency Tab 4.
[28] Agency Tab 3.
[29] Agency Tab 6.
[30] Agency Tab 11.

Required to assist: Grievant does not contest that she was responsible for providing care for Patient. Grievant contends she was required to assist another staff member and the evidence indicates that she was asked to help another staff member. Patient was in her charge and she was responsible for providing care and services necessary to the health, safety, and welfare of Patient. The evidence indicates she was unaware where Patient was and what he was doing until a phone call required a headcount be performed on the unit.

The actual time Patient was unattended and the actual time between leaving the unit and Grievant discovering Patient left the unit depends what time (between 5:40 A.M. and 5:50 A.M.) he actually left. Patient was not on the unit for between 20 to 30 minutes (approximate) before Grievant became aware he was missing. Patient was left unattended and unsupervised by Grievant for about 30 minutes (from about 5:40A.M. to 6:10A.M.).

While Grievant was requested to assist a staff member she also was required to provide for Patient's safety and security and that of other clients. Patient's Behavior Support Plan provided staff needed to closely monitor Patient to ensure that he does not have the opportunity to be alone with a peer(s).[31]

The length of the 30 minute time period Grievant did not know where Patient was, what he was doing, or what was going on with him is of concern. This period of time ended only when a telephone call was received requesting a head count. The evidence indicates Grievant was responsible for Patient and knew or should have known of his Behavioral Support Plan and his pattern behavior of trying to leave/going to the door. The evidence further indicates Grievant did not ask for assistance or ask a supervisor to provide additional help during this period.

Doors locked: Grievant contends the unit's doors should have been locked. Patient's unit has two doors via which persons could enter or exit the unit. Neither door was locked on April12, 2013. Patient's unit was not and is not considered a "secure living environment" wherein all of the entrances and exits require a key to enter and exit.

As of the date of hearing, one of the two doors of Patient's unit is generally kept locked requiring a key to enter or exit the unit through this door. The other door is not locked from the inside at any time allowing anyone to leave the unit at any time without a key. However, this door can be locked to persons entering the unit so as to require a key to be used to enter.[32]

The decision to lock a client on a unit or lock a unit is a decision for management and/or medical practitioners and involves a number of considerations including legal rights and duties, client needs and abilities, ethical considerations, and applicable policies, statutes, and law.

Management has the duty and the right to manage the affairs of Agency. Facility Policy has been established and implemented providing, "While individuals have the right to be protected from harm, they also have the right to live in the least restrictive environment consistent with their identified need for supports."***{emphasis added}***

[31] Agency Tab 6.
[32] Testimony.

Policy acknowledges that some clients, due to special conditions, will require more intense supervision as ordered by his/her primary health care practitioner. Policy provides that Facility will take necessary action to ensure the safety and wellbeing of individuals while affording each person the opportunity to live in the least restrictive environment consistent with his/her condition and presenting skills. Additionally, Policy requires that Facility will act in a proactive manner to make necessary improvements in an individual's support/treatment plan to promote his/her safety while affording him/her the opportunity to live in the least restrictive environment.[33]

The evidence indicates that Grievant was responsible for Patient who, due to his multiple mental and physical conditions, required care and supervision for his welfare, safety, and security. Policy requires an individual receiving services to be able to live in the least restrictive environment consistent with his/her condition and presenting skills.

Due Process:

Policy Number 1.60 provides for an advance notice of discipline to an employee prior to the issuance of a Written Notice and that the employee must be given oral or written notification of the offense, an explanation of the agency's evidence in support of the charge, and a reasonable opportunity to respond.

Grievant received a letter dated April 12, 2013 concerning allegations of client abuse/neglect and an investigation being conducted.[34] By letter dated May 7, 2013 Grievant was informed that, as a result of an administrative investigation, there was cause to believe that Patient, on April 12, 2013, was left unattended in the day hall and that she failed to notify anyone that she needed someone to sit with Patient when she departed the day hall to assist other individuals in the bathroom. Concern was expressed that this created the ability for Patient to depart the suite/unit unattended and Patient was subsequently found in the parking lot by another staff member. Grievant was further notified this was in violation of Departmental Instruction 201and may result in a Group Ill Written Notice with termination.[35]

Grievant was afforded an opportunity to respond within 24 hours or on the following administrative work day upon receipt of the letter of 5/7/13. She was afforded an opportunity to meet with management and present a written statement in support of her position in response to the charge. Also, she was informed that after the meeting a final decision or recommendation will be made as to disciplinary action. Grievant did provide written response dated May 8, 2013.[36]

The evidence indicates that, prior to the issuance of the Group Ill Written Notice on 5/21/13, Grievant was given notification of the offense, an explanation of the agency's evidence in support of the charge, and a reasonable opportunity to respond and present mitigating factors or denial of the charge.

Mitigation:

Va. Code § 2.2-3005.1 authorizes hearing officers to order appropriate remedies including "mitigation or reduction of the agency disciplinary action." Under Va. Code §2.2-3005, the hearing officer has the duty to "receive and consider evidence in mitigation or aggravation of any offense charged by an agency in accordance with the rules established by the Department of Human Resource Management."

---

[33] Agency Tab 12.
[34] Agency Tab 2.
[35] Agency Tab 3.
[36] Agency Tab 3.

§ VI. (A.) of the *Rules for Conducting Grievance Hearings,* Department of Human Resource Management, Office of Employment Dispute Resolution provides:

> ... a hearing officer is not a "super-personnel officer". Therefore, in providing any remedy, the hearing officer should give the appropriate level of deference to actions by agency management that are found to be consistent with law and policy.

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.[37]

Under a Group Ill Grievant was subject to discharge. Agency mitigated and did not impose termination or any suspension for the Group Ill offense. The evidence indicates that Agency took into consideration mitigating facts including Grievant's service, work history, her not having any prior disciplinary actions, and her performance evaluation having consistently been rated as "Exceeds Contributor". Agency also gave consideration to its obligation to provide a safe and secure environment to Patient and to other residents, to Patient's history and needs, and to Agency's philosophy of "zero tolerance" for abuse and neglect.

Accordingly, because Agency assessed mitigating factors, even if the hearing officer were to disagree with the action, the *Rules* only allow this hearing officer to mitigate the discipline further if the Hearing Officer, upon consideration of the evidence, were to find that Agency's discipline exceeds the limits of reasonableness. Upon the evidence presented in this cause, the Hearing Officer does not find that Agency's discipline exceeds the limits of reasonableness.

CONCLUSION

The evidence indicates, by a preponderance, a finding of neglect and violation of Dl 201. Grievant failed to provide services necessary to the health, safety or welfare of Patient who was receiving care or treatment for a mental illness and/or mental retardation (intellectual disability) at Agency Facility. Grievant was responsible for providing such care and services to Patient when Grievant left Patient in the day hall unattended and Patient walked out of his unit and building and was later found unattended walking/wandering outside in the rain.

For the reasons stated above, based upon consideration of all the evidence presented at hearing, Agency has proven, by a preponderance of the evidence, that:

1. Grievant engaged in the behavior described in the Written Notice.
2. The behavior constituted misconduct.
3. The Agency's discipline was consistent with law and policy.
4. There are not mitigating circumstances justifying a reduction or removal of the disciplinary action and Agency's discipline does not exceed the limits of reasonableness.

[37] Rules for Conducting Grievance Hearings§ VI. B. 2.

DECISION

For the reasons stated above, the Agency has proven by a preponderance of the evidence that the disciplinary action of issuing a Group Ill Written Notice was warranted and appropriate under the circumstances and the Agency's issuance of a Group Ill Written Notice is ***UPHELD.***

APPEAL RIGHTS

As the *Grievance Procedure Manual (effective date: July 1, 2012)* 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.

A. Administrative Review:

A hearing officer's decision is subject to administrative review by both EDR and Director of DHRM based on the request of a party. Requests for review may be initiated by electronic means such as facsimile or e-mail. A copy of all requests for administrative review must be provided to the other party, EDR, and the Hearing Officer.

A party may make more than one type of request for review. All requests for administrative review must be made in writing and ***received by*** the reviewer within 15 calendar days of the date of the original hearing decision. ***"Received by"*** means delivered to, not merely postmarked or placed in the hands of a delivery service.

1. A challenge that the hearing decision is inconsistent with state or agency policy is made to the DHRM Director. This request must refer to a particular mandate in state or agency policy with which the hearing decision is inconsistent. The director's authority is limited to ordering the hearing officer to revise the decision to conform it to written policy. Requests must be sent to the Director of the Department of Human Resources Management, 101 N. 14th Street, 12th Floor, Richmond, VA 23219 or faxed to (804) 371-7401ore-mailed.

2. Challenges to the hearing decision for noncompliance with the grievance procedure and/or the Rules for Conducting Grievance Hearings, as well as any request to present newly discovered evidence, are made to EDR. This request must state the specific requirement of the grievance procedure with which the hearing decision is not in compliance. The Office of Employment Dispute Resolution's ("EDR's") authority is limited to ordering the hearing officer to revise the decision so that it complies with the grievance procedure. Requests must be sent to the Office of Employment Dispute Resolution, 101N. 14th Street, 12th Floor, Richmond, VA 23219, faxed to EDR (EDR's fax number is 804-786-1606), or e-mailed to EDR (EDR's e-mail address is edr@dhrm.virginia.gov).

B. Final Hearing Decisions:

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.

C. Judicial Review of Final Hearing Decision:

Once an original hearing decision becomes final, either party may seek review by the circuit court on the ground that the final hearing decision is contradictory to law. A notice of appeal must be filed with the clerk of the circuit court in the jurisdiction in which the grievance arose within 30 calendar days of the final hearing decision.

Lorin A. Costanzo, Hearing Officet