COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

Office of Employment Dispute Resolution

DECISION OF HEARING OFFICER

In re:

Case number: 12036

Hearing Date: March 13, 2024
Decision Issued: April 12, 2024

PROCEDURAL HISTORY

On September 12, 2023, Grievant was issued a Group I Written Notice of disciplinary action (the Group I Written Notice).[1] The Agency described the offense as follows:

> Through an investigation that concluded on July 27, 2023, it was determined through a preponderance of evidence, that Grievant used state time to conduct research unrelated to his assigned duties. These activities included more than 100 documents related to Covid-19, and more than 20 different Word documents ranging from two (2) to 137 pages in length related to patient abuse, COVID-19 protocols, and facility activities; and required him to access patients' electronic health records for reasons unrelated to his assigned duties. These actions are a violation of, and failure to follow, DHRM Policy 1.60, Standards of Conduct, for not performing his assigned duties and responsibilities with the highest degree of public trust and for misuse of state time.[2]

On September 12, 2023, Grievant was issued a Group III Written Notice of disciplinary action (the Group III Written Notice regarding EHR Access).[3] The Agency described the offense as follows:

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[1] Agency Ex. 4.
[2] Agency Ex. 4.
[3] Agency Ex. 6. The Written Notice form used for this offense initially contained a checked box identifying this offense as a Group I offense which contradicted the Agency's intention, the corresponding due

> Through an investigation that concluded on July 27, 2023, it was determined through a preponderance of the evidence, that Grievant accessed patients' electronic health records for reasons unrelated to his assigned duties. It was determined that he accessed no less than nineteen (19) patients' electronic health records and protected health information without proper authorization between the dates of November 28, 2022, and April 5, 2023. It was confirmed these patients were at no time assigned to his caseload, they were not assigned to his assigned patient unit, and he had no assigned duties involving these patients. These actions are a violation of, and failure to follow DHRM Policy 1.60, Standards of Conduct, DBHDS Departmental Instruction 1001, Privacy, Policies and Procedures for the Use and Disclosure of PHI, and [Facility] Policy 180-027, Request for Patient Information. Specifically, for the inappropriate accessing of patients PHI that was unrelated to his duties at [the Facility]. Ordinarily, inappropriate accessing and copying of sensitive information would be a lower-level offense, but because each of these occurred more than four times, they each constitute a Level 4 offense, per policy. [4]

On September 12, 2023, Grievant was issued a Group III Written Notice of disciplinary action (the Group III Written Notice regarding disclosures to Writer).[5] The Agency described the offense as follows:

> Through an investigation that concluded on July 27, 2023, it was determined through a preponderance of evidence, that [Grievant] accessed, stored, and transmitted patients' electronic health records, protected health information, and/or sensitive legal information for reasons unrelated to his assigned duties, and without proper authorization to an entity outside of [the Facility] and [the Agency], without proper approvals for requests of patient information. In an interview on May 26, 2023, he acknowledged and stated that he shared a document containing patient information to [Writer]. It was confirmed these patients had no active authorizations or approvals to release information to [Writer], nor did he have approvals to release their information as an agent of [the Facility.] These actions are a violation of, and failure to follow, DHRM Policy 1.60, Standards of Conduct, [Agency] Departmental Instruction 1001, Privacy, Policies and Procedures for the Use and Disclosure of PHI, and [Facility] Policy 180-027, Request for Patient Information. Specifically, for the inappropriate and unauthorized disclosure of the PHI of several [Facility] patients to [Writer].[6]

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process letter previously sent to Grievant, and the Agency's discussions with Grievant. The Agency provided Grievant with a corrected form dated September 19, 2023.

[4] Agency Ex. 6.

[5] Agency Ex. 8. The Written Notice form used for this offense initially contained a checked box identifying this offense as a Group I offense which contradicted the Agency's intention, the corresponding due process letter previously sent to Grievant, and the Agency's discussions with Grievant. The Agency provided Grievant with a corrected form dated September 19, 2023.

[6] Agency Ex. 8.

On September 12, 2023, Grievant was issued a Group II Written Notice of disciplinary action (the Group II Written Notice).[7] The Agency described the offense as follows:

> Through an investigation that concluded on July 27, 2023, it was determined through a preponderance of evidence, that Grievant accessed patients' electronic health records for reasons unrelated to his assigned duties. It was determined that he downloaded and/or saved images from patients' electronic health records and transmitted them via his state email address to his personal email address. This data was included in more than 20 different Word documents ranging from two (2) to 137 pages in length, related to patient abuse, Covid-19 protocols, and facility activities; and storing more than fifty (50) images of patients' electronic health record data, for reasons unrelated to his assigned duties. These actions are a violation of, and failure to follow, DHRM Policy 1.60, Standards of Conduct, DHRM Policy 1.75, Use of Electronic Communications and Social Media, DBHDS IT Media Protections Policy, and DBHDS IT Acceptable Use Policy. Specifically for inappropriate accessing, downloading, transmitting, and storing of sensitive information belonging to DBHDS from and on your state issued computer.[8]

On September 12, 2023, Grievant was issued a Group III Written Notice of disciplinary action (the Group III Written Notice regarding disclosures to Attorney).[9] The Agency described the offense as follows:

> Through an investigation that concluded on July 27, 2023, it was determined through a preponderance of the evidence, that Grievant accessed, stored and transmitted patients' electronic health records for reasons unrelated to his assigned duties, and without proper authorization to an entity outside of [the Facility] and [the Agency], without proper approvals for requests of patient information. It was determined that he accessed, stored, and transmitted no less than four (4) patients' electronic health records and protected information, and/or sensitive legal information and documents without proper authorization on the following dates: August 18, 2021, September 21, 2021, March 9, 2022, and June 13, 2023. It was confirmed these patients had no active authorizations or approvals to release information to [Attorney], nor did he have approvals to release their information as an agent of [the Facility]. These actions are a violation of, and failure to follow, DHRM policy 1.60, Standards of Conduct, DBHDS Departmental Instruction 1001, Privacy, Policies and Procedures for the

[7] Agency Ex. 5. The Written Notice form used for this offense initially checked the box to identify this offense as a Group I offense which contradicted the Agency's intention and the Agency's discussions with Grievant. The Agency provided Grievant with a corrected form dated September 19, 2023.
[8] Agency Ex. 5.
[9] Agency Ex. 7. The Written Notice form used for this offense initially contained a checked box identifying this offense as a Group I offense which contradicted the Agency's intention, the corresponding due process letter previously sent to Grievant, and the Agency's discussions with Grievant. The Agency provided Grievant with a corrected form dated September 19, 2023.

> Use and Disclosure of PHI, and [Facility] Policy 180-027, Request for Patient Information. Specifically, for the inappropriate and unauthorized disclosure of the PHI of several [Facility] patients to [Attorney].[10]

On October 11, 2023, Grievant timely filed a grievance to challenge the Agency's actions. The matter advanced to hearing. On November 13, 2023, the Office of Employment Dispute Resolution assigned this matter to the Hearing Officer. The hearing in the matter was originally scheduled to occur on January 17, 2024. At the request of the parties, the Hearing Officer continued the hearing to March 13, 2024, to allow additional time for the parties to try to resolve their issues. On March 13, 2024, a hearing was held in conference room facilities at a court complex near the Facility.

APPEARANCES

Grievant
Grievant's Counsel
Agency Counsel
Agency Counsel
Agency Party Designee
Witnesses

ISSUES

1. Whether Grievant engaged in the behavior described in the written notices?

2. Whether the behavior constituted misconduct?

3. Whether the Agency's discipline was consistent with law (e.g., free of unlawful discrimination) and policy (e.g. properly characterized as a Group I, II or III offense)?

4. Whether there were mitigating circumstances justifying a reduction or removal of the disciplinary action, and if so, whether aggravating circumstances existed that would overcome the mitigating circumstances?

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

[10] Agency Ex. 7.

FINDINGS OF FACT

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

Prior to his dismissal, the Agency employed Grievant as a Psychology Associate II at the Facility.[11] As a Psychology Associate at the Facility, Grievant's core responsibilities included direct patient care.[12] At other times relevant to this case and prior to December 2022, Grievant had been a Health Care Specialist II as part of the Facility's quality management group. In that role, Grievant's duties included identifying and reporting potential triggers of patient aggression, reporting on quality improvement efforts and coordinating the "near misses" program.[13] No evidence of prior active disciplinary action was introduced during the hearing.

At all times relevant to this case, Grievant had Level One HIPAA[14] Access. Grievant's Employee Work Profile described his Level One Access as "complete access to all Patient related Protected Health Information."[15]

Attorney is Grievant's brother.

On August 18, 2021, at 3:29 pm, a paralegal in Attorney's office emailed Grievant at Grievant's Agency email address regarding Patient G. The paralegal requested information from Grievant and stated that "[t]his is one of Attorney's clients who has been admitted into [Facility], [Attorney] asks what is his status?"[16] Grievant replied on that same date at 4:39 pm from his Agency email account with a narrative summary of information from the patient's health record, including information regarding the patient's criminal record, his ethnicity, former city of residence (noting that also was the location of the patient's authorized representative), prior injury (including type and date) and drug use history. Grievant also made the observation that "[t]he evaluations are different here depending on who he talks with."[17]

On September 8, 2021, at 11:57 am, the Attorney's paralegal again emailed Grievant at his Agency email address, this time informing Grievant that Attorney had been court-appointed to represent two patients, Patient C and Patient L, and requesting Grievant to "let him know their status." At 1:10 pm, Grievant replied to ask the paralegal for clarification, writing "[d]o you mean what their classification is, their diagnosis, or how they are behaving?"[18]

On September 20, 2021, at 10:01 am, Attorney's paralegal emailed Grievant at his Agency email address stating that "[Attorney] asks if you could please send him any

[11] Grievant Ex. B at 14-19.
[12] Grievant Ex. B at 14, 16.
[13] Grievant Ex. C at 22-29.
[14] HIPAA refers to the Federal Health Insurance Portability and Accountability Act.
[15] Grievant Ex. B at 14 and Ex. C at 22.
[16] Agency Ex. 3, Administrative Investigation Review, at ex. C.
[17] Agency Ex. 3, Administrative Investigation Review, at ex. C.
[18] Agency Ex. 3, Administrative Investigation Review, at ex. D.

information you have on [Patient C] while he was a patient at [Facility].” Grievant replied from his Agency email account on September 21, 2021, at 11:09 am and provided a narrative summary of information that included, the month the patient transferred to the Facility from another facility, the reason Patient C was admitted to the other facility, and information that the patient had “been found unrestorable” at a prior time. Grievant also provided information about the patient’s discharge to another facility, the patient’s transfer, information about a notation from “Social Work,” information about anticipated future study involving the patient, the name of a community services board member following the patient and that “his mother is involved.”[19]

On March 9, 2022 at 9:49 am, Attorney’s paralegal emailed Grievant at his Agency email address with the request from Attorney that Grievant “let him know [Patient L’s] status.”[20] Grievant replied from his Agency email account at 4:45 pm that same day and provided screen shots of documents and information from Patient L’s electronic health records, including information about the patient’s admission status and admission date, birth date, medications, readiness for discharge, behavior, social worker notes, and diagnoses in addition to screen shots of court documents.[21]

On June 13, 2022, at 2:12 pm, Attorney’s paralegal emailed Grievant at his Agency email address and asserted that Attorney “represents this gentleman in Court tomorrow.” The paralegal requested from Grievant “what can you tell him about [Patient N]?”[22] Grievant replied from his work email account at 3:31 pm that same day and provided a narrative summary of information including where Patient N was from, prior criminal and medical history, specific information about behavioral history, information from notes, name of a former psychiatrist, a quote from a notation made by the patient’s psychologist and a screen shot of notes from the patient’s social worker (including the social worker’s name).[23]

Writer contributes articles to Blog and newspapers across Virginia. Writer testified that his investigative reporting focuses on issues related to healthcare and education in Virginia.[24]

On March 16, 2023, at approximately 11:30 am, Grievant sent an email to the editor of Blog. Grievant provided the editor with Grievant’s personal email address and requested that the editor put Grievant into contact with Writer, a contributor to Blog. Grievant wrote:

> Hello. In many of your [Blog’s] articles I participate in some of the discussions with the pseudo name [penname]. I have commented on some of the systemic abuse I have seen in particular with regards to SARs-2 restrictions in state psychiatric facilities. I have much information – first hand

[19] Agency Ex. 3, Administrative Investigation Review, at ex. E.
[20] Agency Ex. 3, Administrative Investigation Review, at ex. F.
[21] Agency Ex. 3, Administrative Investigation Review, at ex. F.
[22] Agency Ex. 3, Administrative Investigation Review, at ex. G.
[23] Agency Ex. 3, Administrative Investigation Review, at ex. G.
[24] Hearing Recording at 5:15:52-5:16:11.

> and documented I would like to share with [Writer]. He has been kind enough to invite me to connect with him and asked that I contact you. . . .[25]

Writer responded to Grievant at 11:44 am on that same day, as follows:

> Good morning [Grievant]. As background, I was on [Governor's] transition team. The gubernatorial appointees in the Department of Health and Human Resources have been very forthcoming with me up until now.
>
> They don't want bad things to go uncorrected and in my experience with them won't try to cover anything up. I fully expect that they will be very aggressive in pursuing your observations and will get back to me on what they find and do about it.
>
> They will need as much detail as you have – locations, observations, dates, times, names – in order to pursue it. Pass it on to me and I will provide it to them with or without your name and contact information attached as you may specify.[26]

Grievant responded to Writer and the editor at 5:07 pm on March 16, 2023. Grievant thanked editor for putting him in touch with Writer and then provided Writer with additional information about Grievant:

> [Writer] I work at [Facility]. Please let me know what information may be helpful to you as I have much and have spoken with OSIG both by phone and in person, as well as the state human rights advocate. I have contacted [Delegate] via email several times, as well as [Senator A and Senator B]. However actions at this hospital continue to be abusive and I will continue loudly advocate for these patients to whomever may be able to help.[27]

Writer emailed Grievant later that evening:

> I am going to elevate this information above the people you talked to. Let me know if I can use your name or not and whether you would be willing to meet with senior state officials to discuss. I would like details of a couple of specific incidents to make the point.[28]

Writer continued to communicate with Grievant and advised that he was speaking with administration officials of his intent to assist Grievant. On March 21, 2023, at 8:05 am, Writer sent Grievant an email writing:

> The time is very opportune for you to go forward with your complaint about conditions at [Facility]. I have contacted [Cabinet Secretary], and he will personally ensure your complaints are investigated properly. But again, he

[25] Grievant Ex. A at 2.
[26] Grievant Ex. A at 4.
[27] Grievant Ex. A at 5.
[28] Grievant Ex. A at 4.

> will need specifics. If you send them to me I will provide them to him, also personally. He really wants any abuse to stop.[29]

On March 22, 2023, at 10:31 am, Grievant wrote to Writer:

> Thank you. Sorry for the delay but I have a large document I am editing that I would like to send. I am hoping to get that to you today. If not, tomorrow – latest. Since the bulk of it is refers to specific pt. abuse/neglect – is it ok to include their names? Some of it is captured directly from the record.[30]

Writer replied to Grievant at 10:47 am on March 22, 2023, "[t]hat is great. Looking forward to it. I will get it to the Secretary. He will absolutely take action."[31] Later that evening, Writer emailed Grievant and stated: "I have been advised to ask you to redact all patient names."[32]

On March 24, 2023, at 10:01 am, Grievant sent a Word document named "[Facility] Abuse.docx" from his work email account to his personal email account.[33]

On March 24, 2023, at 10:05 am, Grievant sent a document to Writer from his personal email account. Writer replied at 10:09 am, asking "[i]s there anything new here [Grievant]? I already forwarded the other one. It was very powerful."[34]

On March 31, 2023, the Agency's Deputy Commissioner met with the Facility Director and the Facility HR Director to discuss a document that the Office of the State Inspector General had received and then shared with the Deputy Commissioner.[35] The Deputy Commissioner provided a copy of the document, entitled "Statement of [Grievant]"[36] to the Facility Director and directed the Facility Director to develop an action plan to address issues raised by the document. The Facility Director directed the Facility's risk manager to investigate the allegations regarding patient care and alleged abuse raised in the document.[37] The HR Director was instructed to coordinate the investigation into the potential release of confidential patient health information.[38]

The Agency's investigation included a review of information on Grievant's Agency-issued computer and an electronic record of patient electronic health records accessed by Grievant.

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[29] Grievant Ex. A at 5.
[30] Grievant Ex. A at 5.
[31] Grievant Ex. A at 6.
[32] Grievant Ex. A at 6.
[33] Agency Ex. 3, Administrative Investigation Review, at ex. H.
[34] Grievant Ex. A at 6.
[35] Agency Ex. 3, Administrative Investigation Review, Hearing Recording at 2:28:13-2:34:05. No evidence was presented identifying the party that provided the document to the Office of the State Inspector General.
[36] Agency Ex. 3, Administrative Investigation Review, at ex. A.
[37] Hearing recording at 2:29:39-2:34:05.
[38] See Agency Ex. 3, Hearing recording at 25:14-26:21.

On April 7, 2023, Grievant was placed on administrative leave pending an investigation. The Agency's investigation included an interview of Grievant, a review of information on Grievant's Agency-issued computer, and a review of electronic health records Grievant had accessed.

CONCLUSIONS OF POLICY

Unacceptable behavior is divided into three types of offenses, according to their severity. Group I offenses "include acts of minor misconduct that require formal disciplinary action."[39] Group II offenses "include acts of misconduct of a more serious and/or repeat nature that require formal disciplinary action." Group III offenses "include acts of misconduct of such a severe nature that a first occurrence normally should warrant termination."

Additionally, the Agency's Departmental Instruction 1001 (PHI)03 and Manual, Privacy Policies and Procedures for Use and Disclosure of Protected Health (DI 1001) sets forth Agency guidance for the appropriate discipline for failure to properly secure access to protected health information, and for the misuse or improper disclosure of protected health information. The guidance sets forth four levels of offenses, includes examples of each level of offense and a description of discipline associated with each level of offense.

Examples of Level 1 offenses under DI 1001 include: accessing information that an employee does not need to do his job, sharing computer access codes, leaving a computer unattended or unsecured, inadvertently disclosing sensitive information to or inadvertently discussing sensitive information with unauthorized persons and discussing sensitive information in a public area. Level 1 offenses normally would result in a written counseling or notice of improvement needed.

Examples of Level 2 offenses include: a second occurrence of any Level 1 Offense (does not have to be a recurrence of the same offense), copying sensitive information without authorization to copy (note: copying information for an unauthorized reason is prohibited even if the individual has access to the information), changing sensitive information without authorization, failure/refusal to cooperate with Information Security Officer, Privacy Officer, Facility Security Officer, Chief Information Officer, and/or authorized designee, failure to notify management of a potential breach in access to or use of protected health information. A Level 2 offense normally will result in the issuance of a Group I written notice.

Examples of Level 3 offenses include: a third occurrence of any Level 1 Offense (does not have to be a recurrence of the same offense), a second occurrence of any Level 2 Offense (does not have to be a recurrence of the same offense), unauthorized use or disclosure of protected health information, using another person's computer access code (user name or password), failing/refusing to comply with a remediation resolution or recommendation, using social media to comment on consumer(s) in a manner that

[39] The Department of Human Resources Management ("DHRM") has issued Policy 1.60, Standards of Conduct for State employees.

attempts to mask the identity of the consumer(s), and failure to notify management of a potential breach in access to or use of protected health information. A Level 3 offense normally will result in the issuance of a Group II written notice.

Examples of Level 4 offenses include: a fourth occurrence of any Level 1 Offense (does not have to be a recurrence of the same offense), a third occurrence of any Level 2 Offense (does not have to be a recurrence of the same offense), a second occurrence of any Level 3 Offense (does not have to be a recurrence of the same offense), obtaining sensitive information under false pretenses, using and/or disclosing sensitive information for commercial advantage, personal gain, or malicious harm, posting identifiable information regarding consumers via social media, failure to notify management of a potential breach in access to or use of protected health information (may be a Level 1, 2, 3, or 4 violation depending on the nature of the breach and the potential for harm). A Level 4 offense normally will result in the issuance of a Group III written notice and termination.[40]

Group I Written Notice

Whether Grievant engaged in the behavior and whether the behavior constituted misconduct

The Department of Human Resources Management has issued Standards of Conduct that apply to state employees, including employees of the Agency. The Standards of Conduct set forth the expectation that employees will "devote full effort to job responsibilities during work hours."[41]

The Agency asserted that Grievant used state time to conduct research unrelated to his assigned duties. According to the Agency, these activities included creating or saving more than 100 documents related to Covid-19, and more than 20 different Word documents ranging from two (2) to 137 pages in length related to patient abuse, Covid-19 protocols, and facility activities which the Agency asserted required Grievant to access patients' electronic health records for reasons unrelated to his assigned duties. The Agency did not provide any of these documents. The only document provided was the document entitled "Statement of [Grievant]" that Grievant admitted to providing to Writer. Grievant also admitted that he had other similar documents saved onto his Agency computer although, based on the testimony the "similar" documents may have included multiple versions or drafts of the same document incorporating more or less of the same information.

Grievant admitted that he conducted research related to the COVID-19 virus but asserted that he did so in support of his assigned work to prepare the Agency's application for a Malcolm Baldridge award. Grievant also admitted that at times he would "look up" COVID related statistics to use to try to persuade his colleagues that COVID-19 was "not that bad."[42]

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[40] Agency Ex. 18, DI 1001, Appendix G at 111-113.
[41] DHRM, Policy 1.60, Standards of Conduct.
[42] Hearing recording at 6:19:47-6:26:30.

The Agency provided limited information in support of the allegations in the Group I Written Notice. No information was provided as to the period of time during which the referenced documents were allegedly created, and testimony suggested that Grievant had been documenting some of his observations over a period of several years. The Agency did not provide any information regarding how much time Grievant is believed to have taken to download or compile the documents or how Grievant's actions impacted his ability to complete his assigned work. Although Psychology Director testified that she did not assign any work to Grievant that would require him to research any issues related to COVID-19, the Agency did not provide a time period associated with when it believed Grievant had been misusing state time to conduct COVID-19 research. Grievant's Quality Management Supervisor did not testify. The Agency provided among its exhibits an unsigned statement that the Agency asserted was prepared by the Quality Management Supervisor. The unsigned statement from Grievant's Quality Management Supervisor included the assertion that "[a]t no time were there any assignments or directives from myself or the QM department related to reviewing patient charts for COVID related issues." The statement also acknowledged, however, that "[p]riority was given to further activities, such as getting ready for the SPQA Malcolm Baldridge Award program…."[43]

Grievant's Quality Management Supervisor did not testify and there was no other testimony during the hearing to refute Grievant's assertion that at least a portion of the research he conducted was in support of his assigned work related to the Facility's application for a Malcolm Baldridge award.

Further, the Agency's IT Acceptable Use Policy permitted "[o]ccasional and incidental personal use of [Agency's] IT resources."[44] The Agency has not asserted that Grievant failed to complete assigned work. The Agency did not provide any information as to the amount of time Grievant may have used to conduct his research and whether it exceeded approved time for breaks. The Agency has not provided information sufficient to assess whether Grievant's research outside of assigned duties was sufficient to amount to an abuse of time.

The Agency has not met its burden of proving by a preponderance of evidence that Grievant engaged in the misconduct alleged in the Group I Written Notice. Because the Agency has not met its burden of proving that the Grievant engaged in misconduct, the Agency's discipline in issuing the Group I Written Notice is not consistent with policy and must be rescinded.

Because the Agency has not met its burden of proof, this Hearing Officer does not need to consider mitigating or aggravating factors with respect to the discipline issued pursuant to the Group I Written Notice.

Group III Written Notice regarding Electronic Health Record (EHR) Access

The Agency designed DI 1001 to set forth the Agency's policies and procedures for complying with the requirements of the Federal Health Insurance Portability and

[43] Agency Ex. 3, Administrative Investigation Review at ex. K.
[44] Agency Ex. 17.

Accountability Act, Standards of Privacy of Individually Identifiable Health Information (HIPAA Privacy Rule) regarding protected health information.[45] Chapter 2 of DI 1001 sets forth the General Rule for Agency employees that they "may only use or disclose PHI as authorized by the provisions of these policies and procedures."

The Agency has adopted Information Security Policies, including Policy 01200, IT Acceptable Use Policy. The policy applies to all Agency employees and systems. The policy admonishes Agency employees to "[a]void accessing network data, files, and information not directly related to your job."[46] The policy also reminds employees that the "[e]xistence of access capabilities does not imply permission to use this access."[47]

At all times relevant to this case, Grievant had Level One HIPAA Access. Grievant's Employee Work Profile described his Level One Access as "complete access to all Patient related Protected Health Information."[48] Grievant's Employee Work Profile and DI 1001 also set forth descriptions of other levels of access as follows:

> Level Two: Complete Access to PHI only for individuals served/assigned
> Level Three: Limited access, or access for a limited time period (each supervisor should identify the PHI and the reason for access)
> Level Four: No access to PHI[49]

The Agency asserted that Grievant violated Agency policies when he accessed electronic health records for 19 patients not assigned to Grievant's caseload between the dates of November 28, 2022, and April 5, 2023. The Agency did not allege that Grievant disclosed any information from those files.

Grievant admitted that he accessed the records of patients that were not assigned to his care. Grievant testified that he accessed patient records out of concern about issues related to patient neglect, patients bringing weapons into the Facility and other concerns. Grievant argued that such access was consistent with the HIPAA Access Level set forth in his Employee Work Profile. Grievant also asserted that past practices at the Facility had encouraged clinicians to review the charts of patients, even those not specifically part of an assigned caseload. Grievant and other witnesses testified that the Facility circulated a daily morning report that provided patient information, including detailed information about patients' behavior and individually identifiable information (including patient names) to an internal email distribution list at the Facility. Grievant appeared to suggest that the circulation of this type of information by the Facility was consistent with a practice of encouraging staff to be informed about the Facility's patients, even those outside of an employee's caseload.

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[45] Agency Ex. 18, DI 1001, Introduction and Purpose at 2.
[46] Agency Ex. 17, Information Security Policies, Policy #01200, IT Acceptable Use Policy, Statement of Policy, D. at 4.
[47] Agency Ex. 17, Information Security Policies, Policy #01200, IT Acceptable Use Policy, Statement of Policy, D. at 4.
[48] Grievant Ex. B at 14 and Ex. C at 22.
[49] Agency Ex. 18, DI 1001, Ch. 2 at 19; Grievant Ex. B and C.

Grievant's Employee Work Profile indicated that he had "complete access to all Patient related Protected Health Information." During the hearing, the Agency appeared to argue that Grievant's access should have been interpreted by Grievant as more akin to Level Two access, that is "complete access to PHI only for Patients served/assigned." The problem with the Agency's argument is that in the absence of additional instruction from the Agency, which does not seem to have been provided in this case, it is not clear that for an employee with Level One access, an admonition in the Agency's IT Acceptable Use policy to "avoid" accessing information not "directly related to your job" means that the Level 1 access set forth in the employee's Employee Work Profile should be interpreted as actually limited to accessing records of patients assigned to the employee (or more appropriately identified as a Level 2 access).

The Agency has not met its burden of proving by a preponderance of the evidence that Grievant engaged in misconduct when he accessed the records of patients that were not assigned to him. Because the Agency has not met its burden of proving that the Grievant engaged in misconduct, the Agency's discipline in issuing the Group III Written Notice regarding Grievant's access to EHR is not consistent with policy and must be rescinded.

Because the Agency has not met its burden of proof, this Hearing Officer does not need to consider mitigating or aggravating factors with respect to the discipline issued pursuant to this Group III Written Notice.

Group III Written Notice regarding Disclosures to Writer

Whether Grievant engaged in the behavior and whether the behavior constituted misconduct

The Agency designed DI 1001 to set forth the Agency's policies and procedures for complying with the requirements of the Federal Health Insurance Portability and Accountability Act, Standards of Privacy of Individually Identifiable Health Information (HIPAA Privacy Rule) regarding protected health information.[50] DI 1001 defines "protected health information" or PHI as "individually identifiable health information that is maintained or transmitted in any medium, including electronic media."[51] Chapter 2 of DI 1001 sets forth the General Rule for Agency employees that they "may only use or disclose PHI as authorized by the provisions of these policies and procedures."[52]

Chapter 5 of DI 1001 sets forth the general rule for the Agency that the Agency "may not use or disclose PHI to a third party without an authorization from the individual or the individual's [authorized representative], if applicable, that is valid under [Chapter 5]."[53] Chapter 5 also requires Agency employees to verify the identity of the person requesting the information and the authority of such person or entity to access such information before information may be released.

[50] Agency Ex. 18, DI 1001, Introduction and Purpose at 2.
[51] Agency Ex. 18, DI 1001, Ch. 1 at 10.
[52] Agency Ex. 18, DI 1001, Ch. 2 at 19.
[53] Agency Ex. 18, DI 1001, Ch. 5 at 39.

DI 1001 provides that health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information. The inclusion of any of the following elements results in individually identifiable health information:

- Names;
- All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:
    - The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
    - The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000;
- All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such age and elements may be aggregated into a single category of age 90 or older;
- Telephone numbers;
- Fax numbers;
- Electronic mail addresses;
- Social security numbers;
- Medical record numbers;
- Health plan beneficiary numbers;
- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web Universal Resource Locators (URL's) Internet Protocol (IP) address numbers;
- Biometric identifiers, including finger and voice prints;
- Full face photographic images and any comparable images; and
- Any other unique identifying number, characteristic, or code.[54]

DI 1001 further provides that health information that has been de-identified is no longer PHI." [55]

The Facility has adopted Policy 180-027 which sets forth procedures for requests for patient information, including the parties within the Facility that are responsible for releasing such information. Policy 180-027 provides that Health Information Management (HIM) personnel "will take appropriate responsibility for sharing health information about all individuals entrusted to [the Facility's] system of care consistent with the HIPAA

[54] Agency Ex. 18, DI 1001, Ch. 2 at 17-18.
[55] Agency Ex. 18, DI 1001 at 17-18.

Privacy Rule [42CFR], the Privacy Manual, and other relevant state and federal regulations."[56]

The Agency asserted that [Grievant] violated DI 1001 and other Agency policies designed to protect patients' protected health information when Grievant prepared and transmitted the Word document titled "Statement of [Grievant]"[57] to Writer.

Although Grievant was able to access patients' electronic health records, Grievant's access to records did not provide him with authority to disclose information from those records.

Grievant did not have any patient authorizations or approvals to release patient's protected health information to Writer.

Grievant admitted that he shared the document titled "Statement of [Grievant]"[58] with Writer and that he included information from patient' health records in the document.[59] Grievant appeared to argue that he thought that removing the patients' names and using initials was sufficient to de-identify the information. Grievant had been working at the Facility for more than 25 years in both clinical and non-clinical capacities and had been trained regarding Agency policies designed to protect patient privacy and protected health information.[60] The information Grievant chose to disclose to Writer included detailed information about ten patients, including information about the patients' behavior, diagnoses, medication and more. Although Grievant complied with Writer's instruction to remove the patients' names, Grievant did not otherwise, or fully, de-identify the information he provided. In addition to identifying the patients by their initials, Grievant disclosed the admission dates for six of the patients with the information he shared. For one patient, Grievant included the patient's initials, date of admission to the facility and the patient's place of employment.

Grievant also argued that he shared the information with Writer because he believed he had no choice because he had not observed that the other entities to which he was reporting his concerns were acting on those concerns. It was clear during the hearing that Grievant cares about the patients at the Facility. But, the fact that the entities with which Grievant may have been authorized to share protected health information did not act on Grievant's concerns or, did not advise Grievant that they were acting on Grievant's concerns, did not relieve Grievant of his obligation to protect patients' protected health information consistent with Agency policies. Grievant did have a choice with respect to the information and details he chose to share with Writer and Grievant chose to disclose individual patients' protected health information in violation of Agency policies.

To the extent that Grievant suggested that his disclosure to Writer fell within the protections of Virginia's Fraud and Abuse Whistle Blower Protection Act,[61] this Hearing

[56] Agency Ex. 19, Policy-180-027, Request for Patient Information, at 1.
[57] Agency Ex. 3, Administrative Investigation Review, at ex. A.
[58] Agency Ex. 3, Administrative Investigation Review, at ex. A.
[59] Hearing recording at 6:48:29-6:48:31, 6:55:40-6:56:19.
[60] Agency Ex. 20.
[61] Va. Code § 2.2-3009 et seq.

Officer is not persuaded. Both Grievant and Writer testified that Grievant approached Writer in Writer's capacity as a contributor to Blog.[62] Writer was not a regulatory or oversight body for the Facility. Writer was not otherwise authorized to receive the Facility patients' protected health information.

The Agency has proved by a preponderance of the evidence that Grievant engaged in misconduct when he disclosed Facility patients' protected health information to Writer.

Whether the Agency's discipline was consistent with law and policy

Group III offenses include acts of misconduct of such a severe nature that a first occurrence normally should warrant termination. This level is appropriate for offenses that, for example, endanger others in the workplace, constitute illegal or unethical conduct; indicate significant neglect of duty; result in disruption of the workplace; or other serious violations of policies, procedures, or laws.[63]

Under DI 1001 an unauthorized use or disclosure of protected health information is a Level 3 offense. A second occurrence of a Level 3 offense normally results in a Group III Written Notice and termination.[64]

Given the nature of Grievant's misconduct which disclosed the protected health information of several of the Facility's patients, the Agency's consolidation of Grievant's misconduct into a single Group III offense with termination is consistent with law and policy.

Group II Written Notice

Whether Grievant engaged in the behavior and whether the behavior constituted misconduct

The Department of Human Resource Management promulgated DHRM Policy 1.75, Use of Electronic Communications and Social Media. DHRM Policy 1.75 applies to all state employees. The policy specifically prohibits state employees from

> [a]ccessing, uploading, downloading, transmitting, printing, communicating, or posting access-restricted agency information, proprietary agency information, sensitive state data or records, or copyrighted materials in violation of agency or state policy.[65]

The Agency also adopted an IT Acceptable Use Policy which also requires Agency employees to protect data by storing

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[62] Hearing recording at 5:18:47-5:19:11, 6:45:05-6:47:50.
[63] See DHRM Policy 1.60, Standards of Conduct.
[64] Agency Ex. 18, DI 1001, Appendix G at 111-113.
[65] Agency Ex. 15, DHRM Policy 1.75, Use of Electronic Communications and Social Media, Employee Responsibilities and Requirements, D at 4.

> all data files and other critical information only on approved storage media. All sensitive data must be stored on network drives, SharePoint, or other approved storage solutions. No sensitive data is to be stored on a desktop or laptop unless encrypted and approved by the Information Security Officer (ISO).[66]

The Agency asserted that Grievant downloaded and/or saved images from patients' electronic health records and transmitted them via his state email address to his personal email address. According to the Agency this data was included in more than 20 different Word documents ranging from two (2) to 137 pages in length, related to patient abuse, Covid-19 protocols, and facility activities; and storing more than fifty (50) images of patients' electronic health record data, for reasons unrelated to his assigned duties. The Agency asserted that Grievant violated policy by accessing, downloading, transmitting, and storing sensitive information belonging to DBHDS from and on Grievant's state issued computer.[67]

The Agency included among its exhibits an email that Grievant sent on March 24, 2023, from his work email account to his personal email account. The email forwarded a document named "[Facility] Abuse.docx."[68]

Grievant admitted that he sent documents including the information he was gathering and his observations to his personal email account so that he could work on the documents at home.[69] Grievant also admitted that among the information he sent to his personal email account was the document entitled "Statement of [Grievant]" and that he accessed patient health records to prepare that document. [70]

The "Statement of [Grievant]" included detailed information about ten patients, including information about the patients' behavior, diagnoses, medication and more.[71] The information appeared to be directly pulled or copied from the patients' electronic health records and the information was not fully de-identified. In addition to identifying the patients by their initials, the information included admission dates for six of the patients. For one patient, Grievant included the patient's initials, date of admission to the facility and the patient's place of employment.

Grievant had been trained regarding Agency policies designed to ensure information security.[72] Grievant provided no information to suggest that the sensitive data related to patients that he copied into a Word document entitled "Statement of [Grievant]", emailed to his personal email account, and worked on from a non-Agency computer at home was encrypted or stored in any manner that might be consistent with Agency and Commonwealth requirements for securing sensitive data.

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[66] Agency Ex. 17, Information Security Policies, Policy #1200, IT Accept able Use Policy, Statement of Policy, K.
[67] Agency Ex. 5.
[68] Agency Ex. 3, Administrative Investigation Review, at ex. H.
[69] Hearing recording at 6:28:16-6:30:04.
[70] Hearing recording at 6:28:16-6:30:04, 6:55:40-6:56:19.
[71] Agency Ex. 3, Administrative Investigation Review, at ex. A.
[72] Agency Ex. 20.

The Agency has proved by a preponderance of the evidence that Grievant engaged in misconduct when he copied information from patients' electronic health records into a Word document, emailed that document to his personal email account and then worked on the document from a non-Agency computer.

Whether the Agency's discipline was consistent with law and policy

A violation of policy is a Group II offense. The Agency's discipline was consistent with law and policy.

Group III Written Notice regarding Disclosures to Attorney

Whether Grievant engaged in the behavior and whether the behavior constituted misconduct

Chapter 5 of DI 1001 sets forth the general rule for the Agency that the Agency "may not use or disclose PHI to a third party without an authorization from the individual or the individual's [authorized representative], if applicable, that is valid under [Chapter 5]."[73] Chapter 5 also requires Agency employees to verify the identity of the person requesting the information and the authority of such person or entity to access such information before information may be released.

DI 1001 provides that the Agency "may disclose PHI to an attorney that has been appointed by a court to represent a client in a civil commitment proceeding under Va. Code 32.1-127.1:03" but makes clear that such disclosure by the Agency is authorized "[w]hen a copy of the appointment order is produced."[74] The policy also requires that "[p]rior to disclosing PHI pursuant to this section, the appropriate member of the Department's workforce shall document, in the individual's record or as otherwise appropriate, which of the circumstances … applies."[75]

The Facility has adopted Policy 180-027 which sets forth procedures for requests for patient information, including the parties within the Facility that are responsible for releasing such information. Policy 180-027 provides that Health Information Management (HIM) personnel "will take appropriate responsibility for sharing health information about all individuals entrusted to [the Facility's] system of care consistent with the HIPAA Privacy Rule [42CFR], the Privacy Manual, and other relevant state and federal regulations."[76] The Policy includes specific requirements for processing written requests for patient information, including date and time stamping the request and responding within 15 days of receipt.[77] The Policy also sets forth specific requirements for verifying authorizations for release of information.[78]

[73] Agency Ex. 18, DI 1001, Ch. 5 at 39.
[74] Agency Ex. 18, DI 1001, Ch. 4 at 34.
[75] Agency Ex. 18, DI 1001, Ch. 4 at 34.
[76] Agency Ex. 19, Policy-180-027, Request for Patient Information, at 1.
[77] Agency Ex. 19, Policy-180-027, Request for Patient Information, at 2.
[78] Agency Ex. 19, Policy-180-027, Request for Patient Information, at 2-3.

Although Grievant was able to access patients' electronic health records, Grievant's access to records did not provide him with authority to disclose information from those records.

On August 18, 2021, September 21, 2021, March 9, 2022, and June 13, 2022, Grievant disclosed to Attorney, via email to Attorney's paralegal, the protected health information of Facility patients: Patient G, Patient C, Patient L and Patient N respectively.

Grievant did not dispute that he shared the protected health information of those Facility patients with Attorney.

The information Grievant provided included not just the patients' names, but other individually identifiable information as well as information related to status, diagnosis, behavior and other personal information.

Grievant had not received any court orders requiring such disclosures. Grievant had not received any patient authorizations allowing such disclosures. Grievant had not received any appointment order pursuant to Code 32.1-127.1:03 authorizing such disclosures.

Grievant argued that he was not aware that disclosing patients' protected health information to an attorney violated policy because no one could know all of the policies and the Agency's policies were "outdated." Grievant had been working at the Facility for more than 25 years in both clinical and non-clinical capacities and had been trained regarding Agency policies designed to protect patient privacy and protected health information.[79] Grievant provided no evidence that the Agency's policies terminated or were rendered no longer in effect if not updated by a particular deadline.

Grievant testified that he shared the information with Attorney because "he knew [Attorney] was their lawyer because [Attorney] would not lie to [him]."[80] But Grievant's personal relationship with, and trust of, Attorney cannot substitute for properly ensuring appropriate authorization per agency policy to release a patient's protected health information. Although Grievant clearly trusted Attorney, in the absence of an authorization from the affected patients, Grievant had no way of confirming that those patients trusted Attorney with their private and protected health information. Grievant argued that an attorney was entitled to "information" about his client. Grievant did not share just any information with Attorney, Grievant shared protected health information for specific, identifiable individuals without the consent or authorization of those individuals. And Grievant pointed to no law that entitled Attorney to patients' protected health information without a court order or patient authorization. Grievant asserted that he disclosed the information to Attorney because he believed it was in the best interests of the patients because Grievant believed that other employees at the Facility would "drag their feet." Regardless of whether Grievant believed he was acting in the patients' interests, those patients had a right to have their private health information protected and released only

[79] Agency Ex. 20.
[80] Hearing recording at 6:41:13-6:41:16.

as specifically authorized by them, by the policies of the agency responsible for protecting that information, or as required by law.

Attorney testified that over the years he had contacted other Facility employees who had provided him with information about his clients. Attorney did not specify which employees provided such information or whether those employees had the patient's authorization to release such information. Attorney also did not provide any information as to whether Agency or Facility management were aware of such disclosures.

The Agency has proved by a preponderance of the evidence that Grievant engaged in misconduct when he disclosed Facility patients' protected health information to Attorney.

Whether the Agency's discipline was consistent with law and policy

Group III offenses include acts of misconduct of such a severe nature that a first occurrence normally should warrant termination. This level is appropriate for offenses that, for example, endanger others in the workplace, constitute illegal or unethical conduct; indicate significant neglect of duty; result in disruption of the workplace; or other serious violations of policies, procedures, or laws.[81]

Under DI 1001 an unauthorized use or disclosure of protected health information is a Level 3 offense. A second occurrence of a Level 3 offense normally results in a Group III Written Notice and termination.[82]

Given the repeated nature of Grievant's misconduct which on four separate occasions violated policy and the privacy of four of the Facility's patients, the Agency's consolidation of Grievant's misconduct into a single Group III offense with termination is consistent with law and policy.

Grievant's other defenses

Due Process

On January 2, 2024, Grievant's counsel, by email, requested the Hearing Officer issue an order requiring the Agency to provide Grievant with access to all Facility policies in effect at the time of the alleged violations. Grievant's counsel also indicated that the Grievant needed access to his work email account. The Agency objected to the Grievant's requests on grounds of relevance and undue burden. With respect to Grievant's request to be provided direct access to Grievant's emails, the Agency also raised concerns about patient privacy as well as the feasibility and logistics of providing such access. The Hearing Officer scheduled a call with the parties to discuss the Grievant's requests as well as the parties' request for a continuance. Grievant's requests for all policies and for direct access to his Agency emails were discussed during a pre-hearing conference call held on January 11, 2024. Following argument by both parties, the Hearing Officer

[81] See DHRM Policy 1.60, Standards of Conduct.
[82] Agency Ex. 18, DI 1001, Appendix G at 111-113.

questioned the relevance of Grievant's request for direct access to all of his emails and did not believe the relevance outweighed the burden and privacy concerns the Agency had expressed. At that time, Grievant's counsel indicated he believed he could narrow his requests for policies and for emails, but continued to express concern about not having direct access to emails and a lack of trust that all requested emails would be produced. Grievant's counsel and the Agency's counsel indicated they would discuss the Grievant's document requests further to try to resolve their disputes. The parties also had requested that the Hearing Officer continue the hearing scheduled for January 17 to March 13 which was granted to provide the parties with additional time to try to resolve the grievance and which would provide additional time for the parties to try to resolve their document dispute. This Hearing Officer did not receive any further correspondence from either party requesting orders for production or alleging noncompliance by the other party. The Hearing Officer is not aware of any allegations of hearing officer non-compliance related to document requests.

At one point during the hearing, Grievant argued that he was denied due process because the Agency did not provide Grievant with policies related to the Facility's psychology department. Grievant did not assert that the policies provided in the Agency's exhibits were previously requested and not provided to Grievant. Grievant also did not identify the specific policies he alleged were not provided or why such policies were relevant to the issues before this Hearing Officer. Grievant also argued that he was denied due process because the Agency did not provide Grievant with direct access to his Agency emails. Grievant did not identify the relevance of such emails or which facts in dispute would have been resolved by any emails that were not provided.

During the hearing Grievant testified and Grievant, through counsel, had the opportunity to question witnesses and cross-examine Agency witnesses.

Grievant has not identified issues in dispute that would have been resolved by emails or policies that were allegedly requested from the Agency and withheld by the Agency. Grievant has not met his burden of proving that he was denied due process or that the Agency failed to comply with the grievance procedures with respect to document production.

Notice of HIPAA violations

Grievant argued that he was not put on notice that his conduct may have constituted alleged HIPAA violations because the Agency did not include the DHRM Code 54 among the list of coded offenses on the Written Notices issued to Grievant. The Agency's decision not to code Grievant's offenses as a Code 54 violation of HIPAA did not deprive Grievant of due process. The Agency clearly put Grievant on notice for violations of DI 1001 and that is the Agency policy that Grievant was charged with violating. Although the Agency arguably could also have coded Grievant's offenses as falling within Code 54, since DI 1001 is an Agency policy for ensuring the Agency's compliance with HIPAA, the Agency's decision not to do so did not deprive Grievant of notice of the offense for which he was charged.

Retaliation

In order to succeed with a retaliation defense, Grievant must show that (1) he engaged in a protected activity; (2) he experienced an adverse employment action; and (3) a causal link exists between the protected activity and the adverse action.[83] If the Agency presents a non-retaliatory business reason for the adverse employment action, then Grievant must present sufficient evidence that the Agency's stated reason was a mere pretext or excuse for retaliation.[84] The evidence suggests that although Grievant's communication with Writer was not protected activity, Grievant had engaged in protected activity on various occasions, including when he shared his concerns about what he believed was patient abuse with the Office of the State Inspector General and when he had expressed his concerns to Facility Director. Grievant experienced an adverse employment action when he was removed from his employment on September 12, 2023. Grievant engaged in protected activity, however, it is clear that the Agency had non-retaliatory business reasons for the disciplinary action taken against Grievant. The Agency has demonstrated that Grievant engaged in misconduct when he repeatedly violated Agency policies designed to protect patients' protected health information. The clear evidence shows that the Agency's concerns related to Grievant's failure to follow policies designed to protect patient information and his repeated disclosures of protected health information to entities that were not authorized to receive such information in violation of such policies. Because the Agency had non-retaliatory reasons for its disciplinary action and Grievant has offered no evidence to suggest that those reasons are mere pretext, Grievant has not met his burden to prove the Agency's disciplinary action was retaliation.

Mitigation

Virginia 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 Human Resource Management…."[85] 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, and (3) the disciplinary action was free of improper motive. In light of this standard, the Hearing Officer finds no mitigating circumstances exist to reduce the disciplinary action.

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[83] *See* Netter v. Barnes, 908 F.3d 932, 938 (4th Cir. 2018) (citing Univ. of Tex. S.W. Med. Ctr. v. Nassar, 570 U.S. 338, 360 (2013)); Villa v. CavaMezze Grill, LLC, 858 F.3d 896, 900-901 (4th Cir. 2017).
[84] *See*, *e.g.*, Felt v. MEI Techs., Inc., 584 Fed. App'x 139, 140 (4th Cir. 2014).
[85] Va. Code § 2.2-3005.

DECISION

For the reasons stated herein, the Agency's issuance to Grievant of a Group II Written Notice, a Group III Written Notice with termination for disclosures to Writer and a Group III Written Notice with termination for disclosures to Attorney are **upheld**.

For the reasons stated herein, the Agency's issuance to Grievant of the Group I Written Notice and the Group III Written Notice regarding EHR Access are **rescinded**.

The Virginia General Assembly enacted *Va. Code § 2.2-3005.1(A)* providing, "In grievances challenging discharge, if the hearing officer finds that the employee has substantially prevailed on the merits of the grievance, the employee shall be entitled to recover reasonable attorneys' fees, unless special circumstances would make an award unjust." Grievant has not substantially prevailed on the merits of the grievance because his termination is upheld.

APPEAL RIGHTS

You may request an administrative review by EDR within **15 calendar** days from the date the decision was issued. Your request must be in writing and must be **received** by EDR within 15 calendar days of the date the decision was issued.

Please address your request to:

Office of Employment Dispute Resolution
Department of Human Resource Management
101 North 14th St., 12th Floor
Richmond, VA 23219

or, send by e-mail to EDR@dhrm.virginia.gov, or by fax to (804) 786-1606.

You must also provide a copy of your appeal to the other party and the hearing officer. The hearing officer's **decision becomes final** when the 15-calendar-day period has expired, or when requests for administrative review have been decided.

A challenge that the hearing decision is inconsistent with state or agency policy must refer to a particular mandate in state or agency policy with which the hearing decision is not in compliance. A challenge that the hearing decision is not in compliance with the grievance procedure, or a request to present newly discovered evidence, must refer to a specific requirement of the grievance procedure with which the hearing decision is not in compliance.

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.[86]

[86] 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.

Angela L. Jenkins

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Hearing Officer