BRENDA MILLER,

Grievant,

v. **Docket No. 96-HHR-501**

WEST VIRGINIA DEPARTMENT OF
HEALTH AND HUMAN RESOURCES,
HUNTINGTON STATE HOSPITAL,

Respondent.

D E C I S I O N

On November 22, 1996, Brenda Miller (Grievant), a Licensed Practical Nurse (LPN) employed by Respondent Department of Health and Human Resources (DHHR) at Huntington State Hospital (HSH), filed a grievance at Level IV, as authorized under W. Va. Code § 29-6A-4(e), challenging her suspension without pay for twenty-one days. After a pre-hearing conference on January 10, 1997, the parties agreed to consolidate this grievance with six additional grievances pending at Level III, most of which related to a series of disciplinary actions that led up to her lengthy suspension. Following a number of continuances, each of which was granted for good cause shown, a Level IV evidentiary hearing in this matter was conducted in Huntington, West Virginia, on July 9, 1997. This matter became mature for decision on August 15, 1997, following receipt of written post-hearing submissions from the parties. Consistent with W. Va. Code § 29-6A-4, and the practice of this Grievance Board, this disciplinary action has been advanced on the docket for an expedited decision.

BACKGROUND

Grievant has been employed at HSH for 15 years, starting as a Health Service Worker, and receiving a promotion to LPN in 1989, after completing the necessary education and training requirements. On February 14, 1996, Grievant was issued a "verbal reprimand" by Sandra Dunkle, a Nursing Supervisor. Consistent with the employer's practice, this reprimand was memorialized on a

form placed in Grievant's personnel folder. The specific basis for the reprimand is stated as follows:

> I have repeatedly ask[ed] Brenda not to discuss her personal problems at work. This AM she monopolized a staff member from another department with her personal problems. This is disruptive to the work environment and will no longer be tolerated.

J Ex 1. (See footnote 1)

On February 20, 1996, Grievant was issued another verbal reprimand by Ms. Dunkle on the basis of Grievant's alleged conduct at the time Ms. Dunkle gave her the previous reprimand. The basis for the reprimand was memorialized in the following manner:

> Your act of insubordination today 2/14/96 in my office can not (sic) and will not be condoned. You were not only insubordinate, your use of foul language and your yelling was very unprofessional. You were yelling so loud our colleagues could hear your every word in the Nsg [nursing] station. When patients hear & witness staff's out of control behavior of anger and sobbing, and know about our personal problems on a daily basis [it] is very disruptive to the therapeutic milieu that we are to provide to each and every patient on our ward. Patients are not to console staff; I have just learned inthe past few days that a neo-male (sic) patient on two separate occasions has had his arms on your shoulder while you sat at the payphone on A4 crying by your own admission this morning when I asked you about this incident this morning (sic)[.] (This incident occurred 1-19-96 by on coming 3-11 shift @ approx. 2:30 to 2:40 pm). The other incident was earlier in the month of Jan. [Y]ou were sobbing in an out of control manner that this same patient was observed with his arms around you in a consoling way as you were sobbing. I have also witnessed your out of control sobbing & [have] asked you to leave the floor and get yourself under control.

J Ex 2.

The memorandum went on to recite Grievant's alleged "statements and remarks" during the previous verbal reprimand on February 14, 1996, as follows:

> This is harassment by god and I'll file a G-- D--- grievance, you and Becky are out to get me fired. I don't give a F--- now. Tina [Bias] and Monroe [Grievant's ex-husband] can say any D--- thing they want and get away with it. [After] Monroe reports to Becky I'm making phone calls to him and his whore and you all take his D--- word. You believe him why don't you believe me. I'm the one that got screwed, they get away with all their D--- Dirty Stuff. I'll file a G-- D--- grievance.

J Ex 2.

On May 7, 1996, Grievant was issued a three-day suspension by HSH Administrator Desmond Byrne. The suspension letter contains the following allegations:

> The charges for this suspension are unprofessional conduct and violation of Department of Health and Human Resource Policy "Workplace Security", and DHHR Policy Memorandum 2108, "Employee Conduct." The specific reason for these charges is that on April 30, 1996 at approximately 6:45 a.m. you were involved in a heated argument with a co-worker in the elevator in the Clinical Building. This argument included name calling and the use of profanity. The argument was so loud that it could be heard on the unit even before the elevator doors opened. Numerous staff and patients heard parts of the verbal exchange and witnessed the hostility between you and the co-worker. This is unacceptable and will not be tolerated.
>
> On June 9, 1992 you signed a certification form for DHHR Policy Memorandum 2108, "Employee Conduct" agreeing to abide by this policy. On April 17, 1995 you signed an Employee Acknowledgement form for"Workplace Security, indicating that "exhibiting violent behavior, issuing threats, or other activities as indicated are a violation of this policy."
>
> On September 29, 1995, Rebecca McVey, RN, MSN, Director of Nursing, sent you a memo regarding Professional Conduct. This memo indicated that you were expected to deal with all co-workers in a professional manner. It also indicated that personal problems were not to be discussed while on duty in such a manner as to be disruptive to normal business operations. On February 14, 1996 you were given a verbal reprimand from S. Dunkle, R.N. for disrupting the work of others with discussion of your personal problems. Obviously you have not taken these notices seriously.
>
> The conduct you displayed on April 30, 1996 was very unprofessional and cannot be allowed to continue. You have been given ample warning and clear directions on what was expected from you at work. However, you have obviously chosen to ignore this. The statements of all involved parties and witnesses have been reviewed. Regardless of who started the incident, the prudent action for you would have been to refuse to participate, get off the elevator at the first opportunity and report the incident to your supervisor. By your own admission you indicated that you exchanged words with the other party and that both parties used profanity.
>
> . . . . The intention of this suspension is to impress upon you the seriousness of your actions and to prevent further instances of this nature in the future. I must warn you, that should this type of behavior occur again, you will be subject to more severe disciplinary action as severe as dismissal.

J Ex 3. (See footnote 2)

Subsequently, on November 8, 1996, Mr. Byrne notified Grievant that she would be suspended for twenty-one days based upon a number of charges. The pertinent portions of the suspension notice are quoted as follows:

The charge for this suspension is (1) falsification of records for timekeeping, (2) repeated use of profane as well as threatening language toward others, (3) falsification of information in a patient's Medical Record and (4) falsification of a Control Drug Administration Record.

The specific reasons for these charges are:

1. On September 14, 1996 you were seen leaving the hospital grounds at approximately 10:54 p.m. Your scheduled shift did not end until 11:15 p.m. The timekeeping record for A4 [Grievant's assigned unit] on September 14, 1996 indicates by your own hand that you were on duty until 11:15 p.m. By your own admission you said that you signed out at the same time you reported for duty on September 14, 1996. This is in violation of Policy 45H1 "Timekeeping Records."

2. On October 1, 1996 you used profanity, saying "fucking people" while talking on the phone with Donna Montie, Human Resources Secretary. At that time Mrs. Montie interrupted you and told you that the use of that language was not acceptable. On October 3, 1996 Mrs. Montie, in her capacity as EEO counselor did one on one training with you on Sexual Harassment and Diversity which also included counseling on the use of racial slurs and profanity. Mrs. Montie cautioned you, again, about the inappropriate language you used on 10/1/96. She also informed you that you would face disciplinary action if you continued to use such language in the workplace.

Kim Mannon, LPN, reported to Becky McVey, RN, MSN, Director of Nursing, that on October 11, 1996, you used profanity while speaking with her in the medication room stating, "I'm not taking a fucking medication error" and "I'm tired of this shit."

3. On October 15, 1996 at 11 a.m. you documented on the Medication Administration Record for Patient #04690 that his Blood Sugar was 133. However, on the Diabetic Flow Sheet you recorded the 11 a.m. Blood Sugar Reading as 134. Additionally, in the Progress Notes you made a "Late Entry" sometime between 1 p.m. and 1:20 p.m. on October 15, 1996 indicating the 11 a.m. Blood Sugar Reading was 134. A review of the "Memory" of the Glucometer III, the machine which monitors the Blood Sugar level of patients, does not verify this reading. This Memory verifies Blood Sugar readings from October 13, 1996 through October 23, 1996. You have stated that you took the reading but that you must have accidentally deleted it from the Glucometer III. However, Cheryl Ponzo. Customer Service Representative, at the Diagnostic Division of Bear Corporation, maker of the Glucometer III, has indicated that it is not possible to accidentally delete a blood sugar reading.

Based on this information, I believe that you did not test patient #04690 Blood Sugar as required. This is supported by the Memory of the Glucometer III and your conflicting documentation on the Medication Administration Record, the Diabetic Flow Sheet and the Progress Notes.

Your failure to administer this test as required and document the results accurately is

in violation of [HSH] Policy 12C5 "Charting" and 12F5 "Glucom eter III." It also shows a flagrant and willful disregard of a directive of an employer.

4. On October 29, 1996 you were assigned to medications on A4. At approximately 2:15 p.m. you completed a Medication Room drug count with another LPN. It was reported by the LPN, Rosie Combs, that the Xanax Count was "one over." When this was indicated to you, the LPN, Rosie Combs, said you took the extra tablet, opened it and threw it in the sink. The only patient ordered this medication on A4 was Patient 07046. The drug count being one over would indicate that the patient did not receive the 9 a.m. dose of Xanax. The patient's Medication Administration Record and the Controlled Drug Administration Record indicate by your hand that you gave this medication as part of your duties as medication nurse. This patient became increasingly agitated throughout the day and required a PRN more than once thus supporting that the patient may not have received her Xanax.

Your failure to administer the medication as ordered or report the error is in violation of [HSH] Policy 12F1 "Medication Administration." This action on your part also shows a flagrant and willful disregard of a directive of your employer.

* * *

Clearly, Huntington Hospital has an interest in ensuring employees carry out their job duties, especially with respect to administering medical care and medication to patients.

Not only did your action on 10-15-96 and 10-29-96 constitute a flagrant disregard for hospital policy, these policy violations endangered the health and safety of patients for which Huntington Hospital has a duty to care.

J Ex 4.

DISCUSSION

In disciplinary matters, W. Va. Code § 29-6A-6 places the burden of proof on the employer. Broughton v. W. Va. Div. of Highways, Docket No. 92-DOH-325 (Dec. 31, 1992). In order to meet its burden under W. Va. Code § 29-6A-6, DHHR relied upon a substantial amount of hearsay evidence. Because formal rules of evidence, excepting therules of privilege recognized by law, do not apply in grievance proceedings, hearsay evidence is generally admissible. W. Va. Code § 29-6A-6; Seddon v. W. Va. Dept. of Health, Docket No. 90-H-115 (June 8, 1990). Nonetheless, an administrative law

judge must determine what weight, if any, is to be accorded hearsay evidence in a disciplinary proceeding. See Harry v. Marion County Bd. of Educ., Docket Nos. 95-24-575 & 96-24- 111 (Sept. 23, 1996); Seddon, supra.

There are several factors to consider in determining the weight to be allocated to hearsay evidence, including: the availability of persons with first-hand knowledge to testify at the hearing; whether the declarant's out-of-court statements were in writing, were signed, or were in affidavit form; the employer's explanation for failing to obtain signed or sworn statements; whether the declarants were disinterested witnesses to the events and whether the statements were routinely made; the consistency of the declarants' accounts with other information in the case, their internal consistency, and their consistency with each other; whether corroboration for the statements can otherwise be found in the employer's records; the absence of contradictory evidence; and the credibility of the declarants when they made the statements attributed to them. See Borninkhof v. Dept. of Justice, 5 M.S.P.B. 150 (1981).

Further, where the existence or nonexistence of certain material facts hinges on witness credibility, detailed findings of fact and explicit credibility determinations are required. Jones v. W. Va. Dept. of Health & Human Resources, Docket No. 96-HHR-371 (Oct. 30, 1996); Pine v. W. Va. Dept. of Health & Human Resources, Docket No. 95-HHR- 066 (May 12, 1995). See Harper v. Dept. of the Navy, 33 M.S.P.R. 490 (1987). Accord ingly, it is necessary to discuss certain aspects of this matter in detail. Because there areseveral incidents involved, the facts and circumstances surrounding each incident will be addressed separately. Thereafter, the propriety of the penalties imposed for each sustained infraction will be discussed. Finally, three employee grievances on which Grievant bears the burden of proof will be addressed.

A. Verbal reprimand of February 14, 1996.

Rebecca McVey, Director of Nursing for HSH, testified that Grievant's supervisor, Sandra Dunkle, reported that she overheard Grievant discussing her personal problems with another staff member, Ellen Captain, during working hours on February 14, 1996. Ms. McVey previously sent a memo regarding "Professional Conduct" to Grievant and others on September 29, 1995. In that memo, Grievant was specifically warned: "Personal problems are not to be discussed while on duty in such a manner as to be disruptive to normal business operations." The memo further stated that "failure to follow these directives and the attached policies will result in disciplinary action." A Ex 1. (See footnote

3)

Ms. Dunkle is no longer employed at HSH, and did not testify in this matter. Grievant testified that she questioned Ms. Captain about an incident report she had filed relating to Tina Bias. Grievant recalled that Ms. Captain informed her that incident reports involving conduct between employees did not go through her. Grievant did not believe Ms. Captain was agitated by her inquiry. This observation was supported by the testimony ofAnna Sullivan, a registered nurse (RN), who overheard portions of Grievant's conversation with Ms. Captain. In addition, Grievant denied discussing her personal life in detail, noting that by that point, her personal life was already common knowledge around HSH. Ms. Captain, like Ms. Dunkle, was not called as a witness by DHHR. Ms. McVey agreed that discussing an incident report with Ms. Captain would not be inappropriate, as Ms. Captain's duties in Quality Advancement include responsibility for incident reports.

As previously indicated, DHHR has the burden of proving each element of a disciplinary action by a preponderance of the evidence. A preponderance of the evidence is generally recognized as evidence of greater weight, or which is more convincing than the evidence which is offered in opposition to it. Petry v. Kanawha County Bd. of Educ., Docket No. 96-20-380 (Mar. 18, 1997). Grievant's testimony on this matter was frank and straightforward. The undersigned administrative law judge finds Grievant's credible testimony, as generally corroborated by Ms. Sullivan, to be more persuasive than Ms. McVey's hearsay statements attributed to Ms. Dunkle. Accordingly, DHHR has failed to establish by a preponderance of the evidence that Grievant committed the misconduct alleged in the verbal reprimand of February 14, 1996.

B. Verbal reprimand of February 20, 1996.

Ms. Dunkle verbally reprimanded Grievant for insubordination based upon Grievant's use of profanity and yelling at the time Ms. Dunkle administered the previous verbal reprimand on February 14. Ms. Dunkle specifically described Grievant's offensive statements in her contemporaneous notes regarding the incident. Grievant testified that she met with Ms. Dunkle in her office behind closed doors. Grievant admitted she and Ms. Dunkle got in a "heated argument" regarding the reprimand she received for allegedlydiscussing her personal business. She declared both she and Ms. Dunkle were "yelling and screaming" at each other. Grievant apologized at the end of the meeting, although she still disagreed with the action taken. She did not deny any of the comments attributed to her by Ms. Dunkle.

Grievant presented evidence that profanity was commonly employed by the staff at HSH. Indeed, at least one employee has submitted a grievance complaining about the use of profanity by others. Grievant submits that HSH does not enforce its rules prohibiting profanity on duty. However, Grievant was not reprimanded for using profane language in the presence of another staff member, but for directing her profane comments toward her Head Nurse, Ms. Dunkle, who was in the process of reprimanding her for another matter. The context of Grievant's comments indicates she was defying her supervisor's authority, thereby acting in an insubordinate manner. See Conner v. Barbour County Bd. of Educ., Docket No. 94-01-394 (Jan. 31, 1995); Payne v. W. Va. Dept. of Transp., 93-DOH-454 (Apr. 29, 1994). Accordingly, DHHR established by a preponderance of the evidence that Grievant committed the offense charged in the verbal reprimand of February 20, 1996.

C. Three-day suspension of May 7, 1996.

It was reported to Ms. McVey that Grievant got into a loud verbal argument with Belinda Collie, a staff nurse, on an elevator at HSH during shift change on April 30, 1996. Ms. McVey indicated that both employees were shouting and cursing each other to the point that another employee called the police. Ms. Collie was issued only a written reprimand for her offense, because she had not been the subject of any prior disciplinary action in the past year. Grievant testified that, as she got on the elevator on April 30, 1996, Brenda Collie, who was already on the elevator, said "crazy-ass bitch" to her. Grievant replied, "well, that's better than being a lying-ass bitch." Grievant was referring to the fact that Ms. Collie had recently testified in Grievant's divorce proceeding. Grievant asserted that she could not recall what else was said beyond that, but denied physically assaulting Ms. Collie, the allegation which she claims led to the police being called. She did not otherwise specifically deny the charges.

Neither Ms. Collie, nor any other eyewitness, was called to testify in this matter. Nonetheless, Grievant's testimony substantially corroborates DHHR's allegation that she was involved in a heated argument with another employee on the employer's premises during working hours, an argument which included profanity and name calling. Therefore, the infractions charged are supported by a preponderance of the evidence. **D. Twenty-one day suspension of November 8, 1996 - falsification of timekeeping record.**

Tina Chambers, an RN employed by HSH, gave an unsworn written statement on September 22, 1996, that she observed Grievant leaving the HSH grounds at 10:54 P.M. on September 14, 1996,

several minutes before her shift ended at 11:15. A Ex 4. Ms. McVey testified that she interviewed Ms. Chambers and another RN, Jim Pritchard, and both confirmed that Grievant left early on that day. Two other witnesses interviewed by Ms. McVey, including a security guard, were unable to recall the exact time of Grievant's departure that day.

In her testimony, Grievant acknowledged signing in and out at the time she reported for duty on September 14, 1996. Grievant noted that this was a common practice, eventhough it was technically prohibited by HSH policy. Grievant indicated that she was scheduled to work a double shift, sixteen hours in succession, that day. Grievant also asserted that it was not uncommon for staff to leave early, just as they would routinely stay late, until the next shift had arrived, and the process of reporting to the incoming personnel was completed. Grievant never denied the charge that she left early. Accordingly, a preponderance of the evidence indicates that Grievant did not sign out properly at the end of her shift, and departed from her work area before her shift ended.

E. Twenty-one day suspension of November 8, 1996 - use of profane language.

Ms. McVey testified that Donna Montie, a Secretary in Human Resources, told her that Grievant used profanity in a discussion with her. Kim Mannon, an LPN at HSH, signed an unsworn statement regarding a discussion with Grievant regarding a possible medication error on October 11, 1996. Ms. Mannon's statement indicates that Grievant told her, "I'm not taking a F---ing med error on this," and "this is becoming a personal attack on me, everybody makes mistakes and I'm tired of this s--t." A Ex 5.

Neither Ms. Montie nor Ms. Mannon was called as a witness. Unlike Ms. Dunkle, no explanation was proffered regarding their absence. Grievant did not address these allegations in her testimony. Despite Grievant's acknowledgement that she used profanity or got into heated discussions on other occasions, she did not acknowledge a pattern or practice of behavior which would support these charges. Accordingly, DHHR failed to support these allegations by a preponderance of the evidence.

F. Twenty-one day suspension of November 8, 1996 - falsification of Glucometer results. Ms. McVey noted that one of the patients at HSH was a "brittle" diabetic whose condition required regular checks of his blood sugar readings. Due to his condition, his medical records were reviewed in detail. The patient's Medication Administration Record contains an entry indicating a blood sugar level of "133" on October 15, 1996. See A Ex 6. The Diabetic Flowsheet for the same

patient contains an entry indicating a "134" level on the same date. Grievant's signature is adjacent to that entry. See A Ex 6. Grievant also made a "late entry" on the patient's chart at 11 A.M. on October 15, 1996, showing a 134 Glucometer reading. See A Ex 6. It was undisputed that Grievant made all three entries.

Ms. McVey suggested that the preferred practice is to write down the test result and transfer the result to each record requiring an entry, thus avoiding a documentation error such as 133 in one place and 134 in another. However, she acknowledged that such documentation errors at HSH were not uncommon. Ms. McVey also agreed that the documentation discrepancy noted in this particular situation was not life-threatening.

As this detailed review proceeded, the staff was unable to match either entry Grievant made in the patient's medical chart with a corresponding reading in the memory of the testing device, a Glucometer. The Glucometer retains the ten most recent readings in its computerized memory. When an eleventh result is recorded, the earliest result is automatically deleted. Each of the ten readings retained in the Glucometer memory when Ms. McVey began her investigation were matched with readings for other patients. However, there was no memory in the Glucometer that matched the 133 or 134 readings Grievant had recorded. See A Ex 7. Respondent presented a sworn affidavit from Barbara Wetherholt, R.N., wherein she states that she spoke with "Cheryl Ponzo" in the Analysis Assistance section of the Bear Corporation, manufacturers of the Ames Glucometer III used at HSH. Ms. Ponzo told her it was impossible to "accidentally" delete a reading from the machine, as the operator is required to press a button after the display flashes a "d" symbol. A Ex 8. Ms. McVey interviewed Grievant in the process of investigating this matter in the presence of another nurse, Denise Hipes. Grievant was asked if she knew how to delete a reading from the machine, responding that she did not. See A Ex 8.

Sherry Bennett, an LPN employed at HSH over five years, testified that she was trained and certified to train and certify other HSH staff members on the operation of the Glucometer. Ms. Bennett explained that the Glucometer results will automatically delete "if the door is left open too long." Ms. Bennett also noted that she had reported over 300 errors relating to medication documentation to her supervisors over a four-month period without any notable action being taken.

Section No. 12F5 in the HSH Policy and Procedure Manual governs operation of the Glucometer III. G Ex B. The manual provides straightforward instructions on how to delete a test result. Grievant

declared that she used the Glucometer on a daily basis, and was generally familiar with its operation. However, Grievant explained that she had never been trained to delete a result from the Glucometer. She recalled seeing what she thought to be an "upside-down p" on the digital readout. She would push the button and the machine would turn off. It was only after the suspension was initiated that Grievant realized the readout was actually displaying a lower case "d," and she had been deleting the results. Grievant acknowledged that it was not unusual for an hour or longer to pass between the time she recorded a blood sugar result on the Medication Administration Record, maintained in the medication room, and the time the results were recorded on the patient's chart and Diabetic Flowsheet, maintained near the patient. Grievant explained, without contradiction, that it is permissible to accurately document such results as a "late entry" on the patient's chart.

Grievant's testimony regarding the operation of the Glucometer was candid and unrehearsed. She admitted to making a documentation error regarding the blood sugar reading, but consistently denied failing to test the patient's blood sugar. DHHR's evidence that Grievant failed to test the patient's blood was entirely circumstantial. The suggestion that a result could not be "accidentally" deleted from the Glucometer would require that the device be virtually foolproof. DHHR did not establish how Grievant was trained in the operation of this device, nor that she had been required to read and acknowledge understanding of the HSH policy manual on its operation. (See footnote 4) See G Ex B. Moreover, Grievant's witness established that the test results on the Glucometer would be deleted if the door was simply left open too long. In these circumstances, DHHR established by a preponderance of the evidence that Grievant negligently failed to record the patient's blood sugar reading properly in all documentation required. By the same standard, DHHR failed to establish that Grievant deliberately falsified the patient's blood sugar results, or failed to test the patient's blood sugar in accordance with the doctor's standing order.

G. Twenty-one day suspension of November 8, 1996 - falsification of drug records.

Helen Combs, an LPN employed at HSH, testified that she and Grievant were counting controlled drugs on October 29, 1996. Consistent with HSH's policy on controlled medications, Grievant, as the designated medication nurse on that shift, was required to count the controlled medications on hand in the unit, along with the nurse who was assuming responsibility for the drugs, before leaving the unit. See A Ex 10, Atch 6. Grievant had a meeting scheduled with Ms. McVey before the end of her shift. Thus, between approximately 2:15 P.M. and 2:25 P.M., Ms. Combs and Grievant jointly counted

the drugs on hand so that the medication keys could be transferred to Ms. Combs. See G Ex D.

According to Ms. Combs' testimony, when they reached the point in their drug count where they were counting Xanax, an anti-anxiety medication, there was one more pill on hand than the record indicated. Ms. Combs stated that Grievant proceeded to pull the pill off the row of medications, open it, and throw it in the sink. After completing the count, Grievant left the unit, and Ms. Combs stated that she went to Ms. Hipes, the Head Nurse for the day shift, to report the incident.

Earlier, Grievant made an entry in the Controlled Drug Administration Record for the unit indicating that she had administered one dose of Xanax to patient P.M. (See footnote 5) at 9 A.M. onOctober 29, 1996. A Ex 9. An incident report prepared by Ms. Combs was endorsed by Ms. Hipes noting that the patient was agitated, and was given an additional dose of Xanax later that day. Ms. McVey testified that such agitation was consistent with what could be expected if that patient had not been administered Xanax by Grievant. Ms. McVey further noted that HSH employees came in approximately two hours after the incident was reported, took the sink apart, and found no pill.

Ms. Combs acknowledged that she did not follow the written HSH policy because she did not stop the count without accepting the medication key, and call Ms. Hipes to come to the unit. Ms. Combs was counselled by her immediate supervisor for her failure to follow established hospital policy. This was her first offense of violating hospital policy.

In her testimony, Grievant denied that anything abnormal happened during the medication count that day. She recalled that after the medication count was completed, she left the unit with Denise Hipes, her immediate supervisor, to meet with Ms. McVey. Therefore, according to Grievant, Ms. Combs could not have reported the incident to Ms. Hipes "immediately" as Ms. Combs testified. Rather, the report would have had to have been made at least twenty to thirty minutes later, when Ms. Hipes returned to the unit from the meeting.

Ms. Sullivan, an RN working on the same unit that day, was called as a witness by Grievant. She testified that Ms. Combs reported the improper medications count to herthat afternoon, but she could not recall the exact time, other than the fact that Grievant had already left the unit. Neither party called Ms. Hipes as a witness.

Grievant stated that she would have checked to see if she had missed giving a medication, had she been one dose over in the count. She recalled giving the patient the prescribed Xanax dosage, further indicating that the patient was agitated before the Xanax was due, and was still agitated the

next day, after an additional dosage of Xanax had been administered PRN (as needed).

However, Grievant also testified that she knew of several instances where LPNs were one dosage over on a medication count, and they would throw the pill down the sink or put it in their pocket "by mutual agreement of both LPNs." Grievant explained that she did not know if all LPNs did this, but the ones she had counted with did so on more than one occasion. On cross-examination, Grievant partially contradicted her earlier testimony on this point, and appeared evasive.

Assessing credibility on this charge is not an easy task. Ms. Combs appeared to be a candid and forthright witness. Her testimony at the hearing was consistent with her prior written statement. See A Ex 11. There was not even a hint of any motivation for Ms. Combs to invent the allegation she made against Grievant. The fact that there was no pill found in the sink nearly two hours later is not significant; it would be surprising to find a pill after much time had elapsed. Standing alone, the conduct of the patient who should have received the Xanax pill, who Grievant acknowledges was unusually agitated that day and the next, would not be particularly persuasive. However, this circumstance lends slightly more support to Ms. Combs' testimony, than to Grievant's claim that she administered the pill in accordance with the doctor's standing order. Ms. Combs indicated that she reported the improper count to Ms. Hipes sometime after Grievant left the unit. Ms. Sullivan recalled that Ms. Hipes was the Charge Nurse at that point, but Ms. Combs also reported the incident to her. She also recalled that this report was made after Grievant left the unit. Ms. Combs' testimony was not effectively impeached by this minor discrepancy.

Although Grievant's testimony on other issues raised in this grievance was credible and candid, the undersigned found her statements regarding this charge inconsistent and improbable. Ultimately, Grievant's observation that LPNs routinely discard excess medications by mutual agreement, that she personally witnessed such improper counts, but had not reported the misconduct to her superiors, indicates that she had been an accomplice to similar misconduct on prior occasions, at the least. Frankly, such admissions, without any acknowledgement that her prior actions represented anything less than business as usual, provide credibility to Ms. Comb's allegations.

Having determined that the medication count was actually one over, as related by Ms. Combs, the most logical reason for Grievant to dispose of the "extra" pill would be to conceal the fact that she had neglected to properly administer medication to P.M., a more serious matter than an erroneous medication count. Consequently, the undersigned finds that DHHR established by a preponderance

of the evidence that Grievant failed to administer medication to a patient substantially as alleged.

H. Penalties imposed for sustained infractions. As previously discussed, the charges contained in the verbal reprimand of February 14, 1996, were not sustained. Accordingly, that reprimand must be rescinded and removed from all personnel records relating to Grievant.

In regard to the verbal reprimand of February 20, 1996, the charges were sustained. The incidents contested in this grievance were the first infractions by Grievant during her fifteen-year tenure at HSH. Respondent's progressive discipline policy recognizes a verbal reprimand as the first level of disciplinary action for a "minor infraction." The fact that Grievant had been issued a previous verbal reprimand for an unrelated offense on February 14, 1996, was not shown to be a significant factor in the decision to issue the subsequent reprimand. Further, given that Grievant's use of profanity toward her Head Nurse on February 14, 1996, was insubordinate, a verbal reprimand was not an excessive penalty under the progressive discipline policy at HSH, or an abuse of discretion under the circumstances. See Jones, supra; Thompson v. W. Va. Dept. of Health & Human Services, Docket No. 94-HHR-254 (Jan. 20, 1995).

Regarding the three-day suspension issued on May 7, 1996, the charge which led to that action was proven by DHHR. An allegation that a particular disciplinary measure is disproportionate to the offense proven or otherwise arbitrary and capricious is an affirmative defense, and Grievant bears the burden of demonstrating that the penalty was clearly excessive or reflects an abuse of agency discretion, or an inherent disproportion between the offense and the personnel action. Jones, supra; Thompson, supra. See Martin v. W. Va. State Fire Comm'n, Docket No. 89-SFC-145 (Aug. 8, 1989); Schmidt v. W. Va. Dept. of Highways, Docket No. DOH-88-063 (Mar. 31, 1989). Ms. McVey testified that at least two employees other than Grievant had been counselled regarding the use of profanity in the workplace. However, Grievant was the only employee who had been reported using profanity after a prior warning to refrain from such conduct. As discussed earlier, Grievant's previous use of profanity in addressing her supervisor in an insubordinate manner, and the exchange of provocative remarks between Grievant and Ms. Collie, are readily distinguishable from the routine use of incidental profanity which Grievant's witnesses described.

It is apparent that HSH's Progressive Discipline Policy (G Ex E) provides guidelines for the employer's exercise of discretion to discipline employees, rather than a fixed formula to be applied inflexibly in meting out punishments for documented infractions. Ms. Collie, who was at least equally

responsible for the verbal altercation with Grievant, was given a written reprimand, because this was her "first offense" at HSH. Grievant, however, had been recently issued a verbal reprimand for similar misconduct. In these circumstances, the three-day suspension Grievant received for profane name-calling was not shown to be contrary to the employer's written policy, nor an abuse of its discretion in such matters. See Jones, supra.

Finally, certain charges contained in the twenty-one day suspension of November 8, 1996, were sustained, but not the charges that Grievant used profanity toward Ms. Montie and Ms. Mannon, nor that Grievant failed to test a patient's blood sugar on the Glucometer III. W. Va. Code § 29-6A-5(b) provides authority to the undersigned to "provide such relief as is deemed fair and equitable" in accordance with the provisions of W. Va. Code §§ 29-6A-1, et seq. Where the employer fails to establish all of the charges which were alleged to support a particular disciplinary action, the penalty imposed must bereviewed to determine if it is excessive in the circumstances. See Walters v. W. Va. Bureau of Employment Programs, Docket No. 94-BEP-086 (Jan. 23, 1995), aff'd, Cir. Ct. of Kanawha County, No. 95-AA-23 (Dec. 18, 1996); Schmidt, supra. See generally Douglas v. Veterans Admin., 5 M.S.P.B. 313 (1981). As a minimum, Respondent must revise the suspension letter maintained in Grievant's personnel file to eliminate any reference to the charges which were not proven, as well as the verbal reprimand of February 14, 1996, which was not upheld.

The charges sustained include the allegation that Grievant improperly documented the blood sugar readings for a particular patient. In the process of investigating Grievant's suspected offense, it was discovered that two other employees had failed to document properly blood sugar readings in one or more patient records. In addition, two more employees, each with responsibility for conducting control tests on the Glucometer III, failed to record their results on several occasions. Ms. McVey stated that each of those employees was counselled by their immediate supervisor, as this was their first offense. Likewise, this was Grievant's first offense of this nature.

The undersigned is not persuaded that the proven documentation error, standing alone, would warrant more than a written reprimand. Nonetheless, this infraction may be referenced in the suspension letter, and will be considered in determining whether a twenty-one day suspension was an appropriate penalty for the charges proven.

Ms. McVey testified that the issue of properly signing in and out had been discussed frequently at staff meetings. See A Ex 3. Both parties' evidence indicates that this was a recurring issue at HSH.

However, despite Grievant's claims that the policy on leaving early and signing out properly was only selectively enforced, there was no evidence that specificincidents were disregarded when reported to higher management, even though middle managers, including one or more charge nurses, were not strictly enforcing the rules, or consistently following the policy themselves. The undersigned finds that this charge, standing alone, would warrant some punishment up to and including a suspension, given that Grievant had previously been issued a verbal reprimand and a three-day suspension for other infractions.

Reviewing the entirety of the suspension letter issued to Grievant by Mr. Byrne, it is apparent that Respondent viewed failure to perform a blood sugar test, and the improper medication count as the most serious charges. Further, Ms. McVey's testimony indicated that no single offense would have resulted in a twenty-one day suspension. That penalty was based on the accumulated impact of the various offenses charged, as well as Grievant's prior work record. Nevertheless, Grievant's misfeasance in administering and accounting for the Xanax pill represents a serious departure from the professional standards expected of an LPN employed by the State of West Virginia.

Accordingly, the undersigned finds by a preponderance of the evidence that DHHR would not have imposed a twenty-one day suspension for the offenses actually proven at Level IV. Rather than remand this matter for reassessment of the penalty, the undersigned finds that a fourteen-day suspension represents an appropriate penalty, consistent with Respondent's progressive discipline policy, the charges sustained, and Grievant's record of prior discipline, as determined in this decision. Therefore, Respondent DHHR will be required to reduce Grievant's suspension from twenty-one days to fourteen days, to revise the suspension letter in her records consistent with this decision, and to pay Grievantbackpay for those days Grievant lost pay while being suspended beyond fourteen days.

I. Additional grievances.

In addition to grieving each of four separate disciplinary actions, Grievant filed three other grievances alleging that she had been treated improperly in various ways. See J Ex 5-B. As these grievances do not involve disciplinary matters, Grievant has the burden of proving each element of her complaints by a preponderance of the evidence. Procedural Rules of the W. Va. Educ. & State Employees Grievance Bd. 156 C.S.R.1 § 4.19 (1996); Payne v. W. Va. Dept. of Energy, Docket No. ENGY-88-015 (Nov. 2, 1988). See W. Va. Code § 29-6A-6.

Grievant complained that DHHR permitted Tina Bias to harass her without taking appropriate

action. However, no significant evidence was presented to support Grievant's claims that the employer was at fault in permitting Ms. Bias to harass Grievant, or that any harassment, in fact, occurred. Likewise, Grievant's separate claim of harassment by her supervisors was not supported by substantial evidence. W. Va. Code § 29-6A-2(l) defines "harassment" as "repeated or continual disturbance, irritation or annoyance of an employee which would be contrary to the demeanor expected by law, policy and profession." Grievant failed to demonstrate that there was a pattern of improper conduct directed at her by her supervisors. See Hall v. W. Va. Dept. of Transp., Docket No. 96-DOH-433 (Sept. 12, 1997); Phares v. W. Va. Dept. of Public Safety, Docket No. 91-CORR-275 (Dec. 31, 1991).

Grievant's third grievance not directly related to a disciplinary matter states:

> Management has unfairly & unjustly denied me the right to express my feelings & emotions of the situations that have been condoned by management. Management has repeated to different units & co-workers when I was hospitalized.

J Ex 5-B.

Grievant described a meeting held on an unspecified date with Ms. Dunkle and Dr. Bateman, an HSH physician. This meeting took place while Grievant was under a great deal of stress from her pending divorce. Dr. Bateman and Grievant discussed the feasibility of Grievant's admission to a local hospital for treatment. Ultimately, Dr. Bateman increased Grievant's dosage of Xanax, a drug which had previously been prescribed for stress by another physician. Grievant testified that another staff nurse, A.J. Sowards, subsequently told her "word for word" what had taken place in that meeting. Ms. Sowards reportedly told Grievant that Ms. Dunkle had described to her what had happened during the meeting with Dr. Bateman. Grievant alleges that Ms. Dunkle's conversation with another staff member violated the confidentiality of her medical treatment.

Grievant also claimed that Ms. McVey revealed information regarding Grievant's hospitalization at St. Mary's Hospital. Grievant testified that an unidentified staff member overheard Ms. McVey talking to some other employees about Grievant, Grievant's husband, and Ms. Bias. This person allegedly reported what she heard to an unidentified friend of Grievant's, who told Grievant what the first person had heard.

Although DHHR offered no evidence to rebut either of these allegations, the undersigned is not persuaded that Grievant met her burden of proof on these complaints. It is noted that the suspension

letters issued to Grievant on HSH letterhead stationery list a "Mildred Bateman, M.D.," as the Clinical Director. See J Exs 3 & 4. Thus, it is notapparent that Dr. Bateman was providing professional medical services to Grievant, independent of her role as the Clinical Director at HSH. Notwithstanding that Ms. Dunkle's discussion of such matters with other staff personnel with no apparent need to know is a poor supervisory practice, Grievant has not established that her conduct, in the circumstances presented, violated any law, rule, regulation or policy applicable to Grievant as an employee at HSH.

As for the allegations regarding Ms. McVey, she was not questioned about this matter by Grievant's representative. Grievant's triple hearsay testimony established nothing more than the fact that the relationships of Grievant, her husband, and another employee were the subject of "gossip" at HSH. This evidence is insufficient to support a finding that Grievant's supervisors improperly divulged confidential information regarding her hospitalization. Accordingly, Grievant's complaints alleging improper conduct by her superiors must be denied.

In addition to the foregoing discussion, the following findings of fact and conclusions of law are made in this matter.

FINDINGS OF FACT

1. Grievant is employed by Respondent DHHR as a Licensed Practical Nurse (LPN) at Huntington State Hospital (HSH) in Huntington, West Virginia.

2. On September 29, 1995, Rebecca McVey, Director of Nursing at HSH, issued a memo to Grievant, and four other employees, specifically warning that "[p]ersonal problems are not to be discussed while on duty in such a manner as to be disruptive to normal business operations." A Ex 1.

3. Ellen Captain is employed by HSH and is assigned to Quality Advancement. Her duties include responsibility for processing and tracking incident reports.

4. While on duty at HSH on February 14, 1996, Grievant approached Ms. Captain to inquire about the status of an incident report she had filed on the conduct of another employee, Tina Bias.

5. Some portion of Grievant's conversation with Ms. Captain was overheard by Anna Sullivan, a Registered Nurse (RN) working in the same unit as Grievant, and by Sandra Dunkle, Grievant's supervisor.

6. Grievant's inquiry to Ms. Captain was not inappropriate, nor did her conversation with Ms.

Captain unduly disrupt the normal activity in the workplace.

7. On February 14, 1996, Ms. Dunkle issued a verbal reprimand to Grievant for "monopoliz[ing] a staff member from another department with her personal problems." J Ex 1.

8. Grievant and Ms. Dunkle became involved in a heated argument regarding the reprimand, and Grievant repeatedly used profanity while arguing with her supervisor.

9. On April 30, 1996, Grievant was entering an elevator at HSH when she encountered a co-worker, Belinda Collie, a staff nurse at HSH. Ms. Collie had previously appeared as a witness in Grievant's divorce proceedings.

10. Ms. Collie addressed Grievant as a "crazy-ass bitch." Grievant responded by telling Ms. Collie, "Well, that's better than being a lying-ass bitch." Their verbal altercation escalated to the point where they were overheard by other personnel waiting outside the closed elevator doors on the next floor. 11. On September 14, 1996, Grievant signed in and out on her timekeeping record at the time she reported for duty. HSH policy requires employees to accurately sign in at the beginning and out at the end of their shift. A Ex 2. Grievant left her work area a few minutes prior to the end of her shift without obtaining proper approval from a supervisor to leave early, or documenting her early departure on her time sheet.

12. Accurate timekeeping by employees and first-level supervisors is a recurring problem at HSH.

13. On October 15, 1996, Grievant performed a blood sugar check on Patient # 04690, a "brittle" diabetic. Grievant, through incomplete training or incompetence, deleted the reading obtained from the memory of the Glucometer III used to test the patient's blood.

14. Grievant recorded the blood sugar reading for Patient # 04690 as "133" on the Medication Administration Record (MAR) for that patient. Grievant recorded the blood sugar level as "134" on the Diabetic Flow Sheet, as well as on the Progress Notes (or "patient chart") for that patient.

15. Grievant's entry noted that the "134" recorded in the Progress Notes was a "late entry." Such an entry was consistent with HSH procedure, provided that the entry was accurate.

16. On October 29, 1996, Grievant was working the day shift with duty as the Medications Nurse for unit A4. On that date, Grievant made entries in the MAR for patient P.M. and the Controlled Drug Administration Record that she administered one dose of Xanax to patient P.M. at 9 A.M. 17. As the Medication Nurse, Grievant was required by HSH policy to perform a count of all controlled medications with another nurse, before turning over the medication key to the other nurse, or being

allowed to leave the unit. G Ex D.

18. Grievant was summoned to meet with Ms. McVey at 2:30 P.M. on October 29, 1996, before the end of her shift. Accordingly, Grievant performed a medication count with Helen Combs, another LPN.

19. During the medication count, there was one more Xanax pill on hand than was indicated by the unit records. Grievant disposed of the "extra" pill by throwing it down a sink.

20. Ms. Combs accepted the medication keys from Grievant, signed the record, and allowed Grievant to leave the unit, rather than stopping the count and reporting the inconsistency to her immediate supervisor, Denise Hipes, as required by HSH policy. G Ex D.

21. Sometime after Grievant left the unit, Ms. Combs reported the incident to Anna Sullivan, an R.N. on the unit, and to Ms. Hipes.

22. Ms. Combs was counselled for her failure to follow HSH policy during the medication count on October 29, 1996.

23. Grievant previously observed other nurses make incorrect counts and dispose of "extra" controlled medications without properly reporting the incidents to their supervisor.

24. P.M., the patient who was to have received the Xanax at 9:00 A.M., was observed to be agitated, and was given a dose of Xanax to calm her down later that same day. Xanax is an anti-anxiety medication. 25. Grievant did not administer Xanax to P.M. on October 29, 1996, in accordance with the doctor's standing order for that patient.

CONCLUSIONS OF LAW

1. Pursuant to W. Va. Code § 29-6A-6, the burden of proof in disciplinary matters rests with the employer, and the employer must meet that burden by proving the charges against an employee by a preponderance of the evidence. Wellman v. W. Va. Dept. of Health & Human Services, Docket No. 93-HHR-079 (Oct. 18, 1993); Ramey v. W. Va. Dept. of Health, Docket No. H-88-005 (Dec. 6, 1988).

2. DHHR demonstrated by a preponderance of the evidence that Grievant was insubordinate to her supervisor, Sandra Dunkle, on February 14, 1996, by making loud and profane comments regarding her decision to issue a verbal reprimand for another alleged offense. See Grueser v. W. Va. State Bd. of Rehabilitation, Docket No. 95-RS-084 (June 29, 1995), aff'd, Cir. Ct. of Kanawha County, No. 95-AA-192 (Nov. 26, 1996).

3. DHHR demonstrated by a preponderance of the evidence that Grievant participated in a heated

argument with another employee on April 30, 1996, engaging in name calling and profanity, contrary to HSH policy governing employee conduct. See Grueser, supra.

4. DHHR demonstrated by a preponderance of the evidence that Grievant falsified her timekeeping record for September 14, 1996, by indicating that she worked the entire time scheduled, when, in fact, she departed the unit a few minutes prior to the end of her double shift.

5. DHHR demonstrated by a preponderance of the evidence that Grievant failed to administer medication to patient P.M. properly on October 29, 1996, and that Grievantimproperly performed a medication count with LPN Helen Combs, prior to leaving the unit on that date.

6. DHHR failed to demonstrate by a preponderance of the evidence that Grievant unduly discussed her personal problems with another staff member, Ellen Captain, on February 14, 1996, or that such conversation with Ms. Captain was disruptive to the work environment to any significant degree.

7. DHHR demonstrated by a preponderance of the evidence that, on October 15, 1996, Grievant negligently documented the blood sugar reading for Patient # 04690 in at least one of three documents where such results are required to be accurately recorded.

8. DHHR failed to demonstrate by a preponderance of the evidence that Grievant failed to perform a blood sugar reading on Patient # 04960 on October 15, 1996, using the Glucometer III.

9. DHHR failed to demonstrate by a preponderance of the evidence that Grievant improperly used profanity toward or in the presence of Donna Montie on either October 1, or October 3, 1996. Likewise, DHHR failed to establish that Grievant improperly used profanity toward or in the presence of Kim Mannon, on October 11, 1996.

10. An allegation that a particular disciplinary measure is disproportionate to the offense proven or otherwise arbitrary and capricious is an affirmative defense, and the grievant bears the burden of demonstrating that the penalty was clearly excessive or reflects an abuse of agency discretion, or an inherent disproportion between the offense and the personnel action. Jones v. W. Va. Dept. of Health & Human Resources, Docket No. 96-HHR-371 (Oct. 30, 1996); Thompson v. W. Va. Dept. of Health & Human Services, Docket No. 94-HHR-254 (Jan. 20, 1995). See Martin v. W. Va. State Fire Comm'n, DocketNo. 89-SFC-145 (Aug. 8, 1989); Schmidt v. W. Va. Dept. of Highways, Docket No. DOH- 88-063 (Mar. 31, 1989). Grievant failed to establish that the verbal reprimand she received on February 20, 1996, or the three-day suspension which she received on May 7, 1996, represented

excessive penalties for the proven offenses involved in those disciplinary actions.

11. W. Va. Code § 29-6A-5(b) provides authority to an administrative law judge of the West Virginia Education and State Employees Grievance Board to "provide such relief as is deemed fair and equitable in accordance with the provisions of W. Va. Code §§ 29- 6A-1, et seq. Where the employer fails to establish all of the charges which were alleged to support a particular disciplinary action, the penalty imposed must be reviewed to determine if it is excessive in the circumstances. See Walters v. W. Va. Bureau of Employment Programs, Docket No. 94-BEP-086 (Jan. 23, 1995), aff'd, Cir. Ct. of Kanawha County, No. 95-AA-23 (Dec. 19, 1996); Schmidt v. W. Va. Dept. of Highways, Docket No. DOH-88-063 (Mar. 31, 1989). See generally Douglas v. Veterans Admin., 5 M.S.P.B. 313 (1981).

12. Grievant established that a twenty-one day suspension was disproportionate to the charges ultimately proven in this matter. See Walters, supra.

13. In grievances which do not involve disciplinary matters, the grievant has the burden of proving each element of her complaints by a preponderance of the evidence. Procedural Rules of the W. Va. Educ. & State Employees Grievance Bd. 156 C.S.R.1 § 4.19 (1996); Payne v. W. Va. Dept. of Energy, Docket No. ENGY-88-015 (Nov. 2, 1988). See W. Va. Code § 29-6A-6. 14. Grievant failed to establish by a preponderance of the evidence that Respondent DHHR violated any law, policy, rule, or regulation applicable to her employment relationship, or that it condoned harassment by a co-worker, engaged in prohibited harassment through the exercise of supervisory authority or discretion, or divulged confidential information regarding Grievant's medical care and treatment.

Accordingly, this Grievance is **GRANTED**, **IN PART**. Respondent West Virginia Department of Health and Human Resources is hereby **ORDERED** to rescind the verbal reprimand of February 14, 1996, and to delete all references to such reprimand from all personnel records maintained on Grievant by the agency. Respondent is further **ORDERED**, consistent with this opinion, to rescind the twenty-one day suspension issued to Grievant on November 8, 1996, and replace that suspension with a fourteen-day suspension, deleting all references to those charges which were not sustained by this decision, and paying appropriate backpay to Grievant as determined earlier in this decision. All other relief is hereby **DENIED**.

Any party may appeal this decision to the "circuit court of the county in which the grievance

occurred," and such appeal must be filed within thirty (30) days of receipt of this decision. W. Va. Code § 29-6A-7. Neither the West Virginia Education and State Employees Grievance Board nor any of its Administrative Law Judges is a party to such appeal and should not be so named. Any appealing party must advise this office of theintent to appeal and provide the civil action number so that the record can be prepared and transmitted to the appropriate court.

LEWIS G. BREWER

ADMINISTRATIVE LAW JUDGE

Dated: September 30, 1997

Footnote: 1

Exhibits admitted at the Level IV hearing will be identified as "J Ex " for Joint Exhibits, "G Ex " for Grievant's Exhibits, and "A Ex " for Agency Exhibits.

Footnote: 2

An "amended" suspension notice was issued by Mr. Byrne on May 8, 1996, after Grievant waived the eight-day notice period. However, the amendments did not change the allegations which supported the suspension action. See J Ex 3.

Footnote: 3

The same memo was sent to Monroe Miller, who was then Grievant's husband, Steve Bias and Tina Bias, who were then husband and wife, and Grace Bias, the mother of Steve Bias. All of these individuals were then employed at HSH. For purposes of this grievance, it is sufficient to observe that a previously close friendship between the Bias and Miller families, and particularly between Grievant and Tina Bias, had evaporated into an emotionally charged state of antagonism after Mr. Miller and Tina Bias became romantically involved. Grievant and Mr. Miller are now divorced.

Footnote: 4

The HSH Policy and Procedure Manual for the Glucometer III explains how to delete the test results, how to record results, and how to retrieve stored results. Grievant was not charged with failure to follow the policy by failing to properly record the results of the blood sugar test at issue, as DHHR contends she never performed the test.

Footnote: 5

The patient involved in this matter has been identified only by her initials, consistent with this Board's practice respecting the privacy of individuals in such circumstances. See, e.g., Jones v. W. Va. Dept. of Health & Human Resources, Docket No. 96-HHR-371 (Oct. 30, 1996); Edwards v. McDowell County Bd. of Educ, Docket No. 93-33-118 (July 13,1994).