THE WEST VIRGINIA PUBLIC EMPLOYEES
GRIEVANCE BOARD

ANNA COX,
Grievant,

v. **DOCKET NO. 2009-0387-CONS**

DIVISION OF VETERAN'S AFFAIRS/
VETERANS NURSING FACILITY,
Respondent.

DECISION

A grievance was filed by Grievant, Anna Cox, at level one of the grievance procedure, on August 22, 2008, contesting her suspension. On August 25, 2008, Grievant was dismissed from her employment for gross misconduct, and filed a grievance at level three of the grievance procedure, on August 29, 2008, contesting her dismissal. The grievance also alleged that Grievant had been subjected to discrimination, harassment and retaliation, threatened, and that her civil rights were violated during the collection of a urine specimen.[1] The grievances were consolidated at level three for hearing and decision. The relief sought by Grievant is:

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[1] While Grievant may certainly challenge her termination through the grievance procedure, her claims of improper workplace conduct may not be challenged through the grievance procedure unless she is successful in her effort to have the termination reversed. "[A] person who no longer holds employment status is generally not eligible to invoke the grievance procedure after the employment relationship is terminated. *Spiroff v. W. Va. Schools for the Deaf & Blind*, Docket No. 99-DOE-314D (Sept. 30, 1999); *Jackson v. W. Va. Div. of Corr.*, Docket No. 97-CORR-345 (Jan. 30, 1998)." *Ward/Higley v. W. Va. State Univ.*, Docket No. 07-HE-332 (Dec. 20, 2007). In addition, Grievant did not present any evidence or argument to explain or support her claim of retaliation. That claim is deemed abandoned.

> back pay for all the days I would have been scheduled to work from the date of suspension which is August 15th 2008. And reenstated [sic] as an LPN at the facility, along with the benefits that are due to me.

Grievant also asked that Kevin Crickard be removed as an administrator, that Pam Miller, RN, and Margie Brown, Director of Nursing, be dismissed, and that Katherine Hess, Director of Administrative Services, be reprimanded.

A level three hearing was held before the undersigned Administrative Law Judge, on November 20, 2008, in the Grievance Board's office in Westover, West Virginia. Grievant represented herself, and Respondent was represented by Christie S. Utt, Deputy Attorney General. This matter became mature for decision upon receipt of the last of the parties' Proposed Findings of Fact and Conclusions of Law on January 6, 2009.

Synopsis

Grievant, an LPN, was dismissed from her employment at the Veterans Nursing Facility in Clarksburg, for gross misconduct. On August 15, 2008, Grievant was the only LPN on duty, and it was a busy day. Grievant did not initial the Medication Administration Record ("MAR") in 35 places as she dispensed the 7:30, 8:00 and 9:00 a.m. medications to residents of the Facility. This was discovered by Facility personnel when the MAR was reviewed sometime shortly after 10:45 a.m. The MAR is an important record. If it is not initialed, it is assumed that medication was not given. Grievant was aware she was required to initial the MAR as medication was dispensed. Grievant believed her failure to initial the MAR should have been excused because she was so busy, the RN on duty would not help her, and she had 24 hours to make sure she had initialed every space on the MAR. She also asserted that other nurses had not initialed the MAR in a timely fashion. Grievant presented no evidence that she was so busy in the early morning of

August 15, 2008, that she could not have completed her duties as required and properly documented whether the residents of this Facility had taken their prescribed medications. She also did not demonstrate that any other nurse had failed to initial the MAR as she had. In addition, on July 21, 2008, a narcotic, being administered for pain, was missing from a resident's medications. Grievant gave the resident three pills, but initialed on the MAR that she had given the resident four pills, and did not report the missing pill, because she did not want to get a co-worker in trouble. Grievant was verbally counseled when she came forward with this information on August 6, 2008. Grievant did not demonstrate the discipline imposed was clearly excessive.

The following Findings of Fact are made based upon the record developed at level three.

Findings of Fact

1. Grievant began her employment with the Division of Veterans Affairs ("DVA") at the Veterans Nursing Facility ("the Facility") in Clarksburg, as a Licensed Practical Nurse ("LPN"), on May 1, 2007.

2. Grievant reported to work on August 15, 2008, at 6:23 a.m., for her shift. The other LPN assigned to work with Grievant that day had called in and reported off work. Pam Miller, Unit Manager, was the Registered Nurse ("RN") working that day.

3. The Veterans Nursing Facility had 21 residents on August 15, 2008. Nursing staffing guidelines allowed the Facility to have only one LPN on day shift for that number of residents.

4. August 15, 2008, was a busy day at the Veterans Nursing Facility, because one resident was very ill, and someone was being admitted to the Facility. The admission did not occur until 10:45 a.m., and Regina Simmons, an LPN at the Facility in the MDS (minimum data sets) department took care of the paperwork for the admission. Grievant was present for the assessment of the resident to be admitted, but she did not do the assessment. The record does not reflect how much time Grievant was required to devote to the ill resident or to the admission. However, the care of the ill resident had been turned over to Hospice on August 14, 2008, and Grievant called Hospice before 8:00 a.m. on August 15, 2008, and a nurse and physician's assistant came to the Facility to care for this resident.

5. LPNs distribute medications to residents throughout the day, as required by doctors' orders. Medications must be distributed to residents within an hour of the time stated on the order. The medication for each resident, and the time it is to be administered, is listed in the Medication Administration Record ("MAR"). The LPN on duty consults the MAR for each resident, checks the medication that has been prepared for the resident to make sure it agrees with the doctor's orders, and distributes the medication to each resident. The LPN is to make sure the resident takes the medication, and then initial on the MAR that the resident has been given each medication, that it has been given within the required time frame, and that the resident has taken the medication. If a resident refuses to take his medication, the LPN is to circle that medication on the MAR, and write on the back of the MAR sheet why the medication was not given. All of the documentation is to occur as the medication is given in order to maintain an accurate record of medication administration. If the LPN has not initialed that the medication has been given, then all

medical personnel having contact with the resident must assume the medication has not been given. The record keeping is consequently very important.

6. The pharmacist at the Veterans Nursing Facility had brought to the attention of the Facility's administrators, on more than one occasion, that the LPNs were not initialing in the MAR that they were distributing medications. On February 7, 2008, a memorandum was distributed to the nurses at the Facility, which stated in part, "[p]lease place your initials on the MAR after each medication has been given indicating the resident has received their medication." On March 12, 2008, training was provided to the LPNs on the importance of record keeping, and how to properly document medication distribution on the MAR. One of the statements in the training materials presented was, "[i]nitial MAR immediately AFTER administration." Grievant attended this training, and was aware that she was required to initial the MAR as medication was dispensed. Grievant understood that she was not to wait until the end of her shift to document that medication had been dispensed to and taken by the residents.

7. Grievant was responsible for dispensing medications to the residents during the morning of August 15, 2008, and at lunchtime.

8. Grievant took a break at approximately 10:30 a.m. to smoke.

9. When Grievant returned from her break, pharmacy personnel were replacing the old medications on the two medicine carts for the hall where Grievant was working. They needed the MAR to complete this task. Grievant did not tell the pharmacy personnel that she needed the MAR so that she could initial that she had dispensed medications to the residents that morning.

10. Tom Moore, Physician's Assistant at the Veteran's Hospital in Clarksburg, visits residents at the Veterans Nursing Facility. On August 15, 2008, he found medications on a resident's bed. He brought the pills to Ms. Miller around 10:30 a.m. Mr. Moore told Ms. Miller he had found the pills on a resident's bed, and that he did not know what was going on, but he wanted an answer. He explained that the proper medications had to be administered at the proper times, and if this was not happening, he could not provide an accurate evaluation of the resident's health.

11. Ms. Miller called Katherine Hess, Director of Administrative Services at the Facility, and Ms. Hess spoke with Ms. Miller and Mr. Moore. Ms. Miller brought the MAR to her office so they could review the medication records for the resident.

12. Ms. Miller noticed there were many places where the MAR had not been initialed by Grievant for medications that were to have been given to residents at 7:30, 8:00 and 9:00 a.m., on August 15, 2008. Ms. Miller was astonished by the number of places on the MAR which had not been initialed by Grievant.

13. When Ms. Miller and Ms. Hess reviewed the MAR for August 15, 2008, it was not initialed for 3 medications for resident number 4[2] scheduled at 9:00 a.m.; 12 medications for resident number 6, some scheduled at 8:00 a.m. and some at 9:00 a.m.; 11 medications for resident number 11, some scheduled at 8:00 a.m. and some at 9:00 a.m.; 6 medications for resident number 13, some scheduled at 8:00 a.m. and some at 9:00 a.m.; 8 medications or vitamins listed as self-medications for resident number 14; 4

[2] This documentation was admitted into the record as Respondent's Exhibit Number 3. This exhibit lists the initials of the residents, and then assigns a number to each resident, in an effort to maintain the confidentiality of the residents.

medications for resident number 15, some scheduled at 7:30 a.m. and some at 9:00 a.m.; 2 medications for resident number 17, some scheduled at 8:00 a.m. and some at 9:00 a.m.; and 1 medication for resident number 18, scheduled at 9:00 a.m. Due to a problem with resident number 6 accepting medications, his doctor's orders allow the medication to be given to him outside the listed time frame for administration, when this resident will accept the medication. In total, excepting resident number 6, the MAR listed around 35 medications, which should have been given to one-third of the residents, by no later than 8:30 a.m., 9:00 a.m., or 10:00 a.m., which Grievant had not initialed.

14. It is not uncommon for a nurse at the Facility to miss one or two spaces, when initialing the MAR, due to the fact that there are many small spaces on each page for each day. The nurses generally go through the MAR at the end of the work day to make sure they have dispensed all medications, performed all treatments, and to initial where they have missed initialing any spaces.

15. Sometime during the early afternoon of August 15, 2008, Grievant started going through the MAR and initialing that she had dispensed medications to residents that morning, reducing the number of places where she had not recorded that medication had been dispensed from 35, to around 20.

16. Ms. Hess called the Director of Nursing for the Facility, Margie Brown, at home, to advise her of what had been found on the MAR. Ms. Brown advised Ms. Hess that it was not normal to have this many spaces not initialed on the MAR. The Director of the Facility was not available that day, so Ms. Hess called Keith Gwinn, the Director of Veterans Affairs, to discuss what should be done. Mr. Gwinn directed Ms. Hess to contact Steve Forsythe, at the Division of Personnel, and she did so. Ms. Hess believed Grievant

should be suspended, pending an investigation. Both Mr. Gwinn and Mr. Forsythe advised Ms. Hess that this was an appropriate course of action.

17. On July 30, 2008, it was discovered that a narcotic was missing at the Facility. All the nurses were required to submit to drug testing. Grievant's test results came in on August 15, 2008, showing there was an " invalid result." Test results for some other nurses showed this same result, and those nurses were allowed to take a second drug test. Grievant was not retested. Ms. Hess was aware of the test results, and this played a part in her recommendation that Grievant be suspended, pending an investigation.

18. Ms. Brown interviewed Grievant, as well as other employees of the Facility, on August 5, 2008, regarding the narcotic that had been discovered missing at the Facility. Grievant told Ms. Brown she did not know anything about it. The next day Grievant came to Ms. Brown in tears, and told her she had lied to her the previous day. Grievant told Ms. Brown that on July 21, 2008, when she was checking the medications to be given to a resident, there were only three pills in the medication cart for the resident, rather than the four pills the resident was supposed to be given. Grievant told Ms. Brown she had only given the resident three pills, but had initialed on the MAR that the resident had received four pills. The pill missing from the resident's medication was a narcotic being administered for pain. The reason given by Grievant for her action was that she did not want to get a co-worker in trouble. Ms. Brown reprimanded Grievant, verbally counseled her regarding this action, and advised her that the State Police were conducting the investigation of the missing narcotic, and it was out of her hands.

19. Ms. Hess called Grievant into her office on the afternoon of August 15, 2008, and told her they were going to telephone Ms. Brown, and they did so. Ms. Hess explained what she had discovered when she reviewed the MAR. Grievant stated it was not normal for her to have this many places where she had not initialed the MAR, that she had not had time to go back and initial that she had dispensed the medication, and that she had asked Ms. Miller to help her, and Ms. Miller had refused. Ms. Hess advised Grievant that she was being suspended immediately, pending an investigation of this matter.

20. Grievant was advised on August 25, 2008, that she was being dismissed from her employment by DVA, effective September 9, 2008. The reason for the dismissal was gross misconduct on August 15, 2008, "by admitting to not properly marking your paperwork (Medication Administration Records) as required by your nursing standard of care." The dismissal letter states that Grievant failed to initial the MAR in 50 places, creating 50 medication errors. The letter also refers to the previous incident when Grievant gave the wrong amount of medication to a resident, because she did not want to report that a pill was missing.

Discussion

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. *Ramey v. W. Va. Dep't of Health*, Docket No. H-88-005 (Dec. 6, 1988). "The preponderance standard generally requires proof that a reasonable person would accept as sufficient that a contested fact is more likely true than not." *Leichliter v. W. Va. Dep't of Health and Human Res.*, Docket No. 92-HHR-486 (May 17,

1993). Where the evidence equally supports both sides, the employer has not met its burden. *Id*.

The employer must also demonstrate that misconduct which forms the basis for the dismissal of a tenured state employee is of a "substantial nature directly affecting rights and interests of the public." *House v. Civil Serv. Comm'n*, 181 W. Va. 49, 380 S.E.2d 226 (1989). "The judicial standard in West Virginia requires that 'dismissal of a civil service employee be for good cause, which means misconduct of a substantial nature directly affecting rights and interests of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention.' Syl. Pt. 2, *Buskirk v. Civil Service Comm'n*, [175 W. Va. 279, ___,] 332 S.E.2d 579, 581 (W. Va. 1985); *Oakes v. W. Va. Dept. of Finance and Admin.*, [164 W. Va. 384,] 264 S.E.2d 151 (W. Va. 1980); *Guine v. Civil Service Comm'n*, [149 W. Va. 461,] 141 S.E.2d 364 (W. Va. 1965)." *Scragg v. Bd. of Dir. W. Va. State College*, Docket No. 93-BOD-436 (Dec. 30, 1994).

Grievant was charged with gross misconduct. The "term gross misconduct as used in the context of an employer-employee relationship implies a willful disregard of the employer's interest or a wanton disregard of standards of behavior which the employer has a right to expect of its employees." *Graley v. W. Va. Parkways Economic Dev. & Tourism Auth.*, Docket No. 91-PEDTA-225 (Dec. 23, 1991) (*citing Buskirk v. Civil Serv. Comm'n,* 175 W. Va. 279, 332 S.E.2d 579 (1985)). *See Evans v. Tax & Revenue/Ins. Comm'n,* Docket No. 02-INS-108 (Sept. 13, 2002).

Grievant admitted that she had not initialed the MAR as she was dispensing medication to the residents of the Facility, and that she knew she was required to initial the MAR as the medication was dispensed. Grievant believed her behavior should not be characterized as gross misconduct, because August 15, 2008, was a very busy day, and she had 24 hours to initial the MAR.

Certainly, Grievant was busy on August 15, but that was really as far as the evidence went. No detail of the morning activities was provided which would allow the undersigned to evaluate whether Grievant had time to initial the MAR as medication was dispensed. One of the stated reasons for this being a "crazy day" was the admission of a new resident. However, this admission did not occur until 10:45 a.m., well after the time Grievant should have initialed the MAR. Grievant also pointed to the fact that one of the residents was very ill, but a Hospice nurse came to the Facility to care for that resident early in the day. Every other event which Grievant pointed to also occurred after Grievant took her 10:30 smoke break: the change of the medication cart, Ms. Miller limiting Grievant's access to the MAR, and Grievant changing a dressing in the afternoon.

Grievant did not have 24 hours to initial the MAR, and she knew this. Nurses have 24 hours to correct any omissions on the MAR. They generally check the MAR throughout the day, and at the end of the shift to make sure they have not missed dispensing any medications or treatments, and to make sure they have not missed initialing any of the many spaces on the MAR.

Grievant's attitude is disturbing. She did not ever seem to fully grasp how important accurate records are to good patient care. She believed that because she had 24 hours to correct any errors or omissions in the MAR, and she was the only LPN dispensing

medication on August 15, that it was not of any concern to patient care that she had not initialed the MAR in a timely manner. However, persons other than the LPN on duty, such as Mr. Moore, the Physician's Assistant, may also need to consult the MAR to verify whether a resident has taken his medications, and he may draw conclusions about the resident's health based upon this information. It is possible that Grievant would have had to unexpectedly leave the Facility, and if she did, the MAR would need to accurately reflect what medications had been dispensed to the residents. Some medications were to be given to residents at 7:30 a.m. These medications had to be given to the residents by no later than 8:30 a.m, yet Grievant had not noted whether these medications had been given when she took her smoke break at 10:30 a.m., two hours later. Grievant stated she took her break because she was flustered and needed to step away. However, she acknowledged that she probably should have initialed the MAR before she took her break.

Frankly, the undersigned finds the incident with the missing pill even more disturbing. A resident was to receive four pills prescribed for pain, but when Grievant counted the pills, there were only three. Grievant said nothing about this, gave the resident three pills, and then wrote that she had given the resident four. This resident did not get the pain medication he was supposed to receive, but anyone evaluating him would think that he had received the medication. Grievant, however, was more concerned that a co-worker not get in trouble for taking the pill than she was for the resident's health and comfort. Or perhaps she just didn't want the bother of reporting the missing pill. Whatever the real reason, Grievant made a conscious decision to change this resident's prescribed dosage, while recording that she had not done so, in total disregard of the consequences

to the resident. This is inexcusable, dishonest behavior. At the very least, it calls into question Grievant's credibility.

Grievant believed her behavior should be excused because she was overwhelmed on August 15, and did as much as she could do, with no help from Ms. Miller. "The argument a disciplinary action was excessive given the facts of the situation, is an affirmative defense, and Grievant bears the burden of demonstrating the penalty was 'clearly excessive or reflects an abuse of the agency['s] discretion or an inherent disproportion between the offense and the personnel action.' *Martin v. W. Va. Fire Comm'n*, Docket No. 89-SFC-145 (Aug. 8, 1989)." *Meadows v. Logan County Bd. of Educ.*, Docket No. 00-23-202 (Jan. 31, 2001).

In assessing the penalty imposed, "[w]hether to mitigate the punishment imposed by the employer depends on a finding that the penalty was clearly excessive in light of the employee's past work record and the clarity of existing rules or prohibitions regarding the situation in question and any mitigating circumstances, all of which must be determined on a case by case basis." *McVay v. Wood County Bd. of Educ.*, Docket No. 95-54-041 (May 18, 1995) (citations omitted). This Grievance Board has held that "mitigation of the punishment imposed by an employer is extraordinary relief, and is granted only when there is a showing that a particular disciplinary measure is so clearly disproportionate to the employee's offense that it indicates an abuse of discretion. Considerable deference is afforded the employer's assessment of the seriousness of the employee's conduct and the prospects for rehabilitation." *Overbee v. Dep't of Health and Human Res./Welch Emergency Hosp.*, Docket No. 96-HHR-183 (Oct. 3, 1996). "Respondent has substantial

discretion to determine a penalty in these types of situations, and the undersigned Administrative Law Judge shall not substitute her judgement for that of the employer. *Tickett v. Cabell County Bd. of Educ.*, Docket No. 97-06-233 (Mar. 12, 1998); *Huffstutler v. Cabell County Bd. of Educ.*, Docket No. 97-06-150 (Oct. 31, 1997)." *Meadows, supra.*

Grievant did not meet her burden of demonstrating the penalty imposed was clearly excessive. As previously discussed, the undersigned cannot conclude from the evidence presented that Grievant was so overwhelmed early in the morning on August 15, 2008, that she could not have initialed the MAR as she dispensed medication, or that she needed Ms. Miller's help at that time.

Grievant asserted that other nurses had not initialed the MAR as they dispensed medication, but had not been punished, and argued the penalty imposed was discriminatory. WEST VIRGINIA CODE § 6C-2-2(d) defines "'discrimination'" as "any differences in the treatment of similarly situated employees, unless the differences are related to the actual job responsibilities of the employees or are agreed to in writing by the employees." In order to establish either a discrimination or favoritism claim asserted under the grievance statutes, an employee must prove:

> (a) that he or she has been treated differently from one or more similarly-situated employee(s);
>
> (b) that the different treatment is not related to the actual job responsibilities of the employees; and,
>
> c) that the difference in treatment was not agreed to in writing by the employee.

Frymier v. Higher Education Policy Comm., 655 S.E.2d 52, 221 W. Va. 306 (2007); *Harris v. Dep't of Transp.*, Docket No. 2008-1594-DOT (Dec. 15, 2008).

One witness testified that before the training on March 12, 2008, she had found entire days blank on the MAR when she audited them. Respondent acknowledged there was a problem with the nurses initialing the MAR, which is why the training was given. Respondent made clear to the nurses that they were to initial the MAR as the medication was dispensed, and Grievant knew this is what was expected of her. One witness testified that there had been times when she had not initialed the MAR as she dispensed medications; however, she did not state when this occurred, or that anyone in management was aware she had done this. Grievant presented no evidence that, since the March 12 training, any other nurses had failed to record that they had dispensed anywhere close to 35 medications. Several witnesses acknowledged that at times they had missed initialing one or two spaces on the MAR, and had corrected the MAR at the end of the day when they went back and reviewed it in detail, which management expects. None of these witnesses stated that they had failed to initial several pages of the MAR, for multiple residents, as Grievant had done. Grievant also presented evidence that the MAR for July still had some places as of August 13, 2008, which had not been initialed. While this is certainly a concern, again, it is not similar to Grievant's behavior.

Finally, Grievant presented evidence that when some of the residents were taken to the Barbour County Fair, the MAR was not taken on the trip, and was not initialed until the nurse returned. The nurse who dispensed medications during this trip was told not to take the MAR off site, for obvious reasons. As a substitute, however, she placed the residents' medications in individual packages, and wrote on the packages as medication was dispensed. When she returned to the Facility, she transferred her notes to the MAR. This clearly was an unusual situation, and by initialing the packages, this nurse

accomplished the same goal as initialing the MAR. Again, this is not the same as what Grievant did. The punishment imposed upon Grievant was not discriminatory.

The following Conclusions of Law support the decision reached.

Conclusions of Law

1. 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. *Ramey v. W. Va. Dep't of Health*, Docket No. H-88-005 (Dec. 6, 1988).

2. The employer must also demonstrate that misconduct which forms the basis for the dismissal of a tenured state employee is of a "substantial nature directly affecting rights and interests of the public." *House v. Civil Serv. Comm'n*, 181 W. Va. 49, 380 S.E.2d 226 (1989). "The judicial standard in West Virginia requires that 'dismissal of a civil service employee be for good cause, which means misconduct of a substantial nature directly affecting rights and interests of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention.' Syl. Pt. 2, *Buskirk v. Civil Service Comm'n*, [175 W. Va. 279, ___,] 332 S.E.2d 579, 581 (W. Va. 1985); *Oakes v. W. Va. Dept. of Finance and Admin.*, [164 W. Va. 384,] 264 S.E.2d 151 (W. Va. 1980); *Guine v. Civil Service Comm'n*, [149 W. Va. 461,] 141 S.E.2d 364 (W. Va. 1965)." *Scragg v. Bd. of Dir. W. Va. State College*, Docket No. 93-BOD-436 (Dec. 30, 1994).

3. The "term gross misconduct as used in the context of an employer-employee relationship implies a willful disregard of the employer's interest or a wanton disregard of

standards of behavior which the employer has a right to expect of its employees." *Graley v. W. Va. Parkways Economic Dev. & Tourism Auth.*, Docket No. 91-PEDTA-225 (Dec. 23, 1991) (*citing Buskirk v. Civil Serv. Comm'n,* 175 W. Va. 279, 332 S.E.2d 579 (1985)). *See Evans v. Tax & Revenue/Ins. Comm'n,* Docket No. 02-INS-108 (Sept. 13, 2002).

4. Respondent proved the charges against Grievant.

5. "The argument a disciplinary action was excessive given the facts of the situation, is an affirmative defense, and Grievant bears the burden of demonstrating the penalty was 'clearly excessive or reflects an abuse of the agency['s] discretion or an inherent disproportion between the offense and the personnel action.' *Martin v. W. Va. Fire Comm'n*, Docket No. 89-SFC-145 (Aug. 8, 1989)." *Meadows v. Logan County Bd. of Educ.*, Docket No. 00-23-202 (Jan. 31, 2001).

6. In assessing the penalty imposed, "[w]hether to mitigate the punishment imposed by the employer depends on a finding that the penalty was clearly excessive in light of the employee's past work record and the clarity of existing rules or prohibitions regarding the situation in question and any mitigating circumstances, all of which must be determined on a case by case basis." *McVay v. Wood County Bd. of Educ.*, Docket No. 95-54-041 (May 18, 1995) (citations omitted). This Grievance Board has held that "mitigation of the punishment imposed by an employer is extraordinary relief, and is granted only when there is a showing that a particular disciplinary measure is so clearly disproportionate to the employee's offense that it indicates an abuse of discretion. Considerable deference is afforded the employer's assessment of the seriousness of the employee's conduct and the prospects for rehabilitation." *Overbee v. Dep't of Health and Human Res./Welch Emergency Hosp.*, Docket No. 96-HHR-183 (Oct. 3, 1996). "Respondent has substantial discretion to determine a penalty in these types of situations,

and the undersigned Administrative Law Judge shall not substitute her judgement for that of the employer. *Tickett v. Cabell County Bd. of Educ.*, Docket No. 97-06-233 (Mar. 12, 1998); *Huffstutler v. Cabell County Bd. of Educ.*, Docket No. 97-06-150 (Oct. 31, 1997)." *Meadows v. Logan County Bd. of Educ.*, Docket No. 00-23-202 (Jan. 31, 2001).

7. In order to establish either a discrimination or favoritism claim asserted under the grievance statute (WEST VIRGINIA CODE § 6C-2-2(d)), an employee must prove:

> (a) that he or she has been treated differently from one or more similarly-situated employee(s);
>
> (b) that the different treatment is not related to the actual job responsibilities of the employees; and,
>
> c) that the difference in treatment was not agreed to in writing by the employee.

Frymier v. Higher Education Policy Comm., 655 S.E.2d 52, 221 W. Va. 306 (2007); *Harris v. Dep't of Transp.*, Docket No. 2008-1594-DOT (Dec. 15, 2008).

8. Grievant did not demonstrate that the penalty imposed was clearly excessive, or that it was discriminatory.

Accordingly, this grievance is **DENIED.**

Any party or the Division of Personnel may appeal this Decision to the Circuit Court of Kanawha County. Any such appeal must be filed within thirty (30) days of receipt of this Decision. *See* W. VA. CODE § 6C-2-5. Neither the West Virginia Public Employees Grievance Board nor any of its Administrative Law Judges is a party to such appeal and should not be so named. However, the appealing party is required by W. VA. CODE § 29A-5-4(b) to serve a copy of the appeal petition upon the Grievance Board. The appealing party must also provide the Board with the civil action number so that the certified record can be prepared and properly transmitted to the Circuit Court of Kanawha County. *See also* 156 C.S.R. 1 § 6.20 (2008).

BRENDA L. GOULD
Administrative Law Judge

Date: January 30, 2009