

**THE WEST VIRGINIA PUBLIC EMPLOYEES GRIEVANCE BOARD**

**LARRY KAPP,**  
**Grievant,**

**v.**

**Docket No. 2020-1015-DHHR**

**DEPARTMENT OF HEALTH AND HUMAN RESOURCES/  
LAKIN HOSPITAL,**  
**Respondent.**

**DECISION**

Grievant, Larry Kapp, was employed by Respondent, Department of Health and Human Resources, at Lakin Hospital. On March 4, 2020, Grievant filed this grievance against Respondent alleging wrongful termination of his employment. For relief, Grievant seeks reinstatement and back pay.

The grievance was properly filed directly to level three pursuant to W. VA. CODE § 6C-2-4(a)(4). A level three hearing was held on August 6, 2020, before the undersigned at the Grievance Board's Charleston, West Virginia office via video conference. Grievant was represented by Gary DeLuke, Field Organizer, UE Local 170. Respondent was represented by counsel, James "Jake" Wegman, Assistant Attorney General. This matter became mature for decision on November 30, 2020, upon final receipt of the parties' written Proposed Findings of Fact and Conclusions of Law following several extensions of time to file at the request and agreement of the parties.

**Synopsis**

Grievant was employed by Respondent as a Licensed Practical Nurse at Lakin Hospital and had been so employed for seventeen years. Respondent terminated Grievant's employment for resident abuse and violation of federal regulations.

Respondent proved Grievant improperly restrained a resident and forced him to take medication, contributed to a resident's fall, failed to assess or aid the resident after the fall, failed to report the fall, and attempted to conceal that a fall had occurred. Grievant failed to prove mitigation of the punishment is warranted. Accordingly, the grievance is denied.

The following Findings of Fact are based upon a complete and thorough review of the record created in this grievance:

### **Findings of Fact**

1. Grievant was employed by Respondent as a Licensed Practical Nurse at Lakin Hospital and had been so employed for seventeen years.
2. Lakin Hospital is a long-term care facility. To ensure resident and employee safety, common areas of the facility are monitored by video surveillance.
3. On February 10, 2020, Grievant attempted to give resident R.B.<sup>1</sup> oral medication, which is crushed into pudding and given to him with a spoon. The interaction is captured on the video surveillance footage.
4. R.B. is non-verbal and suffers from multiple mental and physical illnesses and disabilities. Of relevance to the grievance are physical disabilities that make R.B. unsteady on his feet, intellectual disabilities, and osteoporosis.
5. Grievant has treated R.B. for years and was very familiar with his habits.
6. R.B. can be uncooperative with staff and does sometimes refuse his medication. Other staff members persuade R.B. to take his medication through verbal

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<sup>1</sup> To protect his right to privacy, the resident will be referred to by his initials only.

encouragement, distraction, or by asking another person to attempt to administer the medication. Other staff have allowed R.B. to refuse his medication, which is his right.

7. When Grievant approached R.B. to administer the medication, R.B. was seated in a padded reclining chair. Grievant attempted to put the spoon into R.B.'s mouth and R.B. batted Grievant's arm away and then attempted to push Grievant away. R.B.'s action was not violent or aggressive but was simply a physical refusal as R.B. is non-verbal. Grievant immediately grabbed R.B.'s arm, forced it down onto the chair arm, and pinned it there by kneeling on it with his right knee. R.B. then opened his mouth and Grievant administered the first dose of the medication. R.B. pulled his arm from under Grievant's knee as Grievant readied the next spoon of medication. Without attempting to administer the second dose, Grievant immediately grabbed R.B.'s arm again, forced it to the chair arm while R.B. struggled, and kneeled on the arm with his knee. R.B. continued to struggle after his arm was pinned and Grievant placed his hand on R.B.'s forehead and shoved R.B.'s head back against the chair. Once Grievant released R.B.'s head and offered the spoon while still pinning his arm, R.B. opened his mouth and took the medication.

8. Certified Nursing Assistant Donna Plants witnessed the interaction, was concerned, and reported it to Director of Nursing ("DON") Vicky Bryant and Assistant Director of Nursing ("ADON") Laurel Sigman.

9. Ms. Plants also provided a signed written statement that she witnessed Grievant hold down R.B.'s arm with his leg and that she felt the force was unnecessary.

10. The next day, February 11, 2020, Grievant had another interaction with R.B. that was also captured on the surveillance footage.

11. Grievant was distributing medication to residents using a “med cart,” which contained medications and supplies.

12. Grievant left his cart unattended in the day room while Grievant entered a resident’s room even though R.B. was seated nearby and Grievant knew R.B. had a habit of attempting to grab things from the med cart.

13. As it contains medication, a med cart should not be left unattended and there was no reason why Grievant could not take the cart into the resident’s room other than convenience.

14. While Grievant was in the resident’s room, R.B. approached the cart. R.B.’s gait is unsteady, although he totters towards the cart fairly rapidly.

15. Grievant exited the resident’s room and rushed to R.B., intercepting him while he was several feet away from the cart, and attempted to block R.B. from reaching the cart. R.B. attempted to push past Grievant and grabbed for items on the cart with his right hand, knocking items to the ground. Grievant grabbed R.B.’s right arm and pulled it away from the cart causing R.B.’s arm to be raised above his head as R.B. struggled, although it does not appear Grievant actually pulled R.B.’s arm above his head. This action caused R.B. to lose his balance and fall backwards onto the floor. Grievant lost his grip on R.B. during the fall. R.B. impacted the ground with enough force that it also caused the back of his head to hit the floor. Grievant did not ease R.B. to the floor and had no grip on him at all for the last foot or so of the fall.

16. Grievant did not assess R.B. for injuries but immediately pulled R.B. to a seated position by his arm.

17. Health Services Worker Leah Bland was returning to the unit and saw R.B. walking towards the med cart. She was out of frame of the video camera, twenty or more feet away. She told R.B. “no” and was walking towards him when she saw Grievant intercept R.B. She believed Grievant pushed R.B. to the floor. She appears in the camera frame as R.B. is falling and reached them as Grievant pulls R.B. to a seated position.

18. Grievant then turned his back on R.B. and began picking items from off the floor and cleaning the med cart while R.B. scooted on his butt approximately fifteen feet back to his chair as Ms. Bland followed him attempting to help.

19. Grievant made no attempt to assist R.B. until Ms. Bland could not get R.B. back on his feet by herself and asked Grievant to help.

20. As soon as R.B. was seated in the chair, Grievant again went back to the med cart where he remained for the last few minutes of the video footage.

21. Grievant told Ms. Bland that they were not going to file an incident report.

22. Grievant entered an electronic nursing note on the same day stating, “Resident attempted to walk rapidly to my med cart [and] throw things. This is not a new behavior. He had a water cup which burst. He became unbalanced [and] tripped. I caught him with my left hand [and] sat him on floor. No fall occurred. Assisted to stand [and] he pushed me away [and] went to his chair. He later went to his room [and] to bed.”

23. The electronic note did not accurately reflect what transpired and was an attempt by Grievant to absolve himself of responsibility.

24. At the end of the shift, another Health Services Worker noticed a “bruise” on R.B.’s elbow and told Ms. Bland. Ms. Bland told Grievant about the bruise and he said, “I guess I will have to make out an incident report.”

25. Grievant did not file an incident report.
26. Ms. Bland was concerned by Grievant's behavior and reported the incident to ADON Sigman the next day and provided a written, signed statement.
27. Upon examination, it was discovered R.B. had sustained a bruise above his right buttock and a scrape to his elbow.
28. By letter dated February 13, 2020, Human Resources Director Randi M. Gheen suspended Grievant without pay pending investigation of allegations that Grievant had physically abused a resident.
29. Stephanie Click, LSW, Social Service Supervisor, investigated both incidents. As part of her investigation, Ms. Click interviewed staff and reviewed the relevant video surveillance footage, care plan, and medical records.
30. Grievant provided two signed, handwritten statements regarding the incidents for the investigation.
31. Regarding the medication incident, Grievant stated that when R.B. refused medication by hitting and pushing Grievant away with his hand Grievant had held his hand down "in as gentle matter as possible" and kneeled on his other hand against the cushioned arm of the chair.
32. Regarding the fall, Grievant states that R.B. walked rapidly to the cart, burst a Styrofoam cup, and tripped. Grievant states he "caught" R.B. with his hand and "sat him down," denying that a fall occurred. Grievant states R.B. crawled away and that Ms. Plants, not Ms. Bland, helped Grievant assist R.B. to a standing position. Grievant states there was no apparent injury and that he resumed med pass after cleaning up the spill.

33. On February 19, 2020, Ms. Click submitted her reports of the investigation; one for each incident. Ms. Click substantiated that Grievant had abused R.B. in both instances.

34. The report of the medication incident noted R.B.'s "long-standing habit" of pushing people away from him. The report describes the video of the incident and finds that Grievant did not attempt any other alternatives to the restraint.

35. The report of the fall notes R.B.'s "long-standing habit" of throwing items off of unattended medication carts. The report describes the video of the incident and notes that Grievant did not assess R.B. for injury or aid him, and that he failed to file an incident report. The report finds that Grievant's assertion R.B. did not fall is refuted by the video and witnesses. The report notes R.B. sustained a small bruise above his buttock and a small circular scrape to his elbow.

36. On February 21, 2020, Director Gheen, DON Bryant, and ADON Sigman conducted a predetermination conference with Grievant. During the conference, Grievant insisted that R.B. did not fall and that Grievant had held R.B.'s arm to assist him to sit on the floor. Grievant stated he did not file an incident report or perform an assessment because R.B. did not fall. Grievant stated he had forced R.B. to take the medication because it was seizure medication it was in R.B.'s best interests to take.

37. Deputy Commissioner Matthew Keefer terminated Grievant's employment by letter dated February 26, 2020. As grounds, Mr. Keefer stated that Grievant failed to follow state and federal regulations in violation of Respondent's employee conduct policy. Mr. Keefer explained that Grievant violated the resident's right to be free from restraint and to refuse treatment when he restrained him to administer medication and that

Grievant committed abuse and neglect for grabbing and pulling the resident's arm causing him to fall, failing to assess the resident after the fall, and failing to report the fall.

38. Respondent's Policy Memorandum 2108 Employee Conduct requires employees to comply with federal regulations.

39. Respondent's Policy NURS 028, *Falls Management Procedure*, provides detailed requirements relating to resident falls. A "fall" is defined as "the failure to maintain an appropriate lying, sitting, or standing position resulting in a resident's abrupt, undesired relocation to the ground." The policy requires that a resident who falls must be "promptly assessed for injuries," that the resident's physician and responsible party must be contacted, and that a *Fall Investigation Worksheet* be completed along with the incident report.

40. Prior to his dismissal, Grievant had not received any other discipline.

### **Discussion**

The burden of proof in disciplinary matters rests with the employer to prove by a preponderance of the evidence that the disciplinary action taken was justified. W.VA. CODE ST. R. § 156-1-3 (2018). "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 & 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.*

Permanent state employees who are in the classified service can only be dismissed for "good cause," meaning "misconduct of a substantial nature directly affecting



the rights and interest of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention." Syl. Pt. 1, *Oakes v. W. Va. Dep't of Finance and Admin.*, 164 W. Va. 384, 264 S.E.2d 151 (1980); *Guine v. Civil Serv. Comm'n*, 149 W. Va. 461, 141 S.E.2d 364 (1965); See also W. VA. CODE ST. R. § 143-1-12.02 and 12.03 (2016).

Respondent asserts the termination of Grievant's employment was justified for Grievant's improper restraint and abuse of a resident in violation of policy. Grievant denies that his actions constituted improper restraint or abuse and asserts that, to the extent he made any error, the discipline of termination was too severe given his seventeen years of good work history.

In situations 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. Dep't of Health & Human Res.*, Docket No. 96-HHR-371 (Oct. 30, 1996); *Young v. Div. of Natural Res.*, Docket No. 2009-0540-DOC (Nov. 13, 2009); See also *Clarke v. W. Va. Bd. of Regents*, 166 W. Va. 702, 279 S.E.2d 169 (1981). In assessing the credibility of witnesses, some factors to be considered ... are the witness's: 1) demeanor; 2) opportunity or capacity to perceive and communicate; 3) reputation for honesty; 4) attitude toward the action; and 5) admission of untruthfulness. HAROLD J. ASHER & WILLIAM C. JACKSON, REPRESENTING THE AGENCY BEFORE THE UNITED STATES MERIT SYSTEMS PROTECTION BOARD 152-153 (1984). Additionally, the ALJ should consider: 1) the presence or absence of bias, interest, or motive; 2) the consistency of prior statements; 3) the existence or nonexistence of any fact testified to by the witness;

and 4) the plausibility of the witness's information. *Id.*, *Burchell v. Bd. of Trustees, Marshall Univ.*, Docket No. 97-BOT-011 (Aug. 29, 1997).

Grievant is not credible. Although Grievant's demeanor and attitude towards the proceeding were appropriate, Grievant's testimony and written statements regarding the fall are refuted by the video evidence and appear to be motivated to cover up the fall. The video clearly shows Grievant grabbing R.B.'s arm, R.B. struggling, and R.B. falling. In his nursing notes and written statement, Grievant omits his grabbing of R.B. and describes the fall as R.B. tripping and attempting to sit, Grievant catching him, and Grievant assisting R.B. to sit on the floor. While the video does not support Ms. Bland and Ms. Click's reasonable but mistaken assertions that Grievant shoved R.B., and, in fact, appears to show Grievant attempting to keep R.B. from falling once he began struggling, it clearly shows Grievant's description of the incident to be false. In addition, Ms. Bland's credible statements, as will be further discussed below, further show Grievant's intent to cover up R.B.'s fall. Grievant's testimony that he watched R.B. to make sure he was moving, that he could not get R.B. up by himself, and that he had to go care for another resident who needed attention are also refuted by the video and are a change from his nursing note and written statement. Ms. Bland was standing beside Grievant while R.B. was seated on the floor and Grievant turned his back on them to clean up the cart. He did not attempt to help R.B. to stand or watch him as he scooted across the floor. He also did not leave R.B. for another resident but stood with the cart for several minutes after R.B. was placed in the chair. Grievant's assertions regarding permission to restrain R.B. to give him medication are unsupported by any other evidence, were not included in his initial written statement of the incident and, again, appear to be self-serving.

Ms. Bland was credible. Although during her testimony Ms. Bland's posture was stooped and she appeared tired, she did not appear to be impaired. Her answers to questions were forthright and her memory of the events appeared good. Ms. Bland appeared genuinely concerned regarding what had occurred. There is no allegation of bias or interest. Ms. Bland's testimony is also supported by the video evidence. Ms. Bland asserts Grievant pushed R.B. down, which the undersigned has determined has not occurred based on the video evidence, but it was reasonable for Ms. Bland to think Grievant pushed R.B. from her viewpoint of the incident and not an indication of untruthfulness.

In order to be eligible to participate in Medicare or Medicaid, a facility must meet the provisions of certain federal regulations. 42 C.F.R. § 483.1(b). One provision is the observance of certain resident rights. Of relevance to the grievance are a resident's rights to respect and dignity, to participate in the planning and implementation of care, and to be free from abuse and neglect. "The resident has a right to be treated with respect and dignity, including: The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. . . ." 42 C.F.R. § 483.10(e)(1). "The resident has the right to be informed of, and participate in, his or her treatment, including: The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive." 42 C.F.R. § 483.10(c)(6). "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart." 42 C.F.R. § 483.12.

“Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.” 42 C.F.R. § 483.5. “Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.” *Id.*

It is not proven that Grievant acted with an intent to harm R.B. but Grievant clearly did not treat R.B. with respect and dignity. Further, intent to harm is not necessary to constitute abuse under the federal regulations, which require only that the action taken was deliberate. Grievant was required by Respondent’s policy to follow the above federal regulations. Grievant was also required by Respondent’s policy to take certain actions when a resident falls.

Grievant’s restraint of R.B. to force him to take his medication was abuse and in violation of the federal regulations. Grievant had no authority, nor was there reason, to restrain R.B. to administer medication. Grievant made no attempt to get R.B. to take his medication through other means and R.B. had the right to refuse his medication. Further, the method of Grievant’s restraint was particularly concerning in that kneeling on R.B.’s

arm would have caused R.B. discomfort if not pain and had a heightened risk of injury in that R.B. had osteoporosis.

Regarding the fall, Grievant should not have left the med cart unattended knowing R.B.'s habit of trying to get things from unattended med carts. Grievant admitted that there was no reason he could not take the cart with him into a resident's room. While it would be appropriate for Grievant to intervene when R.B. attempted to reach the cart, given that there were medications on the cart that may have harmed R.B., the choice to grab R.B.'s arm ultimately led to the fall.

It is clear Grievant grabbed R.B.'s right arm with Grievant's right hand and pulled it away from the cart. It is not clear that Grievant raised R.B.'s arm above his head. As R.B. began to fall, his arm is raised above his head but it appears Grievant's right hand is at R.B.'s waist. It appears Grievant's left hand is on R.B.'s back near his neck. Although Ms. Bland states Grievant shoved R.B. and Ms. Click stated the video looked "more like a shove," the undersigned cannot find the video shows Grievant shoving R.B. or pulling his arm above his head. However, the video does clearly show that it was a fall and that Grievant contributed to the fall. While Grievant could reasonably think that R.B. was attempting to sit rather than becoming unbalanced, Grievant was not in control of R.B.'s descent and R.B. impacted the ground with force, hitting his head. This was clearly a fall and not an assisted seating on the ground as Grievant claimed. It is also clear that Grievant failed to assess R.B. for injuries or aid him after the fall as was required by Respondent's policy. Although Grievant's actions regarding the fall do not appear to constitute abuse as Respondent determined, Grievant's action do constitute neglect in violation of the federal regulations.

Grievant's failures are compounded by his refusal to admit his misconduct and seeming attempts to conceal his misconduct. Grievant's nursing note and written statements are not accurate descriptions of what happened and cannot be explained by confusion regarding the events. Ms. Bland's credible testimony further proves that Grievant knew an incident report should be filed and his attempt to prevent the same. Respondent was justified in terminating Grievant's employment.

Grievant asserts that termination of his employment is too harsh a penalty. "[A]n 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.' *Martin v. W. Va. Fire Comm'n*, Docket No. 89-SFC-145 (Aug. 8, 1989)." *Conner v. Barbour County Bd. of Educ.*, Docket No. 94-01-394 (Jan. 31, 1995), *aff'd*, Kanawha Cnty. Cir. Ct. Docket No. 95-AA-66 (May 1, 1996), *appeal refused*, W.Va. Sup. Ct. App. (Nov. 19, 1996). "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 Resources/Welch Emergency Hosp.*, Docket No. 96-HHR-183 (Oct. 3, 1996); *Olsen v. Kanawha County Bd. of Educ.*, Docket No. 02-20-380 (May 30, 2003), *aff'd*, Kanawha Cnty. Cir. Ct. Docket No. 03-AA-94 (Jan. 30, 2004), *appeal refused*, W.Va. Sup. Ct. App. Docket No. 041105 (Sept. 30, 2004). "When considering

whether to mitigate the punishment, factors to be considered include the employee's work history and personnel evaluations; whether the penalty is clearly disproportionate to the offense proven; the penalties employed by the employer against other employees guilty of similar offenses; and the clarity with which the employee was advised of prohibitions against the conduct involved.” *Phillips v. Summers County Bd. of Educ.*, Docket No. 93-45-105 (Mar. 31, 1994); *Cooper v. Raleigh County Bd. of Educ.*, Docket No. 2014-0028-RalED (Apr. 30, 2014), *aff’d*, Kanawha Cnty. Cir. Ct. Docket No. 14-AA-54 (Jan. 16, 2015).

Grievant asserts that termination of his employment was too severe a penalty given his years of service and good work history. Grievant had been employed by Respondent for seventeen years and had never before been disciplined. Grievant did not introduce into evidence any employee evaluation and did not provide evidence, apart from his own testimony of his work performance. Termination of employment for abuse of a resident is not a disproportionate penalty. Grievant’s refusal to admit to the conduct and dishonesty in attempting to conceal the conduct proves there is limited prospect for rehabilitation. Grievant has failed to prove mitigation is warranted.

The following Conclusions of Law support the decision reached.

### **Conclusions of Law**

1. The burden of proof in disciplinary matters rests with the employer to prove by a preponderance of the evidence that the disciplinary action taken was justified. W.VA. CODE ST. R. § 156-1-3 (2018). "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 & 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.*

2. Permanent state employees who are in the classified service can only be dismissed for "good cause," meaning "misconduct of a substantial nature directly affecting the rights and interest of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention." Syl. Pt. 1, *Oakes v. W. Va. Dep't of Finance and Admin.*, 164 W. Va. 384, 264 S.E.2d 151 (1980); *Guine v. Civil Serv. Comm'n*, 149 W. Va. 461, 141 S.E.2d 364 (1965); See also W. VA. CODE ST. R. § 143-1-12.2.a. (2016).

3. Respondent proved it had good cause to terminate Grievant for his abuse and neglect of a resident and violation of policy.

4. "[A]n 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.' *Martin v. W. Va. Fire Comm'n*, Docket No. 89-SFC-145 (Aug. 8, 1989)." *Conner v. Barbour County Bd. of Educ.*, Docket No. 94-01-394 (Jan. 31, 1995), *aff'd*, Kanawha Cnty. Cir. Ct. Docket No. 95-AA-66 (May 1, 1996), *appeal refused*, W.Va. Sup. Ct. App. (Nov. 19, 1996).

5. "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 Resources/Welch Emergency Hosp.*, Docket No. 96-HHR-183 (Oct. 3, 1996); *Olsen v. Kanawha County Bd. of Educ.*, Docket No. 02-20-380 (May 30, 2003), *aff'd*, Kanawha Cnty. Cir. Ct. Docket No. 03-AA-94 (Jan. 30, 2004), *appeal refused*, W.Va. Sup. Ct. App. Docket No. 041105 (Sept. 30, 2004).

6. “When considering whether to mitigate the punishment, factors to be considered include the employee's work history and personnel evaluations; whether the penalty is clearly disproportionate to the offense proven; the penalties employed by the employer against other employees guilty of similar offenses; and the clarity with which the employee was advised of prohibitions against the conduct involved.” *Phillips v. Summers County Bd. of Educ.*, Docket No. 93-45-105 (Mar. 31, 1994); *Cooper v. Raleigh County Bd. of Educ.*, Docket No. 2014-0028-RalED (Apr. 30, 2014), *aff'd*, Kanawha Cnty. Cir. Ct. Docket No. 14-AA-54 (Jan. 16, 2015).

7. Grievant failed to prove mitigation is warranted.

Accordingly, the grievance is **DENIED**.

Any party 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 Civil Action number should be

included so that the certified record can be properly filed with the circuit court. See *also* W. VA. CODE ST. R. § 156-1-6.20 (2018).

**DATE: January 15, 2021**

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**Billie Thacker Catlett**  
**Chief Administrative Law Judge**