**THE WEST VIRGINIA PUBLIC EMPLOYEES**
**GRIEVANCE BOARD**

**TRACY DICKERSON,**
**Grievant,**

**v.** **Docket No. 2012-1313-DHHR**

**DEPARTMENT OF HEALTH AND HUMAN RESOURCES/**
**MILDRED MITCHELL-BATEMAN HOSPITAL,**
**Respondent.**

## DECISION

Grievant, Tracy Dickerson, filed this grievance on May 17, 2012, alleging that she was suspended from her employment without good cause. Grievant seeks to be made whole, including restoration of all lost wages with interest and restoration of all benefits. Because Grievant was contesting her suspension, she filed directly to level three. *See* West Virginia Code § 6C-2-4(a)(4). An evidentiary hearing was conducted before the undersigned contract Administrative Law Judge on November 19, 2012, at the Board's Charleston office location. Grievant did not appear in person but appeared by her representative, Gordon Simmons, UE Local 170, West Virginia Public Workers Union. Respondent was represented by its attorney, Harry C. Bruner, Jr., Assistant Attorney General. This matter became mature for consideration upon receipt of the parties' proposed findings of fact and conclusions of law on December 19, 2012.

## Synopsis

Grievant was charged with failure to adhere to hospital policies while performing her duties as a Health Service Worker. Respondent met its burden of proof and demonstrated by a preponderance of the evidence that Grievant's five-day suspension was for good cause.

The following facts are found to be proven by a preponderance of the evidence based upon an examination of the entire record developed in this matter.

**Findings of Fact**

1. Grievant, Tracy Dickerson, was employed as a Health Service Worker ("HSW") with Mildred Mitchell-Bateman Hospital ("Hospital"), a psychiatric facility operated by Respondent West Virginia Department of Health and Human Resources ("WVDHHR"). At the time the grievance was filed, Grievant had been employed with the Hospital at least ten (10) years.

2. Grievant was normally assigned to Unit 2 at the Hospital. However, on February 17, 2012, Grievant was pulled to work on Unit A5 during the shift at issue.

3. On that date, patient CW[1] escaped from Unit A5 after Grievant left the dining room area for lunch. Grievant left Unit A5 through a door that did not properly lock and through which CW escaped.

4. Hospital Unit A5 contains long-term patients like CW. According to testimony presented at the level three hearing, patient CW suffers from schizophrenia, obsessive-compulsive tendencies, paranoia, and is an elopement risk.

5. HSW Ashley Jarrell testified that other patients on Unit A5 informed her that patient CW escaped from the unit by following a woman through the dining room door. HSW Jarrell searched Unit A5 for CW and she eventually located CW on the first floor in a stairwell trying to leave the Hospital.

6. HSW Jarrell escorted patient CW from the first floor back to Unit A5 on the second floor, and reported that patient CW had been recovered.

[1] Because the patient's actual identity is not necessary to the issues herein, her initials are used rather than her name to protect her privacy.

7. When she testified, HSW Jarrell prepared and referenced a diagram of Unit A5 which showed the dining room and door through which Grievant and CW exited the unit.

8. Additional testimony from HSW Jarrell indicates that Hospital staff know to "check and re-check" unit doors whenever they pass through them.

9. HSW Jarrell further testified that individual patient concerns and problems on the unit were discussed with staff by the registered nurse when reviewing a "morning report."

10. Footage from a video surveillance system of the Hospital's common areas, including Unit A5's dining area and exit doors, showed Grievant exiting the dining room through a door and, shortly thereafter, patient CW exiting the same door.

11. Evidence presented at the level three hearing shows that patient CW made other attempts to elope on February 4, March 4, and March 12, 2012. According to Grievant, no one on Unit 5 told her of any problem with the door latch prior to the incident with CW and she was unfamiliar with CW's history.

12. No evidence was presented concerning the frequency with which Grievant was pulled from her normal unit, Unit 2, to perform work in Unit A5.

13. Steven Ashley is a Nurse Manager at the Hospital. On February 24, 2012, he filed a patient complaint, which referenced the unsuccessful elopement of patient CW.

14. After the patient complaint was filed, the elopement incident was investigated by Hospital Staff as well as by a patient advocate[2] employed by the Legal Aid of West Virginia ("LAWV").

15. Both the investigations, one conducted by Hospital staff and another conducted by LAWV, determined that CW's elopement was the result of patient neglect by Grievant. Specifically, the March 15, 2012 LAWV Investigative Report states that patient CW is identified in her treatment plan as being an elopement risk and requires one-on-one supervision. *See* Respondent Exhibit 2, Investigation Report, at p. 4. The report further finds that CW was able to leave the unit "[d]ue to staff recklessly exiting the unit and failing to assure the door was locked." *Id.*

16. The Hospital's Director of Human Relations, Kieth Anne Worden, testified that after reviewing the outcome of investigations by Hospital staff and the LAWV, the facts were clear that Grievant failed in her responsibility to ensure that patient CW did not elope from Unit A5.

17. According to the Hospital's Progressive Discipline Action Policy ("PCAP") Number MMBHC015, Grievant may be suspended without pay for any cause involving misconduct of an appropriately serious nature. *See* Respondent Exhibit 3, Progressive Disciplinary Action.

18. Ms. Worden testified that Grievant's first duty as a HSW direct care provider is to ensure the safety of each patient.[3] She further testified that the failure to secure an exit door through which a mentally ill patient escaped is conduct of a serious nature.

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[2] The patient advocate who conducted the investigation was Tami Handley.

[3] Respondent Exhibit 1, Grievant's May 1, 2012 Suspension Letter, reiterates that the first duty "as a direct care provider is to ensure the safety of each patient."

19. On May 1, 2012, Grievant was issued a five-day unpaid suspension for a "continuing failure to adhere to Mildred Mitchell-Bateman Hospital's policies, practices and expectations of behavior" for failure to ensure the exit door to the stairwell was closed and secure when she left the unit on which she worked and for two additional Written Reprimands from 2011 which were contained in her personnel file.[4] *See* Respondent Exhibit 1, Grievant's May 1, 2012 Suspension Letter.

**Discussion**

As this grievance involves a disciplinary matter, the Respondent bears the burden of establishing the charges against the Grievant by a preponderance of the evidence. Procedural Rules of the W. Va. Public Employees Grievance Bd. 156 C.S.R. 1 § 3 (2008); *Nicholson v. Logan County Bd. of Educ.*, Docket No. 95-23-129 (Oct. 18, 1995); *Landy v. Raleigh County Bd. of Educ.*, Docket No. 89-41-232 (Dec. 14, 1989).

> A preponderance of the evidence is evidence of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not.

*Petry v. Kanawha County Bd. of Educ.*, Docket No. 96-20-380 (Mar. 18, 1997); *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.*

Grievant was a permanent state employee in the classified service. Permanent state employees who are in the classified service can only be dismissed for "good

[4] Grievant's suspension letter references two written reprimands, from July 20, 2011, and December 12, 2011 respectively, that involve violations of Hospital Policies governing timekeeping records and hours of work/overtime. Although identified in the suspension letter and collectively submitted as part of Respondent Exhibit 1, the circumstances surrounding these written reprimands were not presented in the level three hearing and will not be considered here.

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 Sloan v. Dep't of Health & Human Res.*, 215 W. Va. 657, 661, 600 S.E.2d 554, 558 (2004) (per curiam).

Respondent issued Grievant a five-day suspension without pay based upon the finding of neglect because Grievant failed to assure the Unit A5 door was locked which allowed CW, a patient who posed an elopement risk, to escape the unit. Grievant counters that she was not familiar with Unit A5 and whether its doors had maintenance issues because she was normally assigned to Unit 2. She further claims that she was not familiar with patient CW's history of elopement attempts or her treatment plan and that this information was not discussed with her prior to beginning her work on Unit A5. Finally, Grievant alleges that the latch on the door she used to exit Unit A5 had not worked properly for months.

The LAWV Investigation Report reflects that on the day at issue, when she left the unit for her scheduled lunch break, Grievant simply listened to see if the door closed behind her. *See* Respondent Exhibit 2, Investigation Report, at p. 3. The LAWV Investigation did not find that anyone had documented a report to maintenance or the engineering department concerning the door not closing completely. *Id.* Also, evidence from HSW Jarrell shows that prior to a shift, a registered nurse reviews a "morning report" with staff and discusses any individual patient concerns and problems on the

unit. There was no evidence presented that on the day in question, this discussion with staff that included Grievant was not held.

West Virginia Code of State Rules defines "neglect" as:

> Any negligent, reckless or intentional failure to meet the needs of a patient, or applicable statutory or regulatory requirements, including but not limited to: lack of supervision, nutritional deprivation, or failure to implement or update a treatment plan.

*See* 64 C.S.R. 59 § 3.12. Policy Number MMBHC015 also states that "[a]n employee may be suspended without pay for any cause involving delinquency or misconduct of an appropriately serious nature…." To reinforce the Hospital's attention to patient safety, this Policy further states that "[a]llegations involving patient safety issues, such as abuse or neglect, may result in suspensions without a notice period from duty or reassignment to another work site pending the outcome of an investigation." Also, WVDHHR Policy Memorandum 2108 governing Employee Conduct states that employees are expected to follow directives of their superiors and exercise safety precautions. *See* Respondent Exhibit 3, Policy Memorandum 2108, Employee Conduct, at p. 2.

Respondent proved that Grievant was at least negligent in her failure to ensure patient safety by not securing the door when she exited Unit A5. That failure allowed patient CW, who is identified as an elopement risk in her treatment plan, to leave Unit A5 without supervision in an attempt to escape the Hospital. Grievant's neglect in that regard resulted in her suspension without pay, consistent with the Hospital's Policy governing Progressive Disciplinary Action. Accordingly, the grievance is DENIED.

## Conclusions of Law

1. The Respondent bears the burden of establishing the charges against the Grievant by a preponderance of the evidence. Procedural Rules of the W. Va. Public Employees Grievance Bd. 156 C.S.R. 1 § 3 (2008); *Nicholson v. Logan County Bd. of Educ.*, Docket No. 95-23-129 (Oct. 18, 1995); *Landy v. Raleigh County Bd. of Educ.*, Docket No. 89-41-232 (Dec. 14, 1989).

> A preponderance of the evidence is evidence of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not.

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2. West Virginia Code of State Rules defines "neglect" as:

> Any negligent, reckless or intentional failure to meet the needs of a patient, or applicable statutory or regulatory requirements, including but not limited to: lack of supervision, nutritional deprivation, or failure to implement or update a treatment plan.

*See* 64 C.S.R. 59 § 3.12.

3. Hospital Policy Number MMBHC015 states that "[a]n employee may be suspended without pay for any cause involving delinquency or misconduct of an appropriately serious nature…." To reinforce the Hospital's attention to patient safety, this Policy further states that "[a]llegations involving patient safety issues, such as abuse or neglect, may result in suspensions without a notice period from duty or reassignment to another work site pending the outcome of an investigation."

4. WVDHHR Policy Memorandum 2108 governing Employee Conduct states that employees are expected to follow directives of their superiors and exercise safety precautions. *See* Respondent Exhibit 3, Policy Memorandum 2108, Employee Conduct, at p. 2.

5. Respondent proved by a preponderance of the evidence that Grievant's failure to secure a door when leaving for lunch allowed a patient to escape a Hospital unit unsupervised and constituted "neglect" as defined in the Code of State Rules at 64 C.S.R. 59 § 3.12. The five-day suspension was justified.

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* 156 C.S.R. 1 § 6.20 (2008).

DATE: March 29, 2013

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STEPHANIE L. OJEDA