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CHILDRENS SERVICES, Petitioner, v.
CYNTHIA CHANDLER, Grievant

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**BEFORE THE TENNESSEE
CIVIL SERVICE COMMISSION**

TENNESSEE DEPARTMENT OF CHILDRENS SERVICES, Petitioner,)))))
v.) Docket No. 26.43-101965J
CYNTHIA CHANDLER, Grievant.)))

INITIAL ORDER

This contested case came on to be heard on December 9, 2009, in Nashville, Tennessee before Administrative Judge Joyce Grimes Safley, assigned by the Secretary of State, Administrative Procedures Division, and sitting for the Civil Service Commission of Tennessee. Ms. Julie Randall Pablo, Assistant General Counsel for the Department of Children’s Services (“DCS”), represented the State or DCS. The Grievant, Ms. Cynthia Chandler, was present and was represented by Ms. Charlotte Ann Leibrock, attorney, of the Newport, Tennessee Bar.

The parties submitted their respective “Proposed Findings of Fact and Conclusions of Law” on February 8, 2010 and February 17, 2010, making this matter ripe for consideration.¹

The subject of this hearing was Grievant’s appeal of her termination from the Department of Children’s Services. Grievant was terminated for allegedly

¹ It is noted that Initial Orders are due within ninety (90) days of the submission of the parties’ “Proposed Findings of Fact and Conclusions of Law”. The undersigned notified the parties counsel in May 2010 that the order would not be issued in May 2010 due to the undersigned’s medical leave for surgery. The undersigned apologizes for the delay.

violating the following Tennessee Department of Human Resources Rules, Tennessee Department of Children's Services Rules and Policies, and Mountain View Youth Development Center's Policies and Procedures: (1) TENNESSEE DEPARTMENT OF HUMAN RESOURCES RULE 1120-1--.06(1) - Inefficiency or incompetency in the performance of duties; (2) TENNESSEE DEPARTMENT OF HUMAN RESOURCES RULE 1120-10-.06(2) - Negligence in the performance of duties; (3) TENNESSEE DEPARTMENT OF HUMAN RESOURCES RULE 1120-10-.06(15) - Acts that would endanger the life and property of others; (4) TENNESSEE DEPARTMENT OF CHILDREN'S SERVICES ADMINISTRATIVE POLICY 20.26 - Accident/Injury Reporting in Youth Development Centers; (5) TENNESSEE DEPARTMENT OF CHILDREN'S SERVICES ADMINISTRATIVE POLICY 27.39 - Use of Shower and Restrooms; (6) MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE 6 - Security Log Procedure; (7) MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE 1 - First Aid Procedure; (8) MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE - Student Shower/Shaving Procedures; and (9) MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE - Waste Management: Infectious Waste - 1A.²

After consideration of the testimony and evidence presented, the arguments of counsel, and the entire record in this matter, it is determined

² During the course of the hearing, DCS's attorney stated that the State was not trying to prove that a fight had occurred between two boys under Grievant's supervision, and stipulated that Grievant's discipline was based upon her actions or lack of actions after the resident at the center of this case sustained his injuries (from whatever cause). Accordingly, no allusions to or insinuations about any alleged fight were considered for any purpose in deciding this matter.

that the Department showed, by a preponderance of the evidence, that Grievant violated the following policies and procedures: (1) TENNESSEE DEPARTMENT OF HUMAN RESOURCES RULE 1120-10-.06(2) – Negligence in the performance of duties; (2) TENNESSEE DEPARTMENT OF HUMAN RESOURCES RULE 1120-10-.06(15) – Acts that would endanger the life and property of others; (3) TENNESSEE DEPARTMENT OF CHILDREN’S SERVICES ADMINISTRATIVE POLICY 20.26 – Accident/Injury Reporting in Youth Development Centers; (4) TENNESSEE DEPARTMENT OF CHILDREN’S SERVICES ADMINISTRATIVE POLICY 27.39 – Use of Shower and Restrooms; (5) MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE 6 – Security Log Procedure; (6) MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE 1 – First Aid Procedure; (7) MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE – Student Shower/Shaving Procedures; and (8) MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE - Waste Management: Infectious Waste – 1A. The Department also showed, by a preponderance of the evidence, that considering all the circumstances, termination is the appropriate discipline in this matter.

Accordingly, considering all the facts and circumstances of this matter, it is **ORDERED** that the appropriate discipline in this matter is **TERMINATION**.

FINDINGS OF FACT

1. Mountain View Youth Development Center, located in Dandridge, Tennessee is a “hard-wire” juvenile offender facility operated by the Tennessee

Department of Children's Services (DCS). The facility houses up to 144 male juvenile felony offenders, ages 13 through 18, who are primarily from East Tennessee. In addition to the on-site school that Mountain View offers, the facility also offers alcohol and drug treatment, a sex offender program, mental health services, and family therapy.

2. At all relevant times, Grievant Cynthia Chandler was employed as a Children's Services Officer ("CSO") with Mountain View Youth Development Center. She began her employment as a CSO with Mountain View Youth Development Center (hereinafter "Mountain View") in 2005. As a CSO, Grievant was responsible for supervision and security of juvenile offenders placed in the Mountain View facility.

3. Grievant's personnel file, including Grievant's evaluations and any past discipline or commendations, was not offered as an exhibit by either party.³

4. On June 17, 2008, Grievant was working within the course and scope of her employment as a CSO at Mountain View. Grievant was responsible for supervising, providing security, and monitoring eleven (11) male juvenile offenders assigned to a dormitory at Mountain View.

³ Grievant's personnel file would have been relevant and material to this case, and it is noted that it is usual and customary at civil service cases for one party or the other, or both parties by stipulation, to enter the personnel file into evidence.

5. At the time of the incident which precipitated Grievant's disciplinary action, Grievant was supervising inmate or resident showers in the shower area.

6. Mr. Phil Ellis, Superintendent of Mountain View, testified credibly regarding Grievant's recounting the sequence of events which constituted the "shower incident" with resident/inmate "RL".⁴

7. Grievant relayed to Superintendent Ellis that she was supervising showers in the Delta Unit dormitory during the evening of June 17, 2008. Grievant was sitting in the dormitory's round tables which are located in front of the showers when "RL" came out of the shower, had a cut on his nose, and was "bleeding freely". By Mountain View policy, all residents are to be in their dormitory rooms during the shower period except for the two residents who are actually showering.

8. According to Grievant, "RL" was a resident of dorm room 15, and showers were scheduled according to room number. "RL" came out of the shower and stated "Ms. Chandler, I slipped in the shower."

9. Ms. Chandler completed a written statement regarding the incident. According to Ms. Chandler's written statement, the events transpired as follows:

Student "RL" bloodied his nose in the shower. I cleaned the blood with his clothes, paper towels and liquid cleaner. After his nose

⁴ Superintendent Ellis is responsible for all operations and personnel within Mountain View Youth Development Center, and has appointing authority from the Commissioner of DCS. He is responsible for recommending disciplinary actions against employees at Mountain View.

was bandaged by “RS” [another resident], I placed “RL” in his room. After about 10-15 minutes I checked (visually) his nose and saw that it was swelling. I called medical and told them the situation and they advised to send him up. I called yard to escort him. Cpl Wilson came onto the unit and took him up, as well as the incident report regarding the injury.

I used items from the unit first aid to bandage his nose. I would like to state that I do my job to the best of my abilities and wholly deny the allegations that have been made against me. /s/ CSO Cynthia Chandler.

10. Grievant Chandler testified that when “RL” came out of the shower he told her that he had “slipped in the shower”, “RL” threw his clothes out into the area where he had dropped some blood”. Ms. Chandler further testified that she *“immediately picked those clothes up and put them in the washing machine”*, and that was that. I asked [“RL”] if he wanted to continue his shower, because of the medication, and he said he did. *And I let him go on and complete his shower while I went to the office and got the liquid cleaner, which does involve ---does have bleach in it, and rubber gloves and paper towels, and the plastic bag from the office trash can, which is just a small bag.”* (Emphasis added).

11. Grievant Chandler’s testimony that she “immediately picked those clothes up and put them in the washing machine” conflicts with her written statement that *“I cleaned the blood with his clothes, paper towels and liquid cleaner.”*

12. Grievant Chandler did not call a “Code Red” when “RL” first came out of the shower and was bleeding and injured. Rather, Grievant and the

other students tried to stop “RL”’s bleeding, had “RL” continue with his shower while she left “RL” and the other residents in the shower area and went to the office for supplies, and then had “RL” go to his room. Bloody clothes and towels were then placed in a clear garbage bag and discarded in the trash can/dumpster in the back of the dormitory (“D” building).

13. Between 25 and 30 minutes after the incident, Grievant Chandler finally called the medical clinic and notified COO (“the yard”) after clinic personnel instructed Grievant to bring “RL” to the clinic. “RL” was still bleeding when he was taken to the facility’s medical unit.

14. “RL” was seventeen (17) years of age at the time of the incident. The other resident, “JL”, who was in the shower area at the same time, was the same age.

15. Superintendent Ellis testified, credibly, that when he initially discussed the incident with Grievant Chandler, Grievant Chandler said “she wasn’t able to see them [the boys in the shower] at the time and didn’t know exactly how the kid had gotten cut[.]” Superintendent Ellis also testified, credibly, that Grievant admitted to him that thirty minutes expired between the time “RL” was injured and he was taken to the medical facility.

16. Superintendent Ellis requested a DCS internal affairs (IA) investigation because of the events surrounding “RL”’s injury. Superintendent Ellis testified that he was concerned about Grievant’s possible violations of policy and procedure due to safety and security issues with the residents.

17. In describing his concern that Grievant “was not able to see [the boys]” in the shower at the time of the incident, Superintendent Ellis described the shower area in the Delta One dormitory. Superintendent Ellis noted that a CSO should be able to observe them during the actual shower because the shower curtains in the area were not floor to ceiling curtains. The shower curtains were three-quarter curtains (which covered individuals in the shower from their chest down) so that the CSO could see the resident in the shower while still preserving the resident’s modesty in the shower.

18. Mr. Steve Harrison, the Security Manager at Mountain View, testified that he is the person at Mountain View who is “responsible for everything to do with security, as far as hiring, and staffing, and do all the schedules, and virtually everything.”

19. Security Manager Harrison is responsible for directly supervising four lieutenants and a secretary. The lieutenants supervise five sergeants, who have fifteen corporals reporting to the sergeants. The CSO’s, such as Grievant Chandler, reported directly to the corporals.

20. Security Manager Harrison testified that Grievant had been disciplined four different times in the past, prior to the “shower incident”. Grievant had received four written warnings previously. Grievant received a warning on February 7, 2006 when she left a student unsupervised on the unit. On August 23, 2006, Grievant received a written warning when she allowed two students to be in one room, and went to another room, leaving the

two students alone and unsupervised in the room. One student was allegedly assaulted at that time. On May 3, 2007, Grievant received a written warning because while Grievant was working the control booth, she allowed nine students to come out of one area by overriding the interlock system, and opened the control booth door. Any or all of the nine juvenile felony offenders could have gone into the control booth because only one officer, Grievant, was in the control booth. The control booth contained the electronics used to secure the doors, the security system, all radio communications, and telephone communications for Mountain View. On October 22, 2007, Grievant received a written warning which was job attendance-related.

21. Security Manager Harrison testified that it is very important for the CSO supervising showers to keep the students (who are showering) within the CSO's line of vision, because the students cannot be allowed to get into a shower with another student. Security Manager Harrison testified, credibly, that "it's a major deal because of sexual allegations, and we actually have a sex offender unit, and there's all kinds of things that can go on....[B]asically its for the safety of the students from being assaulted, because that's the only time really that they're not in a secure room and don't have their clothes on."

22. The first incident report that Grievant completed stated that the "student ["RL"] stated he had slipped. Had a cut his nose." Grievant completed this incident report on the evening of "RL's" injury.

23. Due to additional information offered by other residents, Ms. Wanda Shaver, a case manager at Mountain View, completed a second incident report about “R.L’s” injury the following day.

24. Security Manager Harrison explained that Mountain View personnel are required to file an incident report anytime a student at Mountain View alleges misconduct by personnel, “no matter if it’s significant or how trivial, or how believable or unbelievable it is, we are required, by policy to contact internal affairs...which means we had to report it.”

25. On the morning after “the shower incident” Security Manager Harrison reviewed both the incident report filed by Grievant, and the incident report filed by Ms. Shaver. He then contacted Internal Affairs and forwarded IA the incident reports.

26. Ms. Brandi Money, LPN, testified that she worked as a nurse in the medical clinic at Mountain View. The medical clinic provides medical treatment for resident/student injuries or illnesses.

27. Ms. Money was on duty and was working in the Mountain View medical clinic on the evening of June 17, 2008 when she received a telephone call from Grievant, the CSO on duty at Delta One dormitory. Ms. Money testified, credibly, that Grievant relayed to her that Grievant “had a student that had a nose bleed, but it was no longer bleeding, and that he was fine, and she was just going to observe it, but she wanted to let me know.”

28. Grievant told Ms. Money that she had used the first aid kit. At that point, Ms. Money began asking questions regarding who was injured, why the first aid kit was opened, etc.

29. Only after Ms. Money began asking why Band-Aids were needed for a nose bleed did she learn from Grievant that “RL” was not experiencing a “nose bleed”, but actually had a laceration on the bridge of “RL’s” nose.

30. When Ms. Money learned that “RL” had a cut on his nose, she instructed Grievant to bring “RL” to the medical clinic immediately.

31. Ms. Money, according to policy, took photographs of “RL”’s injuries when he arrived at the clinic. A photograph of “RL” was entered into evidence at the hearing. In the photograph, “RL” has a “black eye” of his left eye, his nose and eye are swollen, and a laceration is apparent on the bridge of “RL’s” nose.

32. At the time “RL” arrived at the clinic, “RL’s” laceration on his nose was still bleeding. The clinic nurses applied pressure to make the wound stop bleeding, and then cleaned the wound with peroxide. The cut required five steri-strips for wound closure.

33. Aaron McMahan, Special Investigator for the Internal Affairs Division, DCS, East Division, testified on behalf of the State.

34. Special Investigator McMahan explained that he is responsible for investigating DCS employee misconduct, in addition to some other investigative duties.

35. Special Investigator McMahan was contacted by the Security Manager at Mountain View and given a case referral to investigate the matter involving Grievant and “RL’s” shower incident and injury.

36. During the course of Special Investigator McMahan’s investigation he interviewed multiple students, employees, and Grievant.

37. During a student interview, Special Investigator McMahan learned that “RL’s” bloody clothing, towels, etc. may have been placed in the dumpster located behind the Delta One unit dormitory.

38. Special Investigator McMahan followed up on the information and found a clear, plastic bag in the dumpster which contained blood-stained clothing, some blood-stained paper towels, and a bloodstained washcloth, and rubber gloves.

39. During Special Investigator McMahan’s interview of Grievant regarding the “shower incident”, Grievant told Special Investigator McMahan that she had the students clean up “RL’s” blood in the shower room. Grievant also admitted to Special Investigator McMahan that she had allowed and instructed students to administer first-aid to other students rather than initially contacting the facility’s medical staff. Grievant further admitted to Special Investigator McMahan that during the designated time for student showers on June 17, 2008, Grievant sat in an area in the shower unit which hindered her ability to see or hear R.L. while he was in the shower. She did not see R.L. fall. Grievant also admitted to Special Investigator McMahan that she

placed a bloody washcloth, and allowed the students to place the bloody paper towels and clothing in the trash can. Special Investigator McMahan's testimony regarding Grievant's admissions was credible.

40. A review of the Delta One dormitory log book for June 17, 2008 shows entries by Grievant. The 1950 [7:50 p.m.] entry states "Shower 9-15".⁵ Grievant's next entry is entered 10 minutes later "Shower 11-10". Twenty minutes after the 7:50 p.m. entry, at 2010, Grievant logs: "Shower 14 – 3, R.L. to med, cut nose---CJC---". Grievant prepared an incident report at "2005" (or 8:05p.m.) in which she stated that RL's incident occurred at "1950" (or 7:50 p.m.)

41. It is unclear how Grievant managed to supervise "RL" and student #9's showers, give first aid to "RL", supervise RL's and student #9's completion of their showers, supervise students #11 and #10's showers, supervise students #14 and #3's showers, go to the office for the first aid kit and cleaning supplies, clean up the blood in shower area, place the bloody towels and clothes in the washing machine, check RL *in his room away from the shower area* "12 or 15 minutes" after his fall/injury, telephone medical to say that she was "observing RL" (who was in his dorm room), and at the same time be supervising and monitoring other students who were taking showers in the shower area.

⁵ The entry refers to students from room 9 and room 15. RL was assigned to room 15.

42. According to Grievant, no more than “12 to 15” minutes elapsed after R.L. completed his shower and Grievant placed “RL” in his room when she “checked visually his nose and saw that it was swelling.”

43. Grievant’s recording of events in her log, her written statement, her recounting the events in her incident report does not jibe with her testimony at the hearing or her admissions to Special Investigator McMahan. Grievant’s testimony was not credible.

44. Frankly, the undersigned does not believe that Grievant could have been supervising showers in the shower area at the same time she was unlocking Delta One’s office and going into the office getting cleaning supplies, nor does the undersigned believe that Grievant could be in “RL’s” room monitoring “RL’s” injury and observing “RL” at the same time she recorded she was in the shower area supervising and observing student #11 and student #10’s showers.

45. At the hearing, Grievant flatly denied telling Special Investigator McMahan that she wasn’t positioned to see RL during his shower, and she denied other statements made to Special Investigator McMahan and Superintendent Ellis.

46. Superintendent Ellis’s and Special Investigator McMahan’s testimony is credible. Grievant’s version on the “shower incident” and the events that transpired afterwards is not credible or believable.

47. Superintendent Ellis testified that he recommended Grievant's termination as the correct discipline in this matter due to his concerns regarding the safety and security of juvenile offender residents at Mountain View.

48. The Commissioner upheld Grievant's termination, following the Level IV Grievance Hearing, by a letter of termination issued on February 4, 2009.

49. Thereafter, Grievant timely appealed her termination.

CONCLUSIONS OF LAW

1. The Department of Children's Services bears the burden of proof in this matter to show that Grievant violated Tennessee Department of Human Resources Rules, DCS Policies, and Mountain View Facility Policies and Procedures. DCS also has the burden of proof to show that the discipline imposed, termination, was the appropriate discipline for any violation of such rules, policies, or procedures.

2. Rule 1120-10.02 of the *Rules of the Tennessee Department of Personnel* provides as follows:

A career [civil service] employee may be warned, suspended, demoted or dismissed by his appointing authority *whenever legal or just cause exists*. The degree and kind of action is at the discretion of the appointing authority, but must be in compliance with the intent of the provisions of this rule and the Act. An executive employee serves at the pleasure of the appointing authority. (Emphasis added)

3. As defined by the *Uniform Rules of Procedure for Hearing Contested Cases before State Administrative Agencies*, Rule 1360-4-1-.02(7), “preponderance of the evidence” means the greater weight of evidence, or that, according to the evidence, the conclusion sought by the party with the burden of proof is the more probable conclusion.

4. The Petitioner, Department of Children’s Services, charges Grievant with the following:

- (1) Violation of TENNESSEE DEPARTMENT OF HUMAN RESOURCES RULE 1120-1--.06(1) - Inefficiency or incompetency in the performance of duties;
- (2) Violation of TENNESSEE DEPARTMENT OF HUMAN RESOURCES RULE 1120-10-.06(2) – Negligence in the performance of duties;
- (3) Violation of TENNESSEE DEPARTMENT OF HUMAN RESOURCES RULE 1120-10-.06(15) – Acts that would endanger the life and property of others;
- (4) Violation of TENNESSEE DEPARTMENT OF CHILDREN’S SERVICES ADMINISTRATIVE POLICY 20.26 – Accident/Injury Reporting in Youth Development Centers;
- (5) Violation of TENNESSEE DEPARTMENT OF CHILDREN’S SERVICES ADMINISTRATIVE POLICY 27.39 – Use of Shower and Restrooms;
- (6) Violation of MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE 6 – Security Log Procedure;
- (7) Violation of MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE 1 – First Aid Procedure;
- (8) Violation of MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE – Student Shower/Shaving Procedures; and

(9) Violation of MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER POLICY AND PROCEDURE - Waste Management: Infectious Waste – 1A.

5. T.C.A. §8-30-331 provides that civil service employees (who have successfully completed their probationary period) have a property right to their positions.

6. Because State of Tennessee civil service employees have “property rights” in their jobs; such employees must be afforded constitutional due process before the State may legally take an adverse action against an employee’s job. Hinson v. City of Columbia, 2007 WL 4562886 (Tenn. Ct. App. 2007). Grievant was afforded due process and timely filed her appeal of her termination.

**Charges of Violations of
Tennessee Department of Human Resources Rules**

7. DCS charges Grievant with violating the following of the TENNESSEE DEPARTMENT OF HUMAN RESOURCES RULES: RULE 1120-1--06(1) - Inefficiency or incompetency in the performance of duties; (2) RULE 1120-10-.06(2) – Negligence in the performance of duties; and (3) RULE 1120-10-.06(15) – Acts that would endanger the life and property of others.

8. “Incompetence” is not defined by the Tennessee Civil Service statutes, or the Tennessee Department of Human Resources Rules. However, *Black’s Law Dictionary* defines “incompetency” as the: “Lack of ability, legal qualification, or fitness to discharge the required duty.”

9. “Inefficiency”, in common parlance, generally means that an employee is not efficient or time-effective in completing tasks or work.

10. Applying the terms “incompetent” and “inefficient” as they are commonly used, the evidence did not preponderate that Grievant lacked the ability, qualifications, or fitness to discharge her duties at the Mountain View facility. Nor did the evidence preponderate that Petitioner was not “efficient” or time-effective in completing her work or assignments. Rather, Grievant elected not to follow established procedures, or was negligent in following established procedures. For these reasons, it is determined that Grievant did not violate RULE 1120-1--.06(1).

11. Turning to the other two HUMAN RESOURCES RULES which Grievant is charged with violating, it is determined that Grievant did violate RULE 1120-10-.06(2) – Negligence in the performance of duties; and RULE 1120-10-.06(15) – Acts that would endanger the life and property of others.

12. The evidence preponderates that Grievant was not in a position to monitor and observe “RL” and Student #9’s shower. She did not see “RL’s” fall or accident. Grievant did not follow established facility protocols for the incident (addressed later in this decision), she did not immediately call COO for assistance, and she did not immediately call the medical clinic and seek treatment for “RL”. Rather, Grievant left the boys alone in the shower area and went to the dorm office to get cleaning supplies. Later, she took “RL” to his room while he was bleeding from his wound and left him in his room alone. It

also appears, from Grievant’s log, that she left two other boys in the shower area later when she went back to “check on” “RL”. Either Grievant was present in two or three areas at the same time, which is impossible, or she was leaving juvenile felony offenders unattended and together. She left a wounded resident, “RL”, in his room alone after he had sustained an injury and was bleeding. Grievant did not follow established facility protocols which were in place for the safety and security of the facilities’ residents and employees.

13. Grievant’s conflicting versions of the events are not believable or credible. Clearly her acts and omissions prior to, during, and following the “RL” shower incident were negligent, violated her duty of care to the facility’s residents and employees, and endangered the life and safety of “RL” and others.

Charges of Violations of DCS Policies

14. DCS also charged Grievant with violating certain TENNESSEE DEPARTMENT OF CHILDREN’S SERVICES ADMINISTRATIVE POLICIES: POLICY 20.26 – Accident/Injury Reporting in Youth Development Centers; and DEPARTMENT OF POLICY 27.39 – Use of Shower and Restrooms.

15. *DCS Administrative policy 27.39* states, in pertinent part:

Subject:	Use of Showers and Restrooms
Authority:	T.C.A. 37-5-106

Application:	To all employees and youths in Youth Development Centers
Policy Statement:	When showers or restrooms are being used by two or more youth, simultaneously, the youth

shall be under the continuous supervision of a staff member.

Procedures: The supervising staff member shall maintain constant supervision over youth who are in Showers and/or restrooms. The staff member Shall at all times remain in the general restroom/shower area and shall make frequent visual contact with all youth.

16. *DCS Administrative Policy 20.26* states in applicable part:

Subject: Accident/Injury Reporting in Youth Development Centers

Authority: TCA 37-5-105, 37-5-106

Application: To All Department of Children’s Services Youth Development Center Employees

Purpose: To ensure that all persons who are injured while in a Youth Development Center will be assessed to determine if further medical care is needed. Each facility will have a process in place for recording and disseminating the report to the appropriate persons.

Procedures: A. Medical Triage
Anyone who sustains or may have sustained a personal accident or injury at the facility must be seen by a licensed health care provider within the facility during clinic hours and referred for treatment as indicated. If an accident or injury Is sustained during the hours the medical clinic Is closed, the injured person shall seek appropriate assessment and treatment in the community as needed.

Documentation: Security staff or designee will initiate form **CS-1066 Accident/Incident/Traumatic Injury**. The injured person will complete and sign the “subject’s version” (how the situation occurred) portion of the form. Any witness to the incident Will complete and sign the “witness’ version” portion of the form.

17. It is determined that DCS proved, by a preponderance of the evidence, that Grievant's actions as detailed in the "Findings of Fact" above, violated *DCS Administrative policy 27.39* and *DCS Administrative Policy 20.26* by her failure to maintain constant supervision and observation of "RL" and Student #9 during the time they were taking showers in the shower room, and by her failure to "at all times remain in the general...shower area" and failure to "make frequent visual contact with all youth [in the shower area]".

**Charges of Violations of
Mountain View Youth Development Center Local Policy**

18. Additionally, DCS charges Grievant with violating portions of Mountain View Youth Development Center's Local Administrative Policies and Procedures: Security Log Procedure (section 6), First Aid Procedure (Section 1), Student Shower/Shaving Procedure, and Waste Management: Infectious Waste (Section 1A).

19. Section 6 of the Mountain View "Security Log Procedure" states:

Staff must record daily in their shift reports and/or logs pertinent information, emergency situations, and unusual incidents.

20. Section 1 of "First Aid Procedures" states as follows:

Upon discovery of an individual needing First Aid/CPR, the staff member shall immediately assess the severity of the situation and apply life saving measures as required. Center Operations Center (COC) will also be notified. The notification may be by telephone or radio communication. The staff member will clearly state the exact location where assistance is required, and the nature of the

emergency (**Code Blue** –respiratory problem, **Code Red** – lacerations.)

21. Mountain View Youth Development Center “Student Shower /Shaving Procedures” states:

1. All students are secured in their rooms at the prescribed time per unit schedule.
2. Two students (one per shower stall) go to assigned area to shower.
3. Student completes shower and returns to assigned dorm room and secures his door.
4. After a student secures his door, the next assigned student will depart his room and go to the shower area and complete his shower.

ONLY STUDENTS SHOWERING OR GOING TO/FROM SHOWER WILL BE OUTSIDE HIS ROOM. ALL OTHERS WILL BE INSIDE ROOMS WITH DOORS SECURED.

NOTE: Shower time equals 60 minutes which equates to a 10 minute shower for each student (x 2 shower stalls).

Staff will position themselves to have full view of the shower area to prevent any physical interaction between students during showers. (Emphasis added.)

22. Additionally, Grievant was charged with violation of Mountain View’s local “Waste Management” procedure, Section 1A, which details:

INFECTIOUS WASTE:

1. Medical Department Infectious Waste:
 - A. The collection and storage of infectious waste and contaminated items must be placed in the container labeled for infectious waste located in the medical clinic (red in color) daily. The red infectious Bio-hazardous waste bag inside this container will be emptied bi-weekly when the contract vender does routine pickup. This includes medical bandages, wipes, blood, blood clean-up kits, body fluids, and vomit.

23. Grievant was charged with violating the Security Log procedure, section 6 “to record daily in their shift reports and/or logs pertinent information, emergency situations, and unusual incidents.” Grievant did reference “RL to med, cut nose—CJC” in her Security Log. However, she neglected to record all pertinent information regarding the cause of the injury, the time of the injury, etc.” Nor did she record that she contacted COO. It is determined that Grievant has violated the Mountain View Security Log procedure, section 6 by failing to log pertinent information.

24. Grievant violated Section 1 of Mountain View’s “First Aid Procedures” by failing to notify COO, request assistance, and call a “Code Red”, as required by the procedure.

25. Grievant violated Mountain View’s local “Student Showers/Shaving Procedure” by failing to position herself to have a full view of the shower area.” The evidence preponderates that Grievant was not monitoring or observing “RL” and the other student who was showering. Grievant did not observe “RL” slipping and falling. Further, the evidence preponderates that Grievant left students in the shower area while she went to the office to get clean-up supplies.

26. The evidence preponderates that Grievant violated Mountain View’s local “Waste Management” procedure, Section 1A, by cleaning up blood with paper towels, clothing and towels, throwing such items contaminated by blood into a regular trash bag, and either disposing of it herself or having students

dispose of the bloody items in the dumpster outside Delta One dormitory. Grievant also violated the “Waste Management” procedure by having students clean up hazardous material (blood).

Appropriate Discipline for Grievant

27. Rule 1120-10-10.22 of the *Rules of the Tennessee Department of Personnel* provides as follows:

A career [civil service] employee may be warned, suspended, demoted or dismissed by his appointing authority whenever legal or just cause exists. The degree and kind of action is at the discretion of the appointing authority, but must be in compliance with the intent of the provisions of this rule and the Act. An executive service employee serves at the pleasure of the appointing authority.

28. The legal standard which constitutes “just cause” to terminate civil service employees is concisely stated in 67 C.J.S., *Officers and Public Employees*, § 137, cited by the Court in Knoxville Utilities Board v. Knoxville Civil Service Merit Board, 1993 WL 229505 (Tenn. Ct. App. 1993), p. 10.

“Just cause” is defined as follows:

“Just cause” is a ground for removal. In this respect, “just case” implies a cause sufficient in law, and is any cause which is detrimental to public service. It may be established by a showing of conduct indicating that the employee lacks the competency and ability to perform the duties of his office.

Where lawful grounds for dismissal of a civil service employee exist, the character and work record of the employee involved is of no importance, and the fact that he has previously received a general rating of satisfactory does not bar his removal.

29. Rule 1120-10-.01(45) of the *Rules of the Department of Personnel*

provides that causes for disciplinary action fall into two categories:

- (1) Causes relating to performance of duties.
- (2) Causes relating to conduct which may affect an employee's ability to successfully fulfill the requirements of the job.

30. Grievant's June 17, 2008 acts and omissions fall within both categories of causes for disciplinary action.

31. Tennessee's Civil Service statutes and rules incorporate the doctrine of progressive discipline. Accordingly, state supervisors are expected to administer discipline beginning at the lowest appropriate step. Kelly v. Tennessee Civil Service Commission, 1999 WL 1072566 (Tenn. Ct. App. 1999). Further, at least one court, in expressing approval of the progressive discipline system, has stated that the legislative mandate for progressive discipline should be "scrupulously followed". Berning v. State of Tennessee, Department of Correction, 996 S.W. 2d 828, 830 (Tenn. Ct. App. 1999).

32. T.C.A. §8-30-330 sets forth the state's civil service progressive discipline system as follows:

(a) The supervisor is responsible for maintaining the proper performance level, conduct, and discipline of the employees under the supervisor's supervision. When corrective action is necessary, the supervisor must administer disciplinary action beginning at the lowest appropriate step for each area of misconduct.

(b) Any written warning or written follow-up to an oral warning which has been issued to an employee shall be automatically expunged from the employee's personnel file after a period of two (2) years; provided, that the employee has had no further disciplinary actions with respect to the same area of performance, conduct, and discipline.

(c) When corrective action is necessary, the supervisor must administer disciplinary action beginning at the step appropriate to the infraction or performance. **Subsequent infractions may result in more severe discipline in accordance with subsection (a).** (Emphasis added.)

33. The Court in Berning v. State Department of Correction notes that the “key word in the statute [T.C.A. §8-30-330] is *appropriate*”. Berning v. State Department of Correction, 996 S.W.2d 828, 830 (Tenn. Ct. App. 1999), *Perm. to appeal denied* (Tenn. 1999). “The language of these provisions does not mandate application of discipline in a routine fashion without regard to the nature or severity of the behavior it is intended to address.” *Id.* At 830, *quoting the chancellor’s order with approval.*

34. An employee’s prior conduct, both good and bad, along with his entire work history, can be considered when determining what the appropriate disciplinary action should be. Kelly v. Tennessee Civil Service Commission, 1999 WL 1072566 (Tenn. Ct. App. 1999).

35. An additional consideration for determining the appropriateness of the discipline to be imposed is whether the punishment imposed upon the Grievant is different than discipline used with other employees who have engaged in the same conduct. Gross v. Gillless, 26 S.W. 3d 488, 495 (Tenn.Ct. App. 1999), *Perm. to Appeal Denied* (Tenn. 2000). No evidence was presented by either DCS or Grievant regarding terminations of other employees for conduct such as Grievant’s.

36. In determining whether or not termination is the appropriate discipline for Grievant, it is necessary to consider whether there is “just cause” to terminate Grievant due a lapse in judgment and negligence in performing his duties.

37. Considering all the circumstances of this matter, including Grievant’s employment record, and Grievant’s disciplinary record, it is determined that the Department of Children’s Services has “just cause” for terminating the Grievant.

38. Neither Grievant nor DCS offered Grievant’s evaluations into evidence. It is noted that Superintendent Ellis testified that Grievant had been a “good employee.” It is also noted that Grievant had received four written warnings within a relatively short period of time prior to the incident on June 17, 2008. Three of the “warnings” regarded serious lapses in judgment by Grievant, which could have compromised the safety and security of both employees and juvenile felony offenders at Mountain View.

39. However, due to the extremely serious nature of Grievant’s position, which involves the security and safety of residents (juvenile felony offenders) and employees at Mountain View, and in light of the fact that Grievant had received three other disciplinary measures in the past for failing to follow procedures meant to uphold the facility’s safety and security, and considering all the facts and circumstances of this case, the evidence preponderates in favor of termination being the appropriate discipline.

40. Grievant's acts and omissions established a pattern of negligent acts and omissions in her work performance, and a failure to follow established safety and security procedures and policies.

It is ordered that **TERMINATION** is the appropriate discipline in this matter. The Department's decision shall be **UPHELD**.

It is so ordered.

Entered and effective this 6th day of August, 2010.

A handwritten signature in black ink that reads "Thomas G. Stovall". The signature is written in a cursive style with a large, sweeping initial 'T'.

Thomas G. Stovall, Director
Administrative Procedures Division