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JAMIE COX

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**STATE OF TENNESSEE
CIVIL SERVICE COMMISSION**

IN THE MATTER OF:

JAMIE COX

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DOCKET NO. 26.15-106115J

INITIAL ORDER

This matter was convened as a contested case hearing in Bolivar, Tennessee, on September 10, 2010, before Rob Wilson, Administrative Judge, assigned by the Secretary of State, Administrative Procedures Division, and sitting for the Commissioner of the Tennessee Civil Service Commission. Western Mental Health Institute of the Department of Mental Health and Developmental Disabilities (the “State”) was represented by Lorenzo Derek Renfroe, Assistant General Counsel. The Grievant, Jamie Cox, was present and was represented by attorney Ernest Sykes, Jr.

Upon consideration of the entire record in this case, it is determined that Grievant’s termination was not warranted and should be reversed. This determination is based on the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. Ms. Jamie Cox was employed as a registered nurse by Western Mental Health Institute in Bolivar, TN from November 1, 2005 until she was terminated by letter dated July 14, 2009.
2. Ms. Cox worked on Unit C during her entire employment tenure at Western Mental Health Institute.

3. On June 20-21, 2009, Ms. Cox worked the Unit C night shift, which began at 5:30 pm and ended at 7:00 am.
4. The only other nurse scheduled to work with Ms. Cox on Unit C during her shift on June 20-21, 2009 (“the shift”) was approximately two and a half hours late for the shift.
5. There were two new patient admissions to Unit C during the shift, the first of which arrived early in the shift while Ms. Cox was still the sole nurse present, and the second of which arrived near midnight. Ms. Cox admitted both new patients.
6. The second new admission of the shift became uncooperative and had to be moved to an area of isolation away from other patients.
7. A heat advisory was in effect in the Bolivar, TN area during the first part of Jamie Cox’s shift. The heat advisory was in place on Saturday, June 20 until 7:00 pm. An email generated by Western Mental Health Institute’s safety officer and sent to employees stated of that heat advisory:

“The combination of hot temperatures and high humidity will combine to create a situation in which heat illnesses are possible... Drink plenty of fluids. Stay in an air conditioned room.” See Exhibit 5.
8. The air conditioner for Unit C was not working during the first part of the shift:
 - a. During the shift, Ms. Cox on two separate occasions between approximately 9:00 pm and 10:15 pm telephoned her supervisor, Tammy Gammel – who was not on Unit C at the time – to complain about the heat on the Unit.
 - b. Western Mental Health Institute maintenance work order No. 08004 indicates that with respect to the Unit C air conditioner on June 20, 2009, the chiller was off and there was a control panel failure as of 10:04 pm. The work order, which is dated

June 20, 2009, states that maintenance was “[c]alled at 12:54 pm [*sic*]” and that the unit was “[r]estarted at 1:20 am.” See Exhibit 23.

9. Unit C was unusually busy the night of June 20, 2009 because, at least until the air conditioner was repaired, the heat was disrupting the patients’ sleep. See pp. 44-46 of the hearing transcript.
10. At approximately 10:00 pm, Ms. Cox telephoned her supervisor Tammy Gammel – who was not on Unit C at the time – to request additional staff. That request was denied.
11. While between scheduled rounds toward the end of her shift on Unit C, Ms. Cox was in a less than fully alert state for a period of at least one but not more than seven minutes:
 - a. Grounds supervisor Tammy Gammel found Ms. Cox sitting in a chair in a less than fully alert state at approximately 4:35 am. Ms. Gammel immediately went to the nurse’s station to summon charge nurse Cheryl Trainum. They immediately returned to the chair in which Ms. Cox was sitting, and when Ms. Trainum touched Ms. Cox on the shoulder, Ms. Cox opened her eyes and noted that it was 4:38 am according to the wall clock in the unit.
 - b. Ms. Cox had made and charted her rounds as scheduled at 4:30 am.
12. Ms. Cox was not sent home at that time and she completed the remainder of her scheduled rounds for the shift.
13. Western Mental Health Institute by letter dated June 23, 2009 recommended that Ms. Cox be terminated for violation of Tennessee Department of Personnel rule 1120-10-.06(15) and (20) and WMHI Hospital Instruction NR-3.726.
14. By letter dated July 14, 2009, Western Mental Health Institute finalized its decision to terminate Ms. Cox for “sleeping or failure to remain alert during duty hours” during her

night shift on June 20-21, 2009, which Western reiterated was in violation of WMHI Hospital Instruction NR-3.726 (“Policy NR-3.726.”).

15. The cited policy, NR-3.726 announces that all Western Mental Health Institute staff members are to remain alert during duty hours “to ensure safety.” See Exhibit 4, § II. Policy NR-3.726 goes on to say:

“If the supervisor determines that the staff member was sleeping or had failed to remain alert during duty hours, the supervisor shall make a recommendation for the staff member’s termination of employment with WMHI.

In certain rare circumstances, mitigating factors may result in the suspension of the staff member for a period of one to thirty days. The Chief Officer, or designee, shall determine whether there are sufficient mitigating factors.”

16. Policy NR-3.726 does not define or provide examples of what is meant by “sufficient mitigating factors” which would allow a staff member found to be in violation of the policy to keep his or her job.

17. Western Mental Health Institute does not otherwise maintain policies, lists, or guidelines which define or provide examples of what is meant by “sufficient mitigating factors” which would allow a staff member found to be in violation of Policy NR-3.726 to keep his or her job. See p. 164 of the hearing transcript.

18. In the three years prior to Ms. Cox’s termination, Western Mental Health Institute had disciplined six other staff members for violating Policy NR-3.726, as follows:

- a. Terrecus Giles: Staff member was found asleep while on duty on three separate occasions over the course of three different dates. Mr. Giles received an oral warning after the second incident, but no other action was taken. After the third

time he was found sleeping on the job, Mr. Giles was recommended for termination, but that recommendation was overturned and **no disciplinary action was taken.**

i. The letter overturning Mr. Giles' discipline documents no "mitigating factors" which protected him from termination (or even so much as suspension) under Policy NR-3.726. See Collective Exhibit 12.

b. William Parks: Staff member was found asleep while on duty on two separate occasions in a single shift. After the first incident, Mr. Park was affirmatively awakened by the supervisor who discovered him – Tammy Gammel, the same supervisor who discovered Ms. Cox in the appeal at issue. After this first incident, Ms. Gammel roused Mr. Parks by herself *without* going to summon a witness, and she gave him an oral warning without taking further action. After the second time he was found asleep, **Mr. Parks was terminated from employment.**

i. **Mr. Parks' termination letter notes that he had not made any entries on his assignment sheet for one hour and twenty minutes prior to being found asleep for the second time.**

ii. **Mr. Parks' termination letter details that prior to the sleeping incidents, he had been subject to disciplinary suspensions on three separate occasions – all within the preceding month.**

iii. **Mr. Parks' termination letter also notes that he is not eligible for rehire.** See Collective Exhibit 13.

- c. Dara Hobbs: Staff member was found asleep at her desk while on duty. **Ms. Hobbs was suspended for one day without pay in lieu of termination.**
- i. **Ms. Hobbs' disciplinary letter cites as a sufficient mitigating factor under Policy NR-3.726 her verbal statement that she felt drowsy because her medications had recently been changed.** That statement was accepted by Western Mental Health Institute at face value, and Ms. Hobbs was not required to provide any documentation concerning her medications. See Collective Exhibit 14.
- d. Andrew Cheairs: Staff member was found either sleeping or failing to remain alert while on duty. **Mr. Cheairs was suspended for one day without pay in lieu of termination.**
- i. **Mr. Cheairs' disciplinary letter cites as sufficient mitigating factors under Policy NR-3.726:**
1. **His statement that he could have dozed off due to taking sinus medication** (for which Mr. Cheairs was required to produce no documentation); **and**
 2. **The fact that Mr. Cheairs had maintained a satisfactory work performance since his employment began at WMHI, less than one year prior to his violation of NR-3.726.** See Collective Exhibit 15.
- e. Dennis White: Staff member was found either asleep or failing to remain alert while on duty. WMHI recommended that Mr. White be suspended for one day without pay, but that recommendation was overturned because of insufficient

witness testimony. However, before the one day suspension was overturned, **Mr. White's disciplinary letter cited as a sufficient mitigating factor under Policy NR-3.726 his claim that he had had a migraine headache.** The letter references no requirement that Mr. White provide documentation concerning his migraine, but it does note that he subsequently sought medical attention. See Collective Exhibit 16 (which was not referenced during testimony, but which was stipulated to by the parties.)

- f. Yolanda Jones: Staff member was found asleep while on duty on three (3) separate occasions in a single shift. The disciplinary letter reveals that Ms. Jones was asleep for 35 minutes the first time, 28 minutes the second time, and 40 minutes the third time—for a total on-the-job slumber of *one hour and thirteen minutes*. The disciplinary letter also states that Ms. Jones' violations of Policy NR-3.726 “resulted in your failure to make four (4) required 15-minute rounds as outlined and that you falsified the patient roster/sleep record.” **Ms. Jones was suspended for two days without pay in lieu of termination.**

i. **Ms. Jones' disciplinary letter cites as sufficient mitigating factors under Policy NR-3.726:**

1. **Her claim that it was a “bad night” for her; and**
2. **The fact that it was “cold on the unit”; and**
3. **The fact that she “demonstrated sincere remorse”; and**
4. **The fact that “it does not appear that you intentionally fell asleep....”**

To reiterate: Ms. Jones was not terminated under Policy NR-3.726 but rather was suspended for two days, even though her violation of the policy was the proximate cause of her perpetrating a fraud on her employer and hence the State. See Collective Exhibit 17.

19. Based on the foregoing, of the six Western Mental Health Institute staff members who were subject to discipline under Policy NR-3.726 in the three years before Jamie Cox's termination, only *one* – William Parks – shared Ms. Cox's fate of termination; and, quite unlike Ms. Cox's case, Mr. Parks' violation caused him to miss work duties; it was the latest in a consistent string of prior disciplinary infractions; and it resulted in him not being eligible for rehire (which Ms. Cox is—see Exhibit 3).
20. In addition to the six above-referenced individuals who were disciplined under Policy NR3.726 in the three years preceding Ms. Cox's termination, there also was a staff member prior to that time frame named Ira Todd who was terminated under Policy NR-3.726, but who was judicially reinstated to his employment, just as Ms. Cox is seeking in this appeal. See pp. 172-173 of the hearing transcript.
21. Starting in March 2010, Dr. Ernest Antwi, a licensed Tennessee medical doctor who specializes in endocrinology, began treating Jamie Cox for hypoglycemia, which is a pre-diabetic condition characterized by low blood sugar levels which can fluctuate. Dr. Antwi testified that, depending on the blood sugar levels at a given time, such patients “shake, react, fall asleep, can be very tired, nausea, vomiting.” See pp. 82-83 of the hearing transcript.

22. Jamie Cox has a congenital physical disability called bilateral hip dysplasia. It does not and never has prevented her from rendering good nursing care. See pp. 67-68 of the hearing transcript.
23. Ms. Cox had a pounding headache toward the end of her June 20-21, 2009 shift. See p. 32 of the hearing transcript.
24. Ms. Cox did not miss any work assignments during her June 20-21, 2009 shift.
25. In her nearly four years of employment at WMHI, Ms. Cox had never previously been disciplined for work performance, and in fact her own supervisors considered her a good nurse. See p. 191 of the hearing transcript.
26. Ms. Cox, who became an RN in 1983, has never been disciplined by the Tennessee Board of Nursing or any like agency.
27. Ms. Cox's supervisors considered her a "complainer," and Ms. Cox had in February 2009 received a vaguely worded oral warning for "complaining." See pp. 193-194 of the hearing transcript; see also Exhibit 10.
28. Ms. Cox and her supervisors had a personality conflict. See pp. 160-161 of the hearing transcript.
29. Complaining was not cited or in any way referenced as a reason for Ms. Cox's termination from Western Mental Health Institute.
30. Western Mental Health Institute is one of five State of Tennessee mental health facilities. Employees of all five such facilities face precisely the same amount of liability, pursuant to the doctrine of sovereign immunity. See pp. 197-198 of the hearing transcript.

31. The maximum penalty for falling asleep or failing to remain alert on the job at any of the other State of Tennessee mental institutions is three days' suspension. See pp. 195-196 of the hearing transcript.
32. Western Mental Health Institute's Policy NR-3.726 on its face calls for termination absent "sufficient mitigating factors," which is far harsher than the penalty for the same offense at any other State of Tennessee mental health institution.
33. Based on Western Mental Health Institute's own documents concerning discipline under Policy NR-3.726, the following qualify as "sufficient mitigating factors" which can and do prevent staff members from being terminated for the offense of failing to remain alert on duty:
 - a. Having maintained a satisfactory work performance (for less than a year of employment in Mr. Cheairs' case);
 - b. Feeling drowsy due to medication – no prescriptions, doctors' notes, or other proof needed;
 - c. Having a headache;
 - d. Having a "bad night";
 - e. The temperature on the unit being uncomfortable;
 - f. Understanding that one should not fail to remain alert, and demonstrating remorse when one has done so; and
 - g. Not falling asleep intentionally.

CONCLUSIONS OF LAW AND ANALYSIS

A. Policy NR 3.726 was misapplied to Jamie Cox in such a way that she has a legal right to be reinstated to her job with full back pay and benefits.

The facts as set forth in Section I of this Order establish that Ms. Cox's employer, Western Mental Health Institute, of the State of Tennessee Department of Mental Health and Developmental Disabilities, acted arbitrarily and capriciously and/or engaged in impermissible disparate treatment in terminating Ms. Cox for briefly failing to remain fully alert in violation of Policy NR 3-726.

In the absence of any definition of "sufficient mitigating factors," the long established and well settled common law principle of precedent must be applied to determine what constitutes "sufficient mitigating factors" that would prevent a staff member from being terminated pursuant to Policy NR-3.726. Precedent, as enumerated in the facts set forth above, reveals inescapably that Ms. Cox had *far more* "sufficient mitigating factors" than did any of the other staff members subjected to the policy – all of whom nevertheless were treated far more leniently than was Ms. Cox. Based on Western Mental Health Institute's own precedents:

1. The extreme heat on Unit C during the early part of Ms. Cox's June 20-21, 2009 shift – when (a) there was a heat advisory in effect and (b) the air conditioning on her unit was not functioning – is a "sufficient mitigating factor" under Policy NR-3.726 to prevent Ms. Cox from being terminated.
2. Ms. Cox's subsequent (and documented) diagnosis of and treatment for symptoms consistent with hypoglycemia – a condition which can cause fatigue or sleepiness

when one's blood sugar level is low – is a “sufficient mitigating factor” under Policy NR-3.726 to prevent Ms. Cox from being terminated.

3. The unusually busy activity on Unit C during the early part of the shift – as evidenced both by two new admissions and by the patients being affected by the extreme heat – is a “sufficient mitigating factor” under Policy NR-3.726 to prevent Ms. Cox from being terminated.
4. The understaffing during the early part of the shift – as evidenced by the fact that her co-nurse was two and a half hours late, which coincided with the extreme heat and with the busier than usual activity – is a “sufficient mitigating factor” under Policy NR-3.726 to prevent Ms. Cox from being terminated.
5. Ms. Cox's satisfactory work performance over the course of her nearly four years of employment—as opposed to the mere eleven months of satisfactory work performance that were necessary to protect Mr. Cheairs—is a “sufficient mitigating factor” under Policy NR-3.726 to prevent Ms. Cox from being terminated.
6. The fact that Ms. Cox did nothing to *intentionally* become less than fully alert while on duty is a “sufficient mitigating factor” under Policy NR-3.726 to prevent Ms. Cox from being terminated.
7. The fact that Ms. Cox was suffering from a pounding headache at the time she was found in a less than fully alert state – at 4:35 am, some eleven and a half hours into a shift during portions of which she had suffered extreme heat and busy activity (conditions which possibly exacerbated her later-diagnosed

hypoglycemia) – is a “sufficient mitigating factor” under Policy NR-3.726 to prevent Ms. Cox from being terminated.

8. The fact that Ms. Cox was in a less than fully alert state for a mere handful of minutes – between one and seven minutes – is a “sufficient mitigating factor” under Policy NR-3.726 to prevent Ms. Cox from being terminated.
9. The fact that Ms. Cox did not miss a single work assignment as a result of being less than fully alert for those handful of minutes – much less the fact that she, unlike staff member Yolanda Jones, did not *falsify documents* as a result of her failure to remain fully alert – is a “sufficient mitigating factor” under Policy NR-3.726 to prevent Ms. Cox from being terminated.
10. Western Mental Health Facility’s termination of Grievant Jamie Cox under Policy NR-3.726 was arbitrary and capricious.
11. Because Ms. Cox has a physical disability (see Finding of Fact 22, *supra*), Western Mental Health Institute’s decision to discipline her far more harshly under Policy NR-3.726 than it has any other staff member places Western Mental Health Institute at risk of having violated the Tennessee Disability Act, T.C.A. § 8-50-103, which prohibits employment discrimination on the basis of a person’s disability.

B. Policy NR-3.726 itself, upon which Western Mental Health Institute relied in terminating Jamie Cox, is unconstitutional and should be stricken or revised.

The facts as set forth in Section I of the Order cast grave doubt on the very legality of the policy upon which Western Mental Health Institute purported to rely in terminating Jamie Cox:

12. Tennessee Department of Personnel rule 1120-10-.06(15) subjects a State employee to discipline for “[s]leeping or failure to remain alert during duty hours.” Policy NR-3.726 is Western Mental Health Institute’s attempt to set forth the disciplinary parameters for such infraction. Policy NR-3.726 on its face calls for disproportionately harsher punishment (outright termination) for a staff member who sleeps or fails to remain alert on the job than do the analogous policies for Western Mental Health Institute’s four fellow State of Tennessee mental health hospitals, which call for a maximum penalty of three days’ suspension. See Findings of Fact 32-33, *supra*.
13. Pursuant to Department of Personnel Rule 1120-10-.03(1), career employees such as Jamie Cox have a “property right” in their State of Tennessee employment position, and as such they are afforded certain due process before they can be deprived of that property right.
14. Because Western Mental Health Institute faces precisely the same liability for staff members who fail to remain alert while on duty as do its four sister State of Tennessee mental health facilities (see Findings of Fact 30-31, *supra*), its disproportionately harsher penalty of immediate termination for the same violation places one group of State employees (Western staff members) at greater risk—arbitrarily and unreasonably—of being deprived of their employment and hence their property right; and the purported ability—unique to Western Mental Health Institute—to immediately terminate staff members for an infraction for which other similarly situated State employees would only be *briefly suspended*,

constitutes a deprivation of due process for Western Mental Health Institute staff members; including Jamie Cox.

15. As noted above in Conclusions of Law 1-9, *supra*, Policy NR-3.726 historically and consistently has been applied to staff members in such a manner that a one-day suspension without pay—or, in the most egregious example, a two-day suspension—is the *de facto* penalty at Western Mental Health Institute for sleeping or failing to remain alert while on duty. The harsh penalty of termination called for by Policy NR-3.726 nevertheless allows the facility to use the policy selectively as a weapon against, for instance, staff members whom supervisors personally dislike, which is what occurred with respect to grievant Jamie Cox. See Findings of Fact 27-29, *supra*. That possibility for the very abuse which has occurred with respect to Ms. Cox could subject Western Mental Health Institute to considerable liability for discrimination claims. See, e.g., Conclusion of Law 10, *supra*. The policy is inconsistent with the analogous policies of sister State agencies, and as this case reveals, the policy as currently drafted can be, and here has been, applied in a non-uniform—indeed, wildly disparate and fundamentally inequitable—manner.

Accordingly, and for the reasons set forth above, it is hereby determined:

1. Grievant Jamie Cox is immediately reinstated to her employment position as a registered nurse with Western Mental Health Institute of the State of Tennessee Department of Mental Health and Developmental Disabilities, at the same employment classification level and the same compensation rate as the date on which she was terminated, and with

full back-pay and full benefits dating back to July 14, 2009, which was the date of her termination; and

2. Western Mental Health Institute shall pay Grievant Jamie Cox her full back-pay and the value of her full benefits dating back to July 14, 2009, to be made within thirty (30) days of the date of this ORDER; and
3. Jamie Cox shall, within sixty (60) days of the date of this ORDER, provide Western Mental Health Institute with documentation showing the total of all COBRA payments and/or other health insurance payments she has had to make out of pocket since the July 14, 2009 date of her termination.
4. Western Mental Health shall reimburse Grievant Jamie Cox the full value of any and all COBRA payments and/or other personal health insurance payments she has made since July 14, 2009.
5. Western Mental Health Institute shall ensure that Grievant Jamie Cox accrues and has available for her future use all sick leave and annual leave she would have accrued since being terminated on July 14, 2009.
6. Western Mental Health Institute shall within thirty days of this ORDER revise the employment file of Grievant Jamie Cox to reflect that as a result of the incident which occurred on her shift of June 20-21, 2009, Ms. Cox was, at most, suspended for one day without pay, and the revised employment entry shall list all “sufficient mitigating factors” which would qualify under Policy NR-3.726, including but not limited to those listed in Conclusions of Law 1-9, *supra*.
7. Western Mental Health Institute shall strike and remove all records of Grievant Jamie Cox having been terminated from employment, and Western Mental Health Institute may

not represent to any person, agency or institution that Jamie Cox was terminated for the actions at issue in this appeal.

8. Western Mental Health Institute, through the Civil Service Commission, shall award Grievant Jamie Cox's attorneys fees and costs for pursuing this appeal, at the maximum rate allowed for by law. Those attorneys fees and costs shall be paid to Ms. Cox's attorney promptly upon receipt of a claim from her attorney submitted in accordance with Rules 1120-13-.01 and .02.

This Initial Order entered and effective this 22nd day of December, 2010.

Rob Wilson
Administrative Judge

Filed in the Administrative Procedures Division, Office of the Secretary of State, this 22nd day of December, 2010.



Thomas G. Stovall, Director
Administrative Procedures Division