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TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, Petitioner, V. ANTWAN RILEY, Grievant

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BEFORE THE CIVIL SERVICE COMMISSION
STATE OF TENNESSEE

IN THE MATTER OF: **TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES,** ***Petitioner***, **V.** **ANTWAN RILEY,** ***Grievant.***	**DOCKET NO: 26.15-117151J**

INITIAL ORDER

This contested case was heard in Nashville, Tennessee, on October 22, 2012, before Ann M. Johnson, Administrative Judge, assigned by the Secretary of State to sit for the Civil Service Commission of the State of Tennessee. Richard R. Prybilla, Assistant General Counsel with the Tennessee Department of Mental Health and Substance Abuse Services (Department or State), represented the State. The record indicates that the Grievant was not represented by legal counsel.

NOTICE OF DEFAULT

The Grievant did not appear for the hearing, in spite of the fact that he received Orders regarding the hearing and pre-hearing conferences set to take place after the initiation of the case. All were sent to the Grievant's address of record, and none was returned to the Administrative Procedures Division. In addition to the Grievant's non-participation at the hearing, the Grievant also failed to participate in pre-hearing conferences, failed to provide a current telephone number

or a witness and exhibit list, as required in pre-hearing Orders, and failed to participate in the proceedings in any way after the appeal was filed. Because the Grievant has an obligation to participate in the administrative appeal he requested, and because he abandoned the appeal at the very early stages of the process, the Department's oral motion for default was granted at the hearing, and the Department was allowed to proceed with an uncontested hearing in default under T.C.A. § 4-5-309.

ORDER ON THE MERITS

The subject of this hearing was the Grievant's appeal of his dismissal from State service by the Department. After consideration of the evidence and arguments placed into the record, it is determined that the dismissal should be upheld. This decision is based upon the following.

SUMMARY OF THE EVIDENCE

The Department provided testimony from four witnesses on its behalf: Shirley Edmondson, Unit Nurse Manager; Karen Hunter, Investigator for Middle Tennessee Middle Health Institute (MTMHI); Margie Dunn, Director of Human Resources for MTMHI; and Donna Finto-Burks, Nurse Executive.

Thirteen documents were accepted into evidence at the hearing:

EXHIBIT 1	MTMHI Policy 0214.01, Management of Patients at Risk;
EXHIBIT 2	Training Transcripts for Antwan Riley;
EXHIBIT 3	MTMHI Staff Assignment Sheet, November 28, 2011;
EXHIBIT 4	Patient Accountability Report, November 28, 2011;
EXHIBIT 5	Disciplinary Decision, August 18, 2006;
EXHIBIT 6	Disciplinary Letter, September 18, 2006;
EXHIBIT 7	Disciplinary Decision, November 1, 2007;
EXHIBIT 8	Disciplinary Decision, June 23, 2009;
EXHIBIT 9	Dismissal Recommendation, January 30, 2012;
EXHIBIT 10	Dismissal Decision, February 22, 2012;
EXHIBIT 11	Appeal for Level IV Hearing;
EXHIBIT 12	Level IV Decision, May 10, 2012; and
EXHIBIT 13	Separation Notice.

The Grievant failed to participate or to present any proof.

FINDINGS OF FACT

1. The Middle Tennessee Mental Health Institute (MTMHI) is a health facility operated by the Department of Mental Health and Substance Abuse Services. It is one of several regional institutes which provide inpatient psychiatric services for individuals with mental illness or serious emotional disturbance.

2. The Grievant was employed at MTMHI as a psychiatric technician since at least 2004.

3. During the Grievant's tenure at MTMHI, he received extensive training regarding his job responsibilities and the facility's policies for providing patient care. Specifically, the Grievant completed multiple training sessions regarding MTMHI Policy 0214.01, Management of Patients at Risk. EXHIBIT 2.

4. On November 28, 2011, the Grievant worked the evening shift from 2:45 p.m. to 11:15 p.m. He was assigned responsibility for the accountability board close observation of patient T.S., an at-risk patient on Hallway B, from 7:00 p.m. to 9:00 p.m. He was assigned to "zone and environment" from 9:00 p.m. to 11:00 p.m. EXHIBIT 3.

5. The duties of "zone and environment" required the Grievant to observe and account for the well-being of T.S., his at-risk patient, at least every 15 minutes, and then to document his observations on the Patient Accountability Check Sheet.

6. On November 28, 2011, from 9:00 p.m. to 11:00 p.m., the Grievant documented observations of patient TS every 15 minutes in his Patient Accountability Check Sheet. EXHIBIT 4.

7. However, a review of the surveillance video for this time period shows that the Grievant failed to make any observations during his nine to eleven time assignment. In fact, the only time the Grievant appeared in the hallway directly outside the room of his patient, the only way of entry into the room, was at 8:59 p.m. when he was observed walking toward the exit with his backpack. He did not have a board or sheet of paper to record any observations and did not observe any patients. Instead, he was seen leaving the locked, secured unit using a key. After 8:59, the Grievant did not appear again outside the patient's room or in the hallway.

8. Later that night, the patient T.S. was found dead with his head in the toilet in his bathroom, an apparent suicide. In order to kill himself, T.S. constructed an elaborate system using the shower curtain and four other make-shift tools, an operation that would have required a good deal of time. Had the Grievant performed observation checks as required, and as he documented that he completed, the death of T.S. might have been prevented.

9. By letter dated January 30, 2012, the Grievant was informed that he was recommended for dismissal from State service. EXHIBIT 9.

10. The Grievant was terminated for the following violations: (1) MTMHI Policy 0214.01, Management of Patients at Risk; (2) Department of Human Resources (DOHR) Rule 1120-10-.05(3), Negligence in the Performance of Duties; and DOHR Rule 1120-10-.05(11), Conduct Unbecoming an Employee in State Service.

11. At the Grievant's request, a hearing took place in which the dismissal was upheld; the Grievant was notified of this decision by letter dated February 22, 2012. EXHIBIT 10. On February 23, 2012, the Grievant appealed the decision, requesting to appeal directly to a Level IV hearing. EXHIBIT 11. On May 2, 2012, the Level IV hearing took place. The termination

was upheld, and the Grievant was notified of the decision by certified letter dated May 10, 2012. EXHIBIT 12. The Grievant then appealed the decision to Level V, the instant case.

12. During the course of the Grievant's employment with MTMHI, he received multiple disciplinary actions in addition to the one at issue in this matter. Included in the record are the following.

(a) August 18, 2006 – three day suspension for violation of Policy 0214.01, Management of Patients at Risk, by leaving alone a patient to which he was assigned 1:1 care. The Grievant's patient was found locked in her room while the Grievant was discovered outside smoking. EXHIBIT 5.

(b) September 18, 2006 – one day suspension for violation of the mandatory overtime policy. EXHIBIT 6.

(c) November 1, 2007 – three day suspension for violation of the policy against sleeping on duty. EXHIBIT 7.

(d) June 23, 2009 – three day suspension for violation of Policy 0214.01, Management of Patients at Risk, when the Grievant left his 1:1 assignment unattended for approximately 20 minutes. EXHIBIT 8.

APPLICABLE LAW

1. The Department, as the party "seeking to change the present state of affairs," has the burden of proof under Rule 1360-4-1-.02(7) of the Uniform Rules of Procedure for Hearing Contested Cases before State Administrative Agencies, TENN. COMP. R. & REGS. ch. 1360-4-1 (June 2004 (Revised)), to prove by a preponderance of the evidence that the discipline imposed was appropriate under State law and regulations.

2. MTMHI Policy 0214.01 contains the following relevant provisions:

> I. PURPOSE: To provide specific guidelines for clinical staff and to define various levels of special observation and care for patients at risk of being a danger to themselves or others.
>
> . . .
>
> II. POLICY: All patients shall be evaluated and observed for risk to themselves or others upon admission and throughout hospitalization. When it is determined that the patient or others are at risk, immediate action shall be taken to prevent danger and harm. The patient shall be provided with a level of security as dictated by the patient's assessed needs. The assigned staff member is responsible for the safety of the patient.
>
> Notes: 1) The intent of all levels of observation is to preserve life. Failure of the assigned staff member to perform the assigned observation and documentation according to this policy . . . may be considered negligence and will be subject to serious disciplinary action, up to and including termination.
>
> . . .
>
> D. Types of Observations
>
> . . .
>
> 4. Close Observation: In the absence of an order for one of the above levels of special observation, <u>all</u> patients will be observed or accounted for at least every fifteen (15) minutes for their well-being and documentation of the observations is to be completed on the Patient Accountability Check sheet.

3. The Rules of the Tennessee Department of Human Resources (DOHR) provide the overall policy for imposing disciplinary action in Rule 1120-10-.02:

> POLICY. A career employee may be warned, suspended, demoted or dismissed by his appointing authority whenever just or legal 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. . . .

4. T.C.A. § 8-30-330 contains the following relevant provisions:

> (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.
>
> . . .

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

5. DOHR Rule 1120-10-.05, in pertinent part, provides that the following are disciplinary offenses:

(3) Negligence in the performance of duties.

. . .

(11) Conduct Unbecoming an Employee in State Service.

ANALYSIS and CONCLUSIONS OF LAW

The weight of the evidence provided by the State in this matter is incontrovertible. On November 28, 2011, the Grievant worked an evening shift at the Middle Tennessee Mental Health Institute, where he was assigned to observe an at-risk patient at least once every fifteen minutes to prevent harm, from 9:00 p.m. through 11:00 p.m., and then to document his observations in a log kept for that purpose. Even though the Grievant completed documentation to show that he had performed the observations, he actually performed none. The security footage revealed that the Grievant did not enter the hallway leading to the patient's room, the only method of access, after 8:59, when he could be observed exiting the unit.

Disastrous consequences ensued. The at-risk patient to whom the Grievant was assigned successfully constructed an elaborate method to kill himself. Although it is impossible to determine whether the Grievant's negligence and dereliction of duty resulted directly in the death, it is certainly possible that frequent observation, as required, could have prevented this tragedy, particularly since the suicide apparatus could not have been hastily built.

As explicitly stated in MTMHI's policy, the purpose of observation is to preserve life. According to the policy, "[t]he assigned staff member is responsible for the safety of the patient." Failure to properly observe and document can result in serious disciplinary action, up

to and including termination. Because of the serious nature of the Grievant's acts, and the tragic outcome that may have resulted from them, the Department dismissed the Grievant from State employment.

Dismissal is appropriate on the basis on this one incident alone; however, this was not the only time the Grievant was disciplined for similar activity. On two previous occasions the Grievant was found to have violated the Management of Patients at Risk policy by leaving at-risk patients unattended. In another case he was disciplined for the comparable offense of sleeping while on duty. Even though some of incidents occurred years earlier, the Grievant has shown a pattern of dereliction that places others at an unacceptable risk.

It is determined that the Department carried its burden of proof, showing by a preponderance of the evidence that the Grievant violated Policy 0214.01, Management of Patients at Risk, and the rule of the DOHR prohibiting negligence. The Grievant also engaged in conduct unbecoming an employee in State service.

It is further determined that dismissal is the appropriate disciplinary action for these violations. There was no alternative disciplinary response to the facts presented by this case; indeed, dismissal is the "lowest appropriate step" in light of the infraction presented here.

It is further determined that the Department accorded to the Grievant all rights of due process rights in the termination action. The facts show that the Grievant was notified of the basis in fact and in law for the discipline. The Grievant was provided with rights to appeal in each step of the process.

IT IS THEREFORE ORDERED that the decision of the Department of Mental Health and Substance Abuse Services to terminate Grievant from his employment is fully **UPHELD**.

This Initial Order entered and effective this 13 day of March, 2013

_____
Ann M. Johnson
Administrative Judge

Filed in the Administrative Procedures Division, Office of the Secretary of State, this 13 day of March, 2013

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Thomas G. Stovall, Director
Administrative Procedures Division