

**BEFORE THE STATE PERSONNEL BOARD
IN THE MATTER OF**

DEBORAH TAYLOR,)	
)	
Appellant,)	
)	
v.)	Case No: 16-14-RCS
)	
ALABAMA DEPARTMENT OF MENTAL HEALTH,)	
)	
Appellee.)	

RECOMMENDED ORDER TO THE STATE PERSONNEL BOARD

This Recommended Order arises from an employment termination action by the Alabama Department of Mental Health (hereinafter “DMH”). DMH terminated the employment of Deborah Taylor (hereinafter “Taylor” or “the employee”) based upon her neglect of a client. DMH relied on the testimony of witnesses and video tape. The evidence presented by DMH during the hearing demonstrated a violation of DMH rules and policies. Therefore, DMH’s decision to dismiss Taylor was within its authority and should be upheld.

A hearing was held on May 10, 2016, at Bryce Hospital in Tuscaloosa, Alabama. David Huddleston, Esq., appeared as counsel on behalf of DMH. Jason Manasco, Esq., appeared as counsel on behalf of Taylor.

DMH introduced into evidence nine exhibits consecutively numbered DMH Exhibits 1 – 9. Taylor did not introduce any exhibits. The undersigned informed

the parties Taylor's personnel file at the Alabama State Personnel Department is included in the record as evidence in this cause.

DMH called as witnesses:

- (1) Francia Webb, Registered Nurse;
- (2) Debra Williams, Mental Health Worker I;
- (3) Kendra Simon, Mental Health Worker II; and
- (4) Shelia Penn, Bryce Hospital Director.

Taylor testified on her own behalf.

I. PROCEDURAL HISTORY AND CHARGES

Taylor began State employment in December 2000 as a Mental Health Worker I when she was hired by DMH at Partlow Development Center ("Partlow"). Taylor was transferred from Partlow to Bryce Hospital ("Bryce") in January 2012. Taylor remained a Mental Health Worker I until her dismissal.

Following the pre-dismissal conference conducted on February 18, 2016, DMH terminated Taylor's employment, effective close of business March 7, 2016. *See* DMH Exhibit 3 (dismissal letter dated March 3, 2016, signed by Shelia Penn, Bryce Hospital Director). DMH determined Taylor violated DMH Policy 19-10, Abuse, Neglect, Mistreatment and Exploitation, Neglect as defined in the DMH Incident Management Plan and Policy 70-5, Employee Conduct and Accountability. *See* dismissal letter. DMH further determined:

...

On January 22, 2016[,] on the Phase II Recovery Care Living Area, Unit-7 Group Therapy Room, Mental Health Workers (MHW) reported that a patient appeared to have sustained an injury. Upon assessment by the RN[,] the patient's nose was noted to be swollen and twisted. As a result of this injury an investigation was conducted, which concluded that the injured patient sustained a fractured nasal bone and cartilage. You neglected to report the injury or call for any assessment of the patient for the injury as is required of you. Additionally, the RN who was called to assess the patient asked the patient what happened and the patient responded[,] "That bitch jumped on me."

A pre-disciplinary conference was held for you in the Video Conference Room on February 18, 2016 to discuss the alleged policy violation. During the conference you presented insufficient information to refute the allegations against you. Therefore, it is my decision to dismiss you from employment at Bryce Hospital.

...

Id.

Taylor timely appealed her employment dismissal to the State Personnel Board and requested a hearing, pursuant to ALA. CODE § 36-26-27(a) (1975).

In its Short Plain Statement of Facts, DMH reiterated its charges against Taylor and cited the same DMH policies listed in the charge and dismissal letters.

On May 10, 2016, the undersigned conducted a *de novo* hearing, at which *ore tenus* and documentary evidence was received.

II. FACTUAL BACKGROUND

Having reviewed the documentary evidence and having heard the testimony presented at the hearing and having observed the witnesses' demeanor and assessed their credibility, the undersigned finds the greater weight of the evidence supports the

following findings of fact.¹

A. Employee's Personnel File²

Taylor's annual performance appraisals while at DMH reflect:

<u>Date Ending</u>	<u>Total Score</u>	<u>Category</u>
10/15	11.0	Partially Meets Standards
03/14	27.0	Meets Standards
10/13	26.0	Meets Standards
10/12	27.0	Exceeds Standards
10/11	19.0	Meets Standards
10/10	22.0	Meets Standards
10/09	27.0	Exceeds Standards
10/08	08.0	Partially Meets Standards
10/07	11.0	Partially Meets Standards
10/06	11.0	Partially Meets Standards
10/05	20.0	Meets Standards
10/04	27.0	Exceeds Standards
10/03	32.0	Exceeds Standards
10/02	12.0	Partially Meets Standards
12/01	21.0	Meets Standards
10/01 ³	23.0	Meets Standards

Taylor's prior disciplinary actions include, in reverse chronological order:

- 3-day Suspension on August 25, 2015 for a violation of DMH Policy 19-10, Abuse, Neglect, Mistreatment and Exploitation.
- Verbal Counseling on July 12, 2015 for punctuality.
- Written Reprimand on July 18, 2011 for punctuality.
- Written Warning on June 22, 2011 for absenteeism.

¹ All references to exhibits and testimony are intended to assist the State Personnel Board in considering this Recommended Order and are not necessarily the exclusive sources for such factual findings.

² See generally State Personnel Board Rule 670-X-18-.02(5) (employee's work record, including performance and disciplinary history, considered in dismissing employee).

³ Probationary Performance Appraisal.

- Written Warning on May 25, 2010 for punctuality.
- Written Reprimand on August 6, 2009 for punctuality.
- 1-day Suspension on April 21, 2008 for punctuality
- 1-day Suspension on October 15, 2007 for neglect.
- 1-day Suspension on July 31, 2007 for punctuality.
- Written Reprimand on January 17, 2007 for punctuality.
- 1-day Suspension on June 19, 2006 for neglect.
- Written Reprimand on April 26, 2006 for sleeping on duty.
- Written Reprimand on March 20, 2006 for unexcused absence.
- 1-day Suspension on March 7, 2006 for neglect.
- Written Reprimand on December 14, 2005 for punctuality.
- Written Reprimand on October 30, 2004 for absenteeism.
- Written Reprimand on February 19, 2004 for punctuality.
- 2-day Suspension on June 10, 2002 for neglect.
- Written Reprimand on August 29, 2001 for unauthorized absence from work station.

B. DMH Policies/Procedures Forming the Basis of the Charges

DMH's Policy #19-10 provides, in pertinent part:

I. POLICY:

Any form of recipient abuse, neglect, exploitation or mistreatment will not be tolerated. The DMH will immediately

investigate and provide for appropriate legal and administrative actions based upon such investigation in any state-operated facility.

II. PURPOSE:

This policy establishes standards for addressing findings of recipient abuse, neglect, mistreatment, exploitation, and other similar incidents in all DMH facilities. While this policy also attempts to ensure consistent and equitable treatment of both employees and recipients, it is not intended to ignore extenuating circumstances and the individuality of situations that arise; but rather, to be the starting point and common ground from which decisions are to be made.

III. STANDARDS:

...

Employees found in violation of this policy shall be subject to disciplinary actions as follows. Facilities will utilize progressive discipline as appropriate and to the extent possible (See DMH Policy Number 60-40, "Progressive Discipline"); however, the DMH reserves the right to take more or less stringent disciplinary action as applicable to the offense(s) by the employee.

...

d. **Neglect** as defined in the DMH Incident Management Plan shall result in disciplinary actions ranging from a minimum of written reprimand to termination.

...

DMH's Incident Management Plan defines neglect as:

The failure to carry out a duty through carelessness, inattention, or disregard of duty whereby the client is exposed to harm or risk of harm, and includes, but is not limited to:

(i) failing to appropriately supervise clients or otherwise leaving client areas unattended;

(ii) failing to ensure that client's basic needs for safety, nutrition, medical care and personal attention are met;

(iii) failing to provide treatment in accordance with the treatment plan or failing to develop a treatment plan; and

(iv) utilizing treatment techniques, e.g. restraints, seclusion, etc., in violation of departmental policy and procedures, whether or not injury results.⁴

...

C. Facts Forming the Basis of Dismissal

On January 22, 2016, Taylor began her shift at 6:45 a.m. Taylor's supervisor, Kendra Simon ("Simon"), instructed Taylor to assist client C.L. to get ready for a morning appointment off campus. Taylor escorted C.L. into C.L.'s room at approximately 7:29 a.m. and closed the door.⁵ Taylor testified she was supposed to help C.L. wash up and change clothes. The dorm is co-ed; therefore, closing the door was appropriate. At approximately 7:32 a.m., Taylor opened C.L.'s door and looked down the hallway for another worker. C.L. can be seen briefly coming to the door and then disappears back into the room. Taylor positioned herself so C.L. could not leave the room. At approximately 7:33:58 a.m., C.L. appeared to pull on the door from inside the room. Taylor hastily entered the room and closed the door.

After 10-12 seconds, Taylor opened the door again and saw Mental Health Worker I Jessica Eubanks ("Eubanks"). Taylor asked Eubanks to bring her a wash

⁴ DMH Exhibit 4, Bates Stamp 9.

⁵ DMH Exhibit 7.

cloth.⁶ Eubanks then left the area and immediately returned with the wash cloth. Eubanks went inside the room, delivered the wash cloth and then walked out of C.L.'s room and closed the door. Shortly thereafter, Taylor opened the door and asked Eubanks for something. Taylor then looked into the room, went back inside and closed the door. Eubanks returned to the room and opened the door. Taylor stood at the door and blocked the doorframe. Taylor and Eubanks spoke briefly through the cracked door and then Eubanks left. A minute or two later another worker walked to the door, peeked in and then closed the door and walked away.

At approximately 7:37:45 a.m., C.L. walked out of the room and headed toward the nurse's station. Taylor followed C.L. out of the room carrying one of C.L.'s shoes. As C.L. passed by the nurse's station she also passed by Mental Health Worker I Debra Williams ("Williams"). Williams noticed C.L.'s nose was blue and twisted.⁷ Williams reported the injury to her supervisor, Simon. Simon approached C.L. and noticed her nose was twisted and swollen. Simon asked Registered Nurse Francia Webb ("Webb") to assess C.L.'s nose.

Webb assessed C.L. and determined C.L. had suffered an injury to her nose. Webb asked C.L. what happened and C.L. responded, "That b**** jumped on me."⁸ Webb testified C.L. did not specifically identify who injured her.

⁶ DMH Exhibit 6, p. 7.

⁷ DMH Exhibit 6, p. 5.

⁸ DMH Exhibit 6, p. 4.

Webb completed an incident report and filed it. The incident report went to Facility Director Shelia Penn (“Penn”) who requested an investigation be conducted by Investigator James Finley (“Finley”). Finley reviewed videotape and interviewed the employees who gave written statements. Finley presented his findings to the Investigative Review Committee who instructed Penn to proceed with disciplinary action against Taylor.

Penn testified she held a pre-disciplinary hearing with Taylor in February 2016. Penn testified there was no evidence to conclude that Taylor abused C.L.; however, she believed Taylor neglected C.L. by failing to notice the injury and failing to disclose the injury to staff and request an assessment by a nurse after the injury occurred. Penn was also concerned that Eubanks went to C.L.’s door and Taylor did not allow Eubanks to enter the room. Penn asked Eubanks about the encounter and Eubanks told Penn that Taylor would not let her enter the room. Penn testified she believed Taylor’s dismissal was for the safety and security of the patients at Bryce Hospital.

The investigation showed C.L. was not injured prior to entering her room with Taylor. Webb testified she saw C.L. in the hallway approximately 30 minutes before she assessed her injured nose and did not see an injury. The video evidence supported this contention. The day room video does not show an injured or twisted nose on C.L. prior to her entering her room with Taylor. However, as C.L. emerged from her room at approximately 7:37:45, the video showed her nose appeared to be

crooked. Furthermore, as soon as C.L. walked by Williams, the video reflected that Williams immediately looked at C.L.'s face as if she detected something wrong.

Taylor testified she did not notice the injury while she was in the room with C.L. Taylor testified she helped C.L. put one shoe on and then C.L. got up and walked out of the room. Taylor followed C.L. to the day room and assisted C.L. with putting on her second shoe. Taylor testified she did not notice the injury to C.L. until it was brought to her attention. Taylor testified she did not injure C.L. and she is not sure how the injury occurred.

III. ISSUE

Did DMH produce sufficient evidence to warrant dismissal of Taylor?

IV. DISCUSSION

Standard of Review

The purpose of the administrative appeal is to determine if the termination of the employee's employment is warranted and supported by the evidence. *Kucera v. Ballard*, 485 So. 2d 345 (Ala. Civ. App. 1986); *Thompson v. Alabama Dept. of Mental Health*, 477 So. 2d 427 (Ala. Civ. App. 1985); *Roberson v. Personnel Bd. of the State of Alabama*, 390 So. 2d 658 (Ala. Civ. App. 1980). In *Earl v. State Personnel Board*, 948 So. 2d 549 (Ala. Civ. App. 2006), the Alabama Court of Civil Appeals reiterated:

“[D]ismissal by an appointing authority ... is reviewable by the personnel board only to determine if the reasons stated for the dismissal are sustained by the evidence presented at the hearing.”

Id. at 559, quoting *Johnston v. State Personnel Bd.*, 447 So. 2d 752, 755 (Ala. Civ. App. 1983).⁹

In determining whether an employee's dismissal is warranted, the departmental agency bears the burden of proving the charges warrant termination by a "preponderance of the evidence." The law is well settled that a "preponderance of the evidence" standard requires a showing of a *probability* that the employee is guilty of the acts as charged. **Thus, there must be more than a mere possibility or one possibility among others that the facts support the disciplinary action at issue.** The evidence must establish that *more probably than not*, the employee performed, or failed to properly perform, as charged. See *Metropolitan Stevedore Co. v. Rambo*, 521 U.S. 121, 117 S. Ct. 1953, 138 L.Ed. 2d 327 (1997), holding that a "significant possibility" falls far short of the Administrative Procedure Act's preponderance of the evidence standard. See also *Wright v. State of Tex.*, 533 F.2d 185 (5th Cir. 1976).¹⁰

An administrative agency must act within its constitutional or statutory powers, supporting its decision with substantial evidence. "Substantial evidence has been defined as such 'relevant evidence as a reasonable mind might accept as

⁹ The Alabama Court of Civil Appeals went further to hold: "both this court and the circuit court must take the administrative agency's order as 'prima facie just and reasonable' and neither this court nor the circuit court may 'substitute its judgment for that of the agency as to the weight of the evidence on questions of fact.'" *Id.* at 559, citing ALA. CODE § 41-22-20(k) (1975); *State Dept. of Human Res. v. Gilbert*, 681 So. 2d 560, 562 (Ala. Civ. App. 1995).

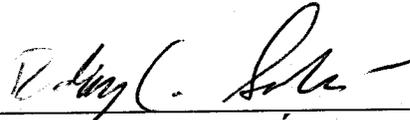
¹⁰ In *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir.1981), the Eleventh Circuit adopted as binding precedent all Fifth Circuit decisions handed down prior to the close of business on September 30, 1981.

adequate to support a conclusion,' and it must be 'more than a scintilla and must do more than create a suspicion of the existence of a fact to be established.'" *Alabama Alcoholic Beverage Control Bd. v. Tyson*, 500 So. 2d 1124, 1125 (Ala. Civ. App. 1986).

In the present case, DMH provided substantial evidence Taylor violated DMH Policy 19-10, Abuse, Neglect, Mistreatment and Exploitation. Neglect is broadly defined in DMH's Incident Management Plan. Neglect includes carelessness, inattention or disregard of duty whereby the client is exposed to harm or the risk of harm. Neglect also includes a worker's failure to properly supervise a client, or failure to provide appropriate treatment. In this case C.L. was injured while in the care of Taylor. Taylor, even if believed, did not notice the injury and did not report the injury to a nurse for assessment. Taylor's contention that she did not know about the injury is untenable. Taylor was working closely with C.L. during the time in which C.L. was injured. Taylor helped C.L. wash up and get dressed for an appointment. Taylor was in very close proximity to C.L. and should have noticed any injury. In fact, as soon as C.L. left her room Williams saw the injury as C.L. merely walked past her. Even after that, Taylor assisted C.L. with her second shoe. Taylor did not notice the injured nose during that time. Taylor was inattentive and failed to properly supervise a client in her charge. Taylor's complete disregard for her client's well-being cannot be condoned.

Accordingly, the undersigned finds the totality of the evidence warrants dismissal in this cause. Therefore, the undersigned recommends to the State Personnel Board that the dismissal be UPHELD.

Done this the 7th day of July, 2016.



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