IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION

MICHELLE SEARS,	:	
	:	
Appellant,	:	
	:	Case No. 11CVF-09-12317
vs.	:	
	:	(JUDGE FRYE)
DIRECTOR, OHIO DEPARTMENT OF JOB AND FAMILY SERVICES, et al.,	:	
	:	
Appellees.	:	

FINAL JUDGMENT & DECISION
REVERSING THE ORDER OF UNEMPLOYMENT COMPENSATION REVIEW COMMISSION

I. *Introduction*

Michelle Sears, L.P.N., appeals the Order of the Ohio Unemployment Compensation Review Commission which disallowed her application for unemployment benefits after she was fired. Hearing Officer Claire E. Patterson held that Ms. Sears had been terminated from employment at Columbus Center for Human Services, Inc., for just cause. The Hearing Officer did so after a hearing at which testimony was given by telephone and from documentary evidence submitted. However, in later appealing to the Commission Ms. Sears submitted additional evidence, which was relevant and material. The Commission did not mention that additional evidence in summarily affirming its Hearing Officer.

This case presents unusual facts. An LPN with heavy work responsibility unquestionably made a mistake and missed a prescription change pertinent to one patient. The change was buried in a handwritten document, and did not come to light for three months. When a public investigation followed, it identified both the mistake by the employee and the lack of a good overall management policy by the employer. Yet, the employee was terminated.

While to be sure an employee cannot disregard work rules and then protest their termination merely to gain unemployment benefits, what happens when work rules are unclear, and an internal, so-called progressive discipline policy is arbitrarily applied? That is, when the event prompting termination is only a negligent mistake may an employer ignore its own systemic failing, disregard its own "progressive discipline" rules and its own pattern and practice of imposing lesser sanctions for such mistakes, and impose termination?

II. *Facts*

For 11 years Ms. Sears was employed at Park West Court Apartments, a facility operated by the Columbus Center for Human Services, Inc. Apparently it is funded by Franklin County.

Ms. Sears is an LPN. So far as the record discloses during her 11 years of employment she made only two mistaken administrations of medicine. The first happened in 2006. It was addressed with a 24-hour suspension, and that "discipline" was removed from her file a year later. (Sears affidavit dated Aug. 25, 2011, filed with her Request for Review from Decision of Hearing Officer papers in August 2011, at ¶¶ 10 – 16.) This case involves her second such incident. It occurred in early 2011. (Id. ¶ 17). Other incidents involving other nurses are reviewed in Ms. Sears' appeal papers, and medication errors by others appear never to have resulted in termination.

It is undisputed that Ms. Sears failed to increase a patient's medication (of Dilantin) from 300 mg to 330 mg as ordered. It was, however, only obscurely noted in handwriting on a physician consult sheet. Ms. Sears reviewed the sheet upon the patient's return from a medical appointment on January 12, 2011. The consult sheet states at the top: "PLEASE WRITE ORDERS..." Ms. Sears acknowledged that it was her duty to process the consult sheet orders. (Tr. p. 3.) (See also, Tr. p. 44). However, medicine was not ordered by separate blank prescription form or using some other format that made it abundantly clear to nursing personnel (like Sears) when physicians ordered medicine to be altered.

Although some medical complications for the patient apparently ensued, it was not until April 2011 that the exact nature of the error was identified by Ms. Sears herself.

A number of months later at her hearing Ms. Sears responded "No" to Hearing Officer Patterson's question "Okay, do you recall receiving the consult sheet regarding the increase in Dilantin on January 12th?" (Tr. p. 27; see also p. 28). The employer's witness recalled having heard Ms. Sears tell them earlier that she did see the consult sheet, or that because she did not understand the physician's order she went so far as to fax the physician for clarification of the order. Whether a fax was sent or not, Ms. Sears conceded that she never followed up on any such clarification request that she might have sought by fax. (See, Investigative Review Minutes, p. 2 "She said that she knows that she faxed the doctor for clarification.") By the time the patient's lab work brought the lower dosage of medication to light months later in April 2011, Ms. Sears could not present a copy of any fax. Consistent with the Hearing Officer's finding, the court assumes no fax was sent to the doctor.

Hearing Officer Patterson recognized that Ms. Sears was "a seasoned nurse who should not have made this type of error." (p. 4 of 5 of Decision) The Hearing Officer also recognized – but apparently gave little weight to – the negligent, unintended nature of this error and downplayed the significance of a finding that Sears' employer had been found to have its own, overarching responsibility for this mistake. "[T]he employer and Franklin County both did independent investigations into the medication error. Both investigations determined claimant was negligent ***. Franklin County [Board of Developmental Disabilities] substantiated findings of neglect against both claimant and the employer." The charges against the employer "of neglect were *** for failing to have proper checks and balances in place for medication changes." (Decision, at p. 4 of 5.) The conclusion drawn by Franklin County was quoted in the record as follows" "It says that it was discovered that there was no system in place at Park West to ensure that the orders by the doctor on the consult sheet were being implemented; as such I am substantiating neglect against Park West." (Tr. 19)

The Hearing Officer also attached significance to the fact that "Claimant had no recollection of the consult sheet from January 2011 and never took any steps to make sure the resident's medication were at the proper levels." She likewise wrote that "Claimant was responsible for the care of the resident. Claimant was notified of the increase (of Dilantin from 300 mg to 330 mg) through a consult sheet from the physician. Claimant failed to increase the resident's medication." From this she jumped to the conclusion "claimant's actions constituted neglect and improper patient care."

The Hearing Officer recognized that the employer maintained a written policy for employees and that Sears was aware that a substantiated claim of "neglect" on her part could result, as it did here, in immediate discharge. However, neither the Hearing Officer nor the Commission itself addressed the meaning of "neglect" in the context of this written policy, or the undisputed, detailed evidence submitted by affidavit from Sears and another nurse (Lori Jones) that no, or much lesser, discipline was imposed for negligent medication errors involving other staff members. There is no evidence that anyone other than Sears was ever terminated in this situation.

The case takes-on a different complexion once one closely-reads the employer's policy, against the backdrop of how it has been applied in practice over a number of years. Two versions of the policy memoranda are in the record. One is from 2007; the second is dated November 2010. They list 30 separately-numbered "violations" that may result in disciplinary procedures. The 30 violations are broken into tiers of seriousness ranging from those that can result in only a "Written Verbal Warning" [sic] to "Written Corrective Action" to "Offense Suspension" to "Offense Termination." (Exactly what constitutes a "written verbal" warning can be left to another day.)

One of the lowest level violations is number 1, "Failure to exercise good judgment [sic] when performing job related duties." The next higher and more serious tier includes violation number 8 of "[c]areless or inefficient performance of duty." What's the difference?

"Negligence, carelessness, or unsafe conduct that could *** create other minor safety hazards" is violation number 9, also placed in the second tier. Only

a third event of misconduct, as defined in that tier of violations, can lead to termination.

Top-tier violations that may result in immediate termination do not include merely negligent mistakes. "Willful" acts like damaging property, insubordination, sleeping at work, leaving residents unattended, and other things not remotely at issue here fall in that most serious category. Neglect of a patient does as well. However, read in context "neglect" of a patient has a much more serious meaning than one isolated act of negligence.

At page 4 of 5 of the policy – the upper tier that could support immediate termination – is violation 23. (Someone circled violation number 23 on the copy of the policy found in the Record.) It appears to have been the peg on which this employer hung Sears' case. "Threatening, participating in, or failure to report physical, sexual, psychological, or verbal assault, abuse or neglect of residents/consumers, employees, volunteers or visitors" constitutes that violation. Read in context, the entire category of offenses includes "willful" or intentional" acts. Yet, at Sears' hearing it was argued that Sears failure to note a small dosage change amounted to having "participated in *** neglect of [a] resident/consumer." Theresa Jones, the "Incident Coordinator" at Columbus Center for Human Services testified "[i]t is policy that whenever neglect is substantiated that that is a policy [sic] for termination." (Hearing Tr. 13.) She thought, contrary to a fair reading of the written policy and to historical practice by the employer that "if you're negligent you're terminated." (Tr. 22).

Jones conveyed a misreading of the employer's policy. Actual practice under the policy is consistent with Sears' contention that isolated negligent mistakes do not support immediate termination.

III. *Standard of Review and Applicable Law*

In *Williams v. Ohio Dept. of Job & Family Servs.*, 129 Ohio St.3d 332, 2011-Ohio-2897, the Ohio Supreme Court set forth the law that applies to this case. *See also, Moore v. Ohio Unemp. Comp. Rev. Comm.*, Case No. 11-AP-756, 2012-Ohio-1424, ¶¶ 19-20 (10th District).

IV. *Discussion*

While the court recognizes that under the law it is "not permitted to make factual findings or determine the credibility of the evidence" and must simply "decide whether the commission's decision is supported by evidence in the record" (*Moore, supra.* at ¶ 20, and cases cited) there is no genuine dispute of fact material to this decision. Instead, the question – left to the court under the standard of review - is whether the decision of the Commission is "unreasonable, or against the manifest weight of the evidence." *Id.* Applying that standard to the essentially undisputed facts in the record (not all of which were mentioned by the Hearing Officer) the court concludes this decision cannot be upheld.

Whether an employer had "just cause" for a discharge depends on the factual circumstances in each individual case. "'Just cause' is 'that which, to an ordinarily intelligent person, is a justifiable reason for doing or not doing a particular act'." *Id.* at ¶ 21.

Ms. Sears was responsible for from 24 to 40 residents. (Hearing Tr. 36.) She had a longstanding, apparently very good record of continuous and almost unblemished service. The court believes the Commission (in upholding its Hearing Officer) ignored all of that evidence as well as the comparatively minor nature of Sears' mistake. Practically speaking her employer shifted blame for its own systemic failure to Sears. The employer had a poor management policy relative to communicating and fulfilling physician orders, and that lies at the heart of what occurred.

The decision in Sears case was buttressed by a misreading of the employer's discipline policy. Termination was premised upon a section of the policy addressed to patient "neglect" rather than to careless mistakes – a far less serious level of misconduct. While it is true that "neglect" and "negligence" have the same root, and may mean essentially the same thing, "neglect" has a far broader meaning ordinarily ascribed to it: to "neglect" a patient suggests more than one incident, and that there is pervasive, intentional or serious misconduct. One source says "medical neglect" means a failure to provide medical, dental or psychiatric care that is necessary to prevent or to treat serious physical or emotional injury or illness." Black's Law Dictionary at 1133, (9th Ed. 2009). Read

naturally the employment policy relied upon here used the word "neglect" in that broader, more serious context, but like the employer the Commission equated it to mere negligent mistakes. In context it has no such meaning. *See, Mohamad v. Palestinian Authority,* recognizing the meaning of "individual" in the context of a statute was limited to a natural "person" and could not include an organization. Case No. 11-88, 566 U.S. ___, slip op. at 7 ("'words that can have more than one meaning are given content *** by their surroundings' [citation omitted.") (April 18, 2012).

An LPN has important responsibilities. However, LPN's have a role subordinate to many other medical providers, and that was true for Ms. Sears. LPN's usually lack the education and other higher level credentials for an RN, or the status of physician or physician's assistant.[1] Recognizing that, together with the "findings of neglect" made against her employer for "failing to have proper checks and balances in place for medication changes" as the Hearing Officer expressly found, there was no just cause for termination shown here. The law can hardly permit employers whose own management systems fail to deflect blame onto relatively low-functioning employees whose conduct relied upon the same management systems. Perhaps if this case involved an RN who made this mistake, and certainly if it involved a physician's assistant or M.D., the reasonableness of a termination might be viewed differently. Those are not the facts.

V. *Conclusion*

Termination here was based upon a single, negligent mistake with one patient. No other criticism of Ms. Sears is reflected in the record. Immediate termination violated the written policy on progressive discipline. An ordinarily intelligent person would not deem that there was "just cause" for termination present here. The employer's written policy as applied to Sears was imprecise, and yielded a highly subjective result in her case. As applied, so far as the record

[1] According to Sears, the Nursing Board investigated this incident and did not find neglect, such that her license remained in good standing. (Tr. 33.) The Hearing testimony of Ms. Jones also supports the conclusion the Nursing Board investigated. (Tr. 15).

shows, this employer routinely gave limited or no discipline when merely negligent mistakes occurred. In marked deviation from that reading of the policy, in this instance the immediate termination of a long-time, essentially trouble free employee was ordered.

Circumstantial evidence reflects that when faced with an investigation by Franklin County (and apparently by the state Nursing Board as well) the event at issue here was mischaracterized as patient "neglect" – suggesting willful or otherwise intentional misconduct – rather than being seen for what it was. Considering the entire factual record, no just cause supports Sears' termination and she is entitled to unemployment benefits.

FINAL JUDGMENT

The court **REVERSES** the Order of the Ohio State Unemployment Commission in Docket No: H-2011016728 in all respects.

Costs taxed to Appellee.

IT IS SO ORDERED.

0A393 - Q93

Franklin County Court of Common Pleas

Date: 04-30-2012

Case Title: MICHELLE SEARS -VS- OHIO STATE DEPT JOB FAMILY SERVICES DIRECTOR

Case Number: 11CV012317

Type: DECISION

It Is So Ordered.

/s/ Judge Richard A. Frye

0A393 - Q94

Court Disposition

Case Number: 11CV012317

Case Style: MICHELLE SEARS -VS- OHIO STATE DEPT JOB FAMILY SERVICES DIRECTOR

Case Terminated: 18 - Other Terminations

Final Appealable Order: Yes