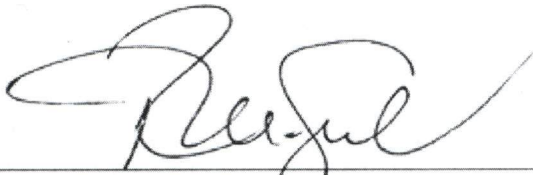


This is the final administrative determination in this matter. Any further review should be pursued in a judicial forum.

DECISION RENDERED BY THE
CIVIL SERVICE COMMISSION ON
NOVEMBER 1, 2017

A handwritten signature in black ink, appearing to read 'R. Czedz', written over a horizontal line.

Robert M. Czedz, Chairperson
Civil Service Commission

Inquiries
and
Correspondence

Christopher S. Myers
Director
Division of Appeals and Regulatory Affairs
Civil Service Commission
P. O. Box 312
Trenton, New Jersey 08625-0312

Attachment



State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NO. CSV 05036-16

AGENCY DKT. NO. 2016-3340

**IN THE MATTER OF ERICA MOFFITT,
DEPARTMENT OF HUMAN SERVICES,
WOODBINE DEVELOPMENTAL CENTER.**

William A. Nash, Esq., for appellant (Nash Law Firm, LLC, attorneys)

Nicole T. Castiglione, Deputy Attorney General, for appellant (Christopher S. Porrino, Attorney General of New Jersey, attorney)

Record Closed: July 18, 2017

Decided: September 1, 2017

BEFORE **JOHN S. KENNEDY**, ALJ:

STATEMENT OF THE CASE

Cottage Training Technician (CTT) Erica Moffitt appeals the action by the Department of Human Services, Woodbine Developmental Center (Woodbine) terminating her employment on grounds of neglect of duty, serious mistake due to carelessness which would result in danger and/or injury to persons or property, conduct unbecoming and other sufficient cause, specifically.

PROCEDURAL HISTORY

CTT Moffitt (appellant) was served with an Amended Preliminary Notice of Disciplinary Action (PNDA) on December 22, 2014 (R-13). A departmental hearing was held on March 1, 2016 and appellant was advised by a Notice of Final Disciplinary Action (FNDA) dated March 8, 2016, that she had been terminated effective March 3, 2016. Moffitt appealed the termination to the Civil Service Commission (CSC) and the Office of Administrative Law (OAL), as required under N.J.S.A. 40A:14-202(d). The matter was heard on April 27, 2017. The record closed after the parties filed written summations on July 18, 2017.

FACTUAL DISCUSSION

Appellant, Erica Moffitt, was employed by Woodbine as a Cottage Training Technician ("CTT"). One of the residents appellant was assigned to care for "M.S.," an eighty-five-year-old woman with extremely fragile, paper-thin skin. Because M.S.'s skin was subject to tearing with any type of shearing or abrasion, an Injury Review meeting was held on November 18, 2014, to discuss ways to prevent further injury to her. It was decided at that meeting that a mechanical lift would now be used to lift her out of bed and a draw sheet would be used any time M.S. needed to be moved or repositioned while in bed. Padded bed rails were also used to protect M.S. from injury. (R-1; R-2).

M.S.'s client card was updated with the new information, and all staff members received in-service instruction regarding the use of a mechanical lift and draw sheet. A client card is a snapshot of each resident and sets forth a summary of what services and care they require. Staff members are expected to know and understand the information contained in a resident's client card, and, therefore, if they do not understand a service or the type of care described therein, they are instructed to ask their supervisor. Supervisors are present during every shift. (R-1; R-4).

During the in-service instruction, staff members were instructed to utilize two people and a draw sheet whenever M.S. needed to be moved. (R-4). A draw sheet is a bed sheet that is folded in half and placed underneath a resident. Because draw sheets

do not require staff members to directly touch a resident, they are used to move residents who have fragile, thin skin. To move or reposition a resident, two staff members hold each end of the draw sheet.

On November 28, 2014, appellant was assigned to care for Group 1 in Cottage 18, which included M.S. (R-5; R-67). Appellant's shift began at 11:15 p.m. (R-67). As part of her assignment, appellant was given M.S.'s client card, which included the updated information regarding the use of a mechanical lift and a draw sheet. Appellant was familiar with M.S. and had cared for her on at least one other occasion after she received in-service instruction regarding the use of the draw sheet.

Appellant changed M.S. with the help of another staff member during the night. They did not use a draw sheet despite having to "rotate" M.S. to change her. Appellant also repositioned M.S. twice during the night without help from another staff member and without using a draw sheet. To reposition M.S., appellant had to move her from one side to the other and adjust the pillows underneath her head, shoulders, arms, knees, and lower legs. Appellant did not notice that one of M.S.'s padded bed rails was on backwards, leaving the metal bed rail exposed.

At approximately 6:25 a.m., appellant went into M.S.'s room to check on her and change her diaper. Appellant took down the bed rail closest to her, leaving the bed rail that was against the wall in place. Without the help of a second staff member or the use of a draw sheet, appellant "rolled" and "turned" M.S. from side to side to undress her and change her diaper. As appellant was rolling and turning M.S. to re-dress her, M.S. hit her head on the metal bed rail that was against the wall. At this point, seven hours into her shift, Appellant noticed that the padded bed rail was on backwards. Appellant alerted her supervisor and accompanied M.S. to Cape May Regional Medical Center. (R-67). M.S. required five sutures to treat the five-inch laceration on her head. (R-7; R-8; R-9; R-10; R-11). A CT scan was also taken of her head and x-rays of each of her knees. (R-9). Upon appellant's return to Woodbine, she was immediately suspended with pay. (R-12).

Testimony

Gene Meloy:

Meloy testified that he is a Charge Nurse at Woodbine for eight years. He described the population at Woodbine and provided examples of direct care duties. His duties are vast and include in-servicing (training) of staff. He conducts approximately five in-services per week. In-service instruction is an interactive process used to educate staff members about the services and standard of care at Woodbine. Staff members are encouraged to ask questions of their in-service instructors to ensure their understanding and comprehension of the subject matter. To document when staff members have received in-service instruction, each person must sign an Event Registration Roster Form. Appellant received in-service instruction on the use of a draw sheet on November 19, 2014. She signed the Event Registration Roster form documenting the in-service instruction.

Meloy provided a written statement (P-1) and testified that M.S. was delicate, and that her skin easily tore. She had to be repositioned in her bed every two hours. He was not working on the date of the incident and did not have any personal observations of the incident with M.S. During his direct examination, Meloy testified that he trained appellant. On cross examination, he corrected his testimony that he did not personally in-service appellant and that in-service of many staff was delegated to others. He did not know if the delegated in-service was simply handing R-4 to the trainees to read or whether the delegated trainer demonstrated the training. The in-service training reflected in R-4 was not a policy or procedure and did not constitute a training course.

Appellant reported the incident to her supervisor and an incident report was prepared (R-6). The recommendation on the Incident Report was for all staff to be more cautious in putting padding on bed rails. The Cape Regional Medical Center nursing notes stated there was no evidence of abuse or neglect.

Ryan Broughton:

Broughton is a Supervisor of Professional Residential services at Woodbine. He described the various duties of a direct care staff. Each patient has a direct care reference card (R-1) that gives instructions to employees on the needs of clients. These reference cards are kept in dorm watch binders along with a client turning schedule. Shift supervisors are responsible to ensure that employees on their shift understand what is required of each client. Employees are instructed to consult employees if they do not understand what is required to properly care for a patient. Broughton did not train appellant on the use of a draw sheet for M.S. and did not know who provided that training. He did not know whether or not the shift supervisor made sure that appellant was properly in-serviced on M.S.

Maggie Wallace:

Wallace worked for respondent as a CTT from 1978 to 2015. The first time assigned to a patient, staff is provided with the client cards. If a new procedure is implemented, sometimes a supervisor reviews the changes and other times, they are given a packet to review on their own while they work during the shift. If they do not understand, they are instructed to ask a supervisor. Supervisors are not always available to ask questions. Staff is required to follow what is stated on the in-service sheet and is not permitted to expand on it.

Erica Moffit:

Appellant is a graduate of Millville High School and has worked for the State of New Jersey since September 2000 at Woodbine. She was hired as a direct care staff. Her last title was cottage training technician (CTT). She was assigned the overnight shift from 11:15 p.m. until 7:00 a.m. the next morning. She mainly works with high functioning consumers. Here, she was assigned to M.S. who is a low functioning consumer. Prior to the date of the incident, she had worked with M.S. She was never in-serviced on M.S. but was provided her patient card prior to the date of the incident. She was never provided with M.S.'s revised card (R-1) and was never informed that it

was revised. The prior card contained no provision for using a draw sheet to reposition M.S. in bed. Appellant testified that on the date of the incident, they were understaffed. She was provided a stack of in-service sheets including one (R-4) pertaining M.S. which she read and signed. She understood the in-service only to require a draw sheet to move M.S. "up and down in bed." She understood R-4 literally and did not believe it was confusing. Prior to the incident, she was not made aware that the IHP (R-3) existed for M.S. Prior to the incident, she was aware of the Physical Management sheet for M.S. (R-2) which did not require a draw sheet be used for M.S. She was never informed that the Physical Management sheet was revised. On the date of the incident, she rotated M.S. and asked another staff to assist her. She needed another staff because M.S. was tight and "balled up". At approximately 5:45-6:30 a.m., appellant entered the room and it was dim. She did not turn the lights on as another consumer was shared the same room and was sleeping. M.S.'s bed was up against the wall. She removed the pillows from the side and removed her diaper. There was no draw sheet underneath of M.S. No one trained appellant on what to do when there is no draw sheet on the bed. Appellant then began dressing M.S. As appellant was putting pants on M.S., this is when M.S. rolled and hit the bed rail. The padding side on the bed pad was facing the wall and not facing M.S. The padding color blended with the wall and in the dark, she did not notice that the pad had been improperly installed. M.S. has pillows around her and these cover up the bed pad and she had not noticed that the staff in the previous shift did not properly install the bed pad. She immediately notified her supervisor of what happened. She completed the Incident Report (R-6) and went with M.S. to the ER. She remained with M.S. the entire time even beyond her shift time for a few hours.

Appellant testified that she was never in-serviced by Meloy or anyone else face to face on the use of a draw sheet. She signed the Event Registration Roster form documenting the in-service instruction "because [she] read the in-service." During her shift with M.S., there was no occasion which required her to move M.S. up and down. After the injury occurred, appellant's supervisor did not mention anything about a draw sheet or whether or not a draw sheet was to be used. Prior to the incident, appellant had observed M.S.'s group leader change M.S. without using a draw sheet. Despite receiving in-service instruction regarding the use of a draw sheet on November 19,

2014, appellant apparently had no knowledge of what a draw sheet was until she was interviewed by Woodbine on December 5, 2014. Appellant did not ask her supervisor any questions about the in-service instruction or for clarification regarding when a draw sheet should be used to move M.S.

In order to resolve the inconsistencies in the witness testimony, the credibility of the witnesses must be determined. Credibility contemplates an overall assessment of the story of a witness in light of its rationality, internal consistency, and manner in which it "hangs together" with other evidence. Carbo v. United States, 314 F.2d 718 (9th Cir. 1963).

A trier of fact may reject testimony because it is inherently incredible, or because it is inconsistent with other testimony or with common experience, or because it is overborne by other testimony. Congleton v. Pura-Tex Stone Corp., 53 N.J. Super. 282, 287 (App. Div. 1958).

Having considered the testimonial and documentary evidence offered by the parties, I deem that the testimony offered by the appellant is not credible. She insists that she did not receive adequate in-service training on how to use a draw sheet or that a draw sheet was required when changing M.S. She admits that she read the in-service and signed the Event Registration Roster form documenting the in-service instruction. She understood that a draw sheet was only needed when moving M.S. "up and down" but not when turning her from side to side. On the date of the incident, she rotated M.S. and asked another staff to assist her. Appellant was familiar with M.S. and had cared for her on at least one other occasion after she received in-service instruction regarding the use of the draw sheet. Therefore, I **FIND** as **FACT** that the appellant received in-service training on how to use a draw sheet and should have understood that a draw sheet was required when changing M.S. I also **FIND** as **FACT** that if appellant had any question about the care of M.S., she was instructed to ask a supervisor.

Based upon due consideration of the testimonial and documentary evidence presented at the hearing and having had the opportunity to observe the demeanor of the witnesses and assess their credibility, I **FIND** the following additional **FACTS**:

M.S. is an eighty-five-year-old woman with extremely fragile, paper-thin skin. It was decided at an Injury Review meeting held on November 18, 2014, that a mechanical lift would be used to lift M.S. out of bed and a draw sheet would be used any time M.S. needed to be moved or repositioned while in bed. Padded bed rails were also used to protect M.S. from injury. M.S.'s client card was updated with the new information, and appellant received in-service instruction regarding the use of a mechanical lift and draw sheet. Staff members are expected to know and understand the information contained in a resident's client card, and, therefore, if they do not understand a service or the type of care described therein, they are instructed to ask their supervisor. Supervisors are present during every shift.

On November 28, 2014, appellant was assigned to care M.S. Appellant's shift began at 11:15 p.m. and she was given M.S.'s client card, which included the updated information regarding the use of a mechanical lift and a draw sheet. Appellant was familiar with M.S. and had cared for her on at least one other occasion after she received in-service instruction regarding the use of the draw sheet. Appellant changed M.S. with the help of another staff member during the night. They did not use a draw sheet despite having to "rotate" M.S. to change her. Appellant also repositioned M.S. twice during the night without help from another staff member and without using a draw sheet.

At approximately 6:25 a.m., appellant went into M.S.'s room to check on her and change her diaper. Without the help of a second staff member or the use of a draw sheet, appellant "rolled" and "turned" M.S. from side to side to undress her and change her diaper. M.S. hit her head on the metal bed rail that was against the wall. M.S. required five sutures to treat the five-inch laceration on her head.

LEGAL ANALYSIS AND CONCLUSIONS

Appellant's rights and duties are governed by laws including the Civil Service Act and accompanying regulations. A civil service employee who commits a wrongful act related to his or her employment may be subject to discipline, and that discipline, depending upon the incident complained of, may include a suspension or removal. N.J.S.A. 11A:1-2, 11A:2-6, 11A:2-20; N.J.A.C. 4A2-2.

The Appointing Authority shoulders the burden of establishing the truth of the allegations by preponderance of the credible evidence. Atkinson v. Parsekian, 37 N.J. 143, 149 (1962). Evidence is said to preponderate "if it establishes the reasonable probability of the fact." Jaeger v. Elizabethtown Consol. Gas Co., 124 N.J.L. 420, 423 (Sup. Ct. 1940) (citation omitted). Stated differently, the evidence must "be such as to lead a reasonably cautious mind to a given conclusion." Bornstein v. Metro. Bottling Co., 26 N.J. 263, 275 (1958); see also Loew v. Union Beach, 56 N.J. Super. 93, 104 (App. Div. 1959).

Appellant was charged with "Conduct unbecoming a public employee," N.J.A.C. 4A:2-2.3(a)(6). "Conduct unbecoming a public employee" is an elastic phrase that encompasses conduct that adversely affects the morale or efficiency of a governmental unit or that has a tendency to destroy public respect in the delivery of governmental services. Karins v. City of Atl. City, 152 N.J. 532, 554 (1998); see also In re Emmons, 63 N.J. Super. 136, 140 (App. Div. 1960). It is sufficient that the complained-of conduct and its attending circumstances "be such as to offend publicly accepted standards of decency." Karins, supra, 152 N.J. at 555 (quoting In re Zeber, 156 A.2d 821, 825 (1959)). Such misconduct need not necessarily "be predicated upon the violation of any particular rule or regulation, but may be based merely upon the violation of the implicit standard of good behavior which devolves upon one who stands in the public eye as an upholder of that which is morally and legally correct." Hartmann v. Police Dep't of Ridgewood, 258 N.J. Super. 32, 40 (App. Div. 1992) (quoting Asbury Park v. Dep't of Civil Serv., 17 N.J. 419, 429 (1955)).

The basis for the charge of conduct unbecoming was appellant's neglectful treatment of M.S. Though the term "neglect of duty" is not defined in the New Jersey Administrative Code, it has been interpreted to mean that an employee has neglected to perform and act as required by his or her job title or was negligent in its discharge. Avanti v. Dep't of Military & Veterans' Affairs, 97 N.J.A.R.2d 564; Ruggiero v. Jackson Twp. Dep't of L. & Pub. Safety, 92 N.J.A.R.2d 214. Neglect of duty can arise from omission to perform a required duty as well as from misconduct or misdoing. See generally State v. Dunphy, 19 N.J. 531, 534 (1955). "Carelessness" is similarly defined as "[t]he fact, condition, or instance of a person's either not having done what he or she ought to have done, or having done what he or she ought not to have done; heedless inattention." In re Leaks, CSV 03913-13, Initial Decision (Aug. 15, 2013), adopted (Sept. 18, 2013) (quoting Black's Law Dictionary (9th ed. 2009)).

Woodbine's policy governing the treatment of individuals served defines "neglect" as:

The failure of a caregiver (person responsible for the individual's welfare) to provide the needed services and supports to ensure the health, safety, and welfare of the individual. These supports and services may or may not be defined in the individual's plan or otherwise required by law or regulation. This includes acts that are intentional, unintentional, or careless regardless of the incidence of harm. Examples include, but are not limited to, the failure to provide needed care such as shelter, food, clothing, supervision, personal hygiene, medical care, and protection from health and safety hazards. (R-16).

I **CONCLUDE** that appellant's behavior did rise to a level of conduct unbecoming a public employee. Appellant's conduct was neglectful, careless, and unbecoming of a public employee. Appellant received in-service instruction on the use of a draw sheet on November 19, 2014. She admitted that she received in-service instruction and signed the Event Registration Roster Form "because I read the in-service." Appellant also admitted that she was given, M.S.'s updated client card at the beginning of her shift. Appellant's conduct placed the patient at risk and was such that it could adversely affect the morale or efficiency of a governmental unit or destroy public respect in the delivery of governmental services.

Appellant has also been charged with violating N.J.A.C. 4A:2-2.3(a)(12), "Other sufficient cause." Other sufficient cause is an offense for conduct that violates the implicit standard of good behavior that devolves upon one who stands in the public eye as an upholder of that which is morally and legally correct. Specifically, appellant has been charged with violating Woodbine policy B-2.1: neglect of duty, loafing, idleness, or willful failure to devote attention to tasks which could result in danger to persons or property, and B-7.2: serious mistake due to carelessness which would result in danger and/or injury to persons or property. Respondent asserts that as appellant violated both B-2.1 and B-7.2, she has also violated E-1.5: violation of a rule, regulation, policy, procedure, order or administrative decision. In re Fahnbulleh, CSV 6080-13, Initial Decision (Sept. 29, 2014), adopted, (Nov. 6, 2014). These violations likewise amount to a violation of N.J.A.C. 4A:2-2.3(a)(12), other sufficient cause. I **CONCLUDE** that the Appointing Authority has met its burden of proof that appellant committed an act in violation of B-2.1, B-7.2 and E-1.5.

PENALTY

In determining the appropriateness of a penalty, several factors must be considered, including the nature of the employee's offense, the concept of progressive discipline, and the employee's prior record. George v. N. Princeton Developmental Ctr., 96 N.J.A.R.2d (CSV) 463. "Although we recognize that a tribunal may not consider an employee's past record to prove a present charge, West New York v. Bock, 38 N.J. 500, 523 (1962), that past record may be considered when determining the appropriate penalty for the current offense." In re Phillips, 117 N.J. 567, 581 (1990). Ultimately, however, "it is the appraisal of the seriousness of the offense which lies at the heart of the matter." Bowden v. Bayside State Prison, 268 N.J. Super. 301, 305 (App. Div. 1993), certif. denied, 135 N.J. 469 (1994). The question to be resolved is whether the discipline imposed in this case is appropriate.

In re Carter, 191 N.J. 474, 484 (2007), citing Rawlings v. Police Dep't of Jersey City, 133 N.J. 182, 197-98 (1993) (upholding dismissal of police officer who refused drug screening as "fairly proportionate" to offense); see also, In re Herrmann, 192 N.J. 19, 33

(2007) (DYFS worker who waved a lit cigarette lighter in a five-year-old's face was terminated, despite lack of any prior discipline):

. . . judicial decisions have recognized that progressive discipline is not a necessary consideration when reviewing an agency head's choice of penalty when the misconduct is severe, when it is unbecoming to the employee's position or renders the employee unsuitable for continuation in the position, or when application of the principle would be contrary to the public interest.

Thus, progressive discipline has been bypassed when an employee engages in severe misconduct, especially when the employee's position involves public safety and the misconduct causes risk of harm to persons or property. See, e.g., Henry v. Rahway State Prison, 81 N.J. 571, 580 (1980).

The record reflects that appellant was suspended from duty without pay for six months from March 20, 2014, until September 20, 2014, following a separate incident where her alleged carelessness resulted in an injury to a patient. (R-19; R-20). Upon her return to duty on October 4, 2014, appellant was given several in-service instructions to educate her about the services and standard of care that the residents in the facility required. After having considered all of the proofs offered in this matter, and the impact upon the institution regarding the behavior by appellant herein and in light of the seriousness of the offense and her prior discipline carelessness which resulted in an injury to a patient, I **CONCLUDE** that the removal of the appellant is appropriate.

ORDER

Accordingly, I **ORDER** that the action of the Appointing Authority is **AFFIRMED**, as set forth above.

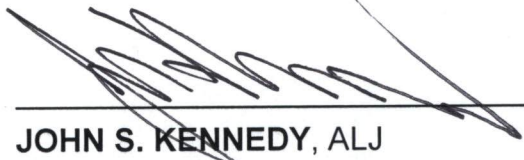
I hereby **FILE** my initial decision with the **CIVIL SERVICE COMMISSION** for consideration.

This recommended decision may be adopted, modified or rejected by the **CIVIL SERVICE COMMISSION**, which by law is authorized to make a final decision in this

matter. If the Civil Service Commission does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within thirteen days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **DIRECTOR, DIVISION OF APPEALS AND REGULATORY AFFAIRS, UNIT H, CIVIL SERVICE COMMISSION, 44 South Clinton Avenue, PO Box 312, Trenton, New Jersey 08625-0312**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

9/11/17
DATE



JOHN S. KENNEDY, ALJ

Date Received at Agency:

9/11/17

Date Mailed to Parties:

9/11/17

/lam

WITNESSES

For Appellant:

Maggie Wallace, CTT
Erica Moffitt, appellant

For Respondent:

Gene Meloy, Charge Nurse
Ryan Broughton, Supervisor of Professional Developmental Services

EXHIBITS

For Appellant:

P-1 Witness Statement of Gene Meloy, RN, dated 12/8/14

For Respondent:

- R-1 M.S. Client Card
- R-2 M.S. Positioning Plan, dated 4/10/14
- R-3 M.S. Individual Habitation Plan, dated 3/4/14
- R-4 M.S. Draw Sheet In-service Records, dated 11/19/14
- R-5 Dorm Watch Checklist, Cottage 18, 11/27/14 – 11/28/14
- R-6 Confidential Incident Report, dated 11/28/14
- R-7 M.S. Active Treatment Notes, 11/25/14 – 12/2/14
- R-8 M.S. Physician's Orders, 11/28/14 – 12/1/14
- R-9 M.S. Emergency Room Reports, Cape May Medical Center, 11/28/14
- R-10 M.S. Neuro Checklist, 11/28/14 – 12/1/14
- R-11 M.S. Body Outline, 11/28/14

- R-12 Preliminary Notice of Disciplinary Action ("PNDA"), dated 12/19/14
- R-13 Amended PNDA, dated 12/22/14
- R-14 Final Notice of Disciplinary Action ("FNDA"), dated 3/8/16
- R-15 Notice of Appeal, dated 12/22/14
- R-16 Administrative Policy 1:20 – Treatment of Individuals Served
- R-17 E. Moffitt Disciplinary History
- R-18 PNDA, dated 11/9/15
- R-19 FNDA and addendum, dated 10/2/14
- R-20 Disciplinary Action Appeal Settlement Agreement, signed 9/23/14
- R-21 Notice of Official Reprimand, dated 3/24/14
- R-22 PNDA, dated 11/25/13
- R-23 Disciplinary Action Appeal Settlement Agreement
- R-24 Written Warning, dated 2/12/14
- R-25 Written Warning, dated 2/11/14
- R-26 Written Warning, dated 11/1/13
- R-27 Notice of Official Reprimand, dated 12/31/13
- R-28 Notice of Official Reprimand, dated 11/6/13
- R-29 FNDA, dated 1/29/14
- R-30 Disciplinary Action Appeal Settlement Agreement, signed 11/21/13
- R-31 FNDA, dated 1/29/14
- R-32 Disciplinary Action Appeal Settlement Agreement, signed 11/21/13
- R-33 FNDA, dated 1/7/13
- R-34 Disciplinary Action Appeal Settlement Agreement, signed 2/14/13, and Notice of Suspension from Duty Without Pay, dated 3/12/13
- R-35 Disciplinary Action Appeal Settlement Agreement, signed 4/14/13, and Notice of Official Reprimand, dated 2/20/13
- R-36 Written Warning, dated 11/26/12
- R-37 Written Warning, dated 7/23/12
- R-38 Written Warning, dated 11/16/11
- R-39 Written Warning, dated 11/15/11
- R-40 Written Warning, dated 11/15/11
- R-41 PNDA, dated 6/6/11

- R-42 Disciplinary Action Appeal Settlement Agreement, signed 7/27/11, and Notice of Official Reprimand, dated 8/17/11
- R-43 FNDA, dated 3/17/11
- R-44 Disciplinary Action Appeal Settlement Agreement, signed 2/16/11
- R-45 FNDA, dated 8/17/10
- R-46 PNDA, dated 4/7/09
- R-47 Disciplinary Action Appeal Settlement Agreement, signed 8/6/09, and Record of Oral Counseling, dated 12/10/09
- R-48 Notice of Suspension from Duty Without Pay, dated 4/8/08
- R-49 Notice of Official Reprimand, dated 1/25/08
- R-50 FNDA, dated 12/31/07
- R-51 Disciplinary Action Appeal Settlement Agreement, signed 11/13/07
- R-52 Notice of Official Reprimand, dated 1/11/07
- R-53 FNDA, dated 7/11/06
- R-54 Disciplinary Action Appeal Settlement Agreement, signed 6/29/06
- R-55 FNDA, dated 4/14/05
- R-56 Disciplinary Action Appeal Settlement Agreement, signed 3/31/05
- R-57 PNDA, dated 11/25/04
- R-58 Return to Duty, dated 12/20/04
- R-59 Written Warning, dated 11/16/04
- R-60 Written Warning, dated 11/16/04
- R-61 Disciplinary Action Appeal Settlement Agreement, signed 11/16/04
- R-62 Notice of Suspension from Duty Without Pay, dated 4/21/04
- R-63 Record of Oral Counseling, dated 8/7/03
- R-64 Notice of Official Reprimand, dated 6/24/03
- R-65 Written Warning, dated 5/9/02
- R-66 Notice of Official Reprimand, dated 6/26/01
- R-67 Statement signed by Appellant, dated 12/5/14