

BEFORE THE STATE PERSONNEL BOARD OF THE STATE OF CALIFORNIA

In the Matter of the Appeal by ) SPB Case No. 28098  
 )  
 **FORTUNATO JOSE** ) **BOARD DECISION**  
 ) (Precedential)  
 From dismissal from the position )  
 of Psychiatric Technician, ) **NO. 93-34**  
 Sonoma Developmental Center, )  
 Department of Developmental )  
 Services at Eldridge ) November 2-3, 1993

Appearances: Stephen Bassoff, Attorney, for appellant, Fortunato Jose; Ellen Moulyet, Staff Services Manager I for respondent, Department of Developmental Services.

Before Carpenter, President; Stoner, Vice President; Ward, and Bos Members.

**DECISION**

This case is before the State Personnel Board (SPB or Board) for determination after the Board rejected the attached Proposed Decision of the Administrative Law Judge (ALJ) in the appeal of Fortunato Jose (appellant or Jose) from his position as a Psychiatric Technician, Sonoma Developmental Center, Department of Developmental Services (Department). The ALJ reduced appellant's dismissal to a 30 days' suspension on grounds that, although appellant was guilty of inexcusable neglect of duty and other failure of good behavior, mitigating circumstances weighed in favor of reducing the penalty.

After a review of the entire record, including the transcript, exhibits, and the written arguments of the parties, the Board adopts the ALJ's Proposed Decision to the extent it is consistent

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with the discussion below but modifies the dismissal to a 90 days' suspension.

### **DISCUSSION**

Appellant became a licensed Psychiatric Technician in August of 1988. As noted by the ALJ, appellant has two previous adverse actions, neither of which are related to the charges presented in the instant case.

Appellant is charged with violation of Government Code § 19572, subdivisions (b) incompetency, (c) inefficiency, (d) inexcusable neglect of duty, (e) insubordination, (f) dishonesty and (t) other failure of good behavior, arising out of appellant's failure to dispense medication as ordered and willingness to cover up his mistake.<sup>1</sup>

The ALJ found appellant guilty of inexcusable neglect of duty in failing to dispense medications as instructed. The ALJ also found appellant guilty of inexcusable neglect of duty for signing that medications had been dispensed before appellant dispensed them. The Board agrees with these two conclusions. In addition, the ALJ found appellant guilty of inexcusable neglect of duty for failing to insist that he himself carry the medications to the off site location. There is no basis in the record for a finding that

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<sup>1</sup>Appellant was also charged with a violation of Government Code section 19572(q), State Personnel Board Rule 172, General Qualifications, which the ALJ properly dismissed. See D [REDACTED] M [REDACTED] (1993) SPB Dec. No. 93-06.

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appellant, a licensed Psychiatric Technician, must retain possession or control over medications once prepared. The record supports only a finding that once prepared, the medications could not be dispensed by any individual other than the individual who "poured" the medication.

The Board agrees with the ALJ's conclusion that appellant's failure to dispense the medication in a timely manner should be mitigated by the lack of procedures for dispensing medications off site and the fact that appellant had never before been assigned to this unit. Appellant's supervisor on the day in question testified that even she did not know when appellant was supposed to sign the medication log indicating that the medications had been given. Nor did appellant's supervisor know how the medication was to be transported. The lack of clear procedures weighs heavily in favor of mitigation.

The ALJ did not specifically rule on the charges of incompetency, inefficiency or insubordination. The record does not support these charges.

There was no showing that appellant's one time error, under the circumstances, constitutes incompetency to perform his duties as a Psychiatric Technician. Incompetency is generally found when an employee fails to perform his or her duties adequately within an acceptable range of performance. For example, in Mercedes C. Manayao, No. 93-14, the Board found appellant to be incompetent

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because her work continued to contain numerous errors despite training, direction and offers of help. As noted above, while appellant erred in failing to dispense the medications in a timely manner, the failure was, at least in part, attributable to a lack of clear procedures.

Nor can appellant be found to be inefficient. A one time failure to timely administer medication does not constitute "inefficiency." "Inefficiency" under Government Code § 19572, subdivision (c) generally connotes a continuous failure by an employee to meet a level of productivity set by other employees in the same or similar position. [See Sweeney v. State Personnel Board (1966) 245 Cal.App.2d 246 (inefficiency found after witnesses testified that others doing same work did more than appellant in same amount of time); Bodenschatz v. State Personnel Board (1971) 15 Cal.App.3d 775 (inefficiency found when court compared statistical data of appellant's productivity with other officers performing like duties).] Here, none of the evidence presented demonstrated inefficiency within the meaning of 19572(c). The charge of inefficiency is dismissed.

Likewise, appellant cannot be found to be guilty of insubordination. Generally, a finding of insubordination is appropriate when an employee fails to submit to authority by ignoring or disobeying a direct order the supervisor is entitled to give and entitled to have obeyed. (See Parrish v. Civil Service

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Commission (1967) 66 Cal. 2d 260, 264.) Here, appellant disobeyed a direct order by failing to dispense the medications. However, to find insubordination, the fact finder must also find that the failure to comply with the direct order was intentional and willful conduct. (Coomes v. State Personnel Board (1963) 215 Cal. App. 2d 770, 775.) The evidence does not indicate intentional or willful failure to dispense medications. This charge too is dismissed.

The ALJ found cause for discipline under Government Code § 19572 (t) other failure of good behavior based on appellant's willingness to participate in a cover up of the fact that the medication had not been dispensed. The ALJ based this conclusion on the testimony of a hospital police officer who had investigated the incident. During the officer's interview of appellant, appellant explained that when he returned to the medication room and encountered the other workers, appellant concluded that the other workers were initiating a cover up of the fact that the medications had not been given. Appellant conceded that he planned to go along with the cover up.

In mitigation, the ALJ pointed to the facts that appellant already had two adverse actions and that he had already committed a grave error that day by failing to dispense the medications, as reasons for appellant's willingness to cooperate in a cover up

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instigated by others. The ALJ concluded that appellant was "trying very hard to do exactly what was expected of him and not get in trouble with anybody."

Here the Board departs from the ALJ's analysis. Appellant's willingness to participate in a cover up should not be mitigated by appellant's desire to avoid further trouble. A cover up of appellant's failure to dispense medication could have serious consequences on this group of severely developmentally disabled clients, clients who are unable to report deviations from the medication schedule. Although there was no effective cover up of the incident, appellant's willingness to cover up his error is a matter of serious concern to the Board. Appellant's failure to readily admit his error constitutes cause for discipline under Government Code § 19572 (d) inexcusable neglect of duty, (f) dishonesty and (t) other failure of good behavior. The issue thus becomes what is the appropriate penalty for appellant's misconduct.

The Board is charged with rendering a "just and proper" decision. (Government Code § 19582.) One aspect of rendering such a decision involves assuring that the discipline imposed is "just and proper." The Board has broad discretion in imposing penalties; it is not obligated to follow the recommendation of the employing power. (See Wylie v. State Personnel Board (1949) 93 Cal.App.2d 838,843, 109 p.2d 974.) The Board's discretion, however is not unlimited. Although the Board may consider other factors as

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well, in setting a penalty the Board is required to consider factors identified by the court in Skelly v. State Personnel Board (Skelly) (1975) 15 Cal.3d 194. These factors are harm to the public service, the circumstances surrounding the misconduct and the likelihood the conduct will reoccur. Id. at 217-218.

The potential harm to the public service resulting from a medication error is obvious. In Tely M. Cabayan (1992) SPB Dec. No 92-16, a registered nurse administered the wrong dose of Motrin. No harm came of the error. The Board found that the "issue is not whether a patient was harmed or likely to be harmed by an overdose of Motrin, but whether a patient is likely to be harmed by a medication error." (Id. at 7.) The failure to dispense medication on a timely basis could have grave implications for any patient relying on medication, but the risk of harm is especially great for clients unable to report that they have not received their prescribed medications. The cover up of a medication error could have an even greater potential for harm.

However, it is important to note that there was no cover up. Appellant expressed what may have been an only momentary willingness to participate in a cover up. There is no indication of a likelihood of recurrence. The Board agrees with the ALJ that appellant's behavior does not warrant dismissal but believes the misconduct warrants more than the 30 days' suspension recommended by the ALJ.

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It is clear from the Department's presentation that the Department was more concerned with appellant's willingness to cover up than with his failure to dispense the medications. A 90 days' suspension should insure against a recurrence of the misconduct in issue.

#### **CONCLUSION**

For all of the reasons set forth above, the attached Proposed Decision of the Administrative Law Judge is adopted to the extent it is consistent with this decision. The penalty of dismissal is modified to 90 days' suspension.

#### **ORDER**

Upon the foregoing findings of fact and conclusions of law, and the entire record in this case, it is hereby ORDERED that:

1. The ALJ's attached proposed decision is adopted to the extent it is consistent with this Decision;
2. The above-referenced action of the Department of Developmental Services in dismissing appellant is modified to a ninety (90) days' suspension;
3. Sonoma Developmental Center, Department of Developmental Services, shall reinstate Fortunato Jose to the position of Psychiatric Technician and pay to him all back pay and benefits that would have accrued to him had he been suspended for ninety days rather than dismissed.



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4. This matter is hereby referred to the Administrative Law Judge and shall be set for hearing on written request of either party in the event the parties are unable to agree as to the salary and benefits due appellant.

5. This opinion is certified for publication as a Precedential Decision (Government Code § 19582.5).

THE STATE PERSONNEL BOARD\*

Richard Carpenter, President  
Alice Stoner, Vice-President  
Lorrie Ward, Member  
Floss Bos, Member

\* Member Alfred R. Villalobos was not on the Board when this case was originally considered and did not participate in this decision.

\* \* \* \* \*

I hereby certify that the State Personnel Board made and adopted the foregoing Decision and Order at its meeting on November 2-3, 1993.

GLORIA HARMON  

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Gloria Harmon, Executive Officer  
State Personnel Board

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BEFORE THE STATE PERSONNEL BOARD OF THE STATE OF CALIFORNIA

In the Matter of the Appeal by )  
 )  
 FORTUNATO I. JOSE ) Case No. 31861  
 )  
 From dismissal from the position )  
 of Psychiatric Technician )  
 Sonoma Developmental Center )  
 Department of Developmental )  
 Services at Eldridge )

PROPOSED DECISION

This matter came on regularly for hearing before Ruth M. Friedman, Administrative Law Judge, State Personnel Board, on October 12, 1992, at Eldridge, California.

The appellant, Fortunato I. Jose, was present and was represented by Steven Bassoff, Attorney.

The respondent was represented by Ellen S. Moulyet, Staff Services Manager I, Sonoma Developmental Center.

Evidence having been received and duly considered, the Administrative Law Judge makes the following findings of fact and Proposed Decision:

I

The above dismissal effective August 7, 1992, and appellant's appeal therefrom comply with the procedural requirements of the State Civil Service Act.

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## II

Appellant became a licensed Psychiatric Technician in August 1988. He has two previous adverse actions. The first adverse action was a letter of reprimand dated May 1, 1991, for inexcusable absence without leave. The second adverse action was a 10 percent reduction in salary for 6 months effective June 20, 1991, for shouting at, threatening, and hitting his supervisor in a dispute about his arriving at work on time. That action was sustained by the Board on June 23, 1992, in Case Number 29970. The current action involves neither absence, tardiness, or discourtesy, and the Department represented that those problems did not recur after the adverse actions.

## III

Appellant is charged with violation of Government Code Sections 19572(b) incompetency, (c) inefficiency, (d) inexcusable neglect of duty, (e) insubordination, (f) dishonesty, and (t) other failure of good behavior either during or outside of duty hours which is of such a nature that it causes discredit to the appointing authority or the person's employment for failing to properly dispense medications and lying about it.

A charge of violation of Government Code Section 19572(q), "violation of this part of the State Personnel Board Rule 172, General Qualifications" is dismissed. Michael Prudell (1992) SPB Dec. No 92-15.

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IV

Appellant was assigned to work as a "floater" on the Nelson Unit on July 20, 1992. He had never worked there before and did not know the patients or their routines. Even though the unit had three "families," each with six or more members, he was one of only two licensed staff members working on the unit that day.

The clients in one of the families on the unit had recently begun a new program which took them off the unit to attend classes at another facility on the grounds, called the Blue Rose Cafe. They were transported to the Blue Rose Cafe in a tram. The program was sufficiently new that no one had worked out specific procedures for handling the dispensing of medications while residents were off unit.

V

When appellant came to the unit, he reported to a Psychiatric Technician who was not a regular supervisor, but had been put in charge in the absence of the regular supervisor, had little experience supervising, and, until appellant arrived, was the only licensed person on the unit. This Psychiatric Technician described the morning of July 20 as chaotic, because a lot was happening with minimum staff and she was unaware of the logistics of certain operations. Initially, this Psychiatric Technician assigned appellant, who she had never seen before, to work with a group that was going to stay on the unit. Later she realized that the group that was going to the Blue Rose Cafe contained six clients who

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needed to take medication at noon, and medication could only be dispensed by a licensed Psychiatric Technician or other licensed person. Therefore, she directed appellant to prepare medication for the clients, who were already at the Blue Rose Cafe. She helped him by pulling the medication charts for these clients and giving him envelopes to mark and in which to place the appropriate pills. She told him to sign the back of each sheet and to initial the front of the sheets to indicate that he had given the medication. This was an improper instruction, since the policy requires that the medication records be initialed after, not before, the medications are administered.

After preparing the medications, it was time for appellant to go to lunch. The Psychiatric Technician in charge told him to go to lunch and then report to the Blue Rose Cafe. She told him she would give the medications to a Rehabilitation Therapist who was going over to the Blue Rose Cafe. This was also improper because only the person who dispenses the medication is supposed to handle it until it is administered directly to the patient for whom it is intended.

The Psychiatric Technician in charge did not give the medications to the Rehabilitation Therapist, who changed her schedule to work at the Blue Rose Cafe later in the afternoon, but rather to the trainer who accompanied the clients. The trainer put the medications in a locked cupboard. He forgot to tell appellant where they were when appellant arrived after

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his lunch and he forgot that the clients were supposed to get medication around noon.

#### VI

Appellant worked with the clients the rest of the shift. He did not ask anyone about the medications and they were not dispensed. At 2:00 p.m., when the trainer was ready to take the clients back to the unit, he realized that the medications were still in the locked cupboard. He called the unit for instructions, and was told to bring the medications back with him and hand them over to the person in charge, which he did. Someone called a doctor, who instructed the person in charge to dispense the medications then (it was then about 3:00 p.m.) and postpone the evening medications a few hours.

#### VII

The Rehabilitation Therapist testified that when she found out that the trainer had found the medication in the locked cabinet and told appellant that they had forgotten to give the medication, appellant told her "It's no big deal; throw them away." She then called the unit supervisor out of a meeting to report appellant's misbehavior. Appellant denies that he made the statement.

#### VIII

Meanwhile, appellant returned to the unit in his car, met the tram with the clients, and helped unload them and accompany them back to the unit. When he got inside, the staff members, including the Rehabilitation Therapist, were discussing the failure of the staff at the Blue Rose Cafe to

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dispense the noon medications. The Rehabilitation Therapist said that appellant came in and said, "I told you guys I gave them." She says that when he told him not to lie, he continued to insist that he gave the medications, even though he did not. Appellant says that he asked, "the meds were given?". He says that he hoped someone else had given the medication, and was asking about it.

It is clear that appellant made some sort of statement on this subject. The account that appellant gave to the hospital police officer reconciles all of the testimony. Appellant told the police officer that when he went into the unit, he heard the acting supervisor and the two staff members who were at the Blue Rose Cafe discussing what to do about the problem. He interpreted their remarks as an attempt to cover up the error, and he wanted to help them, so he said that he had given the medications. Of course, no one believed him, because the pills were still in the envelopes. The reason this account is believable is that after the two previous adverse actions, appellant was, by his own account, trying very hard to do exactly what was expected of him and not get in trouble with anybody.

## IX

The usual policy for dispensing medications requires that the same (licensed) person dispense the medications, given the medications to each client, and then initial the client's medication chart to certify that the client has taken the medication. This policy was designed with the assumption that

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clients would spend the day on the living unit where the medications were delivered by the pharmacy and where the records were kept.

In July 1992, when a group of clients spent the day off the unit, the policy had not been adjusted. The Psychiatric Technician in charge, who was not a regular supervisor, attempted to sign that the medications had been given even though they had not been given, and she broke the chain of custody of the medications by having someone other than the person who dispensed them carry them to the unit.

After this incident, a new procedure was established. A Psychiatric Technician pours the medications on the unit, takes them to the Blue Rose Cafe at noon, administers them to the clients, and then goes back to the unit and signs that they were dispensed.

\* \* \* \* \*

PURSUANT TO THE FOREGOING FINDINGS OF FACT THE ADMINISTRATIVE LAW JUDGE MAKES THE FOLLOWING DETERMINATION OF ISSUES:

Appellant is guilty of inexcusable neglect of duty for failing to dispense the medications to the clients on the day he was assigned to Nelson Unit. He is also guilty of inexcusable neglect of duty for failure to insist that he carry the medications over to the Blue Rose Cafe himself and for signing that he dispensed the medications before he did so. He is guilty of other failure of good behavior during



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duty hours for suggesting that he had given the medication when he had not done so.

Appellant's failure to dispense the medications is mitigated by the fact that he had never been on the unit before and was following the lead of the trainer, who carried the medications over, knew where they were, knew the regular schedule of the clients, and knew who needed medications. Appellant was technically responsible--after all, he had been sent to that group specifically because he was licensed to dispense medications--but even if he had remembered, he would have needed the assistance of the other staff members to connect the names of the clients on the medication envelopes with the clients, who he did not know. He should have remembered about the medication, but the other staff members share responsibility.

Appellant is also not completely responsible for his failure to follow the regular policy for dispensing medications. He followed instructions from a supervisor he did not know, in an unfamiliar setting where no one had devised a standard procedure. He know he was vulnerable to criticism if he did not follow instructions, since he had two previous adverse actions and was conscientiously trying to behave.

Employees, especially licensed professionals like appellant, are expected both to follow instructions and cooperate, and to use independent judgment in following the precepts of their profession.

In this case, appellant failed

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to use the independent judgment required to follow the rules designed to insure that the proper medications are dispensed in a timely manner. Rather than take initiative in getting the medication to the clients, he expressed some willingness to participate in what he (perhaps erroneously) interpreted as a cover up.

Punishment is warranted. However, due to appellant's unfamiliarity with the clients and the routine of the unit where he had been loaned for a day, the lack of leadership from other working on the unit, and the fact that this is the first offense of this type, dismissal is too severe a punishment. Appellant has corrected the behavior that was the subject of the previous adverse actions; therefore, the fact that there have been previous adverse actions does not justify dismissal in this case. A suspension without pay for 30 days is appropriate.

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WHEREFORE IT IS DETERMINED that the dismissal taken by respondent against Fortunato I. Jose effective August 7, 1992, is hereby modified to a 30 days' suspension without pay. Said matter is hereby referred to the Administrative Law Judge and shall be set for hearing on written request of either party in the event the parties are unable to agree as to the salary, if any, plus interest, due appellant under the provisions of Government Code Section 19584.

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I hereby certify that the foregoing constitutes my Proposed Decision in the above-entitled matter and I recommend its adoption by the State Personnel Board as its decision in the case.

DATED: November 10, 1992.

RUTH M. FRIEDMAN  
Ruth M. Friedman, Administrative Law  
Judge, State Personnel Board.