BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between	
MILWAUKEE COUNTY DEPUTY SHERIFFS' ASSOCIATION	Case 325 No. 47234 MA-7206
and	
MILWAUKEE COUNTY (SHERIFF'S DEPARTMENT)	

Appearances:
Gimbel, Reilly, Guerin & Brown, Attorneys at Law, by Ms. Marna M. Tess-Mattne Mr. Timothy R. Schoewe, Deputy Corporation Counsel, on behalf of Milwaukee County.

ARBITRATION AWARD

The Milwaukee County Deputy Sheriffs' Association, hereinafter the Association, requested that the Wisconsin Employment Relations Commission appoint a member of its staff to arbitrate in a dispute between the Association and Milwaukee County, hereinafter the County, in accordance with the grievance and arbitration procedures contained in the parties' labor agreement. The County subsequently concurred in the request and David E. Shaw of the Commission's staff was designated to arbitrate in the dispute. A hearing was held before the undersigned on May 14 and June 8, 1992 in Milwaukee, Wisconsin. No stenographic transcript was kept of the hearings and the parties completed the submission of post-hearing briefs by July 10, 1992. Based upon the evidence and the arguments of the parties, the undersigned makes and issues the following Award.

ISSUES

At the hearing the parties stipulated to the following statement of the issues:

> Did deputy Smith violate the rules as alleged by the Sheriff? If so, what is the appropriate discipline?

RELEVANT CONTRACT PROVISIONS

The parties cite the following provision of their Agreement:

> **5.05 DISCIPLINARY SUSPENSIONS NOT APPEALABLE UNDER S. 63.10, STATS.**
>
> In cases where an employe is suspended for a period of 10 days or less by his department head, pursuant to the provisions of s. 63.10, Stats., the Association shall have the right to refer such disciplinary suspension to arbitration. Such reference shall in all cases be made within ten (10) working days from the effective date of such suspension. The decision of the Arbitrator shall be served upon the Department of Labor Relations and the Association. In such proceedings, the provisions of s. 5.02(2)(c) shall apply.

RULES INVOLVED

1.05.30 RULE 30 - ABSENCE WITHOUT PERMISSION

Members of the department shall not absent themselves from duty without proper authorization.

. . .

1.05.69 RULE 69 - PERSONAL SAFETY CONDUCT

Members shall not, by action or omission, create a situation of risk of injury to themselves or others. Included without limitation as examples of such conduct are the following:

(1) Failure to exercise proper precautions in guarding prisoners;

(2) Failure to make a proper and thorough search of prisoners for weapons or instruments.

(3) Negligently or carelessly leaving personal or confiscated weapons or instruments, in a location which allows accessibility.

. . .

1.05.75 RULE 75 - NEGLECT OF DUTY

Failure by any member to take proper action. Failure to properly supervise subordinates, or to prefer disciplinary charges, or to make other appropriate disciplinary action.

The examples of Neglect of Duty are not all inclusive but are presented as a guide.

--- Failure to report as a witness when duly notified or subpoenaed.

--- Allowing departmental vehicle to be stolen for failing to remove keys when unattended.

--- Failure to thoroughly search for, collect, preserve and identify evidence of persons, property and locations in any arrest or investigation.

--- Failure to properly patrol district, sector or zone and

to make assigned reports to headquarters. Unauthorized absence from assigned area, or failure to respond to radio call.

--- Failure to properly care for assigned equipment and vehicles or any department property. Damaging or causing damage to county property due to neglect or carelessness.

--- Conducting private business on duty.

BACKGROUND

The Grievant, is a Deputy Sheriff I with the Milwaukee County Sheriff's Department and has been employed as such for eight years with approximately five of those years being spent working in the County's jail. This case involves three suspensions that the Grievant received for violation of Department rules. Specifically, the Grievant was given a one-day suspension for failing to report on time for voluntary overtime on June 10, 1991, and a three-day suspension for failing to report on time on June 27, 1991. The Grievant also received a five-day suspension as a result of an incident in the jail where she was alleged to have violated Rule 1.05.69 - Personal Safety Conduct and Rule 1.05.75 - Neglect of Duty.

JUNE 10, 1991

At this point in time the Grievant was volunteering for as much overtime as she could get in the Department. The various bureaus in the Department have somewhat different mechanisms for notifying the employes who are being awarded the voluntary overtime. The Grievant had signed up for voluntary overtime in the Court Services Bureau and had been doing so since October of 1990. On June 10, the Grievant failed to report at 8:00 a.m. on June 10, 1991, as a bailiff in the Court Services Unit as scheduled. A Sgt. Garny contacted the Grievant by telephone and was told by her that after she had volunteered for the overtime she had requested and been granted an O/U day 1/ by the Detention Bureau and that she thought because she was on O/U she could not work overtime. She reported to the courtroom approximately one hour late. Due to her absence, the court handled other calendar matters first and then began the start of a murder trial. The Grievant had been previously counseled about missing scheduled overtime at Milwaukee County Stadium on April 18, 1991 when she had overslept. Lieutenant Lango recommended that the Grievant be given a one-day suspension for her failure to report on time on June 10, 1991.

JUNE 27, 1991

At her disciplinary hearing for the violation occurring on June 10, 1991, Lieutenant Lango discussed with the Grievant her remaining overtime assignments. He specifically mentioned an assignment on June 26, 1991, but did not mention June 27. The Grievant reported for her scheduled overtime assignment on June 26, 1991, but did not report on June 27, 1991 for scheduled overtime in the Process Department (Court Services). Upon her failure to

1/ Similar to compensatory time off.

appear on time she was contacted by a sergeant and reported approximately thirty minutes late and was in her assigned courtroom by 8:40 a.m. The court opened at 8:50 a.m. Lieutenant Lango recommended, and the Grievant received, a three-day suspension for her failure to appear on time on June 27, 1991 for scheduled overtime.

Also on June 27, 1991, after completing her assignment, the Grievant consulted a physician regarding stress, fatigue and forgetfulness. She was advised by the doctor to take a three-week medical leave of absence, which she did, returning to work on July 18, 1991.

JAIL INCIDENT

Unlike the "failure to report" violations, there is some dispute as to the facts in this incident. On July 31, 1991, police officers from a Milwaukee suburb transported a female prisoner, "H", to the Milwaukee County Jail. As a part of the intake process, all new admissions to the jail are screened by the jail nurse, R.N. Tews that evening, to determine whether the prisoner had any medical conditions requiring treatment or special care. There is a medical processing form filled out by the nurse and that is maintained in the inmate's medical file. The contents of that file are not generally revealed to other jail staff. Nurse Tews remembered "H" from prior jail visits and knew that she had multiple medical problems including AIDS, herpes, CMB virus and alcoholism. During the medical screening that evening, Nurse Tews noticed that "H" had a Hickman catheter dangling from her chest. This catheter is an approximately eight to 12-inch tube which is surgically inserted into the large vessel entering the heart and is normally used to administer chemotherapy to cancer patients. It may also be used to administer heavy doses of antibiotics.

Nurse Tews mentioned that "H" had AIDS. Tews then secured the catheter in place with tape and advised "H" and others in the booking room that the catheter should be left in place. There is a dispute as to whether the Grievant was present when Nurse Tews mentioned this. The Grievant concedes she heard Nurse Tews state that "H" had an advanced case of AIDS and that "H" had to go to the hospital. Nurse Tews directed that "H" be taken to the Milwaukee County Medical Complex (MCMC) for a medical clearance before being accepted in the jail.

The Grievant was called to the Booking Room to prepare "H" for transport to the Medical Complex which involved having "H" use the bathroom and change into jail clothing. At the time the Grievant was called to the Booking Room "H" was being searched by Deputy Rose. Deputy Rose and Sergeant Bilda went to the garage to await "H" for transport. The Grievant then went to find the clothes and then took "H" to an area to change clothes. "H" was becoming upset at this time. The Grievant saw the tube and asked "H" what it was for and was told it was like an "IV", according to the Grievant. "H" then asked to use the restroom and the Grievant got her changed and took her personal effects and then told the Booking Officer that "H" needed to use the restroom and he okayed it. Due to her medical condition, the Grievant did not want to take "H" to the "bullpen" restroom and instead took her to the restroom by the dayroom which was cleaner and less crowded. At this point "H" was crying and upset and asked to use the telephone and the Grievant refused her request. It is undisputed that it is against procedures to allow prisoners to make calls before leaving the area. "H" kept pleading to use the phone and the Grievant continued to refuse and then "H" ran into the dayroom where the phones are. When the Grievant told her she could not use the phone, "H" yelled an obscenity at her and then pulled out her catheter and threw it and her jail jacket at the Grievant. At that point, "H" still had on a white T-shirt and her bra. The Grievant asked "H" if she felt dizzy or hurt and "H" responded with obscenities directed at the Grievant. The Grievant testified she saw no blood on "H". The

Grievant then left "H", securing her in the dayroom. The dayroom has glass walls and can be monitored from outside. The Grievant then received a call to search someone in Booking and left "H" in the dayroom. After the Grievant arrived in Booking, she radioed Rose that she was having trouble and needed help putting restraints on "H" because "H" had pulled out her tube. Sergeant Bilda overheard the transmission on his radio and asked by radio whether Nurse Tews had copied it. Tews indicated she did and she and another deputy went immediately to find "H". When she got to Booking, she saw that "H" was not there, but did see the Grievant searching a female prisoner. Tews asked the Grievant where "H" was and was told she was up in the dayroom in the Annex. Tews, Sergeant Bilda and the other deputy then went to find "H", finding her alone in the dayroom. "H" was laying on top of a picnic table in the room. She was developing a hematoma on her chest where the catheter had been pulled out and there was a small amount of oozing blood at the insertion point. Tews asked "H" if she had taken the tube out and was told that she had. When asked where the catheter was, "H" responded she had thrown it. Tews found the catheter, which had a small amount of dried blood on it. Tews called for an ambulance and sent one of the deputies to get some bandages and gloves from her nursing station and when they arrived, she applied the bandages to "H" and had her transported when the ambulance came.

The deputies are given "first responder" training in basic first aid and a procedure to follow in that regard involving the assessment of the situation and calling for help. There is no dispute that the deputies do not receive training regarding catheters and that none of them were familiar with a Hickman catheter.

The Grievant received a five-day suspension for violating work rules involving neglect of duty and personal safety.

The Grievant grieved the three suspensions she received, and the parties, being unable to resolve their dispute, proceeded to arbitration on the suspensions before the undersigned.

POSITIONS OF THE PARTIES

County

Failure to Report

Regarding the June 10 and the June 27, 1991 incidents where the Grievant failed to appear on time for voluntary overtime assignments, the County asserts that it is undisputed that the Grievant was not relieved of her obligations to report on those days and that she understands that she violated the rules. Her attempt to mitigate this by talking about the differing procedures and the separate bureaus of the Department regarding voluntary overtime evaporates under her own testimony. She had to know the various procedures in the various areas because she had signed up for voluntary overtime as much as possible. She knew the procedures and she knew it was important to call in, but did not do so. The Grievant was advised as to those procedures by Lieutenant Lango and immediately upon being so counseled, she again reported late on June 27. While Lieutenant Lango had consistently counseled her, he had never cancelled her voluntary overtime. The Grievant's testimony that other deputies had missed assignments is not germane. Other than her testimony, there is no documentation as to these other deputies missing assignments nor that they were not counseled nor otherwise disciplined.

The County also asserts that the Grievant does not view these incidents as being critical. However, it is clear from the reports in Joint Exhibits 3 and 4 that by her failure to appear, bailiff personnel were additionally burdened

and it caused the alteration of procedures in the courts, including in a first-degree murder trial. Previously her failure to appear had also caused short-handed security assignments at the County Stadium.

Jail Incident

The County asserts that the real key to the discipline in this matter is this incident. This matter is about the Grievant's failure to monitor the situation and to maintain the necessary surveillance so as to avoid a potential medical tragedy from occurring. When the situation occurred, Nurse Tews was not called to the scene, as required by Department procedure, rather, she fortuitously overheard a radio transmission from the Grievant to Sergeant Bilda which merely informed Bilda that "H" was not prepared for transport at that point. The testimony is clear that once the Hickman catheter was torn from "H"'s person, blood was present and a hematoma appeared in the area where the catheter was torn from the chest. Tews testified as to her great concern regarding the possibility of an embolism, a life-threatening situation. Under the First Responder training that all jail personnel receive, the appropriate response would have been to call for assistance and then to stay and monitor the situation. The County does not fault the Grievant for exercising discretion and disengaging from a confrontation with "H" by withdrawing from the dayroom and securing it. Rather, the County asserts that it is her conduct immediately thereafter that violated Departmental rules. The County notes the professed practice of the Grievant to call a nurse for little or no reason, but finds it inexplicable that she did not call her in this instance. Although Sergeant Bilda testified that medical treatment to be provided by available jail personnel amounts to "advanced Band-Aids", he was clear that under the First Responder training, it was the clear duty of jail personnel that when a situation such as this occurred, the deputy was obliged to stay and monitor, i.e., keep an eye on the inmate.

Next, the County cites the testimony of Deputy Feiten, an instructor in Defense and Arrest Tactics and First Responder training in the Department for the last five years. The Grievant received training in these same procedures by Deputy Feiten. Although Feiten had no catheter-specific training, she knew that there could be harm if a catheter were pulled out. Her clear and unrebutted testimony was that in this case the Grievant's knowledge of the situation made it even more important to monitor, since she was alerted that a medical situation existed requiring attention at a hospital and transportation to the medical facility. Knowing that, it should have appeared as an even greater emergency in the attending deputy's eyes. Under department policy and practices, an inmate would not be going to a hospital unless it were critical to the inmate's health and welfare that medical attention be provided. Knowing the inmate's medical problem should sufficiently alarm jail personnel that it was important to monitor the inmate's medical situation. The question was not for the deputy to determine the need for medical care, as that decision had already been made by medical personnel, rather it was important for jail personnel, here the Grievant, to utilize the steps provided in the First Responder training. That training has ten steps:

- arrive
- assess
- alarm
- evaluate
- enter
- stabilize
- initial medical assessment
- long-term monitoring
- communication
- documentation/debriefing

The County asserts that it is the steps of the long-term monitoring and communication where the Grievant failed to perform her duty. After she secured "H" in the dayroom, she walked away, turning her back on a known medical situation, a situation that had changed since the last time medical personnel had an opportunity to assess it. The Grievant was the only person who knew of the changed situation, but it is undisputed that she never called for a back-up to address the situation and never called for medical personnel or anyone else to address that changed medical condition.

The County notes that the Grievant testified she was given no information regarding "H"'s situation, yet somehow she became aware that "H" was alleged to have AIDS. That information could only have come from Nurse Tews when she was advising jail personnel of "H"'s entire medical situation, including the Hickman catheter. Further, it is also clear that the Grievant never sought out any information.

The County also asserts that the Grievant related for the first time at the hearing that she had asked "H" if the tube was operating and allegedly was told "no." The Grievant provided no reason for her asking this question. Further, she recalls it now a year after the incident, but somehow omitted it in her report 12 days after the incident, when her recollection was supposedly much fresher. Also, if that testimony is accurate, the Grievant knew something was wrong with the tube. Common sense would tell someone that people do not casually walk around with IV tubes in their chest and that if they are not operative, almost everyone would know or should know that something was wrong.

While the Grievant testified that she had received First Responder training, she conveniently related in her testimony only the steps of arriving at the scene, assessing and evaluating, and omitted the key steps of monitoring and communication. However, on cross-examination, the Grievant did acknowledge that those steps are part of the training. The Grievant testified that she assessed the situation and determined that the inmate was conscious, not bleeding, and was breathing. However, at that point the Grievant turned her back on the inmate and walked away abandoning the monitoring aspect. When the catheter was pulled out, "H"'s situation changed. However, the extent and impact of that change could no longer be determined by the Grievant. That changed situation should have given rise to the balance of the Grievant's First Responder training, i.e., monitoring and communication. It is asserted that the Grievant's testimony that her training did not require monitoring is rebutted by her subsequent testimony on cross-examination, as well as by the testimony of Deputy Feiten and Sergeant Bilda. Further, her attempt to cover-up her misdeed by saying she had communicated by radioing Sergeant Bilda, falls short as she did not reveal to Sergeant Bilda the fact that an emergency existed or that a medical situation had changed. Rather, by her own testimony, she merely communicated that "H" was not ready for transport. Further, Bilda testified that he did not communicate personally with the Grievant, but overheard her transmission. Also, the Grievant admitted she did not summon the nurse.

The County concludes that while the missed overtime assignments require exacting a measure of discipline to correct that conduct, it is the matter of inmate "H" that is much more significant. It is clear that the Grievant did not follow procedure, did not follow her training and that it was only fortuitously that a potentially tragic situation did not occur. Thus, the County requests that the suspension be sustained.

Association

Failure to Report

The Association notes that the Grievant received a one-day suspension for failing to report as scheduled on June 10, 1991 and a three-day suspension for failing to report as scheduled on June 27, 1991. The Association does not dispute that the Grievant failed to report for those voluntary overtime assignments. It asserts that the issue is not whether the Grievant violated the rule, but whether four days of suspension is the appropriate discipline.

While the Grievant received counseling for missing an assignment in April, she continued to work numerous voluntary overtime assignments without incident until June 10 when she did not report because she had become confused about the different overtime procedures in the different bureaus and because she believed she could not work overtime while on O/U status. Within a few weeks, the Grievant again missed an overtime assignment and later that day saw her physician who ordered her to take a three-week medical leave of absence for stress and fatigue. There is no indication in the record that she has had any problems making her assignments since returning from medical leave.

The Association notes Lieutenant Lango's view that if the Grievant needed medical attention, she should have sought it after the second violation "when it was apparent that a pattern was developing." However, the pattern did not actually develop until the third incident. The first absence in April was due to oversleeping. While oversleeping may indicate fatigue, the confusion and the forgetfulness that led to the Grievant's seeking medical advice were not yet evident. It was only in June when she became confused about assignments twice in three weeks that she sought medical treatment for a pattern that had begun to develop.

The Association also cites as an additional mitigating factor the absence of any significant disruption in activities as a consequence of the Grievant's failure to report on time. Both the missed assignments in June were bailiff positions in the county courts. On June 10, the court heard its regular calendar first and then began the murder trial after the Grievant arrived. On June 27, the court had not even opened yet when the Grievant arrived there 40 minutes late.

The Association concludes that although the Grievant took remedial action by obtaining medical treatment and has had no further instances of missed voluntary overtime assignments, the Department has treated the two violations as two separate steps in terms of discipline. While an Employer is expected to utilize progressive discipline for repeated violations, four days is excessive under the circumstances, where medical treatment was needed and obtained and there have been no subsequent violations. The Association requests that the penalty be reduced to a one-day suspension for each violation, given that the violations occurred closely in time and that the employe remedied the underlying problem.

Jail Incident

The Association takes the position that discipline is not appropriate for the jail incident because the Grievant exercised her discretion in accord with her training. The Association notes that the Grievant is accused of neglecting her duty and creating a risk of personal harm by leaving "H" alone in the dayroom after she pulled out the catheter. It is asserted that the Grievant was acting in accord with her training both in medical assessment and in controlling agitated inmates. If her understanding is incorrect, she should be counseled and retrained and not suspended.

The Association asserts that there is no dispute that the Grievant is an experienced and conscientious deputy who is extremely concerned about inmate's well-being to the extent that she has a reputation for referring inmates for medical care for the most minor complaints. In addition, she took extra precautions for "H"'s health because she knew "H" had AIDS, even though her training and Department rules did not require it. Surely the Grievant would have monitored "H" until medical help arrived if she believed "H" was in any medical danger. Like the other deputies, the Grievant received only minimal medical training limited to first aid, CPR, and First Responder techniques. The latter involves assessing a person's condition and determining whether medical care is needed and if so, how urgently. Based on her training, the Grievant assessed the situation after "H" pulled out the catheter. "H" was conscious and breathing and Grievant could see no blood other than some dry blood on the tube. Accordingly, she concluded that "H" was not in need of medical care. While Nurse Tews testified that serious physical harm could result from traumatic removal of the catheter, she admitted that the deputies would not be aware of those risks. She did not tell anyone in the Booking Room about the potential harm, but merely said the tube should be allowed to remain in place. Tews did not recall whether the Grievant was in the area when she said that, and the Grievant testified she knew nothing about the catheter until she saw the tube taped to "H"'s chest. The Grievant had no knowledge of Hickman catheters and was not aware of the potentially serious problems that traumatic removal could cause.

Discipline is characterized as being designed to train and correct employes, especially in the absence of intentional wrongdoing. Here, there is no suggestion that the Grievant deliberately ignored established rules or procedures. On the contrary, the Department has no procedures concerning catheters of any kind, since people requiring catheters are always removed to the Medical Complex.

The Association contends that the County's argument that the Grievant violated rules by failing to remain on the scene and monitor "H" until medical help arrived, begs the question by assuming that "H" needed medical care and that the Grievant was capable of recognizing that need. The Grievant simply did not view the situation as a medical emergency. Based on her training and assessment of the situation, she concluded that leaving "H" alone to calm down was appropriate under the circumstances. She also notified Sergeant Bilda of the situation. Even if the Grievant is found in hindsight to have acted incorrectly, her mistaken judgment does not warrant a five-day suspension. She has no history of ignoring or deliberately violating Department rules, other than absenteeism matters discussed previously, and Sergeant Bilda characterized her as a conscientious employe whose job performance is good. Under the circumstances, discipline should be corrective and not punitive, and a five-day suspension is excessive. If any discipline is appropriate, the Association urges that it be reduced, at most, to a written reprimand and retraining.

DISCUSSION

Failure to Report

The only issue regarding the one and three-day suspensions the Grievant received for failing to report on June 10 and June 27 is whether the discipline imposed is appropriate. There is no dispute that the Grievant failed to report on time for the voluntary overtime on those dates.

As mitigating circumstances for the June 10th incident, the Association offers the Grievant's assumption that she could not work overtime on a day that she was taking O/U, her confusion over the overtime assignment procedures, and the assertion that her reporting late did not disrupt the court's business. The evidence indicates that the procedure for voluntary bailiff overtime in the Court Services Unit is that the deputies are assigned upon request for specific dates and are to report on those dates at 8:00 a.m., unless notified not to report by the Court Services Sergeant. Given the Grievant's tenure in the Department and her experience working overtime in the various bureaus in the Department, she is deemed to know the overtime assignment procedures. If she was not sure whether she could work overtime on a day she took O/U, she should have checked with the Sergeant. As the County asserts, the fact that there was no major problem by the Grievant's failure to report is only fortuitous and not a basis for diminishing the offense or the discipline. Further, it did cause the delay of the murder trial. Having received a written reprimand for her failure to report for a voluntary overtime assignment in April, a one-day suspension for a similar incident within two months is not inappropriate.

With regard to the June 27th failure to report, the Association offers as an excuse the Grievant's growing fatigue and stress from working excessive amounts of overtime. While Lt. Lango's Investigative Summary of the incident seems to agree that the Grievant may have overextended herself, he also noted that she voluntarily took those overtime assignments. The irony may be that the Grievant was being disciplined for working too much; however, an individual has to realize when they are taking on more than they can handle and still do the job. That realization should have occurred when the Grievant started suffering the symptoms she described to her doctor. It especially should have occurred to her when she had her disciplinary hearing with Lt. Lango on June 25th regarding her failure to report on June 10th. That was just two days prior to the June 27th failure to report.

The Arbitrator notes that in neither instance did the Grievant simply decide not to report, and in fact did report for the assignments as soon as she could get there after being called and reminded of the assignments. Further, as the Association points out, the Grievant did take steps on her own to correct the problem after finally recognizing that a problem existed. For those reasons, and given her length of service in the Department, and her otherwise satisfactory work performance at the time, the three-day suspension is considered excessive and is reduced to a one-day suspension.

Jail Incident

The Grievant was given a five-day suspension for violating Rule 69 - Personal Safety Conduct and Rule 75 - Neglect of Duty - by not continuing to monitor "H" and by not immediately radioing for medical assistance after "H" pulled the catheter from her chest.

The primary factual dispute in this matter is whether the Grievant was present when Nurse Tews said that "H"'s catheter should remain in place. It appears likely that since the Grievant heard Tews state that "H" had AIDS and had to go to the MCMC, she was present when Tews stated the catheter should be left in place, as it was part of the same statement. That said, it does not

necessarily follow that the Grievant would be aware of the potential seriousness of the consequences if the catheter were pulled from "H"'s chest, and the County concedes as much. The Grievant did, however, have to be aware that "H" had a medical condition because of Nurse Tews' statement, because of the presence of the catheter and because "H" was being taken to the Medical Complex.

There is no dispute that the Grievant left "H" alone in the secured dayroom upon being called to go to Booking to search a female prisoner. Contrary to the County's assertion that the Grievant never did call for help in the situation, the reports filed by other deputies shortly after the incident indicate she eventually did report the matter. There is, however, conflicting evidence as to when the Grievant radioed that she had a problem with "H" because "H" had pulled out her catheter and who she radioed. The Grievant testified she radioed Sgt. Bilda after she arrived in Booking and that she could not radio for help before that because she was receiving the transmission from the Booking Officer. Bilda testified he only heard part of the transmission and Sgt. Endter's August 15, 1991 report indicates he talked to Deputy Rose who told him that the Grievant had radioed her. Deputy Maas' report indicates the Grievant radioed Deputy Rose several minutes after she was in Booking. Thus, while the Grievant did call for help after "H" pulled out the catheter, the evidence indicates she waited several minutes to do it and left "H" alone in the dayroom in the meantime. Given the situation, the Grievant could have continued to monitor "H" from outside the dayroom and radioed Booking or Sgt. Bilda and informed them of the situation. There is no indication from the evidence that the call from Booking was urgent or an emergency requiring immediate response from the Grievant.

The Grievant was suspended for violating Rules 69 and 75 by not continuing to monitor "H" and by not immediately radioing for medical personnel after "H" had pulled out her catheter. While the Grievant could not be expected to know the potential seriousness of the situation, she knew "H" had a medical condition and that the situation changed when the catheter was pulled out. Deputy Feiten testified that the deputies, including the Grievant, are trained to continue to monitor such a situation until medical help arrives. Rather than make the assessment that it was not a medical emergency, as the Grievant testified she did, she should have called for medical personnel to make that assessment. It is concluded that by leaving "H" unattended and failing to immediately call for help, the Grievant did, by her actions, "create a situation of risk of injury to. . . others", in violation of Rule 69 - Personal Safety Conduct. Having reached that conclusion, it is unnecessary to determine whether the Grievant's actions also violated the more general Rule 75 - Neglect of Duty.

With regard to the level of the discipline imposed, coming as this violation did on the heels of the Grievant's other rule violations for failing to report, it is concluded that the five-day suspension is not excessive.

Based upon the foregoing, the evidence and the arguments of the parties, the undersigned makes and issues the following

AWARD

The grievance is sustained in part:

> The three (3) day suspension for the June 27, 1991 violation is reduced to a one (1) day and the County is to make the Grievant whole under the Agreement for the two (2) days of lost pay.

The grievance is denied in part:

(1) The one (1) day suspension for the June 10, 1991 violation is upheld.

(2) The five (5) day suspension for the July 31, 1991 violation is upheld.

Dated at Madison, Wisconsin this 16th day of November, 1992.

By David E. Shaw /s/
David E. Shaw, Arbitrator

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