BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between SHEBOYGAN COUNTY INSTITUTION EMPLOYEES, LOCAL 2427, AFSCME, AFL-CIO and SHEBOYGAN COUNTY	Case 174 No. 48197 MA-7593

Appearances:

Wisconsin Council 40, American Federation of State County and Municipal Employees, by Ms. Helen Isferding, Staff Representative, 1207 Main Street, Sheboygan, WI 53083 appearing on behalf of Local 2427.

Ms. Louella Conway, Personnel Director, 615 North 6th Street, Sheboygan, WI 53081, appearing on behalf of Sheboygan County.

ARBITRATION AWARD

Pursuant to the provisions of their collective bargaining agreement, Sheboygan County (hereinafter referred to as the County) and Local 2427, AFSCME (hereinafter referred to as the Union) requested that the Wisconsin Employment Relations Commission designate a member of its staff to act as arbitrator of a dispute over hiring rates. The undersigned was so designated. A hearing was held on December 23, 1992 at the Courthouse in Sheboygan, Wisconsin, at which time the parties were afforded full opportunity to present such testimony, exhibits, other evidence and arguments as were relevant to the dispute. Post hearing briefs were submitted, which were exchanged through the undersigned. On March 16, 1993, the record was closed.

Now, having considered the evidence, the arguments of the parties, and the record is a whole, the undersigned makes the following Award.

ISSUE

The parties agreed that the following issue was to be determined herein:

"Did the employer violate the contract when it gave Christine "Tina" Mahuta a10 day suspension on 12-2-1991? If so, what is the appropriate remedy?"

PERTINENT CONTRACT LANGUAGE

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ARTICLE I
AGREEMENT

This Agreement made and entered into by and between the Personnel Committee of the Sheboygan County Board of Supervisors … and Local 2427 … for the purpose of maintaining harmonious labor relations and to maintain a uniform scale of wages … and to facilitate a peaceful adjustment of all grievance and disputes which may arise between the County and the employees and primarily to maintain the best care and humanitarian consideration of the residents and patients in the facilities involved.

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ARTICLE 3
MANAGEMENT RIGHTS RESERVED

Unless otherwise herein provided, the management of the work and the direction of the working forces, including the right to hire, fire, promote, transfer, demote, or suspend, or otherwise discharge for proper cause, and the right to relieve employees because of lack of work or other legitimate reason is vested exclusively in the Employer. If any action taken by the Employer is proven not to be justified, the employee shall receive all wages and benefits due to him/her for such period of time involved in the matter.
. . .

… The Union agrees at all times as far as it has within its powers to preserve and maintain the best care and all humanitarian consideration of the patients at said institutions and otherwise further the public interests of Sheboygan County.

In keeping with the above, the Employer may adopt reasonable rules and amend the same from time to time, and the Employer and the Union will cooperate in the enforcement thereof.

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BACKGROUND

The County provides general governmental services to the people of Sheboygan County in southeastern Wisconsin. Among the services provided is the operation of the Sheboygan County Comprehensive Health Care Center, a health care facility for developmentally disabled citizens.

The Union is the exclusive bargaining representative for the non-professional employees of the facility. The grievant, Tina Mahuta, is an attendant who has worked at the facility since June of 1981. She works an early day shift, reporting at 5:30 a.m. and leaving at 2:00 p.m. Among her duties is seeing to the needs of mentally retarded residents and implementing the care plans set for the residents.

In August of 1991, a resident drowned while left in a bathtub unattended for a period time. In the aftermath of the drowning, Linda Behr, the Supervisor of Health Services, placed a notation in the log book: "All staff check on residents in shower/tub areas q 15 mins. @ least if they are unsupervised." Staff members are responsible for reading the log book for instructions when they come on duty. In addition, a sign was posted on the tub room door, reading:

Check residents every 15 minutes
while in shower/tub area unless
more frequent checks are required.

In practice, this required that the staff member placing the resident in the tub check on him or her. This policy was discussed at a staff meeting in September. A formal directive was issued setting procedures for maintaining visual awareness of the patients' whereabouts and activities was issued, including a protocol requiring that the tub room be locked at all times, that the staff member initiating the bath or shower complete it and re-lock the doors, and that residents be monitored every 15 minutes at least, unless contraindicated by their care plans. This policy was withdrawn for further review after objections were raised as to whether constant monitoring was possible given staffing levels, and whether it was consistent with the directions of a former staff psychologist who had advised giving residents as much freedom as possible. The sign remained on the tub room door after the policy was withdrawn.

On November 26, 1991, the grievant was working on ward 2 South, along with fellow attendants Jerilyn Richart and Shelley Kaat, and LPN Brenda Mueller. She approached by a resident, Timmy, who asked to be put in the tub. She recalls this as being between 1:00 and 1:15 p.m. She opened the door for him and drew a bath. After checking the water temperature, she went and got him soap and a change of clothes. When she returned, Timmy was masturbating, as was his practice when bathing. She left him in the tub room.

Another resident asked for his mail, so the grievant went and got the mail. She brought some towels to Timmy, who was fine. She then left the wing to check on some clothes orders for residents. She returned at about 1:50, and again checked on Timmy. She left work at 2:00 p.m. Timmy was still in the tub when she left.

Between 2:15 and 2:30, Brenda Mueller checked the tub room door to make sure it was locked. Finding it open, she entered and found Timmy in the bath. She had noticed the grievant taking Timmy into the tub room at about 12:40. Mueller got Timmy out of the tub and had him dress and return to his room. She checked with Richart and Kaat to see if the grievant had told them that Timmy was still in the tub room when she left work. They said she had not.

Mueller related her discovery to her supervisors. They discussed possible disciplinary responses including discharge. In consideration of the grievant's length of service, they imposed a ten day suspension without pay for poor work performance. The instant grievance was thereafter filed. It was not resolved in the grievance procedure and was referred to arbitration. Additional facts, as necessary, will be set forth below.

THE POSITIONS OF THE PARTIES

The Position of the County

The County takes the position that the grievant violated a basic safety rule by leaving work without informing other staff members that a resident was in the tub room. In light of the then-very recent drowning of another patient, this was a serious breach of procedures. The County notes that it is heavily regulated by the state and federal authorities, and that a failure to adequately guard the safety of residents subjects it to very substantial penalties. Thus it has a legitimate interest in insuring that staff members do not ignore safety rules. The rule at issue in this case was communicated through the log book, inservice training and a sign on the tub room door. Given this degree of notice, the grievant cannot credibly argue that she was unaware of the policy. If she did not live up to her responsibility to review the log book because she was too busy, as she claimed at the hearing, she certainly should have known of the policy from the sign and the staff meetings.

The grievant, by her own admission, did not ask anyone to take over responsibility for this resident before leaving work. Even if, as the grievant claims, other employees were aware of the resident's presence in the tub, the fact remains that she had the obligation to either make sure he was out of the tub before she left, or to expressly hand off responsibility to one of the other staff members. Simply assuming that other staff members are aware of the situation or will take over her duties is not consistent with her responsibility to insure resident safety.

The county asserts that it had proper cause for discipline, and that the measure of discipline is fair and reasonable, given the life threatening situation the grievant left the resident in when she left work. The ten day suspension was decided on after reviewing the grievant's work history, including a previous one day suspension for violating safety rules just six months before this incident. For all of these reasons, the County asks that the discipline be sustained and the grievance denied.

The Position of the Union

The Union takes the position that proper cause for discipline is not present and that the grievant should be made whole for the ten day suspension. The grievant testified that she checked on Timmy at least every 15 minutes, and there is nothing in the record to contradict this. Furthermore, Timmy was not the grievant's responsibility. The Health Care Center has a policy

of assigning residents a contact person from the staff, who is responsible for knowing where the resident is and what the resident is doing via checks every hour. Timmy's contact person on the day in question was Jerilyn Richart. Contrary to the suggestion that Richart did not know Timmy was in the tub, she must have known since otherwise she would have missed him on her hourly check. Procedures require reporting residents as missing if they are not accounted for in these hourly checks, and there is no indication that Timmy was ever reported as missing.

The Union notes that there was no effective rule governing the use of the tub room or monitoring residents in the tub room at the time of this incident. The draft policy was withdrawn after it was questioned, and the final rule was issued two months after the grievant was suspended. As understood by the grievant, the care plan for this patient called for allowing him to be as independent as possible and do as much for himself as he could. Thus a degree of independence while he was in the bath was consistent with the care plan and not contrary to any valid rule. Since the grievant acted in accordance with the procedures as she understood them, and since other staff members who shared responsibility for monitoring this resident were not disciplined, the suspension should be set aside and the grievant made whole.

DISCUSSION

The suspension in this case rises or falls on the allegation that the grievant violated County rules and procedures by failing to expressly hand off responsibility for Timmy to another staff member before leaving work. The record does not establish the claim that she did not check on him every fifteen minutes while she was on duty. Although her testimony was contradictory on this point, she claims that she did check on him every fifteen minutes and none of the County's witnesses was able to track her movements closely enough to effectively refute her claim. In considering the issue of proper cause then, the question is whether the grievant had reason to know that she was required to hand off responsibility for this resident, and whether she failed to do so.

The facility suffered a drowning in August and immediately instituted procedures regarding the monitoring of residents in the tub room. A sign was posted on the door requiring checks every fifteen minutes, and this requirement was noted in the logbook. The staff was advised in October that the person responsible for placing a resident in the tub was also responsible for checking on the resident or handing off responsibility to another staff member. The Union makes much of the fact that the specific formal protocol was withdrawn for revisions, and was not reissued until after this incident, but frankly I cannot attach great weight to that argument. Every witness except the grievant, including four other bargaining unit members, testified that they were aware of the procedures and understood them to be required. Even in the absence of a written rule, it strains credulity to suggest that an attendant in a health care facility where a drowning had taken place only four months earlier could believe that it was permissible to leave a resident in the tub when her shift ended without telling someone he has in there. Common sense would tell a person of normal intelligence and maturity that this was a reckless course of action.

The grievant contended that it was Jerilyn Richart's responsibility to monitor this resident, since she was his assigned contact person that day. She also argues that Richart was present on the

ward at all times and was perfectly well aware that Timmy was having a bath. Mueller and Richart both testified that Richart went downstairs with a group of residents at about 12:45, and did not return until 1:30 p.m. According to Richart and Mueller, Richart then conducted a party for residents where they were paid their tokens as a reward for good conduct. This took her a little longer than usual because the grievant did not show up and Richart had to pay tokens to the grievant's residents as well as her own. This get-together began at 1:30 and lasted until about 1:50 when she went back downstairs with another group. Richart returned to the ward at about 2:10 p.m.

The grievant alone believes that Richart was on the ward at all times. Richart's normal work duties would have precluded her presence on the ward during her groups and Mueller and Richart both swore that Richart was not present on the ward during most of the time that Timmy was in the tub room. While I am strongly inclined to credit Richart and Mueller on this disputed point, it is not necessary to resolve this in order to resolve the grievance. The grievant unlocked the tub room and placed Timmy in the tub. She checked on him during her shift. She acknowledges not telling anyone that he was still in the tub when she left work. She simply assumed that Richart and Mueller knew he was still in the tub.

Accepting, solely for the sake of argument, the grievant's version of events, both Mueller and Richart knew that Timmy had been placed in the tub between 12:45 and 1:15 p.m. There is no reasonable basis for the grievant to have gone the extra step by assuming that the two other staff members also knew that the tub room door was still unlocked and Timmy was still in the tub an hour to an hour and a half later when she quit. Whether Richart shared some responsibility for monitoring Timmy is beside the point. Whether Richart and Mueller could have known that Timmy was still in the tub room is similarly beside the point. Common sense, the tragic recent history on the ward and the procedures established in the wake of the drowning all dictated that the grievant not take the chance of just assuming that someone else would be responsible for this resident's safety. Having opened the room for him, placed him in the tub and taken responsibility for monitoring him while he was in the tub, the grievant was also responsible for making sure that he was supervised after she left for home. Instead, the resident sat unsupervised in the tub for at least half an hour between the time when the grievant last looked in on him and the time that Mueller chanced upon him while checking the door. The tub room was also unlocked and unsupervised during this stretch of time, posing a hazard to other residents.

The grievant was the only person who knew for a fact that there was a mentally retarded resident sitting in the same tub where a fellow resident had drowned four months earlier. Rather than taking the simple precaution of telling another staff member he was there and insuring that he would be supervised after she left, she put the patient and the facility at risk. In so doing, she also exposed herself to discipline for poor work performance. No evidence was adduced at hearing to show that a ten day suspension is outside the norm for this offense, and the grievant has previously been suspended for violating safety rules. For these reasons, and based upon the record as a whole, I have made the following

AWARD

The County did not violate the contract when it suspended Christine "Tina" Mahuta for 10 days on December 2, 1992. The grievance is denied.

Signed this 28th day of April, 1993 at Racine, Wisconsin:

By Daniel Nielsen /s/
Daniel Nielsen, Arbitrator