BEFORE THE ARBITRATOR

In the Matter of the Arbitration
of a Dispute Between

LOCAL 150, SERVICE EMPLOYEES
INTERNATIONAL UNION

and

MOUNT CARMEL HEALTH AND
REHABILITATION CENTER

Case 26
No. 52927
A-5385

Appearances:

Previant, Goldberg, Uelmen, Gratz, Miller & Brueggeman, S.C., Attorneys at Law, by Mr. John J. Brennan, appearing on behalf of the Union.

Mr. John W. Martin, Director of Labor Relations, Hillhaven Corporation, appearing on behalf of the Employer.

ARBITRATION AWARD

Local 150, Service Employees International Union, hereinafter referred to as the Union, and Mount Carmel Health and Rehabilitation Center, hereinafter referred to as the Employer, are parties to a collective bargaining agreement which provides for the final and binding arbitration of disputes arising thereunder. The Union, with the concurrence of the Employer, requested that the Wisconsin Employment Relations Commission designate a member of its staff to act as an arbitrator to hear and decide a grievance over a discharge. James W. Engmann was appointed as the arbitrator but due to his unavailability, the undersigned was designated the arbitrator. Hearing was held in Milwaukee, Wisconsin, on November 3, 1995. The hearing was transcribed and the parties filed post-hearing briefs which were exchanged on January 3, 1996.

BACKGROUND:

The facts underlying this grievance are not in dispute. The Employer operates a 692 bed facility which provides long- and short-term care, skilled nursing services, subacute medical and rehabilitation services, outpatient rehabilitation, home health and adult day care services. The grievant was employed by the Employer as a Patient Care Aide (PCA-1) beginning on September 23, 1993, until her termination on May 19, 1995, for failure to immediately report observed patient abuse. On May 15, 1995, the grievant and another PCA, April Kelly, were attending to a resident, hereinafter referred to as X. X is a 91 year old woman who has dementia,

arthritis, chronic atrial fib and other diagnoses. Due to X's dementia and confusion, she at times becomes combative. At about 7:00 p.m. on May 15, 1995, the grievant and Kelly were getting X ready for bed and while they were putting a Houdini restraint on X, X allegedly punched Kelly. Kelly retaliated by punching X in the stomach. The grievant observed this and said, "why did you do that?" and Kelly indicated that X had hit her. After putting X to bed, the aides left the room and Kelly informed another PCA that she and the grievant had beaten X. Upon hearing this statement, the grievant denied having anything to do with it. The grievant knew she had to report what she saw and was going to report it that night but her fellow workers gave her a surprise baby shower and she did not make any report of the incident. May 16, 1995 was an off-day for the grievant and she made no report of the incident. On May 17, 1995, the grievant rode to work with her cousin, Charlene Sullivan, who is also a Union steward. The grievant did not discuss the incident at that time. Shortly after punching in to work, the grievant sought out Sullivan and told her what had happened. Sullivan called Lyne Brunt, the Union's Business Agent, who advised that a supervisor should be contacted as soon as possible to report the incident. The grievant did not report it immediately but put residents to bed and passed dinner trays. Sometime earlier on May 17, 1995, aides who had heard about the abuse reported it to supervision. Before reporting the incident to her supervisor, Joan Martin, the Nurse Manager, contacted the grievant on May 17, 1995, and directed her to make a written statement of what occurred with X on May 15, 1995. The grievant made a written statement and was directed to leave work. On May 19, 1995, the grievant was terminated for failure to report observed abuse. The discharge was grieved and appealed to the instant arbitration.

ISSUE:

The parties stipulated to the following:

> Did the Employer have just cause to discharge the grievant, Deena Dronso?
>
> If not, what is the appropriate remedy?

PERTINENT CONTRACTUAL PROVISION:

ARTICLE 8 -- DISCHARGE

> 8.1 The Employer may discharge or suspend an employee for just cause, but in respect to discharge shall give a warning of the complaint against such employee, except that no warning notice or progressive discipline need be given to an employee if the cause for such discharge is:

A. Dishonesty

B. Theft

C. Abuse, neglect or misappropriation of property of a resident as defined by Wisconsin state registry

D. Physical altercation on facility property

E. Bringing a firearm or weapon into the facility

F. Unauthorized possession of narcotics or drugs

G. Use of alcoholic beverages on duty or reporting for duty under the influence of alcohol

H. Insubordination

I. Any other event which seriously affects the functioning of the facility.

The Union will be notified as soon as possible after a member is discharged.

EMPLOYEE HANDBOOK PROVISIONS:

Our Expectations

We seek to efficiently provide needed health services on a personalized basis and to create a pleasant environment for both our residents and employees. To do so demands much of each of us. Just as you expect us to be a fair and responsive employer, we expect that you will:

* Immediately report to the Administrator or other management representative any of the following: PATIENT ABUSE, THEFT, DISHONESTY, VIOLENCE or VIOLATION OF SAFETY RULES. Your confidentiality will be protected whenever possible.

. . .

House Rules

. . .

In addition to meeting the positive guidelines outlined in "Our Expectations," you also need to have knowledge of the following house rules. Obviously, this involves avoiding all these prohibited actions, any of which may result in disciplinary action, up to and including termination:

. . .

2. **Engaging in any type of patient abuse or failing to report observed or suspected patient abuse.** This includes rough physical treatment, abusive or disrespectful language, and neglect or failure to respond to residents' needs.

. . .

SPECIAL NOTE: Patient abuse, theft and drug/substance abuse are considered very serious infractions. We all must take personal responsibility to avoid and protect others from these occurrences, and, therefore, it is considered equally serious to fail to report observed or suspected patient abuse, theft or substance abuse.

EMPLOYER'S POSITION:

The Employer contends it had just cause to discharge the grievant. It submits that decision to terminate the grievant for failure to report abuse was based on the findings of its full and complete investigation and was in accordance with the Employee Handbook, past practice, company policies, State Regulations and the collective bargaining agreement. It claims the evidence of past practice and policies is that an individual who actually witnessed abuse and did not report it, is terminated because their conduct is as wrongful as the actual abuser. It notes that an employe, Amy Price, was terminated for failure to report observed abuse. It points out House Rule #2 and the Special Notice support its position. It maintains that the evidence establishes that the grievant was trained in orientation and at in-service sessions to report the abuse she observed and she knew it was wrong not to report abuse. It insists that the grievant had the opportunity to report the abuse on several occasions, but she never came forward, and it was only when she was asked to make a statement that the truth came out. The Employer asserts that other employes who

knew of the abuse but failed to report it did not actually observe it as did the grievant so their cases are not the same or even similar. It argues that it has a duty to protect residents from abuse and where an employe has violated a rule meriting discipline, the Employer may decide upon the proper penalty. It takes the position that the grievant's discharge demonstrates that it will not tolerate the failure to report abuse and its decision to terminate the grievant was justified. It asserts that its decision to terminate should not be overturned because it will change the Employer's practice and policy on witness responsibility to report abuse. It maintains the grievant failed to give the required patient care to X and allowing her to return would condone her failure to act. It asks that the grievance be denied.

UNION'S POSITION:

The Union contends that two determinative facts are undisputed by the Employer; the first is that the grievant was prepared to report the abuse on May 17, 1995, the same day others reported it, and secondly, she was treated much more harshly than the others who reported it before her and received only two-day suspensions. The Union claims that nothing in the Employer's rules or the State's rules require immediate reporting and employes are not provided notice of such a requirement. In support of its argument, the Union points out that a co-worker believed there was a 24 hour grace period. The Union points out that nothing in the rules or contract distinguishes between reporting witnessed abuse and suspected abuse. It notes that the two terms "observed abuse" and "suspected abuse" are used in tandem. The Union refers to the contract which lists offenses for which discharge may result from the first offense but failure to report abuse is not among them.

The Union submits that rules on which a penalty is based must be consistently enforced and widely disseminated, and it alleges that no employe has been put on notice by the Employer that there is a difference between witnessed abuse and suspected abuse or that penalties may be distinct dependent on that fact. It insists that even if the Amy Price case serves as an example of how the Employer has treated witnessed versus suspected abuse in the past, the grievant was not employed at the time Price was discharged and had no knowledge of it, and there was no evidence that this distinction was made known to employes.

The Union argues that it is axiomatic that discipline must be consistent in its application and employes who engage in the same misconduct must be penalized similarly. It maintains that the Employer cannot make a distinction between one who witnesses abuse and one who suspects it when it does not do so in its own rules and contract. The Union takes the position that the grievant did nothing different than the other employes and if she is to be penalized, it should be no more than a two-day suspension.

The Union contends that the grievant was a credible and forthright witness and an objective overview of her testimony demonstrates that she is neither evil spirited nor a wrongdoer. It

observes that she is a simple person who was truly confused and frightened about what she had to do and she acted as quickly as her co-workers who were not discharged. It claims that the grievant was prepared to report the incident and checked with her Union steward which is neither unusual nor poor judgment and she should not be penalized for checking first with the steward. It maintains that the grievant did nothing to warrant her discharge and did the best she possibly could have. It asserts that the Employer suffered nothing from the grievant's belated report and the discharge is exceedingly harsh and inappropriate. It believes the grievant deserves her job back with no more punishment than others who acted identically. It asks that the grievance be sustained and the grievant returned to work with no more than a two-day suspension, if any.

DISCUSSION:

It is undisputed that the grievant observed April Kelly punch X in the stomach on May 15, 1995. It is also undisputed that the grievant failed to report what she observed until her supervisor directed her to write a report about the incident. The issue in dispute involves the penalty imposed by the Employer. The Union has argued that the grievant did not violate any rule requiring immediate reporting of the incident because the Employer has no such rule. The Employer Handbook under "Our Expectations" clearly states: "Immediately report to the Administrator or other management representative any of the following: PATIENT ABUSE, . . ." 1/This is also reinforced under "House Rules" which state: "In addition to meeting the positive guidelines outlined in 'Our Expectations,' you also need to have knowledge of the following house rules." 2/ The House Rules make it a prohibited action to fail to report observed or suspected patient abuse. The Employee Handbook does provide notice to employes to immediately report patient abuse. The grievant signed a statement that she had read and understood the contents of the Employee Handbook. 3/ The grievant also signed the Residents Rights/Residents Abuse policy which states as follows:

> 1. An employee witnessing an act of resident abuse shall report the incident immediately and directly to the Administrator, Director of Nursing, or immediate supervisor. 4/

1/ Ex. 6.

2/ Id.

3/ Ex. 13.

4/ Ex. 15.

The grievant did not report what she observed on May 15, 1995, even after being advised by the Union to do so on May 17, 1995. The grievant claimed she was going to report it but never did until the Employer contacted her. She could always claim that she was on the verge of reporting it but the fact remains that she did not. Had she reported it after conferring with the Union, the result may have been different, but unfortunately that is not the case.

The Union claims that the Employer does not distinguish between failure to report suspected abuse and observed abuse in its rules. It submits that it is disparate treatment to discharge the grievant but to mete out only a two-day suspension to those who failed to report what they had heard. Common sense dictates that there is a significant difference between suspecting abuse and actually observing it. In a case of suspected abuse, there is doubt that abuse occurred. It may be based on a rumor, an opinion, a hunch or circumstantial evidence which leaves doubts as to whether abuse has occurred. Observed abuse dispels all doubt because it is actually witnessed. In this case, the grievant saw Kelly punch X and asked Kelly why she did it. She clearly knew what occurred and didn't suspect otherwise. There is a big difference in seeing what happened and suspecting what happened based on second-hand information. Additionally, it may be extremely difficult to prove actual abuse where it is merely suspected but observed abuse may prove actual abuse occurred. The Patient Rights/Residents Abuse policy clearly refers to witnessing an act of resident abuse. 5/ There is such a big difference between observed and suspected abuse that it warrants different penalties for failing to report suspected as opposed to observed abuse.

The Union has argued that the penalty must fit the crime. It asserts that there was no harm to the Employer. This argument misses the point. It ignores that the issue here is harm to the resident X. In her statement to the police, the grievant stated that Kelly punched X in the stomach causing X to double over. 6/ X, a 91 year old woman, punched in this manner could have suffered internal injuries such as a ruptured spleen which is very serious. It seems that any delay in reporting what occurred would prevent X from receiving a proper physical assessment or receiving medical treatment. The failure to report this physical abuse for a couple of days is almost as serious as the actual abuse. If the grievant is as simple and easily confused as the Union alleges, then it would appear that she lacks the basic qualifications to work in the environment she is seeking to return to.

The Employer has argued that its past practice of discharge for failure to report observed abuse is established by the prior discharge of Amy Price. The undersigned finds that this case is distinguishable in that Price had not reported the observed abuse for a month which establishes that

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5/ Id.

6/ Ex. 7.

she never intended to report it. 7/ While the instant case is consistent with the discharge of Price, the Price case has not been given a great amount of weight. The Employer has argued that determination of the proper penalty for violation of its rule is a function of management which should not be overturned. While arbitrators should not lightly interfere with management's discharge and discipline decision, this by no means suggests that they should fail to act firmly when management's decisions are found to be unjust or unreasonable under all the circumstances. 8/ Leniency and clemency do reside in management, but the arbitrator has the authority to modify a penalty found to be too severe. 9/ Thus, the inquiry here is whether the penalty of discharge is too severe.

As a Patient Care Aide, the grievant had the responsibility to provide proper care and treatment of X. The grievant saw X, a 91 year old woman, punched in the stomach with enough force to double her over. The grievant knew she had to report it. She also knew that Kelly was bragging about abusing X. X did not receive any medical evaluation or treatment until the incident was reported. Also, Kelly had the opportunity to abuse other residents during the time the grievant delayed reporting the incident. Resident abuse is serious and abusing a 91 year old resident in this manner by Kelly cannot be tolerated. The failure to report it likewise cannot be tolerated as it condones such conduct and is almost as bad as the abuse itself. Under the circumstances, the undersigned cannot conclude that the penalty of discharge here was excessive and unwarranted.

Based on the above and foregoing, the record as a whole and the arguments of the parties, the undersigned issues the following

AWARD

The Employer had just cause to discharge the grievant, Deena Dronso, and therefore the grievance is denied.

Dated at Madison, Wisconsin, this 19th day of February, 1996.

7/ Ex. 14.

8/ Elkouri & Elkouri, How Arbitration Works, (4th Ed. 1985) at 666-667.

9/ Id.

By Lionel L. Crowley /s/
Lionel L. Crowley, Arbitrator