BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

LOCAL 1901, AFSCME

and

BROWN COUNTY MENTAL HEALTH CENTER

Case 606
No. 54844
MA-9808

Appearances:

Mr. Richard Badger, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, appearing on behalf of the Union.

Mr. John C. Jacques, Assistant Corporation Counsel, Brown County, appearing on behalf of the County.

ARBITRATION AWARD

The Union and County named above are parties to a collective bargaining agreement that provides for final and binding arbitration of certain disputes. The parties jointly requested the Wisconsin Employment Relations Commission to appoint the undersigned as the arbitrator to hear and decide the grievance of Bharti Jethani. A hearing was held on November 20 and 21, 1997, in Green Bay, Wisconsin, at which time the parties were given the opportunity to present their evidence and arguments. The parties completed filing briefs by February 25, 1998.

BACKGROUND

The parties agree that the issue in this case is whether the Grievant was discharged for just cause, and if not, what is the appropriate remedy. The Grievant is Bharti Jethani, also called B.J. She came from Bombay, India about ten years ago and has a better command of written English than the spoken language. She can make herself understood in most cases but, because of the language differences, does not always understand what is being said to her or asked of her. She worked as a nursing assistant at the Mental Health Center for six years before she was discharged on January 20, 1997. She worked substantial amounts of overtime, picking up extra shifts regularly. The discharge was for her role in an incident on January 9, 1997, when a patient that she was observing died.

The patient or client, referred to as Mr. X in this Award, was a 41 year old male who was mentally retarded and schizophrenic. He had been in a group home before being transferred to the Mental Health Center on December 28, 1996. He had been unpredictable without medication, and by the second week of his stay, he became better with medication. He needed assistance with his dressing, bathing, toileting and food preparation.

The client's guardian was his mother, who chose to put her son in a no-code status upon being admitted to the Mental Health Center. A no-code meant that if the client were to have a cardiac or respiratory arrest, CPR would not be performed on him. A no-code order does not apply to rescuing someone from choking on food by performing the Heimlich maneuver.

Under some circumstances, the facility provides clients with a one-to-one supervision and observation, where the person observing watches one client and no one else. The one-to-one supervision is to provide safety for suicidal clients or those who are self-destructive or unable to control their behavior. During the first part of Mr. X's stay at the facility, it was more likely that a male nursing assistant would be assigned to observe him because of his unpredictable and assaultive behavior. By the second week, the facility had some females assigned to watch him on the one-to-one basis. Nursing assistants were assigned to the one-to-one duty by registered nurses. The Grievant has worked a lot of on-call hours on overtime and has worked a lot of one-to-one situations. She has CPR certification with includes training in the Heimlich maneuver.

The Grievant was assigned to the one-to-one observation of Mr. X on January 9th by Mary Steckart, a registered nurse on the acute adult unit. There is some disagreement between Steckart and the Grievant about how this assignment came about. Steckart testified that the Grievant asked to work a one-to-one with Mr. X, but the Grievant testified that another nursing assistant, Scott LaLonde, asked Steckart to put him on the one-to-one assignment with Mr. X and give the Grievant the floor. However, Steckart said to just keep it the way it was. The Grievant was afraid to ask Steckart to change it again, so she accepted the assignment, although after hearing that Mr. X had been in seclusion all night because of his behavior, she was concerned about the assignment.

On January 9, 1997, the Grievant first relieved the night person watching Mr. X behind a desk on a monitor from about 7:15 a.m. until 7:30 a.m., when the client was brought back to his room. The Grievant had a chair right outside of the door and could watch him through the doorway. Judy Laskowski, a nursing assistant, brought a breakfast tray for him around 7:52 a.m. The Grievant prepared his breakfast, first by putting a straw in the milk carton. She cut up toast in six pieces, and cut one boiled egg in six pieces. The Grievant then gave him toast and milk, and when the client finished with the toast, she brought the egg and put in on his tray. He took two pieces of egg at a time, and the Grievant told him to slow down. He drank milk after eating two pieces of egg, took two more pieces of egg, drank milk. The

Grievant said that after the third time, when he took his last two pieces of egg, he gave a little cough, then he drank the rest of his milk and rushed to the bathroom.

The Grievant watched Mr. X from the bathroom door and said that he was inside the bathroom for only five to ten seconds. When he turned around, she saw that he had become incontinent and was wet. He coughed again and some saliva dropped on her hand. She asked him to change his pajamas because they were wet, and he followed her directions. He sat on the edge of the bed, took his pajama pants off, and then slid to the floor. The Grievant then called for help while inside the room, then went to the doorway and called again for help and Laskowski responded.

When clients receive breakfast trays in their rooms, the trays are usually brought from the kitchen about 7:45 a.m. Laskowski was passing out breakfast trays between 7:50 and 8:00 a.m. when she heard the Grievant call for help. Laskowski testified that she went in the room and then went up to the desk to ask the RN on duty for help. She then got a blood pressure cuff and brought it back to Mr. X's room and took a blood pressure reading.

Laskowski testified that the Grievant had not asked her to go to the desk for help, but Laskowski did it on her own because she felt the patient was in danger. However, both Steckart and the Grievant recall that it was the Grievant who came up to the desk and asked Steckart for help. The Grievant told Steckart that something had happened, that Mr. X ate breakfast fine, he went to the bathroom and wet himself, and slid on the floor.

Pam Spang-Schmit, a registered nurse, responded to the emergency. When she came into the room, Mr. X was laying face down, naked, with Steckart kneeling beside him and asking the Grievant what had happened. Spang-Schmit testified that Steckart was asking questions such as, did he have a seizure, was he choking, did he bump his head, all of which were answered "no" by the Grievant. Steckart asked the Grievant if Mr. X had choked, and the Grievant said that he "ate fine." Spang-Schmit and Steckart put Mr. X on his side and checked for vital signs, noting that his pulse was weak and his respirations were shallow. Steckart thought that he was breathing, because his chest was going up and down and he had 12 respirations, a little lower than normal. Steckart was concerned about the patient's no-code status and wanted to verify it, so she went back to the desk where she called 911 and said that she had a unconscious patient that was breathing. She also called a code ER over the facility's intercom, which is a code that brings professional staff in for an emergency. Steckart went back to Mr. X's room.

By that time, Spang-Schmit said they had put Mr. X on his back, opened his airway, and continued to check his vital signs. Steckart confirmed that he had a no-code order when she returned, and other people were responding from the code ER call. Dawn Schaefer, an RN, and Phil Adam were in the room, according to Spang- Schmit's recollection.

Spang-Schmit stated that she opened the patient's airway by the jaw lift, hyperextending the neck. She could see Mr. X's chest heave up and down at that time, and she believed that his airway had been opened. She looked in his mouth and throat with a flashlight and found nothing blocking the airway. She saw a small amount of egg in the right side of his cheek and she removed the egg. Spang-Schmit thought about whether the patient had been choking when she found the egg, but she stated that developmentally disabled people will commonly carry a little bit of their last meal in their cheeks. Spang-Schmit was familiar with Mr. X and knew that he was always placed in a one-to-one observation because of his aggressive behavior. The facility was concerned for his safety as well as the safety of other clients on the unit.

LaLonde also came to help with Mr. X, and by the time he got to the client's room, Steckart, Spang-Schmit, Laskowski and the Grievant were all in the room. LaLonde went to get am emergency kit. When he came back, he helped the RN's by elevating the client's feet.

James DeGroot, a firefighter and paramedic with the Green Bay Fire Department, was one of four emergency personnel that responded to the 911 call. The 911 call came in at 8:04:59 on the morning of January 9, 1997 and the Green Bay emergency crew arrived at 8:12. During the drive to the Mental Health Center, the fire department's records show that the crew was told that the patient was unconscious but breathing at 8:06:57, and that the caller on the phone was Paula Froehlich. When DeGroot and the crew arrived on the unit, the patient had no pulse and was not breathing. They were told that a no-code order was in effect, and their only duty at that time was to notify the coroner. A heart monitor was put on the patient, but it showed no electrical activity in the heart.

The Grievant testified that one of the paramedics asked her if the client was choking, and she said no, that he was not choking. She stated that she did not see any choking sign, and if she had, she would have started the Heimlich maneuver. The Grievant believed that the couple of small coughs that Mr. X gave were too minor to be connected with any signs of choking. The coughs were not continuous, but short and similar in nature to way many people cough briefly. The client coughed once while eating and once while in the bathroom, put did not have a coughing spell. The Grievant's training in the Heimlich maneuver includes a handbook given to her by the County. It warns not to begin choking rescue unless the person cannot breathe or is turning blue and that you are certain that the person is choking. The handbook states that a person who is choking cannot cough, talk, or breathe, and may turn blue or dusky. The client's color had not turned at the point that the Grievant was alone with him.

Shirley Gruender is the RN unit manager for the acute adult psychiatric unit at the Mental Health Center. She was not at the facility when Mr. X died, but was called at home and arrived after Mr. X's body had been removed from the facility. After the body was transported, an investigator for the Medical Examiner's office, Al Klimek, met with the Grievant, Steckart, and Gruender for about 20 minutes. Gruender did not recall what the Grievant told Klimek in this meeting.

Steckart told the Grievant to make a late entry on Mr. X's chart, well after the emergency. The Grievant complied and noted a late entry, stating the essential facts as she saw them, without noting that the client coughed twice.

The Medical Examiner for Brown County, Gregory Schmunk, performed an autopsy on Mr. X on January 10, 1997, and conducted an investigation into the cause of his death. The autopsy report concluded that the cause of death was asphyxia due to aspiration of food bolus (or a large portion of food lodged in his throat that choked him), and that the manner of death was an accident. Schmunk found that the food was an egg-like substance that had completely impacted the upper portion of the airway. In Schmunk's opinion, a person that had food impacted in the airway would lose consciousness within a minute, more or less, with the blood pressure and pulse first rising, then falling and the pulse becoming irregular. Schmunk testified that one would expect to see the patient's chest heaving as he attempted to breathe, even after the patient became unconscious. There is some medical literature that indicates that the brain can have some kind of electrical activity for up to 15 minutes in rare cases, but death usually occurs within five minutes. In Schmunk's opinion, the death of Mr. X was preventable, because the food could have been removed once it was recognized that the food was the source of the problem. Schmunk testified that if a nursing assistant reported to a registered nurse that she had observed the patient spit in a sink and spit up on her arm and cough twice, the death would have been preventable, and that the failure to report those conditions was a substantial factor in causing the death of the patient.

Schmunk also testified that he believed that the Grievant had been less than truthful during the subsequent investigation into Mr. X's death, and that she did not communicate the fact that Mr. X had packed food into his mouth. Schmunk stated that it is common with people of Mr. X's type of disability to take large quantities of food and shove it in their mouths. Schmunk said the Grievant did not give that information to his investigator, Al Klimek, and that if she had observed Mr. X shove large quantities of food in his mouth, the Grievant should have reported it. Schmunk also testified that she should have reported that he was spitting up, that he was choking, and that he was eating immediately prior to his collapse.

At the arbitration hearing in this matter, Schmunk testified that someone looking into the patient's mouth would not be able to see the food (TR-Vol I, page 34). At the unemployment compensation appeal hearing, Schmunk testified that one could have seen the bolus of food in the airway by opening the patient's mouth and looking in there with a flashlight (Co. Exhibit #8, page 119).

Schmunk testified that most people who do not have mental problems would probably grab at their throats and make a universal sign of choking, but a person such as Mr. X who was compromised mentally might not make that move. Also, the type of medication taken by Mr. X decreases saliva, making it more likely that food is not being swallowed properly. Schmunk

noted that it was possible that a nursing assistant would not be aware of the dry mouth associated with medications. The Grievant was not aware of any side effects of the medication that Mr. X took.

Steckart talked with Laskowski after the death of Mr. X, and Laskowski told her that when she went into the room, she told the Grievant that she needed a nurse. That is when the Grievant went up to the desk. Laskowski expressed her surprise to Steckart that the Grievant had called her, a nursing assistant, into the room for help, when Laskowski thought she should have been calling an RN. Steckart repeated that conversation to Gruender the following day.

Gruender met with the Grievant on January 14, 1997 to give her an annual evaluation. At that time, Gruender asked the Grievant to summarize the incident with Mr. X. Gruender had the autopsy results by then and was concerned that the patient died due to choking on food. Gruender testified that she became alarmed when the Grievant told her that Mr. X was eating food, starting to cough, gulped some milk, went to the bathroom where he spit up pieces of food. Gruender told the Grievant that she neglected to give this information to the medical examiner when he was questioning the Grievant after the death of Mr. X.

Gruender gave the Grievant a notice of investigation and then interviewed her and other staff members before issuing the notice of discharge. The other staff members included Steckart and Laskowski, but not Spang-Schmit, Gillis, LaLonde, Schaefer, Adam, Froelich or Dr. Mannem. On January 15, 1997, Gruender interviewed the Grievant in the presence of Union representative Doug Reetz and Jane Smith, the Unit 1 RN Manager.

Reetz sat in on the interviews with the Grievant twice on the same day. The tape recording made at the first interview did not work, so a second interview was conducted. The Grievant was upset and tearful, according to Reetz, and he was not sure that she understood everything.

Gruender's discharge letter, while lengthy, is worth noting here because it states the reasons for the discharge and the circumstances. It states:

> **CIRCUMSTANCES:**
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> At approximately 0800 on January 9, 1997, a Code ER was called for Client #17794 who was subsequently pronounced dead at the scene.
>
> This client was admitted on December 28, 1996 and placed on a 1:1 because of aggressive behaviors upon admit.

It was observed that he was much improved on January 8, 1997, but needed to be secluded that evening and spent approximately nine hours in seclusion.

Bharti Jethani was assigned 1:1 to this client on the AM shift of January 9, 1997. Statements from Mary Steckart and Bharti Jethani conflict as to why this assignment was made.

Mary Steckart, RN and Judy Laskowski, NA, were called to the room by Bharti Jethani when this client "slid to the floor."

Shirley Gruender, Nurse Manager of Unit 7, met with Bharti Jethani to discuss these events after discussion with Dr. Schmunk, Medical Examiner, on January 13, 1997, who stated that the client's cause of death was an airway obstruction caused by an impacted bolus of food.

The discussion with Bharti Jethani occurred on her next working day which was January 14, 1997. Her description of the event caused concern and she was put on Notice of Investigation.

On January 15, 1997, a taped interview took place with Bharti Jethani. Bharti Jethani stated that she observed this client as he ran to the bathroom while eating his breakfast. She then went to the bathroom door and without entering, observed him attempting to cough up pieces of food over the sink. She made no attempt to assist him, stating she was fearful of the client and apparently made only a feeble attempt to call for assistance at this time. Only when he exited the bathroom and "slid to the floor" did she call for help. When the RN staff was summoned, she was asked specifically whether the client had choked and she responded, "no." Without the history of the coughing spell, the RN staff did not know that this incident was caused by an airway obstruction. With this knowledge, an attempt at removal would have been made, which may have been life-saving for this client.

The investigation has determined that Bharti:

1. did not carry out her responsibilities to a client placed in her care by failing to assist him while in distress.

2. used poor judgment in failing to recognize the seriousness of the client's condition and responding appropriately.

3. distorted information and failed to provide factual information which would have enabled professional staff to provide the appropriate emergency care.

II RULES VIOLATED:

Negligent and careless disregard of the employer's interest by misconduct of:

1. Failure to perform the responsibilities and expectation of the position of a Certified Nursing Assistant by breach of duty in action of:

-- Failure to provide a therapeutic atmosphere by not providing for the safety of the client.

-- Failure to provide for appropriate client care to meet the physical need of the client.

-- Failure to observe and report the change in condition to the RN immediately.

-- Failure to respond to the emergency and/or crisis situation affecting the client.

-- Failure to activate appropriate intervention (Heimlich Maneuver) for the client.

-- Failure to use reasonable, professional judgment as a Certified Nursing Assistant in providing care to this client.

-- Failure to manage personal stress associated with unpredictable client behavior.

-- Failure to maintain the principles of documentation in a timely manner of the recording of events of the situation in the client's chart.

-- Failure to provide accurate and factual information immediately to the registered and licensed staff.

2. Failure to abide by organizational rules, policies and procedures.

3. Failure to abide by state and federal regulations related to client care.

The document concludes that the penalty of discharge was appropriate for the situation.

Gruender testified that the Grievant should have given the client assistance in eating, that he was not managing his food after he ate. She furthered stated that the Grievant observed pieces of food coming out of his mouth, which was a change of condition because there were no choking incident with this client before, and that the Grievant failed to report it when directly questioned about it. Gruender felt that the Grievant did not call for help in a timely manner and that she could have summoned help long before the client slid to the floor unconscious. Also, nursing assistants are trained to perform the Heimlich maneuver, and Gruender felt that the Grievant should have done this maneuver on the client. Gruender also stated that the Grievant could have identified the choking to the professional staff so they could deal with it. Gruender's remark in the discharge letter about managing personal stress relates to the Grievant's statement that she was fearful of the client. And while a late entry to acceptable in documenting records, the late entry did not accurately document the events, in Gruender's opinion. The late entry did not refer to the client running to the bathroom and coughing up pieces of egg, which Gruender felt to be significant. Gruender felt that the Grievant failed to provide that kind of information to the nursing staff, based on what Steckart had told her.

Gruender testified that she believed the Grievant had given different stories at different times. Gruender stated that the Grievant told Klimek that there was no coughing and no choking, that the client ate a good breakfast. Then during her evaluation on January 14th, Gruender heard the Grievant say that the client rushed into the bathroom and coughed up pieces of food in the sink, and when Gruender interviewed the Grievant on the next day, the Grievant said that the client drank a little milk, then he was coughing a little bit, then he ran to the bathroom and was coughing in there. Gruender concluded that the Grievant's use of the term "coughing" meant "choking" in this case. Because Gruender felt that she could not rely on the Grievant to give accurate information to the professional staff, she determined that the Grievant should be discharged.

The Grievant disagreed with Gruender's recitation of the facts in the discharge notice, particularly where Gruender stated that the Grievant observed the client attempting to cough up pieces of food over the sink. The Grievant did not make such a statement. She also did not know what Gruender meant by a coughing "spell."

The Grievant signed the typed transcription of the investigatory interview that was taken on January 15, 1997 by Gruender. It is not clear what date it was signed, since it was not typed until January 16th. On January 20th, after the Grievant was terminated, she corrected a time in the document to read 7:50 instead of 7:15. She made no other corrections to the investigation report. The Grievant signed the termination notice with a notation that she protested it. Her signature on that document is an acknowledgment that she received a copy, not that she necessarily agreed with what was written, according to the pre-printed statement on the form right above her signature.

The Administrator of the Brown County Mental Health Center, Earlene Ronk, took part in the decision to terminate the Grievant's employment. Ronk discussed the situation with Gruender and James Kalny, the Human Resources Director for Brown County. They were concerned that the Grievant failed to recognize that the client was choking, that she failed to respond accordingly, that she failed to report it accurately to the nursing staff, and that her story about the situation had changed several times. Ronk also reported the death to the State Bureau of Quality Assurance and the Nurse Aide Registry. The Registry investigated the circumstances and determined that the Grievant would remain on the Registry.

Kalny asked Union Representative Robert Baxter to hold the grievance in abeyance to wait for a decision by the Nurse Aide Registry before proceeding to arbitration. Baxter agreed to do so, and on May 13, 1997, following the investigation by the Bureau of Quality Assurance, Baxter asked that the Grievant be reinstated with back pay and benefits. The County refused, and the parties proceeded to arbitration.

In an affidavit submitted after the arbitration hearing, LPN Paula Froelich stated that she also responded to the code ER and among those present in the room were LaLonde, Spang-Schmit, B.J., Adam, Steckart, and Dr. Mannem. Froelich went back to the desk and told the 911 crew that the patient was unconscious but breathing. Froelich's statement taken on December 19, 1997 gives a general recitation of the facts as stated before. Then Froelich states that later in the day on January 9, 1997, the Grievant told Froelich that she tried and tried to call for help but she was so scared that she couldn't get anything out. Froelich thought that this was a change in her story and explained why no one responded to her immediately. The following Monday, according to Froelich's statement, the Grievant returned to her first statement about calling for help, and the Grievant asked Froelich why no one went to help her. Froelich stated that the Grievant was upset and angry about being assigned to Mr. X, and that the Grievant felt that Laskowski should have been assigned because she had less seniority than the Grievant.

The County did not discipline any other employee in connection with the death of Mr. X.

THE PARTIES' POSITIONS

The County

The County asserts that it had just cause to discharge the Grievant. It states that Gruender conducted a thorough and fair investigation of the facts. The basic reasons for the discharge were failure to perform required duties as the one-to-one nursing assistant, dishonesty in failing to disclose life-saving patient information, violation of one-to-one procedures, and gross negligence and incompetent performance of required nursing assistant duties which were substantial factors in causing the death of Mr. X by choking on his food. The patient's right

to adequate treatment under the law was violated by the Grievant, as well as the basic patient care to which he was entitled. The testimony of Dr. Schmunk who performed the autopsy established the Grievant's gross negligence and incompetence. In his uncontroverted medical opinion, the failure of the Grievant to act and accurately report patient conditions to staff nurses was a substantial factor in causing Mr. X's death. The County asserts that Schmunk's testimony gave the Employer just cause to discharge the Grievant.

While the Grievant denied any wrongdoing at the hearing, the County argues that her testimony was inherently incredible. Her deceit in answering questions from Steckart and Spang-Schmit on January 9, 1998 as to the patient's condition was a substantial factor in causing Mr. X's death. The patient's life could have been saved had she answered the nurses' questions truthfully since it must have been obvious to the Grievant that the patient was choking on his food. If the Grievant was unable to recognize the patient's problem, she should have at least disclosed that he ate his food at once, coughed and spit up.

The County submits that the Grievant's failure to properly observe and report that the patient was choking on his food violated minimally acceptable standards of performance of a nursing assistant. The Grievant was the only nursing assistant assigned to Mr. X and she was required to observe him at all times. Froelich's affidavit indicates that the Grievant did not observe him at all times, as she should have followed him into the bathroom and recognized that he was choking on his food before he went into the bathroom as well as while he was in the bathroom. The Grievant admitted that Mr. X coughed at least twice and spit up on her arm. A minimally competent nursing assistant must be able to recognize that a patient is in danger from choking on his food and to assist him or summon help. A minimally competent nursing assistant must be able to assist a patient in eating slowly so as not to choke on his food, as well as be able to perform the Heimlich maneuver and to recognize when to begin the Heimlich maneuver. The Grievant received CPR training including the Heimlich maneuver only two days before the death of Mr. X. A minimally competent nursing assistant must also be able to exercise judgment as to when to summon help. The Grievant watched Mr. X pass out before summoning help and failed to intervene by using the Heimlich maneuver thereafter.

The County argues that the Grievant had been properly trained, but that the qualities of judgment and honestly in reporting information cannot be trained. The fact that the Grievant withheld information and falsely answered questions as to whether Mr. X was choking on his food demonstrates not only incompetence but also the lack of trustworthiness which would endanger patients in the future should she be reinstated.

The County believes that the Grievant had 10 minutes between the time that Mr. X began eating the eggs and toast and the time the Grievant called for help. It states that she did nothing to help him between 7:50 a.m. and 8:00 a.m., until he had already passed out and suffered irreversible brain damage. The nurses were deceived by the Grievant's answers to their

questions and were unable to determine that the patient's windpipe was blocked by food, and they acted on her misinformation and believed that Mr. X had suffered a brain seizure, heart attack or head injury. It was unfortunate that Mr. X was under a no-code order signed by his guardian, but the no-code order would not have applied to accidental choking. The Grievant answered "no" to the question, "Did he choke?" The nurses as well as LaLonde and Froelich indicated that the Grievant was asked by the nurses if Mr. X was choking.

The County maintains that the Grievant was lying to the nurses and continued to lie to Gruender and the medical examiner's investigator. She attempted to deceive her Employer as to the true facts of Mr. X's eating all at once, coughing and spitting up food on her arm. She has demonstrated that she cannot be trusted to observe or report patient conditions truthfully and accurately, and she cannot be trained to report truthfully and can never be trusted with the lives of patients who are severely mentally retarded and/or mentally ill.

The County finds a number on inconsistencies in the Grievant's testimony -- between direct and cross examination at the hearing, between the hearing and statements made to Gruender on January 13 and 15, 1997, between the hearing and statements made to Froelich, between the hearing and the testimony of Steckart and Spang-Schmit, between the hearing and the testimony of LaLonde.

The County contends that the penalty of discharge was justified, and that the Grievant's future behavior cannot be corrected. She does not acknowledge any wrongdoing or remorse for causing Mr. X's death. The wrongdoing involved lying about a patient's condition, failing to report the patient's condition, and failing to intervene. These are serious matters where the only proper penalty was discharge. Her claim that the nurses did not ask her relevant questions is incredible, and her claim that she saw Mr. X swallow his food was medically impossible, according to Dr. Schmunk. To reinstate the Grievant, one would have to find that Steckart, Spang-Schmit, LaLonde and Froelich all lied. Reinstatement of an employee who has continually changed her statements and versions of events would put future patients at risk. Her grievance should be denied.

A grievant's testimony must be evaluated in terms of the self-interest in the outcome of the arbitration proceeding, the County points out. The Grievant's testimony was inconsistent with previous statements she made to Gruender and the state unemployment compensation hearing examiner as to coughing, swallowing and spitting up. The Grievant's testimony was inconsistent in some way with every direct evidence witness of the incident, including Steckart, Spang-Schmit, LaLonde, Laskowski and Froelich. The Grievant's testimony as to the events prior to the death are contradicted by Dr. Schmunk, who testified that food was not swallowed and the patient could not have swallowed his food. The discipline given to the Grievant was applied without discrimination, since she alone was responsible and culpable.

The County submits that the just cause standard was met in this case. The facts surrounded the patient's death were undisputed, the Grievant's responsibility for his death has been established, her failure to provide accurate patient information to staff nurses was proven, and her reason for withholding patient information and lying about the events can be inferred to be to cover up her failure to observe the patient at all times as required. The investigation was conducted fairly and objectively. The Grievant was given the opportunity to state her version of the events. She lied about her failure to observe the patient and her failure to give patient information to the staff nurses during the investigation interview.

The County asserts that the Grievant's testimony is unworthy of credence based on internal inconsistencies and contradictions with the testimony of other witnesses, and that her testimony is highly suspect. The grievance should be denied and an arbitration award issued in favor of the employer.

The Union

The Union submits that the Grievant should not have been discharged. The County's case centers on its belief that Mr. X choked on his food in an obvious manner and that the Grievant failed to take appropriate actions to save his life. However, the Union argues, the primary flaw in the County's analysis is that there was no obvious sign that Mr. X was choking to death, and without that fact, the County has no case.

The County would have the Arbitrator believe that coughing and choking are the same thing, but they are not. The Grievant never stated that Mr. X was choking. She stated that he coughed a little, but that is not the same as choking. It is clear from the interview conducted by Gruender -- Exhibits 17 and 40 -- that Gruender tried to put her words into the Grievant's mouth.

While the County tried to infer that one of the main reasons that Mr. X was monitored on a one-to-one basis was so that his eating could be observed, the County's own witnesses stated that he did not have significant trouble eating and that it was his aggression that lead to monitoring him one-to-one. Spang-Schmit explained that his eating or choking on food was not a major concern of the staff, and that his episodes of aggressive behavior concerned the staff for his own safety as well as the safety of other clients on the unit.

The Union argues that the County does not provide formal feeding training, even though it spent much effort describing the extensive training provided to nursing assistants at the Mental Health Center. There is no documented evidence that the Grievant ever received specialized training in feeding patients such as Mr. X, and no one could name the last time any employee received such training. The Union asserts that Mr. X's eating habits were consistent for him as well as for the patient population on that floor, in that those patients eat relatively quickly and

tend to pack food in their mouths for long periods of time. Spang-Schmit testified that developmentally disabled people will carry a little bit of their last meal in their cheeks to the next meal.

The Union points out that the Grievant followed the County's own guidance on evaluating choking victims and determined that Mr. X was not choking. Mr. X was following the Grievant's instructions and appeared healthy until his collapse, and at no time did he appear to be choking. The book provided to all CNA's called "Healthwise Handbook" warns that one should not begin choking rescue unless the person cannot breath or its turning blue or that one is certain that the person is choking. The County places an unfair burden on the Grievant when it punishes her for following this guidance.

The County has claimed that the Grievant did not properly call for help when Mr. X collapsed. While there is some questions as to whether the Grievant panicked for a few seconds or had difficulty getting her voice for the first few seconds, it is undisputed that Laskowski arrived in the room right after Mr. X collapsed, and that he was still alive and remained so for the next 20 minutes or so.

Next, the County has contended that the Grievant failed to properly answer questions regarding Mr. X's condition, specifically whether or not he was choking, and that her testimony has changed over time. The Union contends that this is the County's third or fourth kick at the cat, and even its witnesses have not been totally consistent from hearing to hearing, but the Grievant's testimony has remained consistent. She never denied that Mr. X coughed a little while he ate and after he ate, but she has consistently denied that he was ever choking. The County has argued that the Grievant withheld critical information from the staff nurses by not telling them that the patient had difficulty eating, but he did not have any trouble eating, and his habit of gulping and coughing a little was consistent for that patient population. Everyone knew it was breakfast time and that Mr. X had just finished eating. It was the Grievant's responsibility to let others know of unique conditions that could have called Mr. X's collapse. Personnel on hand even checked his mouth and throat for obvious obstructions. If Mr. X did not appear to be choking to the Grievant when she was alone with him, how could she be charged with failing to report critical information?

The Union argues that the County conducted a witch hunt rather than a fair hearing, and it is disturbed about the manner in which Gruender treated the Grievant. The Grievant's difficulty with the English language is self-evident, but Gruender seems to have manipulated her statements. The Grievant was confused during the interview. The Union questions Gruender's motive for discussing the death during the annual performance evaluation. Gruender claimed that she was just curious, but the Union contends that Gruender made up her mind as to the Grievant's guilt that morning when she got the medical examiner's report. Therefore, her

discussion with the Grievant concerning the incident without a steward present was inappropriate.

The Union points out that the Grievant was cleared of any wrongdoing by the state and is free to perform as a certified nursing assistant, a factor that should be considered. The Union also notes that the County has changed numerous policies since this incident. Gruender revised the code ER policies, the no-code/do-not-resuscitate orders, and the documentation flow procedures. The death of Mr. X exposed flaws in the County's existing policies and they were corrected.

The Union states that Froelich's statement should be dismissed, It was made a year ago and the County did not know about it until two months ago. The statement had no bearing on the County's decision to terminate the Grievant, and most of it is hearsay which is disputed by the Grievant. The fact that the County was unaware of Froelich's statement lends credence to the Unions' argument that the County's investigation was not very thorough.

The Union is asking that the Grievant be made whole in all respects, including an award of back pay to reflect the significant overtime the Grievant worked.

In Reply

The County

The County responds to the Union's arguments by first stating that the undisputed facts lead to the only reasonable conclusion that the Grievant was responsible for the death of Mr. X. The only real dispute is the degree to which she can be held responsible. The County argues that she was clearly negligent in the performance and omission of her nursing assistant duties. Her intentional dishonesty in withholding information constitutes just cause for discharge. While the Union argued that the Grievant was "cleared" of charges, those charges related to patient abuse as defined in the administrative code as being "willful, wanton, wrongful intent, evil design, or intentional disregard" of a nurse's aide's duties. The County does not assert that the Grievant intended to abuse Mr. X or cause his death. It contends her job performance was clearly negligent, inefficient, unsatisfactory and erring in judgment, which does not constitute patient abuse in the code.

The Union correctly stated that some policies were changed after this incident, including a clarification of the "No Code" policy. However, the "No Code" policy did not apply to accidental choking victims either before or after Mr. X's death, and there was no flaw in the previous policy which would absolve the Grievant of culpability. Contrary to the Union's assertions regarding training, the Grievant had extensive experience in feeding and monitoring the eating of mentally disabled patients prior to January 9, 1997. She saw Mr. X eat quickly

and then allowed him to collapse when it should have been obvious that he needed help. The County asserts that it was evident or should have been evident to the Grievant that Mr. X was choking on his food, and she admitted that he coughed a little when he ate. Gulping food and coughing a little can only be considered reportable patient conditions and trouble eating.

The County states that the Grievant violated the one-to-one procedure by not following the client into the bathroom. Further, it states that her answers to questions in this regard were inconsistent, indicating a lack of credibility. Further, had she told the nurses what she had observed and what happened in the bathroom, the nurses would not have ruled out choking on food. The Grievant's deception and false answers to the nurses' questions and her dishonesty in not disclosing the patient's conditions caused his death. Her late entry charting was also dishonest and inaccurate, in that there was no mention of the patient's problem with coughing to spitting. The Grievant admitted that she saw him cough and spit up, but she failed to chart these patient problems.

While the Union argues that the Grievant had no obvious sign that Mr. X was choking to death, the coughing and spitting up were obvious signs and any minimally competent nursing assistant would have report these things to the nurses and charted such patient conditions. The County agrees with the Union that coughing and choking are not the same, but the coughing right after eating should have made it obvious that the patient had a problem eating and swallowing his food. The County disputes the Union's assertion that the Grievant was not responsible for Mr. X's improper eating, and notes that the one-to-one procedure makes the nursing assistant responsible to observe at all times and report problems such as eating relatively quickly.

The medical evidence established that Mr. X suffered irreversible brain damage from lack of oxygen within five minutes of losing consciousness. The Union claims that death occurred about 25 minutes after the patient's collapse, but this is immaterial since CPR would have been beneficial and saved his life without irreversible brain damage only if begun within five minutes of his collapse. That was the time that the Grievant should have provided accurate patient information to the nurses. She was the only person who knew that Mr. X had coughed and spit up, and these were unique conditions that could have caused his collapse. Moreover, the Grievant's testimony has not been consistent with her previous testimony at the unemployment compensation hearing as to swallowing and observing Mr. X in the bathroom.

If the Grievant were merely incompetent, the County concedes that additional training could be part of corrective discipline. However, deception as to essential life-saving patient conditions is of such a serious matter that discharge is justified, the County asserts. The Employer is being asked to entrust highly vulnerable patients' lives in her hands, and she is untrustworthy and incompetent.

The Union

The Union stands by its arguments made at hearing and in its initial brief and gives ten reasons why the Grievant was treated unfairly:

1. Coughing and choking are not the same;
2. Mr. X was placed one-on-one due to his aggression only;
3. Brown County provided no formal feeding training;
4. Ms. Jethani followed County guidance on evaluating choking;
5. Ms. Jethani answered questions appropriately;
6. Mr. X remained alive for an exceptionally long time;
7. The County conducted a witch hunt rather than a fair hearing;
8. Ms. Jethani was cleared of all state and federal charges;
9. The County changed numerous policies since this incident;
10. The Paula Froelich statement has little relevance.

The Union states that the underlying flaw in the County's arguments is that the patient exhibited no clear signs that he was choking to death to the Grievant or to the more highly trained nurses who tried to save him for nearly 20 minutes. The County has the burden of proving that the patient was choking to death when he was alone with the Grievant, but it has not provided clear and convincing evidence that the Grievant failed to perform her job as a certified nursing assistant.

A key witness -- Al Klimek -- never appeared at the arbitration hearing, but he testified at the unemployment compensation hearing and stated under oath that the nurses should have and could have done more to save the patient's life. He also testified that the County's no-code procedures may have played a role in the death of Mr. X.

The Union disputes the County's claim that the Grievant withheld information. Everyone in the facility knew it was breakfast time and patients were eating or finishing breakfast. The Grievant has consistently testified that the patient did not appear to be choking, and no one else in the room identified the patient as a choking victim. The Union also disputes the County's claim that the Grievant was incompetent. The evidence shows that the Grievant followed County-provided guidance to not perform the Heimlich maneuver in situations where the patient does not appear to be choking. The County's reliance on the Froelich statement is a last gasp attempt to make a case when the County has continuously failed during all previous hearings and investigations.

The Union states that Gruender's investigation lacked any element of impartiality and bordered on intolerance and condescension. Much of what the County submits as proof of the Grievant's inconsistent testimony is directly attributable to Gruender's manipulation of the Grievant's words. A review of the taped testimony shows that Gruender put her words into the Grievant's mouth. This is troubling since Gruender was well aware of the Grievant's difficulty with English.

DISCUSSION

The resolution of this case turns on the Grievant's credibility, because the Grievant was alone with the patient when he ate and passed out on the floor. The Grievant is the only person who knows what happened in Mr. X's room before he passed out, and she alone knows whether he gave any indication that he was choking on food or not.

The County has raised several doubts about the Grievant's credibility, but it had no reason to doubt the Grievant's reporting of Mr. X's condition until the Medical Examiner ruled the death accidental, preventable, and attributable to choking on food. The record is unclear as to why the County started to have doubts about the Grievant's version of the events regarding Mr. X's death. Gruender claims that she started to doubt the Grievant during a routine performance evaluation interview. However, the interview that was presented into the record, taken a day after the performance evaluation interview, shows no reason for this suspicion on the part of Gruender.

The Grievant described the coughs that Mr. X made while eating and in the bathroom as small, minor coughs, nothing that would indicate that he was choking on his food. However, when Gruender interviewed the Grievant on January 15, 1997, Gruender started to use the term "coughing spell" for the first time. See County Exhibit #17, page 4. The Grievant never described the conduct of the patient as involving a coughing spell -- these are the words of Gruender alone. Gruender started to equate coughing with choking after learning from the Medical Examiner that the patient had choked to death. The Grievant always considered the two small coughs as to be so minor that they were not worth mentioning at the time that Mr. X passed out and she called the RN's for help.

If the Grievant had seen Mr. X show signs of choking, there is no reason for her to lie about it. She could have performed the Heimlich maneuver herself or had the RN's do it. She had recently taken a refresher course on CPR, which included information on the Heimlich maneuver. The County asserts that the Grievant lied and did not tell the RN's what really happened in the room before they arrived to help, but why would the Grievant be lying about this? What motive would the Grievant have had to withhold information from the RN's or medical personnel at this point in the morning of January 9, 1997? The Grievant knew what her

responsibilities were, and there is nothing in the record to indicate that there would be any reason for this Grievant to withhold information or lie to the nurses about what she had seen.

Certainly, the Grievant would have been scared at the time that the patient she was observing passed out. However, she was able to run to the desk, get Steckart to come help, and relay to Steckart the information that Mr. X had eaten his breakfast, went to the bathroom, wet himself, and was changing his pajamas when he slid to the floor. The Grievant was coherent enough to tell Steckart that the patient was choking -- if in fact there were ever any signs of choking. But the problem is -- there were no signs, at least not the ordinary signs, that the patient was choking on his food. Two minor coughs would not show that he was choking.

Everyone has likely choked on his or her own food at some time or at least seen someone who has done this. It is a common event within the ordinary experience of people, and one does not have to be very expert in medicine to recognize choking. The Grievant would have recognized the ordinary choking signs. But there was an absence of anything to indicate that Mr. X was choking. There was no coughing "spell," there was no wheezing or gasping for air, no clutching of the throat, no signs of choking.

The County has argued that the Grievant's testimony must be evaluated in terms of self-interest. What interest would the Grievant have had in withholding vital information from the nurses? What interest would the Grievant have had in withholding such information from the Medical Examiner's investigator? The Grievant's self-interest in protecting her job would have come up only after January 9, 1997 and not until January 15th when Gruender made it clear during the investigatory interview that she was blaming the Grievant for the patient's death. Thus, at the time the County claims the Grievant withheld critical information that could have saved the patient, the Grievant had no self-interest or motive in withholding such information. She was taking care of a patient, and it would not have been in her interest in any manner to watch him choke or die without helping him or getting help for him.

The Grievant's statements regarding the facts and her testimony have remained substantially consistent over a year's worth of investigations and hearings and interviews. The Grievant never stated that Mr. X choked, and always maintained that he only coughed a little. She properly cut up his food and gave it to him in small pieces at a time. She saw him drink milk, indicating that he was managing to get food and liquid down his throat. He went to the bathroom, gave a small cough, and spit some saliva or water on the Grievant's hand or arm. Still no indication of choking. He followed her request to change his pajamas, indicating that he was not in dire distress or choking at that time. This patient did not give normal signs that reflected his true condition. The Grievant cannot be held responsible for that, only for what she did. If she saw no sign of choking, she could not report it. Nowhere in the record is there any statement by the Grievant that she saw Mr. X spit up pieces of food or egg in the sink.

Nowhere in the record is there any statement by the Grievant that Mr. X had a coughing spell or that he showed any signs of choking.

I find her testimony credible in this respect, and it is the major finding that results in concluding that the County lacked just cause for discharge. The Grievant's account of the events was always substantially the same. Those questioning her have sometimes twisted and embellished the account, but the Grievant's testimony appears to the Arbitrator to be substantially truthful.

The County also asserts that the Grievant could have called for help earlier. The sequence of events -- from the time that the patient went to the bathroom and became unconscious -- happened so quickly that the Grievant could not have called for help, at least not any sooner than she knew that she needed help. The patient was in the bathroom for only a few seconds, perhaps five to ten seconds. There was no need to call for help until it was clear that help was needed, when the patient slid to the floor. There was nothing negligent in the Grievant's conduct when she called for help. At the most, Froelich's belated statement would tend to show that when the Grievant first called for help, she lost her voice but then regained it. There was no undue delay on the part of the Grievant in seeking help.

No one disputes that the Grievant was trained to perform the Heimlich maneuver, and that she could have done so if she realized that the patient was choking. Even the Grievant has stated that she would have performed the Heimlich maneuver on him. However, the Grievant could not do this unless she clearly knew that the patient was choking, and since she never saw any signs of choking, she could not perform that maneuver, as it is not to be used unless it is clear that the person is choking, according to the County's own procedures. The County's handbook given to the Grievant warns that one should not begin choking rescue unless the person cannot breath or its turning blue or that one is certain that the person is choking. The handbook states that a person who is choking cannot cough, talk or breath and may turn blue or dusky. The parties agree that the patient coughed -- at least twice, according to the Grievant's own admission. The nurses determined that the patient was still breathing after he became unconscious. Therefore, the County's own handbook would have indicated to the Grievant -- as well as the nurses -- that the patient was not choking. The error of all of this was only determined after the fact, by an autopsy. The Grievant cannot be held responsible for knowledge that the patient was choking when there were no obvious signs and the RN's could not recognize it either. Whether or not the RN's would have recognized that the patient was choking had the Grievant told them that he gave two little coughs is speculative at best, since Spang-Schmit made an independent determination that the patient's airway was open. Steckart also determined that the patient was breathing (see County Exhibit #15, page 4, as well as County Exhibit #18, page 1).

The County also asserts that one could infer the Grievant was lying because she was covering up for not observing the patient at all times. There is nothing in the record to indicate that the Grievant did not watch the patient at all times. She was uncomfortable following him into the bathroom, but she watched him through an open door. This is an acceptable procedure, perhaps even the preferred procedure, according to the County's policy on one-to-one supervision/observation (see County Exhibit #16, page 2). The County's policy states that "Staff will observe client from a position immediately outside bathroom door." Nothing states that the nursing assistant or person observing should follow the patient directly into the bathroom.

The fact that the Grievant did not make a notation that the patient had two minor coughs on the late entry on the chart is of no consequence whatsoever in this case.

The County's investigation of the incident lacks elements of a fair and thorough investigation. Given the tragic outcome, one would expect at least a very thorough investigation. Gruender interviewed the Grievant, Steckart and Laskowski, but not Spang-Schmit, Gillis, LaLonde, Schaefer, Adam, Froelich or Dr. Mannem. Spang-Schmit played an important role in the incident, as she had hyperextended the patient's neck, determined that he was breathing, looked in his mouth with a flashlight, found a piece of egg, knew that breakfast had just been served, and concluded that the egg in his cheek was nothing unusual. If Spang-Schmit found nothing unusual about egg being in this patient's cheek at the time the patient was unconscious, how can the County claim that the Grievant should have reported two minor coughs as an unusual condition or change in patient condition? Also, the County knew or should have know that Froelich was involved in the incident, since she called 911 and reported that the patient was breathing. The statement that Froelich made after the arbitration hearing in this matter has not been given much, if any, weight. However, the failure to interview Froelich and Spang-Schmit, as well as all of those people who responded to the emergency, shows that the investigation was not thorough. It is also worth noting that the Grievant speaks English with some difficulty, and while she can make herself understood, she speaks rapidly, jumping ahead of herself at times, and those interviewing her need to listen more closely, and with an open mind.

However, the basic reason for sustaining this grievance is that the County cannot show in any convincing manner that the Grievant performed her duties in a negligent manner or lied when being questioned about what had happened when she was alone with Mr. X. Therefore, the County lacked just cause to discharge the Grievant.

The Remedy

The Grievant is entitled to reinstatement and back pay which should include an amount for overtime. The reinstatement order will be to her former position or a substantially equivalent position. Since the County has several units at the Mental Health Center, it is not necessary that the County offer reinstatement to the same unit from which she was discharged. It may be a more successful relationship for both parties in the future if the Grievant were not to work with the very people who have testified against her in this proceeding as well as several other proceedings. There are generally many openings and shifts available in institutions such as this. As long as the shift is equivalent, in terms of pay and preference of hours that the Grievant may have attained by her seniority, it is not necessary that the Grievant be reinstated to a position on Gruender's unit.

Back pay is usually obvious to calculate. Any money earned elsewhere may be deducted, including sums collected from unemployment compensation.

Overtime is usually not included in back pay awards because it is often speculative, either that the overtime opportunity would have been available or that the grievant would have worked the overtime. 1/ However, where it can be shown with a reasonable degree of certainty that a grievant would have worked overtime if he or she were available, overtime may be granted. 2/ The Union has shown in this case that the Grievant regularly worked substantial amounts of overtime. A make whole remedy should include some overtime. The only question is how much. The parties may look at their records to make such a determination and find a formula that would adequately compensate the Grievant and make her whole for such lost work. The Arbitrator will hold jurisdiction open until the date noted below in case the parties are unable to agree on the amount of overtime to be included in the back pay or to resolve any other dispute over the scope and the application of the remedy ordered.

AWARD

The grievance is sustained. The County violated the collective bargaining agreement when it discharged the Grievant, Bharti Jethani, without just cause.

The County is ordered to immediately offer reinstatement to the Grievant of her former position or a substantially equivalent position, and to pay to the Grievant a sum of money for back pay and overtime in accordance with the remedy noted above, less any sum of money earned elsewhere, from the time of the discharge to the date of reinstatement, and to make the Grievant whole for any loss in wages and benefits.

The Arbitrator will hold jurisdiction until October 1, 1998, as noted above, for the sole purpose of resolving any disputes over the scope and the application of the remedy ordered.

Dated at Elkhorn, Wisconsin this 9th day of April, 1998.

Karen J. Mawhinney /s/
Karen J. Mawhinney, Arbitrator

ENDNOTES

1/ See SENECA STEEL DIVISION, 96 LA 838 (Arb. Fullmer, 1991).

2/ See ARMSTRONG AIR CONDITIONING, 99 LA 540 (Arb. Harlan, 1992).

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