BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

**COLUMBIA COUNTY EMPLOYEES, LOCAL 2698,
WCCME, AFSCME, AFL-CIO**

and

COLUMBIA COUNTY (HEALTH CARE CENTER)

Case 188
No. 56176
MA-10196

Appearances:

Mr. David White, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 8033 Excelsior Drive, Suite B, Madison, Wisconsin 53717-1903, appearing on behalf of Columbia County Employees, Local 2698, WCCME, AFSCME, AFL-CIO, referred to below as the Union.

Mr. Donald J. Peterson, Columbia County Corporation Counsel, 400 DeWitt Street, P.O. Box 256, Portage, Wisconsin 53901-0256, appearing on behalf of Columbia County Health Care Center, referred to below as the Employer or as the County.

ARBITRATION AWARD

The Union and the County are parties to a collective bargaining agreement which was in effect at all times relevant to this proceeding and which provides for the final and binding arbitration of certain disputes. The parties jointly requested that the Wisconsin Employment Relations Commission appoint an Arbitrator to resolve a grievance filed on behalf of Mary Fischbeck, who is referred to below as the Grievant. The Commission appointed Richard B. McLaughlin, a member of its staff. Hearing on the matter was held on May 21, 1998, in Wyocena, Wisconsin. The hearing was not transcribed. The parties entered their positions at the hearing, and chose not to file written briefs.

ISSUES

The parties stipulated the following issues for decision:

Did the County have just cause to suspend and reassign the Grievant?

If not, what is the appropriate remedy?

RELEVANT CONTRACT PROVISIONS

ARTICLE 2 – MANAGEMENT RIGHTS

2.01 The County possesses the sole right to operate County government and all management rights repose in it, subject only to the provisions of this contact (sic) and applicable law. These rights include, but are not limited to the following:

A) To direct all operations of the Health Care Center;
B) To establish reasonable work rules and schedules of work;
C) To hire, promote, transfer, schedule and assign employees to positions within the Health Care Center;
D) To suspend, demote, discharge and take other disciplinary action against employees for just cause . . .

ARTICLE 14 – MISCELLANEOUS PROVISIONS

. . .

14.02 Evaluations and written reprimands will be in effect for a twelve (12) month period. At the end of twelve (12) months they shall become null and void and shall serve no further purpose.

. . .

BACKGROUND

The County's Health Care Center, referred to below as the Center, includes four residence wings radiating at right angles from a lobby area, which includes a nurses' station. The parties have stipulated that the incident underlying the discipline, referred to below as the Incident, occurred on October 16, 1997, in and around Room 408 on the residence wing known as Birch Boulevard. The residents then living in that room were KW and GH. KW was, at the time, aphasiac and incontinent. GH was in the facility for a period of convalescence, hopefully to return home after a limited stay. He was, at the time, alert and responsive to others. The Grievant and RS, another Aide, at that time worked the 10:00 p.m. to 6:30 a.m. shift. SS, a Registered Nurse, was the shift supervisor at that time. The

Grievant's team leader was JH, a Licensed Practical Nurse.

The first documentation of the Incident was filed by the Grievant at the close of her shift on October 16. The Grievant reported the Incident to JH and SS. SS spoke to GH, then asked the Grievant to document her view of the Incident. The Grievant's written response states:

> At approximately 2:20 am, on Oct. 16, 1997, we (RS & I) were doing our bedcheck on Birch Blvd. We heard KW yelling "Hey, Hey" while we were in room 413. Approximately seven minutes later we headed to K's room. In the course of the seven minutes, K's room-mate, GH, rang his call bell. After finishing in room 413, we headed to K's room. Upon entering the room, GH was swearing saying, "this f***ing call bell's been on forever." I did not answer. I walked past G directly to K's bed. My partner . . . tried to explain why it took seven minutes to get to the room. He kept hollering at R about not being taken care of. He then told R if "you don't want to do your f***ing job, then quit." I did not hear all of the conversation as it transpired. She didn't answer G after his last statement. We finished changing K and left the room without further conversation.

On October 21, GH filed a complaint with Heather Blackmore, a Center Social Worker. Her written summary of the complaint states:

> G reports that his roomate (sic) . . . was verbally calling for help when he heard a CNA in the hallway loudly state "I hope K learns to use that fucking call light soon!" G at that point pushed his call light as he knew it was difficult for K. When the CNA entered the room to help K, G stated "This is not a 'fucking' call light, it is a call light" in order to correct the CNA's language as G felt her language was not appropriate. The CNA responded "Why are you talking to me like that" in an angry tone. G responded "I'm just repeating to you what you said earlier, & I don't approve of that." G also reports that during this altercation the CNA stated "I have 26 other res. to care for on this unit that need our attention." G replied to that "If you don't like your job then why don't you quit." G tells writer he says this because the CNA was becoming very angry . . . G reports that the altercation ended when the CNA stated "if you don't like it here, you can talk (with) Social Services in the AM" and G stated he would do that. G did report this to LPN DW A.M. of 10/18/97. Writer asked res if he could identify the CNA or knew the name. G. stated

"No, I couldn't because she was behind the privacy curtain while doing cares for K and my side of the room was dark, but it had to either be R or M because they were the only ones there that noc."

. . .

GH's complaint was ultimately brought to the attention of Sharon Kotowski, the Center's Director of Nursing.

Kotowski interviewed the Grievant and RS on October 24, 1997. The interviews were separate and the Grievant and RS were each afforded a Union representative. Kotowski took handwritten notes of each interview, then had those notes typed. She discarded the original notes. Her typewritten notes of the interview with the Grievant state:

1. How long before you heard him calling and answered?
   - Ken yells when he wants something.
   - We were in E's room doing her bed check. We went from E's room to K's room and took care of him.
   - The light went on between the ladies. (Could tell because they hear a light go on and Ken was still yelling.)

   sk - You went right from E to K's bedside.
   - We finished in the room and then went to care for K.

   sk – You didn't care for anyone accept (sic) E prior to going to see what K needed.
   - We finished in the room and left.

2. What did K need
   - He needed to be changed.

3. What did you say outside the room.
   - We never said anything.

   I read the quote –
   - No, that didn't happen.

4. Did you report the incident.
   - After the bedcheck we came up and told. Told S "G went off. He was pretty mad at us."

5. What did nurse say.
   - S gave us letter head and asked us to write down what happened.

6. Why did you prepare a statement.
   - S asked us to.
   sk – Do you do this often?
   - No. This was unusual for him to be that mad at us.
   sk – This was different.
   - Yes, Not his usual self, usually he's just grumpy.
   sk - Have you ever told S about issue with G.
   - She said he gets grumpy. She told us he had complained about the noise at night, he would complain that the wheels on the linen cart was (sic) squeaking too loud. She told us we needed to be more quiet at night.
   sk- Did you feel you had done anything wrong.
   - I suppose you can answer this question. I've asked many people what do you do if your (sic) taking care of someone and some one puts on a call light. Do you stop what you're doing and answer there's (sic)?
   sk - Obviously you need to complete the care or task that you are doing. If there are two staff and it is safe, one should go and at least acknowledge that they will be next. Otherwise if it is not safe, you should both go and answer the light when you are finished with the resident. . . .
   sk - Have you show (sic) K how to use his call light.
   - We've shown him how to use it. G apparently puts his on for K because he figures K can't.
   sk - But if K is calling for help, it wakes him up and no one is coming, don't you think he was trying to get help for his roommate?
   - Maybe. I haven't talked to him at all since this happened. I go in and do my business and leave. I don't say a word. I've never seen him this mad.
   sk - And can you tell me why it was different this time?
   - No.
   sk - What do you remember about the conversation in the room.
   - I don't remember much, G was swearing at R, saying it took so long. I pulled the curtain and took care of K. I know she was trying to explain that we were doing cares. But he wouldn't listen.
   sk - Is there anything else you remember or want to tell me.
   - No.

. . .

Kotowski suspended the Grievant with pay at the close of this interview, pending further investigation. Kotowski's typed notes of the interview with RS state:

1. How long before you heard him calling and answered?
   - We were caring for E, K was yell (sic) for about 6-7 minutes before G put on his light. (The Grievant) and I chose to check A, B, N and R. E, A and B were wet and had to be changed.

   sk - How long did that take.

   - five minutes.

   sk – It took you five minutes to check five residents, change, do peri care and reposition them.

   - We only changed three of them, N and R were dry. We don't move them if they are sleeping. S said it is better to let them sleep.

   sk - So you are saying that K was yelling, the light was on and you took five minutes to check and or change five residents.

   - We chose to finish with our rounds. You don't work nights so you don't understand. We knew that the reason he was hollering was because he probably pooped.

2. What did K need
   - He needed to be cleaned.

   sk - He was laying in his feces?

   - Yes, But sometimes he isn't he wants something else.

3. What did you say outside the room.
   - Nothing.

   sk - read the statement.

   - No, we never said such a thing. The next morning Yvonne said she had heard that R was swearing at G.

4. Did you report the incident.
   - We told what happened, that he was angry.

5. What did nurse say.
   - S had us write our statements. She asked us how long it took from when K was yelling until we took care of him. She and J didn't have a problem with it.

6. Why did you prepare a statement.
   - S said she knows how G can make complaints and turn things around.

   sk – Can you tell me why you chose not to answer the light.

   - Because, he is incontinent, he sits in it and hollers. . . .

- My statements were probably out of line. That's why we don't spend as much time with G. We only do what we have to. We try not to ignore him. But we get out as fast as possible so he can't complain about us.

sk - R, I can appreciate the care you have given. However, you still haven't explained why you let some one who is oriented yell for help without acknowledging him, wake his roommate, who puts on his light. You and M decide for some reason you can't explain, to wake up other residents to check and change them. Then you get into a shouting match with a resident and blame all of this on him. I am going to suspend you with pay until completion of this investigation.

- So you're going to suspend me because of such a silly thing. I hope you know how short they are going to be. I hope someone hurts there (sic) back and it will be your fault.

sk- I know you are angry. But I must insure that you and the residents are protected until I can determine what needs to happen.

- You have no idea what goes on at night. You don't understand that we knew he had pooped. So what. . . .

In a letter dated October 29, 1997, Kotowski and Lisa Olejniczak, the Center's Administrator, filed a "Facility Self Report" with the State of Wisconsin's Bureau of Quality Assurance. The report states:

> On October 21, 1997 (sic) at approximately 2:30 a.m. KW, resident on Birch Blvd. began calling out for help. He woke his roommate, GH, with his calling. G put on the call light for K. . . .
>
> RS, CNA and (the Grievant), CNA were in EG's room taking care of her. They both heard K calling and heard the call light audible signal. They both state that they knew that K would yell when he had moved his bowels. The aides completed care on E. They then decided to continue rounds. They both acknowledged that there were no other residents calling out and there were no other call lights on. They proceeded to check and clean DV, AJ, and BS who had been incontinent. They also checked NS and RZ, who were dry. They both entered the room of K and G.
>
> G states that before the aides entered the room he heard one of them say "I hope K learns to use the Fucking call light soon." They deny making such a statement. G states when they entered the room he said "This is not a fucking call light, it is a call light." The aides state that G questioned them on the length of time it took to answer the light. A verbal altercation issued between R

> and G. At on (sic) point R stated "If you have a problem, you need to to (sic) and talk to Social Services in the morning". G stated he would. The aides completed care on K and left the room. . . .

The letter notes that the Grievant received a fifteen-day suspension and "will be reassigned to the day shift for closer observation and supervision." It also notes RS received a ten-day suspension and "will be reassigned to the evening shift for closer observation and supervision." The letter also notes that SS "has been counseled . . . (and) reassigned to the evening shift for closer observation and supervision."

The discipline prompting the grievance is set forth in a letter from Sharon Kotowski, the Center's Director of Nursing, to the Grievant. The letter, dated October 31, 1997, states:

> This letter is to inform you that you have been found in violation of resident rights, Columbia Health Care Center and Columbia County, policies and procedures.
>
> On October 24, 1997 an investigative meeting was held with you, Yvonne Boomsma CNA, union representative and myself. You were informed of the complaint filed against you. On the night of October 21, 1997 (sic) you and a peer were caring for E.G. in room 413 when you heard resident K.W. calling for help in room 408 (you state that he yells when he has had an involuntary stool). You then stated you heard a call light sound and assumed it was K.W.'s roommate G.H. (assisting his roommate since no one was responding to his yelling). You both continued to care for the roommate D.V. You state that you both then went directly to room 408.
>
> You're (sic) peer states that after finishing the residents in room 413 you both discussed what to do next and decided to complete rounds. You both then went into room 411 and cared for A.J. and B.S., you then proceeded to room 412 to care for N.S. and R.Z.
>
> You state that upon entering room 408, G.H. had a verbal altercation with your peer due to the delay of answering the call for help. You state that you could not hear all of the conversation because you pulled the curtain between G.H. and K.W. You stated you began to clean K.W. who had an involuntary stool. You then left the room with your peer and reported to the nurse that G.W. had been very angry.
>
> When questioned if you felt you did anything wrong, you did not answer the question. You were suspended with pay upon completion of the investigation.

> Upon completion of the investigation we find that you failed to give complete and accurate information regarding the incident. You failed to report the residents (sic) request to file a complaint with the facility. You also failed to uphold the residents G.H. and K.W. (sic), rights to be treated with dignity and respect.
>
> Your behavior is in violation of Federal Regulation F241 483.15 (a) . . . You are also in violation of HSS 132.31 (e) . . . You have also violated CHCC policy and procedure on Resident Rights. And to have violated Columbia County Work Rules (10) . . .
>
> Review of your personnel record indicates the following discipline: A ten day suspension without pay due to a resident rights violation, on November 9, 1995. A verbal warning regarding excess absence from work on October 7, 1997. A written reprimand regarding excessive absence from work on October 1, 1997.
>
> Due to your repeated intentional misconduct and negligence as well as continued failure to comply with policies and procedures as directed, progressive discipline will be followed. Effective October 28, 1997 you began a fifteen day suspension without pay. Upon completion of the suspension you will be reassigned to the day shift to allow increased observation and supervision. You will also meet with the Director of Social Services to review resident rights. . . .

The Union responded by filing a grievance dated November 3, 1997, which seeks the following: "Place Grievant back on noc. shift – remove all paperwork from files – Reimburse for all wages lost."

It is undisputed that federal and state regulations govern the Center's operation and that those regulations sanction verbal abuse and patient neglect. It is also undisputed that the Center maintains policies, which also sanction verbal abuse and patient neglect. Those policies treat a failure to report patient abuse or neglect as tantamount to abuse or neglect. It is undisputed that the Grievant was aware of these policies and regulations. There is no dispute that these policies are reasonable and enforceable.

The balance of the background to the grievance is best set forth as a brief overview of witness testimony.

Sharon Kotowski's Testimony

Kotowski noted that she determined the level of discipline to be imposed. She based the discipline on the Grievant's failure to respond promptly to the calls of KW and the call light of GH. She also based the discipline on the Grievant's failure to promptly and accurately report abusive behavior. She testified that the Grievant's written statement is inaccurate and understates the severity of the health care issues. She also interpreted the Grievant's October 24, 1997 account to be inconsistent with her written statement of October 16 and irreconcilable to GH's and RS's account of the Incident.

The Grievant's Testimony

The Grievant has served as a County CNA for roughly six years. She testified that she completed the care for the residents of room 413 before moving her laundry cart closer to a water fountain located in the vicinity of room 412. She then went to room 408, entered it shortly after RS, went to the bathroom to moisten a cleaning towel, then proceeded to K's bed, drawing the privacy curtain behind her. She stated that GH, without provocation, started to swear at RS about the amount of time the "fucking call light" had been on. She could hear GH and RS arguing, but could not make out what they were saying. She testified she did not hear RS swear at GH. She acknowledged RS spoke to GH "kinda loudly" but she stated RS speaks "loudly anyway." After she had finished cleaning KW, she left the room. While leaving, she did hear GH state that he wanted to turn them in. She then went to the nurses' station, but could not report the Incident, because no one was there. She reported the Incident after she had completed her rounds. JH and SS were then both at the nurses' station.

The Grievant acknowledged her recall of the Incident was less than photographic. She repeatedly reaffirmed her belief that she did not tend to any residents after she finished in room 413. Rather, she proceeded directly to room 408. Her recall of where she left the laundry cart was, to her, an indication that she had placed it to permit her to return to her rounds at rooms 411 and 412 after she finished in room 408.

Tracy Hohn

Hohn is the Center's Human Resources Manager. She noted that the County will discipline employes for failing to promptly respond to a call light signal. She could not, however, recall any case in which an employe had been suspended for failing to promptly respond to a call light.

Further facts will be set forth in the **DISCUSSION** section below.

THE COUNTY'S POSITION

The County contends that the suspension rests on two sound bases. The first is the Grievant's failure to promptly report the Incident and the second is the Grievant's lack of candor in describing the Incident when she finally reported it.

The County asserts that there is no dispute that the Grievant was aware of the need to promptly, accurately and fully report the entire Incident. The extensive and rigid regulatory background to resident care establishes the egregious nature of the Grievant's conduct. Abusive behavior is extensively addressed in Federal and State regulation, County policy, and the Grievant's job description.

That KW is incontinent establishes that the Grievant should have responded more promptly to him and that her failure to do so is egregious. The suspension imposed for this conduct should be considered reasonable.

That the Grievant casually informed her team leader that an Incident had occurred is an inadequate response. At a minimum, the Grievant should also have informed her team leader that GH wanted to make a formal complaint. Beyond this, the Grievant's response to supervisors regarding the events surrounding the Incident has been less than candid. The evidence establishes that this Incident manifests more than "slap on the wrist" type of conduct, and that the County had just cause to suspend the Grievant for fifteen days. Given the rigid regulatory framework the County must operate within, its disciplinary response must be swift and sure, as it was in this case.

The County further contends that the Grievant's reassignment from the night shift reflects the valid exercise of a management right, independent of the Incident underlying the discipline.

THE UNION'S POSITION

The Union notes that the reasonableness of the rules and regulations governing the Grievant's conduct is not at issue. Rather, the issue is whether the Grievant acted as the County asserts. The Union contends the County has failed to prove any conduct by the Grievant which could support a reassignment or discipline.

It is undisputed that KW called for assistance, but the Union argues that the Grievant was, at the time of KW's call, dealing with a soiled resident. That she finished her duties in that room before proceeding to KW was proper. That GH and RS had a verbal row cannot be held against the Grievant, who did no more than perform her job.

Nor can the Grievant's report of the Incident be faulted. She promptly reported the Incident to her team leader, and did nothing to hide any relevant detail. No testifying witness,

other than the Grievant, witnessed the underlying Incident. The County's case rests on dubious hearsay. The Union contends that this hearsay cannot be viewed as a more accurate portrayal of the Incident than the Grievant's direct testimony. Kotowski's notes are a dubious guide to the Incident, since they rest on hearsay and have been edited to leave out any part of the events which might corroborate the Grievant's testimony. In any event, that the Grievant did not report a loud argument between RS and GH has no disciplinary significance, since the Grievant did not believe such a dispute occurred and believed RS was attempting to calm GH.

The Union concludes that the County has failed to demonstrate any conduct warranting discipline. Beyond this, the Union argues that the Grievant's reassignment must be considered disciplinary. She used her seniority to secure work on the night shift. By losing that work she has lost her chosen shift and the premium pay associated with it. The Union requests that the grievance be sustained and the Grievant be made whole for the County's failure to act with just cause.

DISCUSSION

The stipulated issue is whether the County had just cause to discipline the Grievant. In the absence of the parties' stipulation of the standards appropriate to a just cause analysis, the determination of cause must address two elements. First, the County must establish the existence of conduct by the Grievant in which it has a disciplinary interest. Second, the County must establish that the discipline imposed reasonably reflects that interest.

Application of the first element is troublesome. Kotowski stated the conduct supporting the discipline in her letter of October 31. The sixth paragraph of that letter isolates the two themes advocated during the hearing. The first is that the Grievant "failed to report the residents (sic) request to file a complaint with the facility." The second is that the Grievant "failed to uphold the residents (sic) . . . rights to be treated with dignity and respect."

The first allegation is unproven. At most, it questions the completeness of the Grievant's written statement of the Incident. The allegation presumes GH made a request to file a complaint with the facility. GH did not testify, and what he wanted must be inferred from his written statement, the statements from the October 24 interviews, the Grievant's testimony, and Blackmore's testimony. None of that evidence indicates GH requested to "file a complaint with the facility." Rather, the evidence indicates he engaged in a verbal sparring match with RS and responded to her suggestion or taunt that he talk to social services in the morning. This is more than a technical point. The discipline assumes GH sought to file a complaint and that the Grievant was aware of this request and deliberately ignored it. The evidence is that RS and GH argued, and the Grievant heard bits and pieces of the argument. Her written statement reflects precisely what the evidence indicates. She knew GH was sufficiently angry to make the Incident reportable. There is no dispute she reported it. Her

written statement confirms her verbal report to JH and SS. Her statement details what it could reasonably be expected to. Once the Incident was reported to Center management, the investigation was in their hands.

Against this background, the first allegation is unproven. At most it quibbles with how the Grievant reported the Incident. More significantly, it presumes the Grievant's account is incredible, and holds her accountable for failing to relate a request she claims she never heard. Even if her account was incredible, it is not apparent that there is an established complaint procedure the Grievant could have, or should have referred to. Even if there was, it is not clear how she can be held disciplinarily accountable for her report of the Incident. Her report provoked contact between Center management and GH. That contact is the essence of a complaint procedure. There is, in sum, no proven conduct in which the Center has a disciplinary interest regarding the first allegation.

The second allegation is the focus of the County's arguments, and poses troublesome issues. Kotowski's October 31 letter asserts the Grievant failed to "uphold" the right of KW and GH "to be treated with dignity and respect." This broad statement is itself troublesome. If the Grievant is to modify inappropriate behavior, there should be a concise statement of what the improper behavior is, and how it can be made proper. The second, third and fourth paragraphs of that letter recount the Center's investigation, but must be taken as the statement of what was inappropriate in the Grievant's behavior. The ninth paragraph of the letter would appear to assert that the Grievant's conduct constitutes "intentional misconduct" and "negligence."

The contention that the Grievant is guilty of "intentional misconduct" is unproven. It presumes the Grievant and RS completed their rounds before administering to KW. This presumption credits RS's account and discredits the Grievant's. This is a defensible conclusion, but must be rooted in either RS's account or the Grievant's. The evidence will not, however, afford reliable support for concluding RS and the Grievant completed their rounds before attending to KW. Significantly, there is no evidence Center management weighed the two accounts against each other. Rather, they presumed the Grievant's account was incredible. That the accounts were not weighed is, standing alone, a troublesome point. A facial review of Kotowski's October 24 interviews establishes RS and the Grievant were not acting in concert to cover up the Incident. Rather, those accounts are irreconcilable. The Grievant's account depicts a direct response to room 408 after the completion of room 413, while RS's account depicts no response to room 408 until the end of their rounds.

There is no reliable basis to reject the credibility of the Grievant's account. Her account was internally consistent and credible. She admitted without prompting that her recall was less than photographic. She did not attempt to cover up potential errors of judgment. Beyond this, her account is consistent with Kotowski's notes from the October 24 interview.

Those notes manifest the Grievant's acknowledgment that she was unsure whether to complete room 413 before responding to room 408. This establishes, at most, an error of judgment. It falls far short of "intentional misconduct." Beyond this, there is reason to question the reliability of RS's account. She did not testify, but Kotowski's notes from the October 24 interview show evident anger and an unwillingness to acknowledge fault outside of intemperate statements to GH. According to those notes RS vaguely threatened Kotowski. Why Kotowski would credit this account over the Grievant's is not apparent.

At best, then, the second allegation turns on a potential error of judgment or negligence. Significantly, the error in judgment is ill defined. Nowhere in the October 31 letter is the improper conduct specified. Presumably the objectionable conduct is the amount of time it took to respond to KW. Since the assertion that RS and the Grievant completed their rounds is unproven, and since the Grievant's contrary assertion is credible, the negligence must turn on RS's and/or the Grievant's failure to leave room 413 to respond to KW. This is underscored by Kotowski's response to the Grievant's questioning whether "you stop what you're doing and answer" a call light.

Kotowski's response to this question succinctly states the improper conduct and its remedy. It presumes the response to room 408, however it occurred, was tardy and thus negligent. The objectionable behavior thus becomes the Grievant's failure to respond to the call light or her failure to ask RS to do so.

The evidence will support a conclusion that objectionable conduct occurred. The credibility of the Grievant's account cannot undercut this conclusion. Her account acknowledges, but cannot explain the level of GH's anger. Since it is undisputed GH was upset before RS and the Grievant entered his room, there is no way to account for his anger other than by concluding the response to room 408 was tardy.

The strength of this conclusion should not, however, be overstated. Significantly, Blackmore's record of GH's statement posits a hallway obscenity, not the delay in response, as the immediate cause of his anger. That there was a delayed response is proven. The amount of delay remains, however, undetermined.

In sum, the only proven misconduct is the tardiness of the response to GH's call light. It now becomes necessary to determine whether the reassignment and suspension reasonably reflect the County's disciplinary interest in this conduct.

By the terms of the October 31 letter, the suspension is rooted in "intentional misconduct" and "negligence." The absence of any intentional misconduct by the Grievant severely undercuts the degree of the County's disciplinary interest.

Nor will the error in judgment noted above support a suspension. It is undisputed that the County's progressive discipline system starts with a written warning. There is no reason to conclude the Grievant's conduct would warrant more than such a warning. As Kotowski's notes of the October 24 interview show, the Grievant was confused about what she should have done. The record shows no reason to believe the Grievant could not have understood or would not have followed Kotowski's response:

> Obviously you need to complete the care or task that you are doing. If there are two staff and it is safe, one should go and at least acknowledge that they will be next. Otherwise if it is not safe, you should both go and answer the light when you are finished with the resident.

The difficulty posed in the determination of the reasonableness of the County's disciplinary response is that the County imposed two levels of discipline. Concluding it had cause to issue the Grievant a warning leaves untouched whether it had cause to reassign her to the first shift.

The County contends the reassignment can be viewed as a management right, and the language of Section 2.01 offers support for this view. The stipulated issue, however, focuses on cause to discipline, and it is apparent that the reassignment would not have occurred in the absence of discipline. Thus, the reassignment must be treated as disciplinary. As noted above, the County disciplined the Grievant for egregious misconduct, but the evidence establishes a far more subtle error of judgment. That misconduct cannot reasonably support two levels of discipline.

The issue thus becomes remedial and complex. Resolution of this point requires some discussion. The error in judgment posed was, in a sense, shared. RS no less than the Grievant failed to split the team to address the situation in room 408 while room 413 was completed. What evidence there is would cast greater doubt on RS's conduct than the Grievant's. There is no dispute the Grievant moved the cart and initiated the hands-on care of KW. Nor is there any reliable evidence to indicate the Grievant started or exacerbated the verbal sparring between GH and RS. Thus, the County's disciplinary interest in the Grievant's conduct is attenuated.

As the County notes, the Center's response was swift and sure. Three of the four night shift employes involved in the Incident were disciplined and reassigned. This reflects the Center's zealous concern for resident rights. An excess of concern on this point arguably promotes the quality of resident care, and reflects that night shift employes must be expected to function with limited oversight. The reassignments reflect Center concern that employes be observed and trained to earn or to restore the confidence underlying assignment to a shift with limited supervision. This cannot be considered unreasonable.

The Award entered below overturns each aspect of the discipline but the reassignment. The error in judgment noted above cannot support two levels of discipline. I have selected the reassignment as the sole level of discipline for which cause exists. The reassignment, unlike a warning or suspension, reflects the uncertainty underlying the events of the Incident. Reassignment reflects the Center's consistent and reasonable concern with observing the conduct of employes working under limited supervision. Subtle errors of judgment are more significant in situations in which that judgment must be exercised autonomously. Reassignment also reflects that responsibility for the Incident is shared, and that the Grievant's personal responsibility will not warrant both reassignment and traditional discipline. Beyond this, reassignment, unlike a suspension or a warning, permits the Center to break up a team of employes it may have lost confidence in, while permitting the Grievant and Center management to establish a relationship built on confidence in observed conduct. Returning the Grievant to the night shift, on this record, would do nothing to address evident mistrust between her and Center management. This is, however, a two edged sword. The reassignment cannot be considered permanent punishment. Nothing said in this decision should be taken to limit any contractual right the Grievant may have to return to the night shift in the future. The Award cannot guarantee that return, but can establish conditions under which her return may become possible.

The make-whole aspect of the Award requires only limited discussion. Although it is arguable that she could have been reassigned at the point she was suspended, the fact remains that she was not. The County chose to punish her twice. Thus, the back pay award includes her shift differential, if any. The expungement of her personnel file(s) poses a subtle point. Reference to the disciplinary nature of the reassignment should be carefully tailored to reflect the specific and narrow nature of the Center's disciplinary interest in the Grievant's role in the Incident. In the event this poses more problems than it solves, the Award permits the County to place this decision in her file(s) as the documentation of its disciplinary interest.

AWARD

The County did not have just cause to suspend and reassign the Grievant. The County did, however, have just cause to reassign the Grievant.

As the remedy appropriate to its violation of Section 2.01 D), the County shall make the Grievant whole by compensating her for the wages and benefits, including any shift differential, she would have earned but for the fifteen day suspension noted in the October 31 letter. The County shall expunge any reference to the suspension from her personnel file(s). The County may, however, amend her personnel file(s) to note that she was reassigned to the first shift to permit increased observation and supervision. This amendment shall not state nor

imply that the reassignment precludes a return to any other shift, and shall not state a disciplinary interest in conduct broader than that sustained in this decision. If the County elects not to so amend her personnel file(s), it may include a copy of this decision in her personnel file(s).

Dated at Madison, Wisconsin, this 9th day of July, 1998.

Richard B. McLaughlin /s/
Richard B. McLaughlin, Arbitrator

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