BEFORE THE ARBITRATOR

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In the Matter of the Arbitration of a Dispute Between

**BROWN COUNTY EMPLOYEES LOCAL 1901 of the AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES AFL-CIO**

and

**BROWN COUNTY, WISCONSIN**

Case 655
No. 60134
MA-11535

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Appearances:

**Mr. Michael J. Wilson,** Representative-at-Large, Wisconsin Council 40, AFSCME, AFL-CIO, 8033 Excelsior Drive, Suite B, Madison, Wisconsin 53717-1903, appearing on behalf of Brown County Employees Local 1901 of the American Federation of State, County and Municipal Employees AFL-CIO, referred to below as the Union.

**Mr. John C. Jacques**, Brown County Assistant Corporation Counsel, 305 East Walnut Street, P.O. Box 23600, Green Bay, Wisconsin 54305-3600, appearing on behalf of Brown County, Wisconsin, referred to below as the County or as the Employer.

## 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 Irene Seefeldt. The Commission appointed Richard B. McLaughlin, a member of its staff. Hearing on the matter was held on December 18, 2001, in Green Bay, Wisconsin. A transcript of the hearing was filed with Commission on January 24, 2002. The parties filed briefs by February 26, 2002.

## ISSUES

The parties stipulated the following issues for decision:

Did the Employer have just cause to discharge the Grievant?

If not, what is the appropriate remedy?

## RELEVANT CONTRACT PROVISIONS

ARTICLE 1. MANAGEMENT RIGHTS RESERVED

Unless otherwise herein provided, the management of the work and the direction of the working forces, including the right to . . . discharge for proper cause . . . is vested exclusively in the Employer. If any action taken by the Employer is proven not to be justified, the employee shall receive all wages and benefits due him/her for such period of time involved in the matter.

. . .

ARTICLE 26. GRIEVANCE PROCEDURE – DISCIPLINARY PROCEDURE

. . .

DISMISSAL: No employee shall be discharged except for just cause . . . If the cause for discharge is dishonesty, intoxication on the job or drinking or use of illicit drugs on duty, and/or if an employee is convicted in the illicit sale of drugs or pushing drugs, the individual may be dismissed immediately from employment with no warning notice necessary.

DISCIPLINARY PROCEDURE: The progression of disciplinary action normally is, 1) oral, 2) written, 3) suspension, 4) dismissal. However, this should not be interpreted that this sequence is necessary in all cases, as the type of discipline will depend on the severity of the offense. Oral warnings shall be maintained in effect for six (6) months, written warnings for (12) months an (sic) disciplinary suspensions for eighteen (18) months during which time a repetition of an offense can result in a more serious disciplinary action.

. . .

## BACKGROUND

The grievance challenges the Grievant's discharge on June 19, 2001 (references to dates are to 2001, unless otherwise noted). Earlene Ronk, the Hospital and Nursing Home Administrator for the County Mental Health Center, issued the letter of termination, which states:

**Circumstances:**

Incident of March 10, 2001 when a client was found hanging in an attempted suicide on Unit 7 and patient complaints.

**The following facts were brought out as a result of the investigation:**

A client was found hanging in an attempted suicide on March 10, 2001. You responded to the client's room but did not follow the procedure on Code Emergency (ER) or call Code ER or 911 as directed by the RN. A staff person at the desk called 911. The staff person who called 911 did not know what to report to the 911 dispatcher because they did not witness the emergency. The staff person then asked you to report to the dispatcher. You told 911 dispatcher that there was an attempted suicide at BCMHC. After you hung up the phone you proceeded to the ambulance entrance as assigned by another staff person since you were aware of the location and the reason 911 was called. When you got to the ambulance entrance you opened the door and stated to the staff outside that "some bitch tried to hang herself", and then went back inside the building. These actions are in violation of:

- Brown County Mental Health Center's policy and procedure "Code Emergency", which states "Any staff member discovering a medical emergency should dial 4880 to activate the phone intercom (PA System) and announce in a loud, clear, and controlled voice: "Code ER on Unit ____" three times over the PA system.

- Brown County Mental Health Center's policy on Abuse, Neglect or Mistreatment of Clients "Neglect includes such actions as failing to follow standard procedures and treating in accordance with instructions of a physician, nurse or supervisor".

- Brown County Mental Health Center's policy on Courtesy, "Conduct yourself in a professional manner by exemplifying the standards and ethics attributed to your occupation or profession".

- BCMHC's policy on Work Rules/Code of Conduct "discourteous treatment of patients or the use of profanity or threatening language".

- BCMHC's Policy on Discipline "unsatisfactory conduct", "insubordination or failure to comply with a proper order from your supervisor".

- Brown County Code of Ordinances 4.94 Grounds for Discipline (11) Failure to adequately perform assigned job duties. (12) "Failure to follow duly established work rules, policies and procedures" and (13) Professional unethical conduct or behavior."

**Findings:**

You admit and it is substantiated that you have been trained in the Brown County Mental Health Center's procedure on Code Emergency. . . . You said that you did not initiate the Code Emergency because no one told you directly. It is substantiated by a staff RN that you were directly told to call 911.

On May 11, 2001 you stated that you didn't witness the medical emergency, but that you knew there was a medical emergency but didn't know what kind of medical emergency. You previously admitted on April 26, 2001 that you responded to the call for help and saw the client on the bed and then heard someone say "call 911". You admitted that you were on the phone with the 911 dispatch after they had been called by another staff member and that you told 911 dispatch that there was an attempted suicide at MHC. Your response of May 11th was dishonest.

You admit that you went to the ambulance entrance and saw staff but deny saying "some bitch tied to hang herself". It has been substantiated that four staff witnessed you saying, "some bitch tried to bang herself" at the ambulance entrance. Your denial of the statement was dishonest

**Circumstances:**

A number of client complaints were received regarding rude behavior. These complaints are dated September 21, 1999, two on April 22, 2000, January 30, 2001, February 6, 2001, three on February 5, 2001, February 7, 2001, and February 13, 2001. Mr. Jones met with you on February 20, 2001, in attempts to correct this behavior. Additional client complaints were received on March 12, 2001, April 14, 2001, April 16, 2001, and April 17.2001.

**The following facts were brought out as a result of this investigation:**

In February 2001 MHC received several client complaints regarding your rude behavior and inappropriate remarks. Bill Jones, Deputy Director talked to you and recommended that a staff member work with you in a supportive coaching role to observe and point out situations where your behavior could be perceived as rude. You were agreeable to this suggestion and said you would use Cheryl Metoxen, RN.

In March and April 2001 MHC received several more client complaints regarding your rude behavior and inappropriate remarks. All client complaints were consistent in so far as you're displaying rude behavior. In April Bill Jones investigated these complaints and found that you did not take the opportunity to use Cheryl Metoxen in a supportive coaching role that was agreed upon in February. When Mr. Jones asked you if you had been in contact with Ms. Metoxen you were dishonest. You stated you sought Ms. Metoxen's feedback "half a dozen times". Ms. Metoxen has confirmed that you never solicited her feedback.

. . .

**Findings:**

When Bill Jones . . . investigated complaints you agreed with Mr. Jones . . . that you would use Cheryl Metoxen in a supportive coaching role. When you met with Mr. Jones on April 25, 2001 regarding additional patient complaints you stated that you sought Ms. Metoxen's feedback "half a dozen times". Ms. Metoxen confirmed that you had never solicited her advice. Your statement to Mr. Jones regarding soliciting feedback from Ms. Metoxen was dishonest. you admit that you were rude to Ms. Metoxen during your statement on May 11th because she is on the phone a lot and sometimes you need an immediate answer.

**Employment History:**

- You were hired 4/8/98
- 01/25/00 – Oral Warning Did not attend Education Day
- 2/22/00 – Written Summary – to submit overtime cards
- 04/14/00 – Written Summary – Used U1 as a thoroughfare
- 05/02/00 Written Warning – Failed to show proof of CPR Recertification
- 06/08/00 – Oral Warning – Tardy

- 06/22/00 – Written Summary – rude and disrespectful to clients
- 06/22/00 – Written Summary – refused mandatory overtime
- 07/20/00 – Written Warning Rude and disrespectful toward client on 4/28 & 7/20/00 authoritative and loud with client.

**Conclusion:**

This investigation leads to the conclusion that continued violations and disregard for the clients' rights and the clients' mental and emotional needs. You used poor judgment and decision making by failing to respond appropriately to an emergency situation. You were dishonest and do not accept responsibility or take accountability for your actions. You were rude and disrespectful to staff and clients.

Because of these continued violations, the County must terminate your employment effective today, June 19, 2001.

The parties dispute significant portions of the substance of this letter. Thus, the background will start with that part of the factual background that is not in dispute.

The Grievant worked as a Nursing Assistant for the County from April 8, 1998 until June 19. She worked as a part-time employee throughout her tenure, starting work on the Center's adolescent unit, then posting into a position on Unit 7. The posted position afforded her sixteen hours per week, but she picked up hours beyond those posted, sometimes working forty hours per week.

There is no dispute that the "Employment History" section of the June 19 letter is accurate. The Grievant did not grieve any of the cited disciplines. The "Written Summary" entries are not items of progressive discipline. Rather, a written summary is an informal counseling notice to an employee of a work rule infraction. An employee can respond to a written summary, but the summary and response are considered informal responses to workplace issues rather than part of progressive discipline.

The "client complaints" listed in the "Circumstances" section of the June 19 letter are not substantially in dispute, and are addressed in greater detail below.

The events of Saturday, March 10 are disputed. The Grievant was working on the PM shift at Unit 7 that evening. Teresa Traas and Ida Tiske were the Registered Nurses for Unit 7 for that shift. Jancie LaBelle is a Licensed Practical Nurse who worked on Unit 7 for that shift. A female patient within the Grievant's caseload attempted suicide by hanging herself in

her room. Steve Shefchik found the patient while doing a "fifteen minute" check of the room. The County does not claim that the Grievant was negligent in monitoring the patient. Shefchik held the patient up and called for help. Eric Gilles, Tiske and Traas, among others, responded. Shefchik, Gilles and Traas pulled the patient down. Word was relayed to the nurses' desk to phone 911. LaBelle was at the desk, awaiting instructions, when word came to her that an emergency response was necessary, and that she should call 911. LaBelle did so, but had no knowledge of the circumstances prompting the call, and handed the phone to the Grievant to advise the 911 dispatcher of the circumstances. The Grievant spoke with the dispatcher, then, sometime later, went to the entrance through which the emergency personnel would enter. Emergency personnel responded to the call, and transported the patient from the Center to a hospital. The intervention proved, however, unsuccessful and the patient died.

Shirley Gruender is County's Nursing Services Administrator for the Acute Hospital. She is the supervisor of Unit 7. The Center is regulated by federal and by state law, and Gruender's duties include the investigation of patient injury or death as well as incidents implicating the impact on employee conduct on patients' rights. She is responsible for the initial phase of investigating the patient's death as a personnel matter and as a regulatory matter.

Gruender did not learn of the events of March 10 until March 12. Traas and others contacted Gruender to voice concerns with the events of that evening. From March 12 through late April, she interviewed individual employees, including the Grievant, who were direct participants in the events of March 10. Some of the interviews were informal, and others were reduced to writing.

Gruender turned her investigation records to Sue Gladh, a Human Resources Analyst, in late April or early May. On May 11, Gladh, Gruender, the Grievant, and Mike Ratachic, a Union Steward, met concerning the status of the investigation. Gladh read a statement to the Grievant that covered the results of the County's investigation concerning the Grievant's role in the events of March 10, as well as the County's investigation concerning the Grievant's conduct toward residents prior to and following March 10. The statement included a recitation of a series of violations of Center work rules and County policies. Gladh read the statement, then asked the Grievant whether she had "any other information that you . . . would like to be considered" before the County determined "any appropriate action" to take regarding its investigation. The Grievant responded in some detail, as noted below. The County suspended the Grievant with pay on May 11, pending further investigation. Ultimately Gruender and Gladh turned the results of their investigation effort over to their supervisors. Ronk and James Kalny, the County's Human Resources Director, made the decision to terminate the Grievant.

Gruender also is responsible for investigating patient complaints at the Center. Patient complaints have a County personnel and a state regulatory dimension. Roughly speaking, the County personnel interest is triggered by any informal complaint, and concerns the County's interest in the quality of patient care services. The state regulatory interest flows from state mandates establishing patient rights. That complaint process demands the filing of a formal complaint. William Jones is the County's Deputy Director of Human Services. He is responsible for responding to patient complaints as a regulatory matter. He shares responsibilty with Gruender regarding patient complaints as an informal, County personnel matter. On the filing of a formal complaint, Jones transmits it to the employee's immediate supervisor for investigation and consultation with the patient and employee. Some complaints are informally resolved at this point. If no resolution is possible, Jones completes a formal investigation. As a matter of County administrative hierarchy, Jones reports to the County Director of Human Services, Mark Quall. Gruender reports to Ronk.

The "Circumstances" portion of the June 19 letter states fourteen complaints. Of those fourteen, the following were formal complaints: September 21, 1999; February 6; each of the three on February 5; March 12; April 14; and April 16. After a formal investigation, Jones found a client's rights violation on only the September 21, 1999 complaint. The February 6 complaint did not, in Jones' view, reflect sufficient evidence for the finding of a client's rights violation, but demanded that the Grievant be counseled concerning the matter. In response to the three complaints of February 5, Jones discussed patients' perceptions of the Grievant with the Grievant and with Cheryl Metoxen, an RN. The Grievant agreed to use Metoxen as a mentor on patient care issues. This arrangement was informal. Jones did not require any specific contacts between Metoxen and the Grievant, and did not require that any contacts be documented. The April 14 and 16 complaints did not produce a finding of a client right's violation, but prompted Jones to write a memo to Ronk dated May 1.

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

**Earlene Ronk**

Ronk's role in the decision to discharge was based on the investigation efforts of Gladh, Gruender and Jones. She never spoke to the Grievant concerning the discharge investigation or decision. The discharge decision, in her view, rested on a number of bases. Her concern with the Grievant's dishonesty is rooted on three fundamental factors: (1) the Grievant's statement to Jones that she had used Metoxen as a mentor on a number of occasions; (2) her denial of referring to the suicide victim as a bitch; and (3) her denial of being directed to call 911 on March 10. Beyond this, Ronk viewed the Grievant's work history to manifest a continued pattern of rude and disrespectful conduct toward patients. The decision to discharge reflected to her the failure of progressive discipline and the egregiousness of the Grievant's conduct on March 10.

**Theresa Traas**

Traas testified that on March 10, she was on the phone in a back office, when she heard someone shouting for help. She came out of the office, and saw the Grievant leaving the room in which the patient had attempted suicide. The Grievant and Traas approached each other, and the Grievant asked Traas to call 911, then said "No. you'd better go in" (Tr. at 45). Traas then instructed the Grievant to call 911 and a Code ER. Traas then proceeded into the patient's room. When she entered, Shefchik and Tiske were there. Traas attended to the patient until emergency personnel took her from the Center.

On March 23, Gruender formally interviewed Traas. Gruender's written summary of the interview reads thus:

> I am requesting that you answer my questions completely and honestly. I also request that you do not discuss this interview until our investigation is completed.
>
> 1. Describe the procedures, which staff should follow during a Code ER.
> I expected staff to remove the clients from the area and keep them occupied. Instead, (the Grievant) kept popping in and out of the room.
> 2. Was CPR performed?
> Yes.
> Describe this procedure.
> I know that (the Grievant) saw the client hanging before I did. All staff should know to call a Code ER and 911 immediately. I had to tell (the Grievant) to do so.
>
> . . .
>
> 4. Describe (the Grievant's) behavior.
> She was running back and forth with her arms and hands waving. She was not helpful.
> 5. What did she say?
> She complained loudly at one point. "I don't know what's taking so long, they don't have her tubed yet." Rescue and police heard this, also.
> 6. What did she do?
> Nothing useful as far as I know.
> 7. Where were you?
> In the client's room until she left.

8. Did you say anything to her?
   As she did not call the Code ER, I said, "you must not have heard me when I asked you to call the Code ER." I also asked what she told the 911 dispatcher, as Rescue did not know she was "down."
9. What was her response?
   I can't remember exactly, but she claimed that the dispatcher asked her questions that she did not feel needed to be answered.

. . .

Traas' answers to Questions 8 and 9 reflect a discussion she had with the Grievant on March 11. She signed Gruender's written summary of the interview on April 12. She testified that she believed she and the Grievant were "within arms' reach" (Tr. at 61) when she directed the Grievant to phone 911 and call a Code ER. She acknowledged that it was possible that the Grievant did not hear her.

**Peggy Niemi**

Niemi was, on March 10, a Nursing Assistant assigned to Unit 8. Niemi, Anne (Pinky) Betts, Darcy Zienert, and Christine Kelly were taking a smoke break outside of the Center, in the area through which ambulances enter.

As Niemi approached the door to the Center, (the Grievant) opened the door and said "the bitch hung herself." Niemi confirmed the statement in a formal interview with Gruender on April 23. She testified that the Grievant was within roughly ten feet of her when the Grievant made the statement. The Grievant appeared to be "upset and shaky" to Niemi, but did not ask anyone to do anything. Niemi acknowledged that staff use the term "bitch" in workplace conversations. She signed Gruender's summary of the April 23 interview on April 27.

**Darcy Zienert**

Zienert is a Nursing Assistant, and was taking a smoke break with Niemi, Betts and Kelly when she heard a supervisor being paged to Unit 7. In her interview with Gruender, she responded thus to the question "How was (the Grievant) involved?

> (The Grievant) came down from Unit 7. Opened the door and said, "some or the bitch tried to hang herself" then went inside to get the elevator. Ron McIntosh then came and said, "Pinky, you're needed on Unit 7."

Zienert testified that she heard the Grievant use the term "bitch tried to hang herself" but was unsure what preceded the words. She estimated they were five feet apart when the Grievant made the statement. Gruender interviewed her on March 20, and Zienert signed Gruender's written summary of the interview on March 28.

**William Jones**

Jones has served in his present position since 1998, but has served the County in various positions involving the care of mentally ill patients since 1969. He suggested mentoring to the Grievant in February in response to the complaints noted above. The Grievant suggested Metoxen would be suitable, and Metoxen agreed. In April, while investigating another complaint, Jones interviewed the Grievant. He asked if she had used Metoxen as a mentor. The Grievant responded that she had approached her on at least six occasions. Jones then contacted Metoxen, who informed him that the Grievant had not contacted her as a mentor, but that Metoxen had counseled the Grievant on one occasion that she had behaved toward Metoxen in an insubordinate fashion.

Jones' May 1 memo to Ronk states:

> Although no violations were found, I do have concerns over (the Grievant's) attitude and perception of clients. . . .
>
> There is a consistent reaction among clients interviewed that (the Grievant) comes across as angry, controlling and frustrated. . . .
>
> I believe that . . . (the Grievant) does come across in a negative way and reacts to clients when they become hostile. In addition she appears to lack an understanding of mental health issues and the need for a supportive approach in dealing with clients.
>
> Her approach and attitude toward clients has been an ongoing issue and I believe that clients' right to be treated with dignity may be compromised.

Jones did not issue a copy of this memo to the Grievant, and was not aware what, if any, action it prompted.

**Sue Gladh**

Gladh stated that she interviewed the Grievant in late April and again on May 11. Ratachic recorded the May 11 interview and had a typed summary prepared. That summary states the Grievant made the following responses to Gladh's statement:

. . .

> You state a client was found hanging. I didn't know she was hanging, I didn't see her in her room. I heard another staff member yell for help . . . Nobody ever, ever, and I never heard the words say, call Code E.R. Never. And I was the person on the phone with 911. And I didn't witness the emergency. All I know is we had a medical emergency; of what kind I have no idea . . .
>
> And I didn't hang up the phone and proceed to the ambulance entrance. I hung up the phone and went down to where another staff person was standing on a one to one and I sent this male staff person to help only because he was a male staff person, bigger, stronger, and I could watch this person that was sleeping. They might need a male down there. So I didn't go the ambulance entrance immediately, I went and stood in the hallway with the one to one. And I never, ever said some bitch is trying to hang herself . . . And I talked to Cheryl Metoxen all the time, why Cheryl said I'm not using her as a sounding board, I have no idea. I did not lie to Bill Jones, dishonesty, I talked to Miss Metoxen a lot, ask her. Now if Miss Metoxen said I was rude, I have to agree with that because she is on the phone a lot and sometimes I need an instant answer . . .

Gladh did not participate directly in the decision to discharge the Grievant.

**Shirley Gruender**

Gruender noted that the Grievant's July 20 written warning rests on informal complaints filed by patients on April 28 and on July 10. The warning states the "Circumstances" thus:

> On April 28, 2000, (the Grievant) performed two room checks on a Unit 1 client. The checks were not requested or approved by the RN. An investigation . . . revealed that the checks were done without consulting with the RN. The procedure for room checks was not followed as the client's belongings were "thrown on the floor" with some items torn by (the Grievant). The client complained that (the Grievant) was, "rude and disrespectful" toward her.
>
> On July 10, 2000, (the Grievant) was observed to be authoritative and loud with a client on Unit 1. Her manner toward this client caused the client to become more disturbed and defiant. She became angry with the client and was displeased when the client was reassigned to another staff person.

These were informal complaints, and Jones played no role in them. Gruender estimated that she receives perhaps five to six patient complaints per day. She testified that in her twenty-eight years of experience no nursing assistant had ever received as many complaints as the Grievant did within her tenure at the Center.

Gruender's investigation of the events of March 10 did not indicate that any patient heard or could have heard any remark made by the Grievant to employees in the smoking area. She noted that her investigation took a considerable amount of time, in part because of the difficulty of coordinating the investigation with the working hours of the various participants.

**Ann Betts**

On March 10, Betts served as RN on Unit 8. She noted that while on break, Ron McIntosh came from Unit 8 to summon her to the emergency. At roughly the same time, the Grievant opened the door to the ambulance area and said "some bitch tried to hang herself" and then returned into the building. Betts arrived at Unit 7 before any personnel responding to the 911 call. She has heard employees use the term "bitch." Gruender interviewed Betts on March 20, and Betts signed the written summary on March 22.

**Jancie LaBelle**

LaBelle was at the Nurses' Desk on March 10, awaiting directives from an RN. She heard someone shout from outside of the patient's room to call 911. LaBelle did so, then gave the phone to the Grievant because "I was not sure what had happened . . . (the Grievant) was there and I asked that she give them the information." She testified that she could not answer the questions the 911 dispatcher was asking her, and thus gave the phone to the Grievant who "had come from that end of the hall" (Tr. at 154). She could not recall what the Grievant said to the 911 dispatcher, and never heard any directives issued by an RN.

**Cheryl Metoxen**

Metoxen testified that Jones approached her sometime in February concerning patient complaints about the Grievant. Metoxen was unfamiliar with the circumstances of the complaint and so informed him. Jones subsequently asked her if she would be willing to serve as a mentor for the Grievant and she agreed. Jones confirmed the understanding with Metoxen and the Grievant. Sometime during this period, Metoxen counseled the Grievant that the Grievant had behaved insubordinately toward her on two occasions. Several weeks after setting up the mentoring arrangement, Jones again approached Metoxen, seeking to determine if the Grievant had used her as a mentor. Metoxen stated that the Grievant had not done so. This answer, however, reflected, to Metoxen, no more than that no patient-care issues had arisen during that period. She confirmed that she and the Grievant spoke often during the period, but Metoxen did not regard those contacts as counseling or mentoring.

**Christine Kelly**

Kelly worked as a Nursing Assistant on Unit 8 on March 10. Gruender interviewed her on April 23. Kelly stated during the interview that the Grievant came out of the building into the ambulance area, but did not ask anyone to respond to the emergency. Kelly informed Gruender that the Grievant said something to the effect that "Someone hung herself or the bitch hung herself." Kelly could not recall the specific statement. The Grievant appeared "lost and not knowing what to do." She signed Gruender's written summary on April 24.

**Steve Shefchik**

Shefchik discovered the suicide attempt, held the patient and called for help. A patient relayed his call down the hallway. He looked up at one point and briefly saw the Grievant in the doorway of the patient's room.

**Eric Gilles**

Gilles testified that just before he entered the patient's room, the Grievant left it. Tiske and Shefchik were in the room when he entered. Traas arrived sometime later. On March 10, Gilles worked on Unit 4, but responded to Unit 7 on the direction of the House Manager.

**The Grievant**

The Grievant denied the accuracy of any testimony that she observed the patient's suicide attempt at any time. She also denied ever referring to the patient as a bitch. She stated that she spoke regularly with Metoxen, asking general questions about patient care.

On March 10, she responded to the call for help by following some nurses toward the patient's room, but never got far enough down the hallway to observe it. She did not hear anyone tell her to call a Code ER, but did hear someone say that someone should call 911. She denied that Traas directed her to do so, testifying that "She never said that" (Tr. at 204). At some point after speaking with the 911 dispatcher, someone told her to go down to the ambulance area "and make sure the elevator and the doors were unlocked and ready for the ambulance personnel when they got there" (Tr. at 205). She could not recall who directed her to do so.

She acknowledged that she had received complaints from patients, and that Jones responded to them. She did not, however, perceive that Jones regarded the complaints as serious or even worthy of serious consideration until he discussed her use of Metoxen as a mentor. She spoke with Metoxen regularly after that. The contacts were, however, casual conversations about work rather than patient complaints. She has heard employees use the

term "bitch" to refer to patients, and acknowledged the impropriety of the reference. She did not use the term on March 10. She summarized her response on that evening thus:

> I responded to the emergency to the best of my capability. I gave dispatch all the knowledge that I had at the time. I got the doors and the elevator open and operating, because the elevator really wasn't operating that night. Had to make a special call to maintenance to get them there because they needed the elevator for the gurney. I sat with one-to-one clients while someone else was helping out in the hanging client's room. I soothed patients' nerves. I tried to keep the halls clear of any and all debris left over from emergencies like there are caps and whatnot lying around. I tried to keep clients away from everyone that was working on the emergency as best I could. I stayed calm under the entire thing and did my job to the best of my ability (Tr. at 213).

She acknowledged that she knew Code ER procedures, but denied that she had any knowledge that could prompt her to call the code or 911.

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

## THE PARTIES' POSITIONS

### The County's Brief

After a review of the evidence, the County argues that the record establishes just cause for the Grievant's discharge. The labor agreement provides that "(m)isconduct of a serious nature constitutes just cause for discharge." The Grievant's remarks, including referring to a dying resident as a "bitch," are "so inappropriate and so disrespectful to the patient that they constituted just cause for discharge."

Beyond this, the Grievant's failure to promptly respond to Traas' direction to call a Code ER violates established policy to a degree constituting "gross incompetence," which standing alone warrants discharge. The Grievant's failure to respond honestly to County personnel about the events of March 10 further establish cause for discharge. The Grievant denied referring to the patient as a "bitch," denied witnessing the emergency, and denied being directed to call a Code ER. The pattern of false statements itself establishes cause to discharge.

Further considerations support this conclusion. The Grievant misrepresented her contacts with Metoxen in an attempt "to mislead Jones into believing that she was, in fact, attempting to improve her behavior with clients." Jones sought, in February of 2001, to have Metoxen mentor the Grievant to address the Grievant's rudeness with patients. The Grievant failed to follow this suggestion, and incurred four complaints in March and April. Prior discipline failed to have any corrective impact on the Grievant's behavior.

Nor does the record establish any mitigating factors concerning the Grievant. She worked for roughly three years as a part-time employee, and her "short employment history is replete with disciplines." To tolerate the Grievant's use of profanity and disrespect of patients would undermine "patients' right to respectful treatment." The severity of the conduct of March 10, viewed against the ineffectiveness of prior discipline and the Grievant's "dishonesty and lying" underscore not just the absence of mitigating factors, but the presence of "aggravating factors supporting . . . discharge in this case."

Viewed as a whole, the Grievant's inability to take responsibility for her actions establishes the necessity of discharge. That the labor agreement recognizes "dishonesty" as grounds for "immediate dismissal" underscores this. Arbitral authority further establishes the propriety of the County's discipline. The County concludes that the "grievance should be denied and award issued for the employer."

**The Union's Brief**

After a review of the evidence, the Union argues that the County has failed to establish just cause for the discharge. Ronk based the termination decision "upon dishonesty and 'a continued pattern of rude and disrespectful behavior towards patients.'" The incident prompting the termination occurred on March 10, and the evidence on the circumstances of that evening falls short of establishing dishonesty. That the discharge letter fails to cite dishonesty as a work rule violation itself warrants disregarding the allegation.

Even ignoring this, the evidence fails to establish that the Grievant was directed to call a Code ER. Traas was not sure whether the Grievant heard her directive. Other testimony fails to demonstrate a clear directive for the Grievant to call a Code ER.

Beyond this, the County inexcusably delayed taking action on the events of March until June. Patient complaints following the events of March 10 demonstrate that the County was "stockpiling enough offenses to effectuate the discharge." That Jones made a suggestion to the Grievant that she use Metoxen as a mentor fails to establish a clear directive to actively pursue mentoring. In any event, the Grievant's alleged lying concerning mentoring contact falls short of conduct that independently warrants discharge. Similarly, the reference to a patient as a "bitch," although inappropriate, cannot be considered so egregious that it warrants summary termination. The remark was made "outside of the institution where patients could not hear the remark."

Arbitral precedent establishes that "(t)imeliness of discipline is an element of 'just cause.'" To establish just cause, the County must demonstrate it acted "within a reasonable amount of time after it had convincing knowledge of an infraction." Even though what constitutes a "reasonable time" can be subject to doubt, the County's actions manifest an amount of delay that makes the termination double jeopardy.

Beyond this, "it is crystal clear that the Employer embellished the disciplinary record of the Grievant in order to justify discharge." Ronk testified that she viewed the Grievant's personnel record as a significant factor in the termination decision. That record, however, includes discipline beyond contractual time limits as well as unsubstantiated claims. Thus, the personnel record fails to establish cause.

"Just cause" establishes "a concept of due process, fair investigation, timely discipline and much more." The County's untimely action dooms a conclusion that the termination reflects just cause. No extraordinary circumstances justify the delay. That the Grievant may not be blameless cannot obscure that she is entitled to the benefit of just cause for the County's actions against her. Since the "purpose of discipline is correction" and since progressive discipline "was never fairly attempted," it follows that the County has failed to justify its discharge decision. Complaints "of rude and disrespectful behavior is a performance issue subject to progressive discipline" and the Grievant's disciplinary history includes only "one written warning prior to the decision to discharge." It follows that the grievance should be sustained.

## DISCUSSION

The stipulated issue questions whether just cause exists for the Grievant's discharge. In my opinion, when the parties do not stipulate the standards defining just cause, two elements define it. First, the employer must establish conduct by the Grievant in which it has a disciplinary interest. Second, the employer must establish that the discipline imposed reasonably reflects its interest. This does not state a definitive analysis to be imposed on contracting parties. It does state a skeletal outline of the elements to be addressed, relying on the parties' arguments to flesh out that outline.

The first element demands the definition of the conduct the County asserts a disciplinary interest in. The discharge letter is four pages, and thus the conduct needs to be isolated. The events of March 10 constitute the core of the County's disciplinary interest. The June 19 letter also cites patient complaints and dishonesty.

The citation of patient complaints reflects less the existence of conduct with independent disciplinary significance than the presence of aggravating factors concerning the level of discipline. This falls under the second element of the cause analysis.

The allegation of dishonesty in the June 19 letter should be read as another aggravating factor rather than an independent basis for discipline. Dishonesty, under Article 26, can be the basis for immediate discharge. The County's conduct does not manifest a summary termination for dishonesty. It is unclear from the termination letter when the County became convinced of the Grievant's dishonesty. Presumably this came sometime after May 11, when the County suspended the Grievant pending further investigation. The June 19 discharge was arguably

"immediate" under Article 26 since no warning notice preceded it. However, it was less than immediate in relation to the events prompting it.

Under either party's arguments, this allegation is best addressed under the second element. The Union argues that even if dishonesty is considered proven, the County's delay in imposing discipline undercuts it. This argument focuses less on the existence of dishonesty than on whether it warrants discharge. County arguments highlight dishonesty, but it is difficult to address that contention as anything other than a part of what sanction to apply. The June 19 letter identifies dishonesty not as conduct warranting discharge, but as a subordinate part of other conduct. The asserted dishonesty concerning mentoring contact with Metoxen focuses less on whether the Grievant's conduct warranted immediate action than on whether she could respond productively to complaints. The asserted dishonesty concerning March 10 is subordinate to events that concern patient neglect or abuse. Whether she heard Traas direct her to call 911 or a Code ER responds to a charge of dishonesty, but does not address the County's disciplinary interest in the quality of her response.

In sum, ongoing patient care issues and the Grievant's response to the events of March 10 form the core of the County's disciplinary interest under the first element of the cause analysis.

There is little dispute on the existence or substance of the series of patient complaints against the Grievant. Nor can there be a serious dispute that the County has a disciplinary interest in the conduct underlying the complaints or in the Grievant's ability to address them. Their role in the discharge remains to be addressed under the second element.

Thus, the core of the dispute on the first element focuses on the events of March 10. The parties' arguments focus on whether the Grievant improperly failed to call a Code ER or 911; what she said to the emergency dispatcher; whether she opened the door onto the ambulance entrance and told four Center employees that some "bitch" tried to hang herself; and whether her overall conduct was in any way effective.

The first area of conduct pits Traas' testimony that she informed the Grievant to call 911 and a Code ER against the Grievant's testimony that she either did not receive such a directive or did not hear it. The conflict between Traas' and the Grievant's testimony is more fully addressed below. Even on the Grievant's testimony, her response to the emergency was dubious. Under her account, she followed some nurses down the hall, then walked back up the hall, where LaBelle handed her the phone to speak with the emergency dispatcher. The Grievant stated at one point that she did not hear Traas direct her to call 911, then at another point insisted Traas never gave such a direction. The insistence that Traas never gave the directive is inconsistent with the assertion the Grievant never heard it. In any event, she does not dispute that she received Code ER training, and does not assert she independently considered calling it. This begs the issue whether she saw the suicide attempt or whether a Nursing Assistant should be

expected to show initiative in an emergency response beyond awaiting orders. In any event, the testimony on this issue affords little support for the quality of the Grievant's response, and prefaces more troublesome issues concerning the reliability of her account of it.

What she said to the emergency dispatcher is troublesome and poses broader issues. LaBelle had not seen the suicide attempt, and handed the phone to the Grievant so that someone with greater knowledge of the incident could speak to the dispatcher. LaBelle did not hear what the Grievant said to the Dispatcher. Traas testified that the emergency response team did not know the full extent of the injuries sustained by the patient, thus indicating the Grievant said little of any value. As above, the Grievant's testimony affords little support for a conclusion that the County lacks a significant disciplinary interest in her conduct. Presumably, LaBelle handed the Grievant the phone believing the Grievant had information to impart to the dispatcher. Even assuming LaBelle was confused on this point cannot account for why the Grievant took the phone from her. Crediting the Grievant's account demands concluding she took the phone from LaBelle to inform the dispatcher that, like LaBelle, she had nothing she could say. Unlike LaBelle, the Grievant took no steps to locate anyone who could speak to the dispatcher. At a minimum, this negligence is conduct the County has a disciplinary interest in.

However, the weakness of the Grievant's account stands in marked contrast to other testimony. Traas testified that she saw the Grievant leave the patient's room. This accounts for Traas' attempt to have the Grievant call a Code ER and 911. Her testimony thus explains her own conduct, unlike the Grievant's. The Grievant's testimony cannot account for why she took the phone from LaBelle.

Significantly, Shefchik's and Gilles' testimony corroborates Traas. Shefchik testified he saw the Grievant in the doorway, while Gilles testified he saw the Grievant in the patient's room. The discrepancy is insignificant. That Shefchik would have less than a precise awareness of the Grievant's presence is understandable, considering that he discovered the attempt and stood, supporting the suicide victim, while he called for and awaited help. The discrepancy between his and Gilles' testimony is, in any event, of little significance given the emergency presented. The attention of each witness focused on something other than the Grievant.

In any event, their testimony stands in stark contrast to the Grievant's claim that she was never close enough to the room to see any indication of a suicide attempt. This is difficult to square with the fact that the patient was within the Grievant's caseload. At a minimum, her lack of concern, even curiosity, is significant. More to the point, her testimony is impossible to square with that of Traas, Shefchik and Gilles. There is no evident relationship between these witnesses and no reason to believe they could or would manufacture a common, yet untruthful, account. Minor discrepancies between their accounts enhance their veracity. The Grievant's testimony that she never saw any indication of the suicide attempt is singularly unpersuasive when contrasted to the testimony of these three witnesses.

The unpersuasiveness of the Grievant's account is highlighted by the testimony concerning her comments to the four employees at the ambulance entrance. The Grievant claims she never made any comment to the effect that "some bitch tried to hang herself." This claim is unreliable in light of the evidence. The Grievant's account affords little, if any, reason for her presence in the smoking area. At most, the Grievant's testimony establishes that someone directed her to the elevator. The source or goal of the direction is notably unclear in her testimony. That Niemi, Zienert, Betts and Kelly fabricated the Grievant's appearance in the smoking area defies belief. Kelly, unlike the other three witnesses, was unsure whether the Grievant used the term "bitch" to refer to the patient. This discrepancy is of little significance, and lends credence to her credibility as a witness. More to the point, the Grievant's testimony cannot account for why these four Center employees commonly perceived her. Nor can it account for their common perception of her anger and confusion over the incident. The perceived confusion is a consistent theme among the witnesses who observed the Grievant that evening. In sum, the evidence demonstrates that the Grievant appeared in the smoking area, failed to summon assistance, and obscenely referred to the patient.

Little remains to be said of the final area of conduct highlighted by the County. Only the Grievant's testimony affords any reason to believe she behaved effectively during the events of March 10. That testimony is internally inconsistent, and stands in stark contrast to that of other witnesses. On balance, the evidence manifests a common thread. That common thread involves the Grievant's confusion throughout the evening of March 10. She failed to call a Code ER. She failed to phone 911, and when asked to speak to a dispatcher, failed to impart meaningful information or to take any action to secure meaningful information. She appeared in the ambulance area for no evident reason, then referred to the suicide victim in a derogatory fashion. The County has established a disciplinary interest in the Grievant's conduct on March 10.

The second element questions whether discharge reasonably reflects the County's proven disciplinary interest. The Union has made a number of forceful arguments concerning due process aspects of the discipline. More specifically, the Union contends that there was excessive delay between the events of March 10 and the June 19 discharge. The Union also contends the County stockpiled patient complaints against the Grievant to support the discharge.

The force of the Union's arguments must be noted. The allegation of dishonesty is troubling to the extent it is argued as a basis of conduct that independently warrants discipline. The Grievant's failure to credibly account for her actions on March 10 constitutes proof that she acted as the County alleges. To isolate that dishonesty as a separate offense brings concepts of double jeopardy into play. Beyond this, circumstances surrounding the complaints following March 10 grant at least the appearance that the County sought to stockpile offenses to create a case for discharge. The complaints and discipline cited in the June 19 letter include oral and written warnings exceeding the effective dates specified in Article 26. Similarly, the June 19 letter includes references to Written Summaries that are not disciplinary, and to complaints that

did not result in a finding of a violation of patient rights. Gruender's testimony establishes that she receives five to six patient complaints per day. These circumstances can be viewed to create at least the appearance that the County stockpiled complaints to strengthen its case for discharge.

That appearance, however, lacks a sufficiently solid evidentiary basis to undercut the discharge. The force of the Union's arguments must, however, be acknowledged. More specifically, those arguments establish that it is unpersuasive to consider the alleged dishonesty an independent basis warranting the discharge. Similarly, the patient complaints and disciplinary history are insufficient to establish discharge is warranted as the final step of the progressive discipline stated in Article 26.

However, the evidence supports discharge as a contractually and factually appropriate sanction for the Grievant's conduct. As a matter of contract, Article 26 does not mandate progressive discipline "in all cases." Rather, it states that "the type of discipline will depend on the severity of the offense."

The Union's due process concerns are more compelling as a matter of argument than of fact. The delay in the investigation is troubling, but Gruender had to coordinate a wide variety of full and part-time schedules. The time between her interview and the employee's execution of the summary underscores the time consumed in doing this. Beyond this, the delay did more than hold the Grievant in suspense. It created a period of time for the County to evaluate and for the Grievant to demonstrate the potential effectiveness of progressive discipline.

The evidence fails to establish that the Union's due process concerns are sufficiently well established to undercut the discharge. That patient complaints do not demand discharge as a matter of progressive discipline cannot obscure that they reflect poorly on her performance as an employee. It is undisputed that the Grievant generated a disproportionately high number of patient complaints in her relatively brief tenure as a part-time Center employee. Nor does the evidence indicate any reason to believe she acted meaningfully to address this. The Union's arguments establish the impossibility of labeling the Grievant's description of her mentoring contacts with Metoxen as "dishonest." However, this fails to demonstrate any significant effort on her part to address patient complaints. More significantly, her testimony establishes that she treated her conversation with Jones as lightly as she did the asserted contacts with Metoxen. That testimony reflects no reason to believe she took patient complaints seriously, or meaningfully assumed responsibility for them.

This sets the troublesome background to an assessment of her conduct on March 10. Even disregarding the conflict in testimony, the Grievant's account of the evening fails to establish acceptable conduct. Review of the credible testimony of the remaining witnesses establishes egregious conduct on her part. That she failed to meaningfully assist Traas is troublesome in itself. The balance of the evening's events exacerbates this. Whether patients

heard her reference to "bitch" or whether employees use "bitch" in day-to-day conversation cannot obscure the obscenity of the term in reference to March 10. Nor can it obscure that she failed to accomplish anything meaningful with the contact. Betts had to be summoned to the emergency by another employee.

The Union's assertion that the discharge was unduly delayed has force. To accept the assertion without reference to the evidence, however, would fault deliberate action on the County's part. On this record, the Union's arguments set the stage for a defense that the Grievant's testimony failed to bring about. Her testimony stands in stark contrast to that of other employees. The contrast manifests her unwillingness to accept responsibility for the events of March 10. That unwillingness underlies her account of mentoring contacts with Metoxen. It is evident the Grievant treated any contact, however casual, as a mentoring contact. This attitude is impossible to square with her personnel record. Her conduct on March 10 was egregious. Her unwillingness to accept responsibility for it lends credence to the County's assertion that progressive discipline served no purpose. That conclusion is reasonable in light of the evidence, and thus the County has established each element of just cause.

## AWARD

The Employer did have just cause to discharge the Grievant.

The grievance is, therefore, denied.

Dated at Madison, Wisconsin, this 19th day of March, 2002.

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

RBM/gjc
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