BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

DOUGLAS COUNTY HEALTH DEPARTMENT EMPLOYEES, LOCAL 2375-A, AFSCME, AFL-CIO

and

DOUGLAS COUNTY (HEALTH DEPARTMENT)

Case 247
No. 61052
MA-11785

(Joan Typpo-Reich Grievance)

Appearances:

Mr. James E. Mattson, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, on behalf of Douglas County Health Department Employees, Local 2375-A, AFSCME, AFL-CIO.

Mr. Frederic P. Felker, Corporation Counsel, on behalf of Douglas County.

ARBITRATION AWARD

Douglas County Health Department Employees, Local 2375-A, AFSCME, AFL-CIO, hereinafter the Union, requested that the Wisconsin Employment Relations Commission appoint a staff arbitrator to hear and decide the instant dispute between the Union and Douglas County, hereinafter the County, in accordance with the grievance and arbitration procedures contained in the parties' labor agreement. The County subsequently concurred in the request and the undersigned, David E. Shaw, of the Commission's staff, was designated to arbitrate in the dispute. A hearing was held before the undersigned on July 17 and 18 and October 1 and 2, 2002 in Superior, Wisconsin. There was no stenographic transcript made of the hearing. The parties submitted post-hearing briefs in the matter by December 23, 2002. Based upon the evidence and the arguments of the parties, the undersigned makes and issues the following Award.

To maximize the ability of the parties we serve to utilize the Internet and computer software to research decisions and arbitration awards issued by the Commission and its staff, footnote text is found in the body of this decision.

ISSUES

The parties stipulated to the following statement:

STATEMENT OF THE ISSUE: Did the Employer terminate the Grievant for Just Cause?

And if not; the appropriate remedy is for the Employer to reinstate the Grievant to her position and to make the Grievant whole for any and all lost wages and benefits.

CONTRACT PROVISIONS

The following provisions of the parties' Agreement are cited:

ARTICLE 4 – MANAGEMENT RIGHTS

A. The County possesses the sole right to operate the Health Department and all management rights repose in it. These rights include, but are not limited to, the following:

1. To direct all operations of the Department;

2. To hire, promote and schedule employees in positions within the Department;

3. To suspend, demote, discharge and take other disciplinary action against employees for just cause;

4. To relieve employees from their duties;

5. To take whatever action is necessary to comply with state or federal law;

6. To introduce new or improved methods or facilities. To change existing methods or facilities;

7. To contract out for goods or services;

8. To determine the means and personnel by which County operations are to be conducted;

9. To take whatever action is necessary to carry out the functions of the Department in situations of emergency;

10. To unilaterally establish reasonable work rules; concerns about the reasonableness of a work rule shall be brought to the Conference Committee's attention and failure to resolve at that level shall make the reasonableness of the work rule a proper grievance;

11. To maintain efficiency of County operations.

. . .

ARTICLE 15 – TERMINATION OF EMPLOYMENT

. . .

C. The Employer will give the nurse and the Alliance twenty-one (21) calendar days written notice of termination of employment, unless such action is taken for gross misconduct. If employment is terminated by the Employer, the nurse is entitled to receive salary for the remaining twenty-one (21) calendar days, plus accrued benefits, except where the termination is for gross misconduct.

. . .

ARTICLE 16 – DISCIPLINE

A. No nurses shall be terminated, suspended, demoted or otherwise disciplined except for just cause. Written notice of discipline, discharge, demotion or suspension and the reasons will be given to the nurse. A copy of the notice will be sent to the Alliance and made part of the nurse's personnel file. Any employee's disciplinary notices will not be used as part of a progressive discipline process if no subsequent discipline occurs within two (2) years. After two (2) years have passed, the disciplinary notices will be transmitted from the Health Department

to the Human Resource Department. Health Department officials will not have access to the notices.

BACKGROUND

At the time of her termination, the Grievant had been employed by the Douglas County Health Department as a Public Health Nurse (PHN) for seventeen years. At the time of her discharge, the Grievant was the Union's President.

For as long as the Grievant has been employed in the Department, Patrick Heiser has been the Department's Health Officer and Director. For approximately ten years, Nancy Hodsdon was the Director of Nursing in the Department, and the Grievant's immediate supervisor. For approximately the last five years prior to the Grievant's termination, Judith Walker has been the Director of Nursing, and the Grievant's immediate supervisor.

In addition to the Grievant, there were five other PHN's and one LPN in the Department's Public Health Division, and nine Home Health Nurses in the Home Health Care Division, as well as the RN's in administration. The Department is a Level 2 Health Department providing services in public health, environmental health, lab, and home health care. The PHN's are assigned various programs for which they will have primary responsibility and all of them provide services in certain areas. To be a PHN, one must have a four-year nursing degree with a certain amount of education in community health procedures. There are State statutes and regulations setting standards for nursing practice, which the Department expects nurses to know when they are hired. RN's receive regular updates of these standards with their nursing license. The Grievant oriented all or most of the other PHN's in the Department when they started. The Grievant was considered to be the nurse in charge in Walker's absence.

The Department of Public Health Division administers a number of programs, including immunizations, maternal child health (MCH), sexually transmitted disease (STD's) communicable diseases, Hepatitis "B" and "C" vaccine, Douglas County Jail Follow-Up, HIV/AIDS and Lyme Disease reports. When new programs are started, all of the PHN's review, and are oriented in, the policies and procedures for the program. There are forms and/or reports that need to be completed and filed within certain time frames for these programs and/or records that must be kept. Reports, forms or records are filed by program and for certain programs, the reports/forms are considered to be confidential, and the reports are to be kept in a specific locked file when not being worked on, e.g., the HIV/AIDS and STD reports. Only Walker and the Grievant had the keys to the locked files. Many of the programs require contact be made with referrals and the contact or attempt at contact recorded. The protocol for some programs require attempts to contact to include a letter, if unsuccessful by telephone. If there are home visits, the visit and information gained as a result of the visit must be recorded, e.g., MCH program.

Some of the programs all of the PHN's work on, and for other programs individual PHN's are given primary responsibility for the program, or share primary responsibility for the program with another PHN. The Grievant had primary responsibility for the Jail Follow-Up and shared responsibility with another PHN, Michelle Hughes, with respect to the STD and HIV/AIDS program, although the Grievant was responsible for the Partner Notification Program. The Grievant and Hughes also did most of the Communicable Diseases follow-ups. The Grievant and PHN Jeanne Rounsville shared responsibility for the school health program. While a program has one or two PHN's assigned primary responsibility for the program, all of the PHN's are given assignments in most all of the programs. In addition, the PHN's handle "walk-ins", i.e., individuals with health concerns or seeking a vaccination, and hold screening clinics and give vaccinations, etc.

According to Walker, on December 26, 2001, while the Grievant was on vacation, Walker went in the Grievant's office to look for some forms that had not been completed. In trying to find the forms on the Grievant's desk, she noticed MCH referral forms sticking out of piles of papers. As she began going through the papers more incomplete forms, assignment sheets, etc., were found. Walker was concerned because some of the forms were over a year old and one could not tell from the forms what had or had not been done. There was also a large box on the Grievant's desk that contained junk mail, memos, STD reports, MCH referral forms, all mixed together. There were other boxes in the Grievant's office with similar contents. Some of the forms had "sticky notes" with notations on them. Also found were copies of old communicable disease reports on her desk that came from reports kept in locked files and HIV/AIDS reports from 1996 in one of the boxes. Walker informed Heiser of her concerns and showed him the Grievant's office. Heiser then contacted the County's Human Resources Department. Walker, and at her direction, some of the PHN's, then began going through the papers, documenting what they found, and in the case of the STD's, doing follow ups, and in the case of some, e.g., immunizations, attempting to reconstruct the records and/or redoing the inoculations.

When the Grievant returned from vacation on January 2, 2002, she was advised that she was being placed on administrative leave pending an investigation. The Grievant was not permitted to go in her office.

On January 4, 2002, Walker compiled a summary of her findings, stating, in relevant part:

01-04-02

Subject: Joan Typpo-Reich, PHN
Performance Report
Summary of Findings/Preliminary Report
Judith Walker – Director Nursing Division

12/26/01 After attempting to find patient records went to Joan Typpo-Reich's office to search. Found office and records in disarray (photos).

Pulled out 166 records with possible problems – records found in piles on desk, in boxes and floor mixed in with junk mail. Also discovered were immunization records from 1992 that needed to be filed.

Joan Typpo-Reich on vacation until 1/02/02.
01/01/02 – Brief discussion and placed on Administrative leave with meeting scheduled for 01/04/02.

01/02/02 and 01/03/02 Closer inspection of the records found in Joan Typpo-Reich's boxes and piles revealed a pattern of:
hiding records, neglected to carry out assignments, incomplete records, mishandling of confidential medical records, failure to complete nursing documentation in accordance with nursing standards of practice and department routine, inappropriate or absent documentation.

Closer examination of the 166 records revealed the following: Problems include but not limited to:

Communicable Disease Investigation Assignments:

1) No contact with patient assigned 10/30/01. Patient was ill and attempted to get treatment while incarcerated but disease report was misfiled in Joan Typpo-Reich's STD file. Very high risk family.

2) TB skin tests from jail inmates from Nov. 01 should have been sent to the jail nurse for documentation and follow-up.

3) Lyme Disease Report from 8/99. No investigation, follow-up or records sent to state as state statute.

4) HIV/AIDS records (3) found unprotected in box with junk mail.

Sexually-Transmitted Disease Investigation, Follow-up and Reporting:

19 case reports in Joan Typpo-Reich's file. All investigations would be late starting June 01 with lack of investigation, follow-up, documentation and handling of records in accordance with state law and department routine.

Immunization Programs Assignments:

45 records in various boxes, piles, etc. Records incomplete, disorganized so as to be useless, not submitted to data input staff for WIR inclusion per our state/CDC grants; Records for infants, children and adults were mishandled and neglected – some dating 1995-1998. Many staff hours have gone into trying to track these records down.

New Baby Referrals/Assignments:

Gross mishandling of these assignments. Of records with preliminary review, 49 had no record of a visit or documentation of follow-up. Of the 49, 20 were high risk infants referred to the health department by Neonatal Intensive Care or hospital birthing centers.

Many other examples can be cited.
Since the discovery of these records on 12/26/01, all the health department staff have been called to do extra assignments to review the 166 records. Many situations have been resolved but many more hours of work will result from this situation. It is vexing to staff that they must do the professional duties that Joan Typpo-Reich has already been paid to do.

Attached to the summary were 39 pages listing the forms by program and with clients' initials that had been found in the Grievant's office. (This included cover sheets that more or less summarized the cases found in that program, and together, the documents make up Employer Exhibit No. 6). The County claims that by the time of the Grievant's termination, it had found another 52 forms/records in the Grievant's office and that the number subsequently climbed to 72.

The Grievant was subsequently given Walker's January 4, 2002 summary and was permitted on nine occasions (17 hours) to review the forms/records after work hours with a Union representative and Walker and/or Heiser also present.

On February 22, 2002, Heiser, Walker, Candace Fitzgerald (Human Resources Coorindator), the County's Corporation Counsel, the Grievant, Staff Representative Mattson and Union President Peggy Nichols met. The Grievant was given the opportunity to explain what had occurred. At that meeting the Grievant admitted that she had failed to complete the paperwork and it was at this time that she first informed the County she suffered from depression. Subsequently on February 22nd, Heiser issued the following termination letter to the Grievant:

> Dear Joan:
>
> Based on the performance issues that were discussed in today's meeting I find it necessary to inform you that your employment with the Douglas County Health Department has been terminated effective as of today, February 22, 2002.
>
> In the near future, you will be contacted by the County's Human Relations Department regarding your separation benefits.
>
> Respectfully,
>
> Patrick Heiser /s/
> Patrick Heiser, R.S.
> Douglas County Health Officer

Regarding her depression, the Grievant testified she first sought help in 1997 and has been receiving treatment on a regular basis from psychologist Michelle Simon in that regard since March of 1999. The Grievant testified that she did not feel comfortable discussing her depression with Walker or Hesier, and thus had not mentioned it to them prior to the February 22, 2002 meeting.

In addition to terminating the Grievant, the Department filed a number of complaints with the State's Board of Regulation and Licensing, which are referenced in Employer Exhibits 10-19. At time of hearing, the complaints were still under investigation and the Grievant still retained her nursing license.

A grievance was filed regarding the Grievant's termination and the parties proceeded to arbitration of their dispute before the undersigned.

POSITIONS OF THE PARTIES

County

The County devotes the majority of its brief to a recitation of what it believes to be the facts established by the testimony and exhibits taken at hearing. In that regard, the County asserts the following. Employees of the County's Health Department entered the office of the Grievant in search of a needed record while the Grievant was on vacation. Massive amounts of records, some of a highly confidential nature, were found in piles on her desk or in boxes on the floor mixed in with junk mail. As of January 4, 2002, the Department was able to document 166 records, some dating back as far as 1992, which were incomplete, misfiled, confidential or indicated a lack of follow-up or documentation thereof. Subsequently, more records were discovered and documented to have been in the Grievant's office, representing a total of well over 200 records with potential problems. The Grievant was allowed to come in and inspect the vast majority of records that were to become the subject of her termination in order to assist her in preparing a response to the evidence against her. At a meeting on February 22, 2002, the Grievant was given the opportunity to respond to charges against her, and it was at that time that the Grievant first mentioned that there had been a problem with her keeping up with her work and that she had been suffering from depression. It was then decided that the Grievant's massive failure to follow the standards of her profession warranted nothing less than termination and she was informed of this in writing by Heiser. It was felt that the Grievant's dereliction of duties was to such a degree that the County had no alternative but to file a complaint with the State Department of Regulation and Licensing, which was documented and detailed through the testimony and Employer Exhibits 10-19.

The Department's employees then had the responsibility of repairing the damage. Sexually Transmitted Disease (STD) referrals, some three to six months old, had to be followed up on where possible. Documentation had to be completed and filed with the State. Outreach, testing and follow-up was necessary for the HIV counseling and testing program within the Jail, as well as for the Hepatitis B and C immunization program. In some cases, billing for the testing had not been done. With regard to the Hepatitis B vaccine program, records were found in grievous disarray, some records being lost, incomplete, or no billing having been done for vaccines for two years. Immunizations the Grievant had given were found in a mess of papers and boxes, not signed, with incomplete information, and others did not have access to the records or follow-up for the database. It took the work of other Department staff and other agencies to determine the status of employee immunizations. City employee records all needed to be rebuilt and some people needed to get a blood test drawn by a PHN and sent to the State lab, as the Grievant's records were lost or incomplete. There were also problems with the Lyme vaccine program, where clients were not followed-up for the subsequent doses of the vaccine and records were lost or disorganized so as not to be retrievable.

The County asserts that the factual context of this case and the licensed and professional nature of the Grievant's position are essential to a determination of just cause. While the Grievant's immediate supervisor did not provide her with a great deal of direction in doing her job, given the Grievant's extensive experience and knowledge, that should not have been necessary. Further, while the Grievant's dereliction of her duties to a great degree escaped the notice of her immediate supervisor, given the Grievant's professional stature and her knowledge of her duties, verification by her supervisor should not have been necessary, and is not necessary for other nurses in the Department. Although the Grievant does not have a serious disciplinary history, the serious and catastrophic nature of her failure to perform her job duties in a timely or professional fashion should have placed her, or any other public health nurse, on full notice that they would be subject to termination.

The County cites the testimony of the Department's Director, Pat Heiser. Heiser observed numerous reports and copies of old communicable disease state reports under the Grievant's desk calendar, copy machine paper boxes full of files and investigations out in the open. There were copies of documents which appeared to be records that should have been filed with the State within a certain period of time and photocopies of communicable disease reports of individuals well-known in the community in full view in her office. There was no standard practice that would justify extra photocopies of these documents.

Heiser testified that he thought that he had a good working relationship with the Grievant, and was not aware of anything that would discourage her from coming to him with a problem, and that she had never mentioned to him that she had any problems completing her work. It was at the February 22 meeting that the Grievant first mentioned that she had been suffering from depression. Hesier testified he had also suffered from depression in the past and had in fact told his staff about it. He further stated that the Grievant did not seem to be depressed to him, nor had she ever relayed that information to him. He did say that other employees had come to him with their health problems. He also testified that he felt that Walker was accessible as a supervisor to her employees.

It was Heiser's decision, in consultation with the County's Human Resources Department and in concert with the recommendation of Judy Walker, to terminate the Grievant. Heiser testified that this was based upon the mishandling of confidential records, the untimely manner of filing information with the State on communicable diseases and in following up with referrals, such as those concerning children with developmental delays, maternal child health and communicable diseases. As there had been a "complete failure to comply with the standards of nursing", he felt there was no recourse but to report the matter to the State's Board of Licensing. Heiser felt that this was the only recourse he could take, as it had become an issue of a lack of trust with the employee who in his opinion, had not only failed to perform her duties, but had made a conscious effort to conceal it.

Hesier testified that the Grievant's position has many unsupervised duties and because of the professional nature of the position, it is not necessary to be supervised, such as to make sure that she had been performing her duties. Walker's main duties as the Director of Nursing are to make work assignments and meet with employees to see if there were any barriers preventing them from meeting their assignments.

Heiser also testified that progressive discipline was considered, as the Grievant had in the past been verbally warned by Walker that STD reports needed to be timely filed with the State. The Grievant had been told that if her work load was unmanageable, she should talk to her supervisor, which she did not do. Heiser felt there was no alternative but to bypass further steps in the disciplinary process due to the severity of the problem.

Heiser stated his conclusion regarding hiding files was based upon the large volume of records and files which the Grievant must have known were accessible to no one else outside her office. He testified that he did not know of any specific individual that had been harmed by the Grievant's lack of follow-up, because without follow- up there is no way to know who might have been harmed, but potentially there were the future sexual partners of individuals named in STD's. Heiser testified that he did not feel there was a need to change current policies or practices of the office, as there had not been a problem with other employees, and that confidential files are not generally left out at the end of the workday. As to a former secretary who had been involved in a theft and not fired, those actions had not jeopardized anyone's health in the community.

The Grievant's immediate supervisor, Judy Walker, testified that to become a PHN requires a four-year program of study, which includes a community nursing background in community prevention. She further testified that the standards for nursing are set at both the federal and state levels. Employer Exhibits 1-4 establish that the Grievant's position as a licensed and regulated professional has standards imposed upon it beyond those imposed by the County, including strict confidentiality requirements upon all records involving sexually transmitted diseases and tests for HIV. Chapters N6 and N7, of the Wisconsin Administrative Code, impose minimum standards of practice for nurses and rules of conduct, including the duty to keep records. N7.03 establishes "negligence" to include "violating any of the standards of practice set forth in Chapter N6, i.e., "an act or omission demonstrating failure to maintain competency in practice and methods of nursing care, failing to observe the conditions, signs and symptoms of a patient, *record them*, or report significant changes to the appropriate person." (Emphasis added).

Walker testified that any nurse would be expected to have knowledge of the above information, as well as the confidentiality of HIV testing and STD records. Walker testified that the Grievant had never demonstrated any noticeable lack of knowledge in her area, and was in fact second in command if Walker was not in the office. Walker also testified that she

had talked to the Grievant about her documentation in the past when she was behind, and that the Grievant always seemed to catch up. She testified that she had seen STD reports or referrals on the Grievant's desk, and that they were supposed to be kept in a locked cabinet in a locked room when not in use. The Department has a very organized filing system. It has 25 programs to administer, and each is filed by program in a locked cabinet in a locked room. STD referrals have to be completed within two months, including documentation of attempts to determine and/or contact other sexual partners. The purpose of the contact with the individual and partners is to make sure that they understand the treatment of their disease and how to prevent it. The standard forms are all issued by the State of Wisconsin and all the PHN's are aware of these forms and how they are to be completed.

Walker testified that once in the past the Grievant had fallen behind her mandated time limits in processing STD's and that she was verbally warned to get them up-to-date. Subsequently, the Grievant had told her that she had filed the appropriate forms with the State, but an employee from the State later contacted Walker and told her they had not in fact been filed. The Grievant subsequently filed the appropriate reports.

With regard to the significance of not charting or following up on new baby referrals, Walker testified that it should be noted even if no contact could be made, and it should be filed so that it could be later looked up and thus would be known. It would be difficult to determine whether or not there had been a follow-up, if that was not charted or documented, and Walker testified that is why they hire professional nurses.

Regarding STD referrals found in the Grievant's office, Walker stated that some of them dated back to June through November of 2001, many beyond the two-month reporting period. Other staff attempted to make all possible contacts and found that many, if not all, had not been contacted. With regard to the immunization records, some dated back to 1995. The Superior School District Hepatitis "B" and "C" program vaccination program files had been mishandled and were incomplete. People whose records were lost or never made in the first place had to be revaccinated because of the lack of documentation.

As to how she could not have known the extent of the problem, Walker testified that the Grievant was expected to know the job because she was a professional. While the Grievant had always spent more time with the file than other nurses, Walker testified it was not her job to monitor a professional's work. It was also her opinion that the Grievant had seemed to be hiding the records. She felt that the Grievant had deliberately misinformed her when she told her STD reports had been filed with the State, when the State had no record of that.

Walker testified that the Grievant was placed on administrative leave after the matter was discovered because there was no longer any trust. It was her recommendation that the Grievant be terminated. She was concerned that the Grievant did not recognize that she had

done something wrong. According to Walker, the Grievant had demonstrated a total lack of professionalism and could no longer be trusted. The duties in question were very basic and well-known to the Grievant. The files and records found did not look like they were going to be looked at again. Walker also testified that she had not noticed any mood differences or depression in the Grievant.

As to whether anyone had been harmed by the Grievant's work, Walker testified that two nurses had gone to a home where a mother and child could have received necessary services several months earlier. There was also an STD referral who had been in jail. Due to no follow-up, this person was ill for a long time. Walker testified that she did not ask for the Grievant's help in following up on the records due to the lack of trust.

Walker also testified that the only documents shredded were some duplicate records, and that all other records were kept together, including the sticky notes.

Finally, Walker testified that she had been very surprised at the amount, and the lack of order, when she had discovered the problems in the Grievant's office. Asked if she thought the Grievant could have updated the files herself if given the opportunity, Walker responded in the negative, as it had taken the rest of the staff six months to repair the damage.

Also testifying were Jeanne Rounsville, Barb Berkseth, Audrey Peterson, Lillian McLeod, and Michelle Hughes, all of whom are colleagues of the Grievant. All but Berkseth are PHN's and members of the bargaining unit represented by the Union. Berkseth is an LPN.

All testified that the PHN's are aware of the procedures to be followed and the paperwork that is required for the various programs. The expectation is that they willl follow the procedures and complete the required paperwork. It is not the supervisor's responsibility to double check to see if the work was done. Their supervisor is entitled to assume the PHN's will follow the procedures and get the work done, as they are professionals and expect to be trusted to do their job.

Berkseth, Hughes, McLeod and Peterson testified that the Grievant did not appear to them to be depressed. Hughes and Peterson added that they would not have a problem talking to Walker about problems they were having with work. Hughes, McLeod and Rounsville testified that they would expect to be terminated, if they had let their work fall as far behind as the Grievant had.

Rounsville also testified that she shared the school health program with the Grievant, although she was responsible for four schools while the Grievant was responsible for one. She testified that there had been problems with record-keeping in reference to shot records that would sometimes be on the Grievant's desk or otherwise not in the file cabinet where they

should be kept. Rounsville also testified as to the complaint filed with the Board regarding the Hepatitis B records for the Superior School District (Employer Exhibit 17), and as to problems with the immunization program at Cathedral and Superior Senior High School. Records of shots given were not properly recorded or not recorded at all, and it became necessary to contact parents concerning shots that may have been given to their children. Rounsville also testified that she had been involved in doing the follow up for the two schools to make sure all immunizations were properly given and documented, and discovered that approximately $13,000 in billings to third parties for Hepatitis "B" shots had not been made. It would have been the Grievant's responsibility to initiate the billing process.

Regarding new baby visits, Rounsville testified that they all knew the process. A primary record was kept on a standard form and it was important in case something later happened to the child or if the baby's doctor needed follow-up documentation. A number of these referrals were found in the Grievant's office in a large envelope with no indication of follow-up. She testified she was very surprised when she found out about this, as she could not believe a nurse would not do the follow-up.

Berkseth shared the office with the Grievant. She testified that she was one of those who helped bring the Hepatitis "B" program up-to-date. Many items of information were missing on the forms, shots in the series were past due, and people needed to be contacted to fill in the missing pieces of information. Billings also had not been initiated. Berkseth testified that the situation increased the workload of everyone and created a lot of stress. As to whether she had been aware of the extent of the condition in the Grievant's office, she replied she had not, and that work is given to nurses with the expectation that it would be completed, there being a certain amount of trust in being a PHN.

McLeod testified that there was no ambiguity in the policies and procedures of the nursing practice, and that they had remained largely the same the past 40 years. McLeod is primarily responsible for new baby referrals and outlined the process and importance of documenting each step. She testified it is a PHN's mandatory obligation to contact a mother in response to a new baby referral and that the obligation is accelerated in high risk cases. McLeod testified that she keeps extensive required records of all home visits and that there is a protocol to be followed which appears on the forms they are required to fill out. McLeod was asked to review a number of the records found in the Grievant's office regarding new baby visits, and she testified that 50 or 60 did not have charts and the paperwork had not been completed. McLeod selected ten documents to be referred to the Board of Regulation and Licensing along with the Department's complaint.

Regarding Employer Exhibit 10, McLeod testified that the protocols had not been observed on that referral. There was no record of contact or a home visit. While the Grievant testified that notations made on the referral reflected weights she had taken during home visits,

it is still supposition to associate the numbers scrawled on the form with home visits, and as the weights were not dated, an observer could not tell whether the baby was gaining weight or losing weight. There is also no indication anywhere that any of the protocols outlined in the exhibit had been followed. This is similarly true for Employer Exhibits 11 and 12. There is no evidence of any follow-up or offer of a home visit. McLeod testified that these exhibits represented only three out of the 50 or 60 referrals found. McLeod testified that she did not follow-up on many of them herself, because most were quite old. One could not tell if the referrals had been followed-up on, as there were only scribbles on the corner of some them and they did not know who wrote it, or what it meant. With regard to the hepatitis records and immunizations, McLeod testified that a lot of time was spent to bring them up-to-date.

The County's last witness, Hughes, testified that there had always been a large number of STD referrals in the Grievant's office and there was also a ledger with personally-identifying information which had been left in the Grievant's office about four times. The ledger should have been kept in the top drawer of file #27, as these records are confidential in nature, and some of them have partners listed. Regarding STD referrals, Hughes testified that it is mandatory to contact the person and that the names of partners should be elicited if possible. STD referrals are also logged in the central notebook and the State requests follow-up within two months of receiving a referral. Hughes testified that a PHN should try at least three times to reach the person involved, and should inquire about sexual partners.

Hughes was asked to help sort out documents found in the Grievant's office, including STD referrals, internal health referrals, and communicable disease referrals, as well as records for the children's screening clinics and hepatitis immunizations. Hughes testified that a City employee was furious that the Grievant had not returned her calls and wanted to know which of their employees still needed immunizations. Hughes initially spent two full days trying to help sort things out regarding the hepatitis program and spent the next four or five months, in addition to her regular work load, trying to assist with the Hepatitis "B" program and partner notification. Hughes testified that there was a folder in the Grievant's office approximately one and half inches thick that was full of confidential, personally-identifying information concerning STD referrals which should have been locked up. It is not necessary to copy these types of forms, as they came with their own copies. She also testified that the child immunization records they found were too old to follow up on.

Employer Exhibit 15, a referral for an individual who testified positive for Lyme's Disease, was over five years old. The request form had never been completed nor returned, and was not filed in the appropriate place. With regard to Employer Exhibit 16, Hughes testified this type of referral usually gets immediate attention because the disease can easily be spread to other household members. There was no evidence the form had been completed, nor of any contact or follow-up. Hughes testified that she had completed those tasks herself. Regarding Employer Exhibit 18, no evidence was found that the doctor had been contacted to

verify whether the person had obtained treatment and there was no attendant documentation. Failure to follow-up in this case might have resulted in harm to an unborn child. Regarding Employer Exhibit 19, this was also submitted to the State, and involved a young girl with chlamydia. She was treated, but no counseling from the Health Department was documented, and there was no evidence she had been offered an HIV test. Hughes was able to locate her through partners and offer them HIV testing as well. It was necessary for Hughes to follow up on other referrals as well.

Hughes testified that nurses are taught that the chart is confidential, and should be locked up when not being worked on. Regarding referrals, Hughes testified that people needed to be followed up with, and that she had learned some of the processes and procedures from the Grievant herself. Hughes also testified it was not her supervisor's responsibility to ensure that the proper forms were filled out in each case, as everyone knows what paperwork needs to be done and she expected her supervisor to trust her. Hughes testified that trust is an important component in her job. She also did not consider the Grievant to be a "team player" and had stopped asking her for help with the office caseload. When asked if she trusted the Grievant, she stated "not always" and explained that the Grievant would say she would do something and then not do it.

The County asserts that the Grievant and her witnesses added few relevant facts and directly contradicted very little of the testimony offered by the County's witnesses. None of the Grievant's witnesses were co-workers, and none of them had any direct knowledge of the Grievant's overall job performance. Further, none of them had any personal knowledge of the Grievant's work situation, nor were they in a position to offer any factual evidence contradicting that of the County. Tim Robinson, the case manager for the AIDS Resource Center of Wisconsin in Superior, would not be able to tell the degree of follow-up and documentation the Grievant either did or did not do. Robinson did state that his agency kept records of sexually-transmitted diseases in a locked file cabinet within a locked office. When asked where he would leave a file that he had been working on, Robinson testified that he would leave it at least behind a locked door.

Gwen Brand works with the Douglas County Jail, and it is her job to notify the Grievant about needed TB testing in the jail. While the Grievant did not always return the paperwork for positive tests right away, it was her practice to let Brand know by phone of the test results. Brand testified that she had not been unhappy with the Grievant's services, but also that she had no idea of what Department procedures were and was not familiar with Department protocol.

Janice Cox testified that she had worked in the Department since January of 2001, and stated that the Grievant "excelled" in handling walk-ins, but she had no other testimony to offer bearing upon the Grievant's work situation.

Michelle Simon, the Grievant's psychologist, testified, "I can't know anything," in response to a question on cross-examination as to whether she knew how truthful and objective the Grievant was with her during her sessions. This is particularly relevant both to the distorted view she may have got of the Grievant's work situation, and also as to the unsupported conclusions she drew as to how management should have dealt with the problems in the office, as perceived by the Grievant. While the County does not seriously question whether the Grievant was in fact suffering from depression, if the Grievant's depression is at all relevant to this inquiry, it is only if it rendered the Grievant incapable of performing her job duties, and was so severe that it either grossly distorted her perception of the job she was doing, or if not, rendered her totally incapable of attempting to address her problems by notifying her employer. Even if that were the case, where an employer is confronted with an employee who is suffering from a malady which renders them totally incapable of performing their job duties, or so uncommunicative that the employer is unable to address their shortcomings, the employer is left with few alternatives.

It is the County's position that Simon's testimony about a condition suffered by the Grievant, but left totally uncommunicated to the employer until after the damage had already been done, is totally irrelevant to the present inquiry. Further, the information indicated to the County by the Grievant, and confirmed in far greater detail by Simon's testimony, confirms that the Grievant's emotional condition was not so severe or disabling as to impair her ability to do her job, nor as to impair her ability to fully understand that her work was not getting done, and the consequences of that to the health of others and to her. Further, the condition was not so severe as to render her unable to either communicate her condition to her employer, or inform her employer that she was not keeping up with her work. The Grievant's depression, measured at its worst, was no worse than "moderate" and her ability to function no worse than having "moderate difficulty". Simon also stated that the Grievant's level of a depression was never such that her co-workers would be able to detect it.

Regarding the Grievant's testimony, the Grievant admitted on cross-examination that documentation was stressed in nursing school, and that nurses are taught that "if it is not charted, it is not done." The Grievant responded to the charges against her with remarkable specificity, given that the great bulk of her testimony was based upon her personal recollection, "sticky notes", and upon her personal calendar. Most telling, is that it was not based upon the charting and documentation that is not only required, but is the hallmark of her profession.

The Grievant introduced a number of performance evaluations which were complimentary to her, however, the most recent evaluations, in 1997 and in 2000, noted that she needed to improve her timely recordkeeping and not keep reports on her desk. The Grievant acknowledged that Walker had once been "mad" and "yelled" at her for failing to complete STD records, although she did not feel she had been given a verbal reprimand. The

Grievant testified that while her desk was messy, she knew where things were, and that other nurses also had messy desks. However, there was no evidence offered that any other nurses in the Department had difficulty locating or processing paperwork, or following up with referrals.

With regard to the individual charges, on some occasions the Grievant explained cryptic notations within the documentation as indication she had followed up on a particular matter, but had not documented it. She testified that contact with individuals testing positive for sexually-transmitted diseases was made either by phone or letter, but there was no indication of attempted contact by letter. Instead, for many of the STD referrals, the Grievant relied upon her personal recollection that she had tried to contact the individual and had received no response. The Grievant was able to respond to a remarkable number of documents found in her office based upon her personal recollection and the use of her calendar. She admitted that she had a problem keeping up with the paperwork. She also admitted that when a visit is made after a new baby referral, the matter should be properly charted and that the use of sticky notes was not proper record keeping. More telling, is that there were a number of documents listed in Employer Exhibit 6 for which the Grievant had no explanation. There were also a number of documents for which she could not remember whether follow-up had been done or whether contacts had been attempted or made. She admitted that she had STD referrals and other STD documents upon her desk with personally-identifiable information, which should have been filed elsewhere. The Grievant was also unable to name more than perhaps one example where she had actually documented and charted, as required by the standards of nursing practice, in response to the evidence against her.

The County asserts that it has met its burden of proving that the Grievant essentially failed to document any work at all on at least 200 items that were stacked in piles or in boxes in her office. Instances of possible duplicative counting within Employer Exhibit 6 notwithstanding, the Grievant's failure to process her work was not just massive, but was catastrophic. The County asserts that it should not be required to prove actual harm to specific individuals. It is the Grievant who should be required to show that individuals were not harmed by virtue of her failure to document or uphold the standards of her profession. The Grievant admitted that nurses were taught in nursing school that if it is not charted, it is not done. By that standard, many items were left undone, and both the general public and her profession were done incalculable harm. It is indisputable that if partners of a person testing positive for a sexually-transmitted disease are not contacted in a timely fashion, it could result in additional people being infected. It is also indisputable that there were numerous items listed within Employer Exhibit 6 to which the Grievant could not state that she had responded. Significantly, almost no evidence offered by the County was directly contradicted by the Grievant.

The County asserts that its response and position is wholly consistent with the principles set forth in *How Arbitration Works*, Fifth Edition, Chapter 15, "Discharge and Discipline".

The Grievant has largely admitted most of the facts presented by the County, although minimizing them as simply a failure to follow up with her paperwork. The County does not dispute the Grievant was suffering from depression, notwithstanding that she had said nothing at all to her supervisor or her department head until the day she was terminated. The evidence does not support a finding that the Grievant was unable to function at a high enough level at any time to perform her job duties, and cannot justify her failure to inform her employer of her condition and of her failure to keep up with her duties. At the very least, the Department was entitled to be told by the Grievant that she was having difficulty keeping up with her workload. The Grievant never intended to do this, without any satisfactory excuse other than that she was not comfortable speaking with her immediate supervisor.

This situation is also not a case where the employee did not know what was expected of her by her employer. The Grievant was an experienced nurse who not only knew her job, and its expectations, but had trained newer nurses in the past. This is also not a situation where there was lax enforcement of work rules. All of the PHN's who testified on behalf of the County knew what their duties and responsibilities were, and none felt it was their immediate supervisor's duty to make sure that assigned work was done in a timely and professional manner. There was no evidence that any of the other nurses had slid in arrears in the work such that the Grievant might allege that she was being singled out in some way.

The County asserts that in this case progressive discipline is not required, as the conduct of the employee is so severe that nothing less than termination provides an adequate remedy. It is important to reiterate that none of the Grievant's colleagues testified on her behalf. Three PHN's testified that if their workloads fell in arrears to the same degree as the Grievant's, they would expect to be fired. As a professional nurse, the Grievant cannot fairly allege surprise at the action taken by her employer. Nursing is a licensed, professional occupation with clear standards of ethics and practice. The Grievant abused these standards. The Grievant's supervisor testified that the issue was primarily one of trust. The Grievant deliberately turned her back on the standards of her profession and the people she was bound to serve, and as such, could no longer be entrusted with the responsibilities of the position. While the Grievant testified she knew of no one who had been harmed by her actions, even if that is taken to be the truth, it is inconceivable that no one could not have been harmed by her work practices. Giving the Grievant the greatest benefit of the doubt, it is inevitable that an STD referral or a maternal child health referral would be lost and not followed up on through her benign neglect, if not gross indifference.

The State, through its statutes and administrative code, has established a clear public policy entrusting the profession of nursing to individuals who are both adequately trained and exhibit the personal qualities necessary to meet the obligations of their profession in order to ensure that the health of the general public is not entrusted to individuals who do not meet those standards. It is not enough to simply leave matters of discipline to the cumbersome machinery of the State's licensing board. The Department has an absolute obligation to act upon conduct which is detrimental to the public it serves. Given the massive breach of trust demonstrated by the Grievant, potentially detrimental to the health of many individuals, the Department was left with no alternative other than to terminate the Grievant.

In its reply brief, the County asserts that the Union's first line of defense appears to be that while the Grievant had a messy desk, so did other workers, and the situation in her office was there for all to see. While the Union asserted that old records were found "over one year" old, numerous records were found that were many years old, and they were found in boxes on the floor where no one would have expected to find such records. There is absolutely no evidence that other employees placed records in boxes, or that any other PHN's were behind in their paperwork. The Union also makes the unsupported allegation that several of her co-workers testified that they were directed to shred, or witnessed the shredding of documents in files located in the Grievant's office, and that as a result the Grievant and her Union representatives never had the opportunity to review those documents. PHN's testified that the only documents that were shredded were unnecessary duplicate records or papers which could not be identified with any particular case or file, and that they were unaware of any other shredding.

The Union's second line of defense appears to be that the Grievant had been coping with depression for years. There is no evidence to suggest that the Grievant was either incapable of doing her job or of addressing the issue with her employer. It is also untrue that the Grievant's depression did not manifest itself in the actual care provided to clients or patients, as she was unable to address dozens of allegations that proper follow-up had not occurred. No other employees working for Walker corroborated the Grievant's allegation that Walker was difficult to approach and had through the years been unsympathetic to personal problems of employees. There was no testimony indicating a strain on the Grievant's relationship with Walker by virtue of her being President of the Union. Moreover, the Grievant admits her shortcomings in dealing with paperwork and only now realizes the need to properly complete and properly file paperwork and that it must be made a priority. The County questions why only now does she realize her job performance was inadequate.

The Union accuses management of failing to manage properly, and asserts management must be supportive of employees. No evidence was introduced that management was ever unsupportive of its employees. The Union calls Walker's surprise at the condition of the Grievant's caseload incredible; however, no evidence was introduced that Walker knew of the

state of affairs prior to inspecting the Grievant's office. The County questions what motive there would have been for it so suddenly entering into a disciplinary mode, absent complete and total surprise. Further, the information the Union asserts that management should have known about would have required double checking and confirmation of such things that a PHN is not only supposed to know, but is expected to do in her professional capacity. All of the other PHN's testified that they did not feel such double checking was Walker's job as their supervisor. The County characterizes the argument as the Grievant simply saying that, "Yes, she did not do her job, but it was management's fault for not catching her. . ."

The Union confusingly asserts that the County should have sought verification of the Grievant's illness. The Grievant provided the County with that verification on the day she was terminated, but she saw fit to never share that information with her employer until then. There is absolutely no excuse for not providing this information to her employer, if she is later going to use it as some kind of mitigation for failing to do her job. Absent extenuating circumstances which might have justified the Grievant keeping this information from the employer, it is duplicitous of the Union to now assert the County has not utilized "balanced supervision." Also, it is not an unusual disciplinary process to place an employee's office and records off-limits to the employee during the ongoing process, especially where termination is being strongly considered.

The County disputes the allegation that its evidence is vague and confusing. Given the huge number of disjointed documents and the confidential information found in the Grievant's office, it would take a miracle to make heads or tails of every bit of information. Further, the Grievant understands, as well as the County, why client initials must be used under the circumstances. The identity of the individuals or the records upon which the initials were based was for the most part not concealed from the Grievant, and she was given every opportunity to review the County's documentation and respond to it.

The assertion that it is some kind of defense that the County has not shown harm to any clients is unjustified by the evidence. The possibilities, and even probabilities, of harm to named and unnamed individuals is present through the Grievant's lack of job responsibility and professional conscience. The County asserts that the real test of this grievance is whether the Grievant had a reasonable expectation of termination. Several of her co-workers testified that under similar circumstances, they would expect to be terminated, and no other professional nurse testified to the contrary.

Union

The Union takes the position that the termination of the Grievant was without merit and without just cause.

The Union first asserts that for several years prior to her termination, the Grievant had been coping with depression, and had been struggling to deal with it for many years. The Grievant testified that many factors created stress and depression in her life. This included stressors related to her family situation, which the Grievant described in her testimony. In the Fall of 2001, these stressful factors, plus the Grievant's depressed state, distracted her from her duties; specifically, attending to, and properly filing the paperwork suffered during this time. However, the Grievant testified that the actual attending to patients and conducting home visits, following-up on shots, and other patient care continued. Her depression manifested itself in her failure to complete and properly file paperwork, but did not manifest itself in actual care provided to clients/patients to whom she had a responsibility to provide care.

The Grievant also testified that she had to deal with stress at work, particularly her difficult relationship with her supervisor. The Grievant noted that Walker was difficult to approach, hard to talk to, and rarely seemed supportive of her work. Given this, the Grievant was reluctant to share any of her issues dealing with depression. The Grievant had observed through the years that Walker was not sympathetic to personal problems of employees. Additionally, the Grievant had served as President of the Local for several years and this added strain to her relationship with Walker.

Importantly, the Grievant had been under professional care for treatment of her depression for several years prior to her termination and was in a long-term treatment plan to first deal with, and then master, her depression. The Grievant had been under the professional care of psychologist Michelle Simon since 1998. Simon testified that the Grievant clearly suffered from depression and reviewed the various stress factors in the Grievant's life, including the fact that the Grievant suffered from sleep apnea for which she has been given medical treatment. In her report dated September 26, 2002 (Union Exhibit 17), Simon identified those issues and also reviewed the history of the stressors acting upon the Grievant's life at both home and at work. Therein, she noted the stressors, specifically relating to one co-worker and her supervisor, and that they were compiling and peaked significantly between September and October, 2001.

Simon testified as to the role of stress on limiting job performance. In this case, the Grievant's depression manifested itself in neglecting her paperwork. Simon also correlated how the Grievant's particular stress acted upon her. Of particular note, is Union Exhibit 19, a document describing occupational stress and referencing the Grievant's situation as follows:

> Condition – Lack of supervisor's support when needed or expected.
>
> Employee Reaction – Anger. Either will react strongly by act of hostility or "getting even" or will avoid action that depend on supervisor's support, thus limiting job performance.

Solution – Always follow through on employee commitment. Clearly acknowledge when fail and assure correction.

That document, as well as the testimony offered by Simon, underscores the heavy load of stressors the Grievant had to deal with. However, as the testimony of both Simon and the Grievant indicated, the Grievant is making good progress in overcoming her depression and more importantly, is learning how to deal with her stress and depression. The Grievant acknowledged her shortcomings regarding her dealing with paperwork and now realizes she must not only provide the proper care to clients/patients, but must make it a priority to finish the paperwork associated with her nursing work, and properly file it. A review of the Grievant's testimony indicates she has now gained insights into her job performance. As she testified, she is well aware of the error she committed, and is ready to return to work. She is certain her job performance will not be hindered as it has in the past.

Next, the Union asserts that management failed to manage properly. The County attempts to excuse its lack of supervision on the argument that nurses are professional employees, not needing constant supervision. While RN's are professional employees and do not need constant supervision, balanced supervision is required. Such supervision is not distant, but is supportive of employees, and is positive. The condition of the Grievant's desk and the boxes filled with papers were there for all to see. Walker was well aware of the situation and should have exercised proper supervision. She should have worked with the Grievant to determine if there was a real problem developing with her paperwork, and then should have worked with her to correct the paperwork completion and filing problem. The so-called "complete surprise" by Walker at the condition of the Grievant's desk and surrounding work area lacks credibility. If paperwork had not been completed and properly filed for this period of time, it certainly would not have gone unnoticed by a diligent supervisor. We are to believe that supervision conveniently returned while the Grievant was on Christmas vacation, and that somehow unfiled and incomplete documents were a newly-discovered crisis.

Management mishandled this situation. At the time of the purported discovery of the incomplete forms and lack of proper filing, management should have acknowledged the information the Grievant provided concerning her depression, and should have sought verification of her illness, which the Grievant voluntarily offered and later supplied. The County should have then started exercising the balanced supervision that had been lacking, by allowing the Grievant to return to work under close supervision, and by utilizing the knowledge and experience of the Grievant in handling her cases. The Grievant offered to work on cleaning up the problem. As shown by her testimony, the Grievant had very accurate and complete knowledge of many cases. Had she been provided the opportunity to review all the paperwork, she would no doubt have completed most of the cases and had them filed. By doing so, the County would have had the advantages of paying the Grievant to work, rather than not to work, and other nurses' time would not have been spent on work that the Grievant

could have done herself. In addition, the Grievant would have been able, with proper guidance, to rehabilitate herself. The Union finds the anger and frustration of the Grievant's co-workers understandable. However, management set up the situation. Had management worked with the Grievant, this extra burden would not have fallen upon her co-workers.

The County argues it can no longer trust the Grievant at her job, thus adding the element of character assassination in its justification for poor managerial actions. In doing so, the County attempts to argue that the Grievant was covering up her actions and imply she was lying about it. The condition of her desk was there for all to see, as shown by Employer Exhibits 21 and 22. Those photos prove there is no hiding this work area from anyone. The incompletion of paperwork was not done to hide her work or non-work. There was no proof presented that the Grievant did not provide her nursing services to her clients. The Grievant did her job of providing professional service to her clients/patients, but simply did not finish the paperwork and neglected to file it. The Grievant acknowledges that this was not proper conduct and testified that she is remorseful. However, she never lied about any of these concerns, nor ever tried to hide her actions. Her actions regarding the paperwork issue stem from serious depression, not dishonesty.

The County also suggested that the Grievant was rude to "walk-ins." However, several witnesses testified that the Grievant handled them professionally and helped these individuals immediately, or sought to direct them to schedule an appointment with a County nurse.

The County also accused the Grievant of not performing her job when dealing with jail inmates. The jail nurse for the past six and a half-years, Gwen Brand, testified that the Grievant was dependable in her performance of her duties as a nurse for the inmates, and noted that she had a good working relationship with the Grievant. Brand testified there was no problem getting timely results from the Grievant, and that her response was always immediate in regard to inmate medical problems. She also noted that there was never a problem in getting paperwork from the Grievant.

The Union asserts that the County's evidence is vague and confusing. The bulk of the County's case is contained in Employer Exhibit 6, which claims to note approximately 166 cases that illustrate the Grievant's paperwork failure. The cases are identified only by the client's/patient's initials. While using initials serves to preserve client privacy, it makes the task of tracking and answering the charges difficult, if not impossible.

The Grievant's ability to remember and explain the details of many of these cases cited is quite remarkable. Often relying upon her memory, the Grievant testified she would make notations on sticky notes, and attach them to the primary form for later entry. By using co-workers to work on her files, many of the sticky notes became separated from the original documents, thus compromising her ability to reconstruct the file document. Furthermore, shredding of various documents made the reconstruction of some files nearly impossible.

A review of some of the cases cited in Employer Exhibit 6 reveals the Grievant did perform the care required. The Grievant testified as to the care she provided in the case referenced in the sexually-transmitted disease section of the document. She testified regarding Case "HF", that a letter was sent in June of 2001; in the case of "CS", she noted she had made a follow-up call. She testified that as to "DJ", she attempted three phone calls. "CH" on the same page, was a partner of a person in another case. Regarding "KG", the case cited in Employer Exhibit 18, the Grievant testified she performed the follow-up on this case, including the phone call. Some cases cited in the report are very old, e.g., "KB" was an old file from 1996, and the Grievant could not recall the specifics of such an old case.

In the section titled "Communicable Disease Follow-Up", there is the case of "MB", also cited in Employer Exhibit 15. The Grievant testified she personally knew the individual in this Lyme disease case, and had contacted him and given the information to his mother. The case of "RC" was another instance where the Grievant knew the person and had spoken with the individual in October of 2001. The Grievant had performed the necessary lab work, but due to her administrative leave in January, was unable to have any follow-up with the client.

The County also accuses the Grievant of leaving confidential files out in the open for anyone to see. The Grievant testified that her desk was in an area where few people would ever simply walk in; that most people coming to the Department would come to a reception desk located in a different area. As to the five cases noted in the section entitled "AIDS/HIV", the Grievant notes these were old cases that were left in a box by her desk, and not out in the open.

In the section titled "New Baby Referrals", the Grievant testified that Case "SO" was a new baby referral from the hospital, and that she had made a home visit, during which she had weighed the baby, talked to the parents, and informed them about the "back to sleep" program. However, she did not complete the paperwork. Regarding the case "MS", the Grievant testified she made phone calls and left messages as indicated by her notes on the form. The paperwork was not filed properly. Regarding Case "BJ", the Grievant stated that in this case several agencies were involved, as well as the mother's personal doctor, and that they did not need the services of the Douglas County nurses. The paperwork was not filed properly. With regard to Case "SM", the case was actually assigned to Lillian McLeod. Often cases were assigned to more than one nurse, and the nurses would confer with each other and consequently the case would be handled by one nurse as her case. This assignment of cases to different nurses raises the number of cases cited, and in some cases, such as this one, they were never the Grievant's cases. The Union notes that McLeod has primary responsibility for SIDS cases, and that Mary Magnuson was in charge of the "Birth-To-Three" program. The Grievant testified regarding her follow-up in Cases "SB" and "KB", which are also mentioned in Employer Exhibits 12 and 11, respectively, and similarly, as to her follow-up in Cases

"KT" and "AL". However, the paperwork was not filed in those cases. As to Case "SC", cited in Employer Exhibit 10, the Grievant made several visits to the home, until the baby was one year old, and notations were made on the form.

Another problem with Employer Exhibit 6 was the double counting of cases, e.g., Cases "MM", "SM", "SO", "JC", "KP" and "SR" are examples of cases found on different pages in this document. Some cases are referenced by the name of the child, and some by the name of the mother, e.g., "SC" and "MC" reference the same case.

While the County attempts to create an illusion that clients/patients of the Grievant were harmed by her paperwork deficiencies, the evidence clearly shows that the Grievant always provided professional treatment to all of her clients/patients. The County failed to produce a single individual who was in any way harmed by the Grievant's paperwork problems. Further, the testimony of Tim Robinson highlights the high regard the Grievant was held in by other medical professionals in the community. Robinson, who is responsible for assisting individuals in testing and getting treatment for HIV, testified that the Grievant always provided timely information and follow-up for HIV cases. Professional and timely treatment for HIV cases are Robinson's primary concern and the Grievant's job performance in his view, met that concern.

Last, the Union asserts that the Grievant is a long-term employee with over 17 years of service in the Department, during which time her work record has been excellent, with no prior discipline. Despite the County's claim that there was prior discipline, no evidence of such discipline was provided, and the Grievant testified she had not received any discipline in her 17 years with the County. Evidence of her excellent work record is clearly shown by her job evaluations and her status within the Department was clearly shown by the testimony that the Grievant was considered second in charge after the management personnel. The high esteem of her co-workers is clearly shown by the fact that they elected her to serve as President of the Local.

While the Grievant admits she fell short regarding her completion and filing of paperwork, she did provide nursing services required by the clients/patients. There are positive ways to rehabilitate the Grievant in the areas regarding paperwork. Any violation of work rules regarding paperwork issues does not merit the punishment of termination. The Union requests that the Arbitrator sustain the grievance and direct the return of the Grievant to her position as a Public Health Nurse, and that she be made whole for all lost wages and benefits.

In its reply brief, the Union asserts that the County has failed to justify the termination of the Grievant and has attempted to turn the principle of justice upside down in asserting that "it is the Grievant who should be required to show that individuals were not harmed by virtue

of her failure to document or uphold the standards of her profession." The County failed to produce a single individual who was harmed. The fact is that the Grievant performed her job and provided the necessary services to the County's clients and patients. The only problem with the Grievant's job performance was in the one area of completing paperwork.

The Grievant suffered from depression and this affected her job performance. On one hand, the County tries to claim that the Grievant's psychologist "can't know anything" about the Grievant's depression, while questioning her co-workers as to the Grievant's state of depression. For the County to rely upon co-worker testimony as to the state of the Grievant's depression is absurd. The Union presented expert testimony through Psychologist Michelle Simon that clearly detailed the Grievant's history of treatment and recovery from depression and the adverse effect depression had upon the Grievant at both home and at work. Simon also detailed the stressful nature of the relationship between the Grievant and Walker, testifying that it was obvious the Grievant could not go to that individual who, in part, created the stress in her life. The Grievant had nowhere to go at work to deal with her depression, and sought outside professional help to deal with it three years before her termination. Over time, the Grievant's depression has improved, but during this time the Grievant had setbacks. At work, the issues of handling and finishing paperwork suffered.

The County will settle for nothing less than having the Grievant in a state of total incapacitation. Simon's testimony clearly detailed that the Grievant was functioning at a reduced level, and that this level changed through time. By the time of the arbitration hearing, her functioning level had improved. While the Union is mocked for its concern for humane and compassionate treatment of employees, that is one of the hallmarks of the Union movement, and the Union makes no apologies for that concern. The Grievant suffers from serious depression, and the human and compassionate approach is to return her to her job. She deserves a second chance, and this is the very least the County can do for a loyal employee of 17 years. As was shown through the testimony of the department head, Heiser, the Department had given an employee who had stole money a second chance.

Regarding the hostility of the Grievant's co-workers, not all of the Grievant's co-workers testified at hearing. Those who were subpoenaed to testify stated the Grievant was viewed as having the most experience and was looked to for her knowledge. She was viewed as being the second in command after management personnel in the department. The Grievant was elected President of her Local for several terms, and served on various Union committees. She was chosen by her co-workers to represent them because she has their respect and trust. What was apparent at the arbitration hearing was that those employer witnesses who were co-workers were angry and frustrated. However, Walker created this feeling of resentment by dropping all of the Grievant's paperwork and files upon them. Thus, the blame rests with management, not the Grievant. It also should not be forgotten that the Grievant offered to finish the paperwork and file it. Had management not overreacted, the Grievant would have

finished the vast majority of the paperwork and her co-workers would have been spared the extra burden of reconstructing the files and unfinished paperwork.

Another insidious aspect of this case was the use of Union-represented employees to perform supervisory work. The investigation of the case and developing the documentation for the State Board of Licensing and for the arbitration case should have been assigned only to management personnel.

The County attempts to excuse its failure to manage by claiming that professional nurses do not need "babysitting." While one extreme is to micro-manage every aspect of work, the other extreme is the supervisor who does not exercise any direction over employees. Both approaches are wrong, and as Walker's testimony clearly illustrates, the management of the Department falls in the latter category. The Union questions why Walker did not know about the condition of the Grievant's work area, and why she did not make regular rounds to observe and communicate her concerns directly to the Grievant. It appears that Walker communicated her concerns only one time, but did not follow up with the Grievant upon later observing that conditions had not improved. The Union also questions why Walker did not double check forms to ensure that they had been properly filled out and filed.

The Union does not dispute that properly filling out paperwork is essential. However, the County laments that the unfiled paperwork went back several years. Some of the responsibility for this lies squarely with the supervisor. A supervisor has responsibility over the action of subordinates, and all employees need reasonable, effective, and sensible supervision. In this case, the Grievant is sacrificed without any effort at rehabilitation.

The County attempts to discredit the Grievant by embellishing on the testimony of the Grievant's co-workers. It attempts to rely on the casual observations of co-workers as "experts" counter to the testimony of Simon regarding the Grievant's depression. The Union notes that all of the Grievant's co-workers who testified were under subpoena. Further, they were angry given the decision by management to unload extra work on them. One of those witnesses was Barb Berkseth, a member of another bargaining unit represented by a different union. Other than offering testimony confirming that the Grievant's desktop was messy, Berkseth's testimony centered on the Grievant making personal phone calls and frequently signing out of the office. No testimony was presented detailing to what extent the Grievant made personal phone calls, and it is noted that she was never disciplined or counseled in that regard. Further, no evidence was presented showing that when the Grievant signed out of the office, she was not out serving the County's clients. Regarding the testimony of Rounsville, the Grievant clarified that they both equally shared the school health program for the four schools. Witnesses Peterson and McLeod also admitted to having messy desks. There is no evidence that either of them had their desks and surrounding work area examined as thoroughly as the Grievant's. McLeod also testified that in the event that she was in a similar situation as the Grievant, that she should be given a second chance.

The final County witness, Michelle Hughes, admitted that she had a long-standing personality conflict with the Grievant and had not trusted the Grievant for 10 years. Her testimony should therefore be viewed in that context. While Hughes testified regarding her concerns that possible harm to an unborn child could occur, no child was in fact harmed by the Grievant's unfinished paperwork. Hughes testified regarding confidential files being left out for anyone to see. While files containing confidential records were not always filed away in the Grievant's work area, no one was rummaging through those files, and her office was situated where the general public would not pass through. Hughes also appeared not to understand the role of the State Board of Licensing. The primary objective of that Board is not to revoke a nurse's license; rather, it is to give the nurse a second chance. The Union posits that there is great wisdom in the approach taken by the Board in approaching these matters in a slower, more deliberate and reasoned fashion than the County's knee-jerk reaction. The Union asserts that the Grievant continues to retain her nursing license.

The Union concludes that it is obvious the County has failed to meet the basic standards of just cause, and has failed to take into account the Grievant's depression as a critical, mitigating factor. The County also failed to follow progressive discipline and to exercise timely and effective management. The County also failed to consider the Grievant's 17 years of dedicated service. The Grievant is an experienced and caring individual who delivered the essential services to the residents of the County. Her shortcomings regarding paperwork in no way justifies termination. The Union requests the Arbitrator to determine the proper penalty for those shortcomings. The Union requests that the Arbitrator sustain the grievance and return the Grievant to her position, making her whole for lost wages and benefits. The Union asks that the Grievant, an experienced and dedicated employee, be shown compassion and given a chance to return to her position where she can render services to the residents of the County.

DISCUSSION

This case involves the termination of a seventeen-year employee with a good work record and no prior discipline, other than perhaps a verbal reprimand. There is no dispute that the Grievant was aware of the procedures and protocol to be followed when given assignments involving communicable disease investigations, STD's, new baby referrals, etc. The Grievant knew what follow-up and reporting was required and how to do it, as she had trained most of the other PHN's in the Department and was considered to be in charge in Walker's absence. There is also no dispute that the Grievant did not complete and properly file numerous reports, forms and records, especially in the latter half of 2001, had copies of old communicable disease reports and AIDS/HIV with personally identifiable information on them in her office, and had uncompleted forms, reports, etc., mixed with junk mail and other items in boxes in

her office. 1/ Finally, there is no dispute that the Grievant has been dealing with depression for a number of years, and receiving treatment in that regard, but had not informed anyone at her work (other than her former office-mate) of that fact until the day of her termination.

1/ While there was also testimony regarding the Grievant's willingness to handle "walk-ins" and to do her share, the Grievant was not terminated for anything related to those matters. Therefore, they are not relevant to the issue before the Arbitrator and are not considered.

With regard to the Grievant's depression, there is no question that the Grievant had serious stresses in her personal life. The Union notes she had been coping with depression for a number of years and that certain stressors in her life had increased in the Fall of 2001, and asserts this was manifested in the Grievant's failure to complete her paperwork. According to the Grievant, she did not tell Walker of her problems because she did not feel Walker would be sympathetic, given what had happened previously with another employee who had been open about her mental illness and another who had went to Walker and Heiser about her problems. While the Grievant clearly viewed Walker as one of the stressors in her life, there is no evidence that Walker bore any animosity toward the Grievant or that she was somehow trying to get the goods on her. Contrary to the Union's assertion, there is also no evidence there was a strain on their relationship due to the Grievant's being President of the Union. Co-workers of the Grievant testified they would not have a problem talking to Walker about problems with their work and contrary to the Grievant's testimony, they did not find her to be unsupportive. It is also noted that, according to Simon, the Grievant's depression would not have been noticeable to her co-workers.

As to the impact of the depression on the Grievant's work, at the point that an employee's problems are seriously affecting his/her work, it is incumbent upon the employee to inform management so that steps can be taken to alleviate the problem, at least as to the work-related aspects. One may not simply not do a significant portion of his/her job for a significant period of time without letting management know of the problem, and then claim as a defense their inability to do the job due to illness or personal problems after it is discovered. It is also noted, that while the Grievant suffered from depression, according to Simon, it was never more than at a moderate level and did not render her incapable of working.

It appears that the Grievant had a growing problem with her paperwork at least as far back as 2000 and that the problem increased significantly by June of 2001. Although she mentioned this to Simon, she did not discuss the problem with Walker or Heiser or seek assistance in that regard. While she might not have been "hiding" it from them, she

consciously chose not to inform them of the problem, 2/ and allowed the problem to continue, if not worsen.

2/ However, the Grievant never satisfactorily explained why she had placed some of the documents in boxes mixed in with junk mail.

The Union asserts that, given the known state of her desk, the Grievant's problem was there for everyone to see, and that Walker should have been monitoring the Grievant's work more. It appears from the testimony that it was well known that the Grievant had a messy desk and that she tended to keep reports, forms, etc. on her desk more so than others, and that she once had had a problem timely filing STD reports with the State. However, that would not make evident that the Grievant was not completing the reports or not timely following up on some of her assignments, or as it appears, not following-up at all in some cases. It would also not be evident that the Grievant was keeping such reports, forms and records in the boxes by her desk. Moreover, the Grievant's status in the Department cannot be ignored. She was the most senior PHN in the Department and had trained almost all of the other PHN's in the Department. She was also considered to be in charge in Walker's absence. Despite Walker's apparent "hands-off" approach, given the professional nature of a PHN, and the Grievant's experience in her job, the need to monitor her assignments to ensure they were being done was not apparent and it was not unreasonable of Walker to assume the Grievant was doing her job as she had in the past. It is also noted that the other PHN's who testified did not feel it was necessary for Walker to monitor their work to make sure that they were doing their job.

The Union asserts that while the Grievant had problems completing and filing the paperwork, she had not failed to provide the actual care or do the required follow-up. It further asserts that the County's evidence against the Grievant, especially Employer Exhibit 6, is "vague and confusing." The evidence, both documentary and the testimony of the other PHN's who attempted to complete the forms and do the follow-ups, established that while there was some duplication in Employer Exhibit 6, there were a significant number of cases, including new baby referrals, STD investigations and communicable disease investigations, where the Grievant had done no, or very little, follow-up on the case. The Grievant acknowledged that as to at least ten of the STD cases listed in Employer Exhibit 6, she either had no recollection of, or could not find any indication of, having called or sent a letter to the individual named on the form. 3/ A case of minimal follow-up involved "HF". The case was

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3/ E.g., See AL, RS, JD, LV, CH, KG, GJ, CS and DL, under the STD portion of Employer Exhibit 6.

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dated June 7, 2001 and the Grievant testified that she sent a letter to the individual in June and that there was no indication of further follow-up. She conceded this type of case is considered a priority and that time was somewhat of the essence due to the potential harm from delay, the expectation being that they were to be done within 4-6 weeks. The Grievant testified she knew the case had not been completed and that it was a priority for her when she returned from vacation.

The evidence also established that the Grievant had not filled in the required information on immunization records. In some cases this required starting a shot series over for individuals or having to reinoculate students, because there was no way to know which students at the particular school had been given shots. It also appears that the Grievant failed to initiate the billing process for immunizations that ultimately totaled approximately $13,000.

The evidence, both documents and testimony, are sufficient to establish that while there had been follow-up in the majority of the cases, in a significant number of cases the Grievant did not do the required follow-up or could not recall doing so, or the paperwork not done required that the follow-up or service be provided anew.

While the Union asserts that it was difficult, if not impossible, for the Grievant to reconstruct some of these cases because her "sticky notes" were removed from some of the documents and other documents had been shredded by the County, the evidence does not support those claims. Those witnesses who testified regarding the shredding of documents testified that the only things shredded were duplicates of forms and notes with information that was not usable, as it could not be identified with a particular case or record. The PHN's who assisted Walker in going through the records found in the Grievant's office testified that the sticky notes that were on a form, were left on the form, although they found notes that were not attached to any form and these were considered unusable. The Grievant was given the opportunity to review the records and forms in order to prepare her defense prior to the February 22nd meeting regarding her case. It is likely that the state of the paperwork contributed as much as anything to the Grievant's inability to reconstruct some of the cases.

There is also the Grievant's inability to explain why she had copies of records from some communicable disease files and AIDS/HIV forms from 1996 with identifying personal information on them in her office. She conceded they should not have been there.

The Union also asserts that the County failed to establish that anyone was actually harmed by the Grievant's actions. There was, however, obvious potential harm to individuals in the STD and communicable disease cases in which the Grievant failed to do the follow-up, as well as potential liability to the County in those cases in which the Grievant failed to document her follow-up or attempts at follow-up. An employer does not have to wait until it can show someone was actually harmed before it can take action. In this case, it is not

necessary to show that someone was actually harmed, as the potential for harm is sufficient, especially where, as here, that potential is significant.

In the end, the Grievant's conduct must be weighed against the years of good service she provided to the County and to the community, and the fact that she suffered from depression, which may have contributed in some degree to the problem. This balancing is often times difficult and certainly is inexact. However, given the nature and extent of the work that was not done, the length of time that it went on, the potential harm to patients and the public health, the potential liability to the County, and her refusal to inform her supervisor of the problem, the Arbitrator finds that the Grievant's conduct was sufficiently serious that he cannot require that the County continue her in its employ; that is, that the County had just cause to terminate her employment without giving her a second chance. While the Union asks that the Grievant be shown compassion, once it has been established that the discipline was justified, compassion is for the County to exercise, not the Arbitrator. The County has chosen not to do so.

Based upon the foregoing, the evidence and the arguments of the parties, the undersigned makes and issues the following

AWARD

The grievance is denied.

Dated at Madison, Wisconsin, this 28th day of April, 2003.

David E. Shaw /s/

David E. Shaw, Arbitrator

DES/gjc
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