BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

BROWN COUNTY MENTAL HEALTH CENTER EMPLOYEES, LOCAL 1901, AFSCME, AFL-CIO

and

BROWN COUNTY

Case 702
No. 64071
MA-12794

(Gagne Termination)

Appearances:

Mark DeLorme, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, on behalf of Brown County Mental Health Center Employees, Local 1901, AFSCME, AFL-CIO and the Grievant, Michael Gagne.

John C. Jacques, Corporation Counsel, on behalf of Brown County.

ARBITRATION AWARD

Brown County Mental Health Center Employees, Local 1901, 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 Brown 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 May 24 and 25 and August 4, 2005, in Green Bay, Wisconsin. A stenographic transcript was made of the hearing and the parties submitted post-hearing briefs in the matter by October 15, 2005. Based upon the evidence and the arguments of the parties, the undersigned makes and issues the following Award.

ISSUES

The parties stipulated to the following statement of the issue:

Did the County have just cause to terminate the Grievant, Michael Gagne? If not, what is the appropriate remedy?

CONTRACT PROVISIONS

The following provisions of the parties' collective bargaining agreement are cited, in relevant part:

ARTICLE 1. MANAGEMENT RIGHTS RESERVED

Unless otherwise herein provided, the management of the work and the direction of the working forces, including the right to hire, promote, transfer demote or suspend, or otherwise discharge for proper cause, and the right to relieve employees from duty because of lack of work or other legitimate reason is vested exclusively in the Employer. If any action taken by the Employer is proven not to be justified, the employee shall receive all wages and benefits due him/her for such period of time involved in the matter.

The Employer shall adopt and publish reasonable rules which may be amended from time to time. Except for rules, regulations and directives from the State of Wisconsin, approving agencies such as the Joint Committee on Accreditation of Hospitals, or other governmental agencies having jurisdiction over the institutions; however, such rules shall be subject to the grievance procedure.

. . .

ARTICLE 26. GRIEVANCE PROCEDURE – DISCIPLINARY PROCEDURE

. . .

The parties agree that the decision of the arbitrator shall be final and binding on both parties to the Agreement. The arbitrator shall not have the authority to add to, subtract from change, alter, modify or delete any of the specific terms or provisions of this Agreement, and his/her ruling will be restricted to an interpretation of the contractual part of this Agreement only.

. . .

DISMISSAL: No employee shall be discharged except for just cause. Any employee who is dismissed, except probationary, shall be given a written notice of the reasons for the action at the time of dismissal, and a copy of the notice shall be made a part of the employee's personal history record and a copy sent to the Union. Any employee who has been discharged may use the grievance

procedure by giving written notice to his/her steward and his/her supervisor within ten (10) working days after dismissal. Such appeal shall go directly to arbitration. If the cause for discharge is dishonesty, intoxication on the job or drinking or use of illicit drugs on duty, and/or if an employee is convicted in the illicit sale of drugs or pushing drugs, the individual may be dismissed immediately from employment with no warning notice necessary.

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

. . .

BACKGROUND

The County maintains and operates the Brown County Mental Health Center (MHC), which includes Units 3 and 4, long-term care for developmentally disabled clients who suffer from mild to profound mental retardation. Some have severe behavior problems, some are wheelchair bound and some are ambulatory. Mary Johnson is the Nursing Service Administrator responsible for overseeing all the care on Units 3 and 4. Wendie Mayer-Bell is a Registered Nurse and is Unit Manager for Units 3 and 4. At the time in question, Judith Van Ryzin was the Administrator at the MHC. The Grievant, Michael Gagne, was employed at MHC as a Certified Nursing Assistant (CNA) from 1998 until his discharge on July 7, 2004. He had no prior discipline. He had previously been investigated by the MHC and the State regarding alleged abuse of a patient. No action was taken against the Grievant by either entity as a result.

At the time in question, May of 2004, the Grievant worked on the "p.m. shift" (2:00 p.m. – 10:20 p.m.) on Unit 3. Also on the p.m. shift on Unit 3 was LPN Patricia Zingler, CNA Carol Vander Bloomen and CNA Jay Koon. MHC at times contracts for CNA staffing from Medical Staffing Network of Green Bay; these contracted staff are referred to as "agency" CNA's.

On the day in question, May 10, 2004, an "agency" CNA, Jennifer Sprang, was assigned to work on the p.m. shift on Unit 3 at MHC. Sprang testified that sometime between 4:00 and 5:00 p.m. on that date, she was sitting in the dayroom on Unit 3 along with Zingler, who was seated to her right, about four chairs away, the Grievant, and a number of residents. One of the female residents, K, was having loud outbursts and the Grievant told her to "shut

up" and got up and shoved K's wheelchair and let it go so that it was going on its own. The Grievant then walked to where K's wheelchair had stopped and hit K on the side of her head with the heel of the open palm of his hand. Sprang described it as a vigorous movement and the described the Grievant's face as being "beet red" and looking very angry. Sprang estimated she was 10-15 feet from the Grievant when he struck K. According to Sprang, later that day she told CNA Vander Bloomen that she felt "very uncomfortable with the way that (the Grievant) treated the residents." Vander Bloomen asked her if she meant the way the Grievant talks to them, and Sprang responded, "No, it's more than that." Vander Bloomen confirmed that Sprang had said something to her to the effect that she did not like the way the Grievant treated the clients.

Sprang testified that the Grievant later confronted her in a client's room, with only her, the Grievant, and the client present. The Grievant closed the door and said something to the effect that he was sorry if he did anything to offend her, that these patients are different than nursing home patients, they have behavioral problems and they are handled in a different manner, that they needed discipline. According to Sprang, the Grievant kept asking, "Are we good?", and she responded, "Yeah". Sprang testified that although the Grievant did not threaten her or act aggressively toward her, she felt threatened by his approaching her after what she had seen and was "so uncomfortable" she just wanted to get out of the room. Sprang interpreted "Are we good?" to be asking "You're not going to say anything?"

Sprang testified she knew she was to report abuse immediately, but that she intended to report the incident to her supervisor at her agency, since the LPN at MHC had been present at the time and had not done anything. She conceded she did not know whether Zingler had seen or heard anything in that regard, but felt that she should have heard the Grievant as he yelled "Shut up" at K. Sprang worked until 10:00 p.m. that evening, and reported what she had seen to the administrator at the facility where she was working the next day, who then called the County to report it. Sprang then contacted her own supervisor at her agency about it and went to the MHC after work that day (May 11, 2004). She gave a written statement to Mayer-Bell and was questioned by Mayer-Bell about the matter. Sprang's written statement is as follows:

5/11/04

> On 5/10/04 I Jennifer Sprang worked from 3 pm – 10 pm on Unit 3. While on duty I witnessed Mike Gagne shoving a resident who was identified by myself from a picture in the medix. At around 4:30 pm Mike, myself and the LPN + residents were sitting in Lounge when (K) had some outbursts. Mike got up out of his lounge chair pushed (K) out of the day rm. and shoved her in the head and told her to shut up. I did mention this to the other female nursing assistant that I was working with. When Mike turned around his face was beat (sic) red and he looked very angry at the client.
>
> Jennifer Sprang 5/11/04

Mayer-Bell's interview of Sprang on May 11th was taped, and a transcript was provided from that tape, which reads as follows, in relevant part:

Wendie: Jennifer, did you work last night on Unit 3?

Jennifer: Yes.

. . .

Wendie: Did you notice anything happen between a staff and a client that could be perceived as abusive?

Jennifer: Yes.

Wendie: What did you see and what time was it.

Jennifer: It was before supper, I would have to say at approximately 4:30; we were sitting in the lounge.

Wendie: We? Who is we?

Jennifer: Me, the LPN on duty and Mike Gagne, and a client had frequent outbursts.

Wendie: And you know that client's name?

Jennifer: No.

Wendie: The medics just brought upstairs for Jennifer to identify which client she was referring to and she has referred to (K) as being the client that was in the Day Room.

Jennifer: As she was having these outbursts, Mike got up out of the lounge chair, took her chair and pushed it forward and kind of left the chair go on its own and then he proceeded to shove her head really hard and told her to shut up.

Wendie: He actually said the word "shut up"?

Jennifer: Yes.

Wendie: Jennifer, can you tell me if in your estimation the client was injured?

Jennifer: No.

Wendie: Was she upset, did she appear to be upset; did she holler, did she yell?

Jennifer: No.

Wendie: Ok. Did you tell anyone or have a conversation with anyone about what happened?

Jennifer: Yes I did. The Nursing Assistant on duty, a female.

Wendie: Did you tell anybody else?

Jennifer: No.

Wendie: Was there anybody else around when this happened?

Jennifer: Yes, the LPN.

Wendie: And she said nothing or did nothing?

Jennifer: No, I'm not sure that she saw because she was on the opposite side of me; she was on one side of me and this happened on the other side of me in the hall.

Wendie: When you talked to the female Nursing Assistant that was working, what did you say to her?

Jennifer: I was in the bathroom and I had mentioned to her that I felt uncomfortable with the way that some of the clients are being treated and she asked me, do you mean the way they talk to them, the way he

Wendie: By he?

Jennifer: Mike, talked to them. And I said no, more than that. But I did not go into detail about what happened because I didn't know, I mean I was going to, you know, be writing out a statement, and I just didn't go any further. And after that, I was in another client's room getting him up and Mike came in and had asked, had told me that, well Carol must have said something to him and he came in and told me that he was sorry if he did anything to offend me that these patients are different than, you know like the

elderly patients that I take care of in a nursing home and that they have behavioral problems and that you know, they are handled in a different manner and he just kept saying he was sorry if he offended me and that and if we're good or not.

Wendie: By telling you that we handle these people in a different manner, did he elaborate on what exactly he meant? Like, how else would you handle them?

Jennifer: No.

When the Grievant reported for work at 2:00 p.m. on May 11th, he was "walked out" of the facility and suspended with pay pending the results of the investigation. He was not told at the time why he was being suspended.

The Grievant testified that at the time he lived approximately three minutes away from MHC. He called Zingler at work at approximately 2:30 p.m. on May 11th and told her that he had been walked out. She asked him "what for" and he responded that he didn't know. According to the Grievant, he didn't ask Zingler to find out why he was walked out and did not call her again that day. He testified that he took his phone off the hook and started drinking. Later that evening, Quinton Crappeau, a CNA and co-worker of his at the MHC called the Grievant at home and told him that Zingler had told him why the Grievant was walked out. Crappeau then told the Grievant that Zingler said it was because he had pushed K's wheelchair, cuffed her in the head and told K to "shut up". The Grievant then called Patricia Carriveau, the Nurse RN Manager at MHC around 9:30 p.m. on May 11th to get the phone number for Susan Gladh, a Human Resource Analyst in the County's Human Resources Office. He then called Gladh's number and left the following message:

Hi Sue,

This is Mike Gagne calling you. I just got three calls tonight why you are investigating me. I know exactly why you are investigating me. Apparently this came from management, why it was leaked out, and I'm demanding an investigation why this was leaked out.

I'm very upset that it was leaked out from management, and I can tell you exactly why I pushed (K) out of the Day Room and apparently gave her a knock on the head.

I'm very upset and embarrassed that the whole Brown County Mental Health Center knows about this before I did.

And, I want an investigation done. Thank you. My number is (omitted). Thank you. Bye.

As to the alleged incident on May 10th, the Grievant testified as follows: He was in the dayroom with the residents, and Zingler and Sprang were also present. K was wheeling herself backward into the dayroom. There were 14-15 residents in the dayroom at the time and K ran over a female resident's feet and that resident screamed, not K. The Grievant got up and pushed K's wheelchair out into the hallway. K's wheelchair came to a dead stop and he stumbled forward, hitting the wheelchair and might have struck K with his upper body, but not his hand. The Grievant had been assaulted by a client two or three days earlier, resulting in his breaking a rib. When he fell forward, he was in pain from the broken rib, so his face could have been red, but it was from pain, not anger. A CNA on another unit, Craig Gunderson, was coming down the stairs in that area at the time, and when the Grievant stumbled, he called him a "klutz". The Grievant then told Gunderson, not K, to "shut up". Later that evening, Zingler told the Grievant that the "agency girl" (Sprang) had said he was "loud" and she told the Grievant to lower his voice. Subsequent to this, Sprang needed help with putting a resident to bed who was a "heavy lift", and asked for help. There were other CNA's present, but as none of them got up to help Sprang, the Grievant did so. He closed the door to the resident's room, as that is MHC policy for resident privacy concerns. According to the Grievant, he told Sprang that he understood she had reported that he was "loud". Sprang responded to the effect, "No, this whole place is loud with these people." She then stated she did not have any experience with the MHC and was used to working in nursing homes. She then apologized, saying "I shouldn't have said anything. I'm sorry." The Grievant then said, "Are we cool?" and she said, "Yes". The Grievant testified he meant "Are we cool as co-workers?" and not "Are you going to report me?"

Zingler was interviewed on May 11th by Gladh and Mayer-Bell, with a Union steward present. The interview was recorded and a transcript made of the tape. The interview included the following questions and responses, in relevant part:

Wendie: Did you see anything happen between Mike Gagne and a client that could have been perceived as abuse?

Patti: No I didn't; no.

Wendie: Can you tell me, did anybody report anything to you that they have seen Mike shove a client?

Patti: No, no.

Sue: Ok, Patti have you ever seen any interaction between Mike and a client that you perceive

Patti: No.

Wendie: And you saw nothing when you were sitting in the Day Room next to Jennifer Sprang?

Patti: I did sit with her for a while and

Wendie: You didn't see anything unusual in the Day Room?

Patti: I was told by, Carol did report to me that she reported to her, this girl

. . .

Patti: that this individual, Jenny, said to her that Mike was a little loud with the clients

Wendie: But nothing else?

Patti: Nothing else. But she personally never came to me through the whole night so I talked to Mike and said, you know, you might be a little loud; you need to be more careful about being loud. Carol said that I was privy to seeing something; I did not see that. If he shoved someone, I did not see that. But I was talking to her, I don't know if my head was turned, I don't know, and a lot of stuff goes on in the Day Room, but I did not personally see that; but she apparently claims that I saw something or heard something.

Wendie: What makes you think that?

Patti: Carol told me that.

Wendie: What did Carol exactly say to you?

Patti: Carol came up to me and I don't know, have the time, I don't know what time it was. I'm going to say after supper. I think I was already starting passing meds so I would say I started last night at 6:45 because we had that in-service to go to so that I had to start earlier. Anyway, Carol came up to me and all she said to me was, this girl said to her down the hall, that she thought the guy with the braces, which would be Mike, was a little loud with the clients, and I supposedly have witnessed that. No. Everybody knows, clients are loud, you know, you hear but you don't hear. I don't know. They watch the client, you know what I mean? So anyway, I said to Carol, what, what. And Carol goes like this, she shrugged her shoulders. So I went to Mike and I said to him, you might be a little loud with the clients you know, you need to cool it.

Sue: And what did Mike say?

Patti: He didn't know what I was talking about. He goes, what are you talking about? I said I don't know. Whatever it is, you are being loud, and to not be so loud. But there was no mention of any push, shove, nothing like that. And I felt by telling him this, I didn't have to go to the RN and report that; I felt that I handled it within my role.

Sue: Have you seen Mike being loud with the clients before. Have you ever seen him be loud with clients before that you had to tell him not to be so loud with clients?

Patti: No, because it was brought to my attention, I felt as the Licensed Practical Nurse on the unit, that I needed to say something to him. But what he was being loud about, I don't know because she never said. I'm not going to her, because she directly did not come to me.

Sue: So, she didn't say what he said, or

Patti: No. This girl did not come to me and I did ask Katie if she went to her later on, if she had any concerns but Katie said no. So if she had anything to report, she did not through the chain of command; as far as I know.

. . .

Patti: Mike, I guess he did go talk to some gal, I can't give you a time but it was before 8:00. It had to be somewhere between I'm going to say 7:30 and 8.

Wendie: To Jenny?

Patty: To Jenny. And I was not there. He took that upon himself. What they had to say you are going to have to ask him and her of course, but the way I got the impression from Mike was that everything was ok. She apologized to him for saying what she said. This is what he told me, it's about hearsay. I was not there when that conversation took place. She asked him not to be mad at her and was truly sorry. She made a comment, I don't know if she made it to him or just in passing, everyone, not everyone, but a lot of people in this whole facility talk loud to these clients, not just Mike. And loud is like, sit down. When two clients are

hitting each other you have to be a little louder than they do in order for them to hear you. It's not that we're yelling at them; it's like, come on you guys – break it up. I just had an altercation down there. I don't know if you heard, you know, I had to go and get them apart. Whatever, you will have to ask him about that private conversation. That's what I got out of it because I had to get our work done to go to the in-service so we didn't talk much about it after that. She seems, she is a very nice gal we sat and talked I really truly did not see him shove or push anyone. I didn't. Ok.

Also interviewed on May 11th was CNA Jay Koon, among the questions and responses are the following:

Wendie: Did you see anything happen between Mike Gagne and a client that could have been perceived as abuse?

Jay: No.

Wendie: Did anyone report to you or talk to you or say anything to you that they had seen Mike shove a client in the Day Room?

Jay: No

CNA Carol Vander Bloomen was also interviewed on May 11th and the questions and responses included the following:

Wendie: Did you see anything happen between Mike Gagne and a client that could have been perceived as abuse?

Carol: No I didn't.

Wendie: Did anyone report to you that they had seen Mike shove a client in the Day Room?

Carol: The agency person said she didn't like the way Mike was I don't know, treating or talking to the client, and I told Patti.

Sue: Did she say what she didn't like about it?

Carol: I don't know. We were working to get everybody in.

Sue: Where were you when she said this to you? What exactly did she say, do you remember?

Carol: She said something like, I don't know how he treats the clients so roughly and I said which one and she said the one with the braces. I was getting (B) dressed and ready for bed after standing there

Sue: So you didn't ask her to elaborate or clarify what she meant by that?

Carol: I think I said something, -- yelled or something

Sue: You asked her if he yelled?

Carol: Yelled or something – I don't actually remember what her response was but

Sue: So you may have asked Jenny if Mike had yelled?

Carol: could have been giving directions

Wendie: And you said you said something to Patti Zingler?

Carol: Yes

Wendie: And what did you say to Patti Zingler?

Carol: _____ about the client

Wendie: And what did Patti say?

Carol: I don't know – she talked to him

. . .

Sue: Why would you have asked the agency nurse if Mike had yelled?

Carol: Just getting the reaction from a client, or whatever

Sue: Have you heard him yell before?

Carol: He just talks loud; to tell a client to get up, don't hit, whatever

The RN on the p.m. shift on May 11th on Units 3, 4 and 6, Kathleen Wettengel, was interviewed on May 11th. The interview included the following questions and responses:

Wendie: Did you see anything happen between Mike Gagne and a client that could have been perceived as abuse?

Katie: No, if that would have happened, I would have reported it.

Wendie: Did anyone report to you that they have seen Mike shove a client in the Day Room?

Katie: No.

Wendie: Did anyone say anything to you regarding Mike Gagne at any point?

Katie: No. No one said anything. The attitude of the whole thing while they were busy you know because they had that 8:00 meeting to go to and you know it was just light and you have to get this done and that sort of thing and then there was a fall at 10 to 8 and some people had to right (sic) out the thing so I was on the unit. There was no tension or no nothing that I picked up on that anything was abuse.

All of those interviewed on May 11th were told to keep it "confidential". However, RN Wettengel testified that after she was interviewed on May 11th, she talked to LPN Zingler around 5:30 p.m. that same day about the allegations. According to Wettengel, Zingler was distressed that people were saying she had seen something when she had not, and Wettengel thought she could help by telling her the circumstances to help her remember. According to Wettengel, she identified K as the client, and asked Zingler if she saw the Grievant "push her and cuff her."

On May 17, 2004, Zingler was interviewed a second time. Zingler was asked if she had discussed the investigation with any other staff or received information from any other staff regarding the investigation and answered in the negative to both questions. She acknowledged being asked about the investigation, but said she could not remember who asked and indicated she told them she did not know how it was going. Zingler acknowledged that the Grievant had called her on the Unit on May 11th and asked her about the investigation and she told him she did not know anything. She also stated she did not know who the Grievant was referring to in his messages, but said somebody on the day shift had leaked information and that people on all of the units knew. She admitted talking to Wettengel, but said she did not recall if Wettengel had mentioned anything about the investigation beyond asking how the Grievant was doing. Zingler conceded in her testimony that she may have mentioned to the Grievant that he was walked out because of K, but stated she would not have known why at the time, which was near the end of her shift on May 11th. Zingler thought she heard from Wettengel that it involved K, but there was no other information. Zingler admitted she talked to Gunderson about the matter "days or weeks" later and that he mentioned a "slip" by the

Grievant. Zingler also conceded she talked to Crappeau on May 11th, but first asserted she only mentioned it involved K and gave no other details because that is all she knew. Subsequently, she conceded it was possible she had mentioned "hitting". Zingler was interviewed a third time on June 16th and in that interview admitted she had told Crappeau that the Grievant was walked out because of something involving K.

Crappeau was interviewed several times and asked from whom he had received the information regarding the investigation. Crappeau refused to answer the first two times and said he could not recall and was given a one-day suspension each time for insubordination. In the fourth and last interview, he identified Zingler as the source and indicated he had passed the information onto the Grievant the same evening he talked to Zingler. According to Crappeau, Zingler had mentioned "pushing, hitting a client" in their conversation on May 11th.

Regarding May 10th, Zingler testified that she saw the Grievant pushing K's wheelchair out of the dayroom into the hallway, but did not see or hear anything beyond that. She did not hear K yelling, did not see the Grievant push K's wheelchair and let go, did not see him slip or hear him yell "shut up", nor did she see Gunderson.

It is clear from the testimony of a number of witnesses that K had a tendency to drag her feet and to let her feet get under her wheelchair when she was being wheeled, causing the chair to stop abruptly.

Mayer-Bell filled out an incident report once she was informed of Sprang's allegations on May 11th. She examined K and found no injuries or physical signs of abuse. The Grievant was interviewed for the first time on May 14th by Gladh and Mayer-Bell and subsequently on May 25th, at which time he asked to meet with MHC Administrator Van Ryzin. According to Van Ryzin, the Grievant told her that he was moving K and her feet got stuck under the wheelchair, causing a problem that was misconstrued. Van Ryzin could not recall if that is the first time she heard that the Grievant claimed he had slipped. For his part, the Grievant could not recall if he mentioned it was Gunderson who he told to "shut up" at either of the meetings with management.

On July 7, 2004, the Grievant was called in and given the following termination letter:

Dear Mr. Gagne:

CIRCUMSTANCES:

It was reported that on May 10, 2004 by an agency Certified Nursing Assistant who was sitting with, Patti Zingler, LPN and you in the day room that she witnessed you shove a resident (K) in her wheelchair at approximately 4:30 p.m. It was reported that client, (K) had an outburst and you got up out of your chair and pushed (K) out of the day room in her wheelchair, shoved her in the head and told her to shut up.

FINDINGS:

You were put on paid Administrative Leave on 5/11/04 and told that a complaint had been received and an investigation would be started.

On May 11, 2004, we talked to the individual staff involved and the staff denies they witnessed you shoving a resident, or witnessed anything that could be perceived as client abuse.

On May 12, 2004 you left a voice mail telling me that you received 3 phone calls the evening of 5/11/04 at home after you were put on paid Administrative Leave from staff telling you why you were being investigated and that it was leaked by management. You stated, "you were very upset that it was leaked out from management and could tell me exactly why you pushed (K) out of the Day Room and gave her a knock on the head."

On May 14, 2004 we interviewed you regarding the investigation and you stated that you were told that you pushed (K) out of the day room and apparently gave her a knock on the head. You stated that you pushed her out of the day room because she was running over another client's foot. You stated that you didn't push her hard and her feet got caught on the floor under the wheelchair and the wheelchair came to a sudden stop. You stated that you didn't give (K) a knock on the head and you stated that you did not tell (K) to shut up.

You stated that you do not recall if you were in the day room around that time and don't recall what clients were in the day room at that time. You stated that (K) was perhaps in the day room. You described (K) as being non-verbal and she is in a wheelchair and that she screams about once every half-hour. You stated that she screams when she's in the hall or up against the wall and she can't move so she screams telling you that she needs assistance.

You stated that the agency CNA told you that she was sorry that night and that everyone in the facility is loud to patients and that she is only used to working in nursing homes with grandma's and grandpa's.

You stated that you confronted the agency CNA and told her that it was reported to you that she had said that you were loud with a client and that you asked her if there was an issue with you and that she told you no. You stated that you told her that she was lying and stated she said, "oh, I'm so embarrassed and that she should not have said anything". You stated that she told you that she was used to working in a nursing home environment. You stated that you told her that this is not a typical nursing home unit and you must be firm but direct with clients. You stated that you asked the agency CNA if the two of you were cool and she stated yes. You stated that you apologized to the agency CNA if you had offended her.

You stated that you explained to the agency CNA that you cannot debate with clients. You cannot tell clients that they have a nice dress, or look nice because the more you talk to clients the more disruptive they get. You state that you have to give the client's

space and have to be direct. You explained debate by stating it is interacting with clients. You defined debate as interacting with clients and that you have to be firm and not debate. You state that clients know new people and they feed off new people in a heart beat.

On May 17, 2004 all staff involved were interviewed a second time. All staff denies that they witnessed the incident and all staff denies that they called you to report to you why you were being investigated or to discuss the investigation.

On May 25, 2004 you met with Mary Johnson, Nursing Services Administrator, Wendie Mayer-Bell, Unit Manager, Laurel Miller, Local 1901 and Sue Gladh, Human Resources Analyst to give you the findings of the investigation and rules violated (Loudermill) and you were given the opportunity to respond and give us any further information you felt necessary before any disciplinary decisions were made. You did not give us any further information to consider during this meeting and stated that you wished to meet with Judy VanRyzin, Administrator and Sue Gladh, Human Resources Analyst alone after the Loudermill meeting.

On May 25, 2004 you met with Judy VanRyzin, Administrator and Sue Gladh, Human Resources Analyst and stated that the staff who gave you the information that you were accused of would not come forward in your behalf. After the meeting was over you telephoned Judy VanRyzin and stated that you remembered that your friend Quinton Crappeau, CNA who works on Unit 4 told you that you were accused of pushing the client, knocking her on the head and telling her to shut up and asked us to speak with him.

On June 1, 2004, June 7, 2004, June 10, 2004 Quinton Crappeau was interviewed and admitted to calling you on May 11, 2004 telling you that you were accused of pushing the client, knocking her on the head and telling her to shut up. Quinton refused to disclose who gave him the information that you were accused of pushing (K), knocking her on the head and told her to shut up but stated that 6 or 7 people called him telling him of the allegation but couldn't remember who called him but that he passed this information on to you.

On June 14, 2004 Judy VanRyzin, Sue Gladh, Cheryl Jahnke and Laurel Miller met with Quinton Crappeau and Quinton stated that Patti Zingler disclosed to him the information of the allegation that you had pushed the client in her wheelchair, knocked the client on her head and told her to shut up. He said that he relayed that information on to you.

On June 16 Patti Zingler was interviewed. Patti stated that when (K) goes into the Day Room she rolls over other client's feet. She stated that you could have gotten up to go to (K) but denied witnessing the allegations.

Patti admitted that she spoke to Quinton Crappeau the night of May 11, 2004 and admits that she told Quinton and told you that (K) was the reason that you were walked out but did not give any other details other than it was because of (K).

Staff have stated that you have had anger management problems during this past year and you are very angry with everyone involved in this incident and that include her, the Union Reps and Administration.

RULES VIOLATED:

"Client Bill of Rights" (1) Clients shall be treated with courtesy, consideration, respect and full recognition of their dignity and individuality by all employees of the facility and all licensed, certified or registered providers of health care. **(11)** Clients have the right to be free from mental, physical, verbal and/or sexual abuse or punishment.

Brown County Mental Health Center Employee handbook "Discipline" III-4 "abuse, neglect or mistreatment of clients", "unsatisfactory conduct", **"Work rules/Code of Conduct", IV-1** "patient abuse, or neglect"

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

HISTORY:

You have been employed by the Brown County Mental Health Center since May 12, 1998. You have been oriented to the Brown County Mental health Center's policies, rules and regulations and have been trained on the Clients Bill of Rights. You have attended annual education day.

CONCLUSION:

You were observed by an agency CNA that after a resident had an outburst in the day room she stated, "You pushed her chair out of the day room, shoved her in the head and told her to shut up". The agency CNA said that when you turned around your face was beat red and you looked very angry at the client.

In addition, you contacted your Human Resources representative on May 12, 2004 asking why you were being placed on administrative leave and stated, "You could tell her exactly why you pushed Jeanne Konop out of the Day Room and gave her a knock on the head".

After refusing to cooperate with the investigation you stated that Quintin Crappeau had warned you that the allegations included knocking the client on the head. After refusing to cooperate with the investigation, Mr. Crappeau stated he heard of the knock on the head from Patti Zingler and passed the information on to you. However, Ms. Zingler states that she was unaware of any allegation of a knock to the head, and therefore, did not include that detail when she told Mr. Crappeau of your being placed on administrative leave.

We conclude that your May 12th awareness of the allegation of shoving Ms. Konop on the head could only come from your first hand knowledge of the incident.

This investigation leads us to conclude that the client abuse incident occurred. Therefore, Brown County must terminate your employment effective immediately.

Sincerely,

BROWN COUNTY MENTAL HEALTH CENTER

Judith VanRyzin /s/
Judy VanRyzin, Administrator

The Grievant's employment at MHC was terminated that date.

In addition to MHC's investigation of the allegations of abuse against the Grievant, pursuant to State statutes the State's Department of Health and Family Services, Division of Disability and Elder Care, Bureau of Quality Assurance, conducted an investigation. By the following letter of September 15, 2004, the Grievant and the MHC were notified of the results of the State's investigation:

Dear Mr. Gagne:

An investigation was conducted by the Bureau of Quality Assurance from May 20, 2004 to June 25, 2004, relating to a report alleging that on May 10, 2004, at Brown County Health Care Center, you physically abused a client. The Bureau's investigation consisted of a review of all relevant records, reports and other documents. The Bureau also conducted interviews of persons with knowledge of the alleged incident.

Based upon its investigation and the information known at this time, there is insufficient evidence to prove that the incident occurred as alleged. Therefore, the Bureau will take no further action at this time. This does not address any work rule violations or other standards of performance that may be determined by your employer.

If you have any questions regarding this matter, please contact me by calling (608) 243-2019 or writing to the address indicated above.

Sincerely,

Susan Larsen /s/
Susan Larsen, Director
Office of Caregiver Quality

As a result, the Grievant did not lose his CNA licensure and at time of hearing was employed as a CNA at a facility in Michigan.

The Grievant filed a grievance regarding his termination. The grievance was processed through the parties' contractual grievance procedure. The parties proceeded to arbitration of their dispute before the undersigned.

POSITIONS OF THE PARTIES

County

The County notes that the parties' Agreement provides that employees will not be discharged except for "just cause" and also states that "The type of discipline will depend upon the severity of the offense." In this case, the offenses constituting just cause were patient abuse – physical, psychological and verbal. The County also notes that the Management Rights provision of the Agreement reserves to the County the right to discharge for "proper cause" and to adopt reasonable work rules such as those against patient abuse.

The County asserts that in discipline cases, arbitrators must apply "special considerations" in weighing testimony. Elkouri and Elkouri, *How Arbitration Works* (Sixth Edition), p. 417. The "special considerations" applicable in this case are that the Grievant has the incentive of financial gain for denying the charge, and the testimony of the eyewitness who has no evidence of ill will towards the accused. Further, the Grievant's past record is generally given consideration. Elkouri at p. 983. Here, the Grievant's supervisor noted previous verbal tirades in her evaluation of the Grievant. Evidence of past acts showing a course of inappropriate conduct should be considered as indicating the likelihood that the employee committed the acts with which he is charged. As to the Union witnesses, it must be considered that the County called witnesses whose interests were adverse to the County. These witnesses have a bias and an interest in the outcome and several were friends of the Grievant.

Arbitrators recognize that in discharge and discipline cases, it is the testimony of the witnesses concerning the facts that led to the disciplinary action that comprise the "most important evidence". Elkouri at p. 349. Here there was direct eyewitness testimony concerning the facts of patient abuse and the Grievant's own inconsistent statements.

The County asserts that the evidence clearly supports the decision to discharge the Grievant. First, the Grievant had notice of the reasonable work rules against patient abuse. Patient abuse is also a felony offense in Wisconsin. Sec. 940.295, Stats. The Grievant admits that he knows he cannot abuse patients, either physically, psychologically or verbally. In this case, he both physically and verbally abused client K. Physically striking a patient, even once, is a serious offense meriting discharge. Verbal abuse clearly includes telling a patient to "shut up". Psychological abuse includes letting go of a wheelchair causing fright to a patient. The Grievant's history of inappropriately teasing patients is corroborative evidence that he abused K on May 10, 2004.

Second, Jennifer Sprang's eyewitness testimony regarding the abuse was highly credible, unbiased, unimpeached and corroborated by the evidence. Sprang testified clearly and unequivocally that she saw and heard the Grievant tell patient K to "shut up" and aggressively shoved her wheelchair and struck her on the side of the head with an open palm. There were no inconsistencies in her testimony or previous statements and absolutely no evidence of any motive to lie. In addition to mentioning the incident to CNA Vander Bloomen, and despite being confronted in a patient's room by the Grievant and feeling intimidated, Sprang reported the abuse to her superior at Medical Staff Nursing at the first opportunity on the following workday. Sprang gave a recorded statement to Nurse Manager Wendie Mayer-Bell at the MHC. Sprang's testimony was consistent with the Grievant's, who corroborated that he and patient K were together at the time and place testified to by Sprang and that he pushed patient K's wheelchair in the dayroom and hallway area before dinner. The Grievant also corroborated the confrontation with Sprang after the incident and after LPN Zingler and CNA Vander Bloomen had become aware that Sprang had a "problem" with the Grievant's behavior toward patient K. The Grievant corroborated shutting the patient's door and questioning Sprang about her problem with his behavior towards K. This confrontation with Sprang was premeditated according to Zingler's discussion with the Grievant.

The County asserts that the Grievant's self-serving testimony denying the abuse is unworthy of credence. The Grievant admits that an incident occurred with K at the time and place Sprang testified to, admits confronting Sprang in another patient's room about his conduct, and admits that he left a voicemail message to HR Analyst Sue Gladh on May 11, 2004 acknowledging his awareness of the incident and that he was accused of physically striking K. His explanation and denial of abusing K is full of self-contradictory statements. He claims tripping against K's wheelchair in front of the nurses station in the hallway, not in the dayroom where Sprang observed him strike K. The Grievant admitted saying "shut up", but claims he was saying it to Gunderson. However, Gunderson's testimony related entirely to the hallway area in front of the nurses station, and testified that he did not hear the Grievant yell "shut up" to anyone, in direct conflict with the Grievant's "new" version of the events at hearing. Further, the Grievant's testimony that he had broken ribs is contradictory to his explanation that he confronted Sprang in order to help her lift the patient who was a "heavy lift". This is a further lie regarding the purpose of his questioning Sprang as to whether she was "good" or "cool" with him. The only reasonable inference of the Grievant's questioning of Sprang was that he was intimidating her so as not to report the abuse, which he knew she had observed from his discussion with Zingler, even though it was not until Friday, May 14, 2004, in his investigative interview by the Employer, that the physical abuse charges against him were revealed to him. At that interview, the Grievant never admitted saying "shut up" to anyone or talking to Gunderson, but only denied physically abusing K.

Given the Grievant's incentive to lie, his explanation of the incident has no credibility whatsoever. Further, his denials and testimony are also incredible with regard to several details which were contradictory to the eyewitness account. There was no credible explanation for his wheeling K out of the dayroom or for yelling "shut up" to Gunderson. There was also no credible explanation for his admission that his complexion was flushed and as to why he

would confront Sprang other than to intimidate her from reporting the abuse. It is also unreasonable to believe that the Grievant, suffering from broken ribs, would volunteer for a "heavy lift" of a patient.

The testimony of LPN Zingler contradicted that of the Grievant as to the issue of his awareness of the charges of physical abuse of K. Zingler refused to tell the Employer who she had told that the confidential investigation concerned K until weeks after first directed to do so. At that time, Zingler informed the County that she had told CNA Crappeau that the investigation of the Grievant related to K without any other details. According to Zingler, she never told Crappeau that the Grievant was accused of physically abusing K and her testimony remained consistent in this regard on cross-examination. While Crappeau falsely testified to the contrary, he is a friend of the Grievant who seeks to help the latter and was disciplined for refusing to answer investigative questions. Zingler remained adamant that she never told Crappeau about the alleged physical abuse charges, only that K was involved, as that was all she knew at the time. This clearly refutes the Grievant's explanation for his admitted awareness of the physical abuse charges on May 11th, three days before his May 14th investigatory interview. The only credible explanation is that it was an admission of his own awareness of the physical abuse and his culpability.

The Grievant's explanation that he wanted to complain to Human Resources that Mayer-Bell had leaked information about the confidential investigation against him is contradicted by Mayer-Bell's testimony that she did not leak such confidential information. Her testimony is far more credible than that of the Grievant. Given her responsibility for the well-being of the patients, and her duty to protect them from abuse, she would never sabotage a confidential investigation by leaking information.

Last, the County cites the expert testimony of County witness Stephanie Hueseman as to the effect of patient abuse on patients. Further, the profile of an abuser fits the Grievant's history of abusing patients and his lack of self-control, as demonstrated here by striking a patient who was acting out. Further, his supervisor, Kathleen Wettengel, evaluated him as having a short temper and a low frustration level, citing a verbal tirade with a co-worker. Also Mayer-Bell and Nursing Manager Mary Johnson had counseled the Grievant as to teasing patients. They further testified that patients' behaviors have improved since the Grievant left. This is corroborated by CNA Vander Bloomen's testimony that Unit 3 has been calmer since he left.

The County concludes that the offense of physically abusing a mentally and physically disabled patient is so severe that only discharge is appropriate. There were no mitigating circumstances in this case. Anyone who would strike a helpless, severely disabled patient would surely lie about it. The Grievant's motive in this regard is self-evident. Conversely, there was no motive to lie on Sprang's part. There was no disparate treatment towards the Grievant and he was afforded ample opportunities to present his version of the incident. His denial lacks any credibility and the grievance must be denied.

Union

The Union takes the position that the County did not have just cause to terminate the Grievant. There is a two-prong test in discipline cases. The first is that the employer must show that the employee committed the acts for which the discipline was imposed. Second, the employer must show that the level of discipline was appropriate. Because discharge for client abuse is distinguishable from other types of discipline cases, where, as here, the long term consequences are far more severe, and the misconduct at issue would constitute the crime of battery, it is appropriate to require the County to prove the Grievant's guilt by "clear and convincing evidence". INDIANA BELL TELEPHONE, 93 LA 980, 987 (Goldstein, 1989). Because of the bad character such a charge casts, the element of evil intent must be proved as part of the Employer's case. SEIU LOCAL 1 A-6112 (Nielsen, 6/04).

The Union first asserts that the Grievant's recollection of events is reasonable. There are three main elements to Sprang's allegations against the Grievant. First, she alleges that he shoved K in the head. The Grievant testified that he stumbled while attempting to push K's wheelchair out of the dayroom and fell forward. He denies hitting K with his hand. Every witness that testified about K confirmed that she drags her feet, and that they are sometimes caught in the wheels causing the chair to stop abruptly. Sprang was not aware of this on the day in question. Second, Sprang alleges the Grievant told K to "shut up". The Grievant explained that CNA Craig Gunderson happened to walk by at the time and made fun of the Grievant for stumbling, to which he responded by telling Gunderson to "shut up". Third, Sprang asserted that the Grievant's face was "beet red". However, the Grievant testified that he had broken a rib when he was assaulted by a client on May 7, 2004. It is reasonable that when K stopped her wheelchair and the Grievant stumbled forward that he would have had pain from his broken rib. Sprang was unaware of the injury.

Gunderson corroborated the Grievant's recollection of events. He testified that he saw the Grievant pushing K's wheelchair out of the dayroom and saw K's legs jerk up and then saw the Grievant getting his balance back like he had lost it, because K had a tendency to drag her feet under the wheels of her wheelchair. Gunderson further testified that he had made a remark to the Grievant like "What a klutz." Gunderson's recollection is consistent with the Grievant's testimony regarding the incident, however, the County chose to ignore this eyewitness to the incident.

The Union asserts that Sprang's story is not believable. The other witnesses who were in the dayroom do not corroborate her story, while Gunderson corroborated the Grievant's testimony and Zingler testified that she did not see the Grievant do anything she would consider to be client abuse. Contrary to Sprang's testimony that the Grievant made a scene and yelled at K to shut up, Zingler testified that she did not notice this, even though she was in the dayroom only feet from Sprang and testified "I think I would have seen that." She does not recall the Grievant yelling at all that day and Gunderson testified that he only heard "the usual noise from the clients in the dayroom."

Sprang's actions also demonstrate that she did not believe there to be a serious incident. Direct care staff are aware of the Patient's Rights provision, including the requirement that if a CNA witnesses client abuse, they are to report it immediately to their supervisor. Despite this training, Sprang did not report the abuse to anyone at MHC on May 10th, but only mentioned to CNA Vander Bloomen that she was uncomfortable with the way some clients were being treated. Further, Sprang did nothing to ensure that K was not injured after supposedly witnessing the alleged abuse. Sprang never reported her claim of abuse to a supervisor at MHC, rather, she mentioned it to a supervisor at another facility, who then notified MHC on May 11th. Thus, Sprang's actions demonstrate that she did not believe the allegation to be very serious. As she took no action to remedy the situation and did nothing to guarantee the client's safety, it must be concluded that she was either unmoved by the abuse of a client or was not sure that she witnessed abuse at all.

Next, the Union asserts that Sprang misinterpreted events. It may be that the events of May 10th occurred as recollected by the Grievant and Gunderson, but were misinterpreted by Sprang as abuse. That is, she mistook the Grievant's stumble as an intentional push to K's head, his yelling "shut up" to Gunderson as being directed at K, and associated the pain on the Grievant's face from his broken rib with anger towards K. As an agency CNA, Sprang was not used to working on a particular unit or with certain co-workers, and was not familiar with K's behavior or with the difficulties in pushing her, nor was she aware of the Grievant's broken rib. All of these things combined could give her a mistaken perception of what occurred on May 10th.

In making its decision to terminate the Grievant, the County placed much weight on his having knowledge of the allegation against him on May 11th and considered it evidence of his guilt. However, the evidence establishes that at approximately 5:30 p.m. on May 11th. RN Wettengel, assigned to Unit 3, told LPN Zingler that the Grievant had been placed on administrative leave due to allegations involving client K and his pushing or cuffing her in the head. At approximately 6 p.m. on that day, CNA Quinton Crappeau spoke with Zingler on the phone and was told by her that the Grievant had been walked out "for pushing, hitting a client." At around 7:30 p.m., Crappeau spoke to the Grievant on the telephone and told him that he had been walked out for pushing or hitting a client.

The County concluded that Crappeau could not have been told of the allegations against the Grievant because Zingler was unaware of what the allegations were, and could not have passed that information on to him. The County's theory depends entirely on believing Zingler did not communicate the allegations to Crappeau. In the Grievant's termination letter, Administrator Judy Van Ryzin stated that Zingler had stated that she was unaware of any allegation of a knock to the head and therefore could not have included that detail when she spoke to Crappeau about the Grievant being placed on administrative leave. However, Zingler had been a difficult witness and had to be interviewed three times. Gladh testified that Zingler was being very uncooperative and did not want to tell her who had given her the information or who had called her and what they had told her. It was not until the last interview that Zingler told Gladh that she had talked to Crappeau about the matter. At hearing, Zingler

testified that she could not recall if she told Crappeau what the allegations were on May 11th, stating that it could be, but that she had the two days mixed up.

The County chose to believe Zingler because they did not believe that she could have known what the allegations were on May 11th. Van Ryzin testified at hearing as to the significance of the Grievant's being aware of the allegation that he gave K a knock on the head, stating that it was "particularly significant", because at that point in time no one had shared any information about the allegation of K being hit in the head. Similarly, Gladh testified it was significant because the Grievant was the only one who said anything about knocking K on the head other than Sprang, and because no one else had that information. However, this conclusion cannot be reconciled with Wettengel's statement on June 2, 2004 which indicated that she had informed Zingler of the allegations around 5:30 p.m. on May 11th, before Zingler talked to Crappeau. This completely undermines the County's position that Zingler did not know of the allegation and Zingler's testimony. The County willfully disregarded this information and did not include it in the termination letter or consider it in its decision-making process.

The Union asserts that the testimony regarding improved client behavior following the Grievant's termination is irrelevant. The facts of consequence in this case concern whether the Grievant yelled at and struck client K. Evidence concerning the overall behavior on the unit is irrelevant, as it does not make it more or less probable that the Grievant committed the acts alleged. This is especially so since K no longer resides at MHC and there is no evidence offered regarding her behavior after May 10, 2004. As the makeup of Unit 3 has inevitably changed since then, any attempt to draw a nexus between the behaviors of the clients and the absence of the Grievant is futile. Further, the County's witnesses confirmed that a number of factors influence behaviors on the unit, but were unable to determine with any specificity the cause of the changes in the behaviors. Thus, they cannot point to the Grievant's absence as the cause of the alleged improvement. Moreover, the testimony regarding the behavior on the unit is not persuasive as the County's witnesses presented conflicting testimony as to whether there had been any improvement. The County had the opportunity to offer more than purely anecdotal evidence to substantiate its claim, but did not produce the data that was available to them, and has failed to substantiate the claim that behaviors on Unit 3 improved.

Last, the Union notes that an employee who is discharged for misconduct is not eligible for unemployment benefits, however, the Grievant applied for and was found to be eligible to receive unemployment benefits. Moreover, the State's Bureau of Quality Assurance reviewed the allegations against the Grievant to determine if there was sufficient evidence of abuse, and concluded that there was "insufficient evidence to determine that the incident occurred as alleged" and thus took no action. The expertise of this agency in investigating this type of case should be given deference and their judgment that no abuse occurred should be accepted.

The Union concludes that the County ignored important information that it had gathered in its investigation and failed to consider the exculpatory evidence in determining the validity of the allegations against the Grievant. The County has failed to establish proof of

wrongdoing, an essential element of the just cause standard. Thus, no level of discipline is appropriate. Further, the County has not met its burden of proof by a preponderance of the evidence, let alone by clear and convincing evidence. The Union requests that the grievance be sustained and the County ordered to reinstate the Grievant, clear his file of any and all references to his discharge and make him whole for all lost wages and benefits.

County Reply

The County disputes the Union's claim of a lack of proof of the criminal misconduct on the Grievant's part in abusing client K. The eyewitness testimony of Sprang, unless totally discounted, established the necessary proof of patient abuse. The nature of the verbal, psychological and physical abuse was so severe that discharge is the only appropriate penalty. The Union does not, and cannot, challenge the credibility of Sprang, only her "misperceptions", as there was no motive to lie and no prior history between Sprang and the Grievant to explain a motive to lie. Sprang's testimony was only contradicted by the Grievant, who would obviously gain from lying.

The County also disputes that Sprang could have misinterpreted the events of May 10th, as she witnessed them from only a couple of feet away in the dayroom. The Union's theory rests upon the Grievant's story that he stumbled. This allegedly occurred outside the dayroom in the area in front of the Unit 3 nurses station. Gunderson, who was situated in the stairwell, could not have witnessed events inside the dayroom from the stairwell. However, Gunderson's testimony corroborated Sprang's that interaction between the Grievant and client K had occurred. If the Grievant had stumbled outside the dayroom, it could only have occurred after he struck K on the head. Zingler did not observe any incident between the Grievant and K because she was preoccupied with the other patients in the dayroom at the time. She neither corroborated the Grievant's testimony as to stumbling, nor contradicted Sprang's testimony because of this.

There was nothing in Sprang's testimony and prior statements to even suggest that she could have "misinterpreted" the Grievant's striking K intentionally. The Union's claim rests entirely upon the Grievant's denial and his testimony regarding stumbling. However, his testimony is totally self-serving and was contradicted by Sprang. While the Grievant corroborates Sprang's testimony as to being "beet red" in his face, he explained this as showing pain from the broken rib which he suffered three days before. However, having the broken rib would have precluded him from performing any "heavy lift" of a patient on May 10th, as he falsely claimed in his testimony as the reason for confronting Sprang in a patient's room after the incident. The reason for doing so was not to help "heavy lift" a patient, but to intimidate her from reporting him. Zingler's testimony corroborates Sprang as to the Grievant's reason for confronting her. Zingler sought to help her friend, the Grievant, and told him about Sprang's concern over his treatment of patients, which led to the confrontation with Sprang.

The County asserts that the Grievant's denials were impeached by his own testimony and prior statements. The Union did not mention the claim that he was telling Gunderson to "shut up" until the hearing in this matter, over a year after his initial interview. The claim that he went to patient's room to help with a "heavy lift" was also absent from his statements at his interviews. These inconsistencies impeach his credibility. His story as to stumbling over K also has no plausibility, as no one could misperceive stumbling with striking a patient from a few feet away. The County posits that in the three days between the Grievant's suspension and the May 14th interview, he had ample opportunity to contact his friends and co-workers to help him develop this "stumbling" incident. Gunderson could not have observed the incident in the dayroom from the stairwell and if stumbling occurred at all, it was after the incident in the dayroom. On the other hand, the Union could cite no inconsistency in Sprang's statements or testimony to back its assertion that she was "not believable". Sprang was both sincere and accurate, and she had the opportunity for close observation. Her testimony meets the requirement of eyewitness testimony the Union asserts is a necessity in such a case as this. Being unable to impeach Sprang's credibility, the Union's fallback strategy was to claim a misinterpretation or misperception on her part. However, there could be no misinterpretation of what she saw from a few feet away.

While the Union disputes the relevancy of the improvement of patient behavior, the improvement was no coincidence, but was related to the Grievant's inappropriate treatment of patients. His actions towards K and other patients were clearly a factor in the clients' functioning on Unit 3 according to Mayer-Bell, who is responsible for the well being of these clients. The improvement in the clients' behavior supports the evidence the alleged actions transpired.

The County concludes that Sprang's unimpeached eyewitness testimony must be considered along with the lack of any motive on her part to lie. Conversely, the testimony of the Grievant was contrary to his prior statements, and his self-serving denials cannot be found persuasive given his interest in the outcome of the hearing. The grievance should be denied, as just cause was clearly established by the unimpeached eyewitness testimony of Sprang.

Union Reply

The Union first asserts that contrary to the County's references to the Grievant's "past acts", the Grievant had no prior discipline in his file. The County stated that the Grievant's supervisors' evaluation of him referenced previous verbal tirades as well as "inappropriate teasing" and that the Grievant possessed a "short temper". While the County referenced Elkouri and Elkouri to demonstrate that past acts showing a course of inappropriate conduct should be considered as indicating a likelihood that the employee committed the acts with which he is charged, that text also indicates that "a distinction should be made between rule infractions that have been proven and mere past charges", casual infractions for which the employee was in no way reprimanded or past warnings that have not been put in such a form as to make them grievable should not be considered. Elkouri and Elkouri, p. 926. None of the alleged inappropriate acts resulted in any form of discipline and should not be considered.

Further, the County could not produce a single evaluation that would demonstrate that the Grievant was anything less than a model employee. While an employee's past record should be considered, in this case, the Grievant's exemplary work record demonstrates that he follows rules and is not the type to commit patient abuse.

The Union asserts that the County's argument that the Grievant must be lying about having a broken rib because he performed the duties required of him as a CNA, is speculative and is contradicted by the testimony of Zingler, who corroborated the Grievant's testimony that he had a broken rib. The County had the opportunity to present evidence in this regard at the hearing, but chose not to and now only merely speculates in its brief. That speculation should be rejected.

While the County asserts that the Grievant never mentioned that he said "shut up" in his interviews with the County, there is nothing in the record to support this argument, as those interviews were not made part of the record. The County had access to the interviews and should have produced them at that time so that the Union would have been in a position to respond. No new evidence may be presented after the hearing, in briefs or otherwise, and the County's attempt to get this information in through the back door is inappropriate. Elkouri and Elkouri, *supra*, p. 376. New evidence can only be submitted subsequent to hearing through a joint submission by the parties, upon a request for information from the arbitrator, or through additional hearing. Thus, this assertion by the County should be rejected as without any basis in the record.

The County's brief ignores the corroborating testimony of Gunderson, which is credible on its face, as he had no reason to lie. The County mentions that Gunderson did not hear the Grievant say "shut up" to him, contrary to the latter's testimony. However, the portion of the transcript cited to support that assertion is Gunderson being asked about the Grievant's interactions with K and if he ever heard the Grievant yell "shut up" to anyone. He was not asked what, if anything, the Grievant said to him. The Grievant testified that he told Gunderson to "shut up" after the latter laughed at him and called him a "klutz", but he did not testify that he yelled at Gunderson. Thus, it is inappropriate to read more into his answer than what was said. The Union concludes that the case ultimately comes down to the credibility of the Grievant and Gunderson versus the credibility of Sprang and her uncorroborated testimony. The testimony of the Grievant and Gunderson and their version of events is simply more believable than Sprang's. The burden of proof rests with the County and it is clear that the County has failed to meet its burden.

The Union requests that the grievance be sustained and the County ordered to reinstate the Grievant, to clear his file, and to make him whole for all lost wages and benefits, and also asks that the Arbitrator retain jurisdiction to ensure compliance with the specified remedy.

DISCUSSION

The parties' Agreement provides that "No employee shall be discharged except for just cause." As has been noted, application of the just cause standard requires a two-part analysis: (1) Has the employer established that the employee engaged in the misconduct for which he/she was disciplined; and if so, (2) was the level of discipline imposed appropriate under the present circumstances?

It is initially noted that there is no dispute that the Grievant was aware of MHC's "Client Bill of Rights" and its rules and policies regarding client abuse. The MHC "Employee Handbook" states in Section III-4: "Certain actions are serious enough to result in immediate dismissal" and among the examples of such actions is "abuse, neglect or mistreatment of clients."

In this case, the Grievant was terminated for allegedly having pushed client K's wheelchair and let go, having struck K in the side of the head with the heel of an open hand, and having yelled at K to "shut up". The MHC's procedures for "client abuse" define "abuse" as any of the following:

> 1. An act or repeated acts by a caregiver or non-client resident, including but not limited to restraint, isolation or confinement, that, when contrary to the facility's policies and procedures, not part of the client treatment plan and done intentionally to cause harm, does any of the following:
>
> a. Causes or could reasonably be expected to cause pain or injury to a client or the death of a client, and the act does not constitute self-defense as defined in s. 939.48, Stats.
>
> b. Subsequently disregards a client's rights under Ch. 50 or 51, Stats., or a caregiver's duties and obligations to a client.
>
> c. Causes or could reasonably be expected to cause mental or emotional damage to a client, including harm to a client's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation or a fear of harm or death, or a combination of these behaviors. This subdivision does not apply to permissible restraint, isolation, or confinement implemented by order of the court or as permitted by statute.

It is not disputed that if the actions alleged occurred, they constitute "abuse" of a client, the allegation of striking K in the head being the most serious. There is, however, an obvious dispute as to what actually occurred in this case.

As the parties note, the primary witnesses as to what occurred on May 10, 2004 between the Grievant and client K are Sprang and the Grievant. As this Arbitrator has stated in the past, arbitrators are not omnipotent and have no special senses to aid them in discerning what actually occurred. The best that can be done in that regard is to review the record evidence, or lack thereof, and reach conclusions on that basis as to what likely took place.

A review of the record in this case establishes that Sprang has no apparent reason to make up the allegations against the Grievant or to lie about what she saw, whereas the Grievant has the obvious motive of hoping to avoid discipline. However, this case is more complicated than simply comparing the motives of these two witnesses.

While Sprang had no apparent reason to make up the allegations or exaggerate what she saw, there are a number of problems with her testimony. Sprang indicated in her testimony and her statements given to the MHC that she did not mention what she saw and heard to Zingler, the LPN on Unit 3, even though Zingler was present in the dayroom at the time the alleged incident occurred, nor did she seek out the RN in charge of the unit to report the incident, even though she knew she was to report abuse immediately. Sprang also conceded she did not check to see if K was injured, albeit in her statement she indicated that K did not yell or seem upset by what had happened and she testified that she felt it was the LPN's role to check on the client.

The Grievant concedes he said "shut up" in the course of pushing K out of the dayroom, but asserts he said it to Gunderson, not K, after he had stumbled and K had called him a "klutz". He also denies giving K's wheelchair a shove and letting it go or that he shoved or hit K's head with his hand.

The County notes that the Grievant has an obvious motive for distorting the truth; however, while motive must be kept in mind in assessing credibility, lack of truthfulness cannot simply be assumed based on the declarer's having something to gain. The testimony of Sprang and the Grievant must not only be examined based on motive, but also examined for internal consistency and compared to the testimony of other witnesses to the events, as well as to other evidence in the record.

In this case, Zingler was also present at the time of the alleged events, but claims to have not seen or heard the Grievant do anything she would consider abuse. Zingler is not a credible witness, however, given her evasiveness and her willingness to be less than forthright in her interviews and her continued refusal to admit she gave Crappeau more information about the allegations than just identifying K. Further, if she was present and saw the alleged conduct and did not report it, she would have the same motive as the Grievant for now denying she had seen anything.

Gunderson was present near the end of the alleged events and testified that he was looking down to take a first step down the stairs and saw K's legs jerk up and the Grievant getting his balance back like he had lost it. He testified that he said something like "what a

klutz", but did not hear the Grievant say anything in response. Gunderson's testimony could be said to support the Grievant's claim that he stumbled at some point, but not his claim that it was Gunderson he told to "shut up", nor does it rule out what Sprang claims to have seen before Gunderson arrived. Gunderson did not appear to shade or exaggerate his testimony to help the Grievant's cause, nor is the fact that he was a co-employee of the Grievant make his testimony inherently suspect.

The County argues that the Grievant's version at hearing of what happened on May 10, 2004, is not consistent with the version he gave in his two meetings with management, in that he never admitted in the interviews that he said "shut up" to anyone and did not mention Gunderson at all, nor did he give the explanation for being in the client's room with Sprang afterward that he was helping her with a "heavy lift". The County did not provide evidence as to what the Grievant said in either of the meetings with management beyond the summaries in the termination letter and Van Ryzin's testimony regarding their meeting on May 25, 2004. According to Van Ryzin, the Grievant stated at that meeting that K had got her feet stuck under her wheelchair while he was pushing her, causing a problem that was misconstrued, but she could not say if that was the first time she heard the claim that he had slipped. The termination letter makes no reference to an assertion by the Grievant that he had slipped or stumbled in his meetings with management, nor does it mention Gunderson in reference to the allegation the Grievant told K to "shut up". The Grievant testified he could not recall if he mentioned in his meetings with management that it was Gunderson he had told to "shut up", rather than K, or if the hearing was the first time he raised it. This does not ring true. Presumably, if one has an explanation that would address an allegation of wrongdoing, one would provide that explanation at the first opportunity and one would remember doing so, if such an explanation existed.

Similarly, the reason the Grievant gave at hearing for going in the resident's room with Sprang, i.e., to help Sprang with a resident who is a "heavy lift", is again not referenced in the summaries of the Grievant's meetings with management set forth in the termination letter, and is inconsistent with both Sprang's testimony and his claim that he was in pain at the time with a broken rib. Sprang indicated that she did not feel the Grievant entered the room to help her, but rather to make sure she was not going to report him. Further, in her interview on May 11th, Sprang indicated that she was in the resident's room when the Grievant entered. There was no indication she had asked for help. Zingler testified that after she told the Grievant that Sprang had complained he was "loud", he said he was going to talk to her.

The termination letter makes clear that Van Ryzin placed considerable significance on the Grievant's statements in the telephone message he left for Gladh on the evening of May 11th, and her testimony confirmed this. In that message, the Grievant mentions he can tell Gladh why he pushed K out of the dayroom and apparently gave her a "knock on the head". Management considered this to be an admission by the Grievant on the basis that he would not have known at the time what the allegations were any other way than to have committed the actions. Despite Zingler's denials that she provided Crappeau with any more information than that the allegations involved K, because that is all she knew on May 11th, Wettengel's statement

and testimony establishes that was not the case. Wettengel's June 2, 2004 statement indicates that she told Zingler on May 11th that the investigation involved K and giving her a push and cuff. Crappeau testified Zingler gave him that information and he passed it on to the Grievant that same evening (May 11th). Like Zingler, it appears that Crappeau had lied previously to management about providing information to the Grievant and refused to cooperate. However, while Wettengel's testimony establishes that the Grievant could have been aware that the allegations involved pushing or cuffing K, there is no mention of striking K's head. While the termination letter states Crappeau admitted informing the Grievant the allegations included him knocking K in the head, it is not clear from the record where he would have got the information regarding the location of the alleged shove or cuff. Thus, there is some basis for the County's conclusions that the Grievant's May 11th phone message to Gladh constituted an admission of sorts. It is also apparent that Zingler and Crappeau were uncooperative in the investigation and that their loyalty was to the Grievant and other employees, rather than the clients and the MHC.

In summary, the record as to the alleged abuse consists of Sprang's allegations, the Grievant's denial, along with an explanation of why Sprang might have thought she saw and heard what she claims, some corroboration from Gunderson that the Grievant may have slipped, but not that he said "shut up" to Gunderson. Although she seems to be a somewhat timid individual, when asked on cross-examination if it was possible that what she saw was the Grievant stumbling, Sprang was adamant that was not the case, stating, "No. He hit her." Sprang has not waivered in her statements of what she saw on May 10th or hedged her testimony in that regard. Conversely, the Grievant's explanation appears to have come in bits and pieces, with the claim that it was Gunderson who he had told to "shut up" and his explanation for confronting Sprang first being offered at hearing and neither being supported by the evidence.

Given the apparent lack of any motive on Sprang's part to fabricate the allegations against the Grievant and her certainty as to what she observed and heard, Sprang's version of what occurred on May 10, 2004 involving the Grievant and K is credited over that of the Grievant. Her failure to immediately report what she saw to her supervisor is troubling, but is explained by Zingler's lack of a reaction and Sprang's being an outsider as an agency CNA. She testified she intended to report it to her agency supervisor the next day, as no one is in the office in the evening, and did so after telling the administrator at the facility she was working at that day. This, along with the Grievant's piecemeal explanation of events, some of which did not come until hearing, provide a sufficient basis for concluding he engaged in the misconduct for which he was terminated. [1]

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[1] The Arbitrator expressly does not rely on the prior allegations of abuse involving the Grievant that were investigated by MHC and the State, resulting in no action being taken by either against the Grievant. Nor does the Arbitrator rely on the testimony of County witnesses regarding the behavior of the clients on Unit 3 following the Grievant's termination, given the change in the client population on Unit 3 since then and the admitted variables that could explain such behavioral changes.

As noted at the outset, the actions alleged, if proven, constitute abuse of a patient. As such, those actions are sufficiently serious to merit immediate discharge. While the State's Bureau of Quality Assurance concluded there was insufficient evidence to prove the alleged abuse occurred for purposes of determining whether the Grievant would lose his CNA license, the Arbitrator cannot find a sufficient basis for disregarding Sprang's statements and testimony, and concludes the evidence is sufficient in this regard to provide just cause for terminating the Grievant's employment with the County.

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 23rd day of May, 2006.

David E. Shaw /s/
David E. Shaw, Arbitrator

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