BEFORE THE ARBITRATOR

In the Matter of a Dispute Between

DOOR COUNTY

and

DOOR COUNTY EMERGENCY SERVICES, INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS, LOCAL 4982

Case 184
No. 73147
MA-15295

AWARD NO. 7922

Appearances:

Grant P. Thomas, Door County Corporation Counsel, 421 Nebraska Street, Sturgeon Bay, Wisconsin, appearing on behalf of the County.

John B. Kiel, Law Office of John B. Kiel LLC, P.O. Box 147, Salem, Wisconsin, appearing on behalf of the Union.

ARBITRATION AWARD

On April 14, 2014, Door County and the Door County Emergency Services, International Association of Fire Fighters, Local 4982, filed a request with the Wisconsin Employment Relations Commission seeking a roster of arbitrators to hear and decide a matter pending between them. From that roster, the parties selected William C. Houlihan, a member of the Commission's staff, to hear the dispute. A hearing was conducted on July 28 and 29, 2014, and on October 5 and 6, 2015, in Sturgeon Bay, Wisconsin. A transcript of the proceedings was taken and distributed. Post-hearing briefs and reply briefs were filed and received by December 7, 2015.

ISSUE

The parties stipulated to the following issue:

Did the County have just cause to discharge the grievant on March 24, 2014?

The parties further stipulated that should I determine that the County lacked just cause I would retain jurisdiction to hear the second portion of the stipulated issue:

If not, what is the appropriate remedy?

BACKGROUND AND FACTS

Door County operates an Emergency Medical Services Department (hereinafter "Department"). As a part of that service, the Department responds to medical emergencies which occur. The Department operates from four stations. The central station is in Sturgeon Bay, with satellite stations in Sister Bay, Brussels, and Washington Island. At the time of these proceedings, there were 12 paramedics, approximately 40 EMTs, and approximately 100 first responders. With office staff and management, the Department employed approximately 155 employees. Department paramedics provide services akin to those provided by a hospital emergency room. EMTs provide a number of services, including CPR, splinting, and the administration of medications.

Grievant Chris Jeanquart was hired by Door County as a paramedic in 1995. He worked in that capacity until the date of his termination. During the course of his employment, Jeanquart generally received strong performance evaluations and was considered an effective and competent paramedic. The record contains a number of letters of praise and commendation. Prior to the events giving rise to this proceeding, Jeanquart had never been disciplined.

During the course of his employment, Jeanquart had taken the initiative to address matters in need of attention, many of which did not fall within his job description or within the expectations of his job. Those efforts included: painting, mowing, fertilizing and landscaping the grounds; installing a light switch dimmer; purchasing boxes to store patient records and transferring the records to those boxes; performing general station repairs, installing smoke detectors; reorganizing the supply room; installing lights, a siren, and a radio in a newly acquired truck assigned to the director; installing a cabinet in the back of a truck to allow for the secure storage of equipment; repairing a leak in the window of a truck; and building brackets to hold and secure oxygen tanks while being stored. Many of these tasks were performed on his own without direction from anyone else. He was not compensated for this work and at times he incurred out-of-pocket expenses to accomplish the tasks.

The Department maintains a stock of drugs in connection with its mission. Those drugs are regularly dispensed in the course of calls. The drugs were stored in a refrigerator in the

central station supply area. The refrigerator was locked with a padlock. The key to the padlock was hung approximately three feet from the lock. The room was unsecured. Security for the drugs did not meet the minimum standards required by law. Anyone with knowledge of the situation had access to the refrigerator.

The protocol for handling the narcotics or scheduled drugs called for two persons to be present whenever the drugs were handled. Securing the drugs, administering the drugs, and stocking or restocking the drugs required the presence of two people. Control sheets existed for the purpose of documenting the handling / use of certain drugs. The two-person protocol was largely, though not universally, followed.

Fentanyl is a Class II category controlled substance. It is a pain control medication, the use of which is regulated by both the State of Wisconsin and the United States federal government. The Wisconsin EMS Controlled Substance Management Guidelines describe Class II products as "High potential for abuse. Use may lead to severe physical or psychological dependence."

Door County stocks and uses fentanyl as one of the drugs carried by its emergency services teams. The County stocks fentanyl in two forms, vials and carpujects. The vial is a glass bottle with a metal cap crimped over the top. The top of the cap has a rubber center. A needle and syringe are used to extract the liquid. The vial is capped with a green top, which provides security and protection to the top of the vial. The carpuject is a prepackaged syringe-like device. The Department's concerns with Jeanquart's handling and use of the fentanyl vials is what led to his termination.

The event which first gave rise to Department concerns occurred on October 5, 2013. That day, Jeanquart discovered that a vial of fentanyl was missing from one of the ambulance rigs to which he was assigned. It was Jeanquart's testimony that he searched for the missing vial and, when he could not find it, he called Ashley Bittorf who had worked the previous shift and signed the control log. Bittorf had no idea why there would be a shortage. Jeanquart documented the missing vial and restocked the medicine bag. He did not immediately file a report to Departmental management. It was Jeanquart's testimony that Eric Christensen, the Director of the Department, did not work on weekends and would not return to the office until Monday, October 7, 2013.

Anthony Luchini was the Deputy Director of the Department. When Christensen resigned on October 11, 2013, Luchini took over as acting director until a permanent director was hired. On October 6, 2013, Luchini received a report from paramedic Ann Schartner indicating, among a number of things, that Jeanquart had reported a missing fentanyl vial. The report caused Luchini to go to the central station on October 6, 2013, to examine the logs. He sent Jeanquart an email requesting that Jeanquart fill out and turn in an incident report. Jeanquart replied that he would do so, but had hoped to talk with Luchini first and felt the report could wait until Monday.

Monday, October 7, 2013, was the first workday for Jeanquart since he reported the lost fentanyl on October 5, 2013. It was cleaning day and Jeanquart was in the process of cleaning. Jeanquart testified that, while he was in the act of cleaning, Aaron LeClair, a co-worker, and Luchini were standing by an ambulance rig. It was Jeanquart's testimony that he was handling a mop and bucket when he discovered the missing vial of fentanyl. Jeanquart testified the top of the vial was off, he saw the vial and called out to the other two that he had found the vial, and he picked up the vial and handed it to Luchini. Luchini's account is similar, except he indicated that he was just entering the room as Jeanquart discovered the vial. Jeanquart filed a report indicating that the vial was found and broken.

Luchini filed an incident report on October 7, 2013. While the record is not clear as to what hour of the day the report was drafted, it summarizes the events of October 6 and 7, 2013. The report indicated that Luchini observed that there was documentation on the refrigerator signed by Jeanquart which provided "… restock from broken vial …." That entry is under the October 6, 2013 observation. Luchini further noted the events of October 7, 2013, as follows:

> Chris Jeanquart stopped me in the ambulance garage, and stated "look at this." I walked over by the mops and then mop buckets and behind one of the mop buckets was a vial of fentanyl with the cap removed. Chris then picked up the vial and stated "found the missing vial, unreal." The vial had clear fluid in it and appeared to be tampered with. Chris wanted to waste the vial and throw it away and I stated that I would be keeping it and contacting medical control.

Luchini testified that he could not understand how the reference to broken vial could have been on the report on October 6, 2013, when the vial was not discovered until October 7, 2013. Jeanquart testified that his initial entry was "restock." He indicated that he completed the entry by adding the words "from broken vial" after he discovered the vial.

Luchini turned the vial over to Christensen and the two men extracted and measured its contents. The vial was supposed to contain 2ml. The vial they measured was reported to have held 2.5ml. They did not document their actions in removing and replacing the fluid. The vial was sent to a private lab for testing, and the lab results came back indicating there was only a trace of fentanyl. Covert cameras were installed in the supply room. The cameras did not work properly. No images were captured.

On January 9, 2014, Jeanquart and LeClair were sent to the Door County Memorial Hospital to pick up medications. They were provided with authorization forms by Luchini and secured 20 morphine and 10 fentanyl vials. Jeanquart and LeClair returned to the central station and placed the drugs into the refrigerator.

On January 20, 2014, Jeanquart and Brian Geibel were sent to the hospital to pick up another drug order. While there, Geibel entered into a conversation with his wife, who is employed at the hospital, and with Dr. George Gorchynsky, who also works at the hospital and is the Medical Director of the Door County Emergency Services. It is under Dr. Gorchynsky's license that the various controlled substances are secured. Jeanquart indicated that at one point Geibel made a crack to the effect of "hey, do you want to party" while holding up a box of morphine.

Jeanquart left the conversation and returned to the pharmacy area of the hospital. Once there he talked with a pharmacy technician, Sue Kipp. Jeanquart explained to Kipp that he believed the Department was experiencing the tops of fentanyl containers coming off and wondered if the pharmacy ever had the same experience and, if so, how they addressed it. Kipp indicated that she had just experienced having medicine caps come off when she opened a box and caught the caps with the cardboard box top. Kipp was commenting on a non-controlled substance, since she was not approved to handle controlled substances. She talked with coworkers and advised Jeanquart that they used foil seals to attach to open vials within the pharmacy. Kipp then provided Jeanquart with a sleeve of approximately 30 foils.

Jeanquart returned to Geibel and the two of them returned to the central station. The drugs were placed in the refrigerator. Jeanquart testified that he then went to see Luchini. It was his testimony that he went to Luchini, returned the DEA form that accompanies a drug pick up, and showed Luchini the blue foils. Jeanquart indicated that he explained the purpose of the foils was to keep the tops of the fentanyl vials from falling off. Jeanquart indicated that Luchini said "okay" which Jeanquart took as authorization to apply the foils. Jeanquart also indicated that he reported the "let's party" comment which he regarded as inappropriate.

At hearing, Luchini denied that Jeanquart ever advised him of the existence of the foils on January 20, 2014. Aaron LeClair testified that he talked with Luchini between January 20 and 29, 2014. LeClair indicated that Luchini expressed doubt about applying blue foils to the fentanyl. LeClair indicated that Luchini referred to the foils as if the decision to apply them was a shared decision.

Jeanquart testified that he left Luchini's office and went to the supply room to apply the foils to the fentanyl vials. As he began to do so, Jeanquart found that the foils would not adhere to the vials, notwithstanding the adhesive on the inside of the foils. He attributed the lack of adhesion to the condensation coming off the cold vials. To overcome the problem, Jeanquart went to a toolbox and secured glue. He indicated he then took each of the 20 vials of fentanyl, turned them upside down, applied two drops of glue to the side of the metal caps below the green tops, and may have turned the foil to secure the glue. Jeanquart indicated that no caps came off while he worked. He then returned the fentanyl to the refrigerator. There were no witnesses to Jeanquart's actions. Jeanquart did not document the application of the foils.

The fentanyl vial is a small glass bottle with a sharply tapered neck. It is approximately 1½ inches tall. It holds about 2ml of liquid. There is a metal cap crimped to the neck of the glass vial. The metal cap measures less than ¼ inch down the side of the vial and has a ½ inch diameter on top. The cap holds a rubber center which is about ¼ inch in diameter. To extract the contents, a syringe with a needle is plunged through the rubber center. The vial is secured by a green plastic cap, which sits on top of the metal cap and extends slightly over the metal cap. It covers the rubber stop. The green cap is secured by a thin circular strip that is embedded on the inside of the green cap. That strip is secured to a circular extrusion built into the underside of the cap. The metal circle is attached to the metal top in a way which permits the green cap to spin when fully attached. All witnesses testified that it is not possible to extract fluid from the vial with the green cap secured to the vial.

The vials with foils were in service for a period beginning January 20, 2014. During this period, two of the vials with foils were used in service runs. One of those runs involved Schartner, who used a vial prepared by Jeanquart. Luchini retrieved the vial from a sharps container. The second run involved Ashley Bittorf.

On January 29, 2014, Jeanquart had a conversation with Schartner where he advised her that he had placed the foils on the containers and had applied them with glue. She told him that it was a mistake to do so. Jeanquart then went to speak with Luchini. In their conversation, he advised Luchini that he had placed glue on the vials as he applied the foils. Luchini told him he should not have done so, and Jeanquart admitted that it was not a good idea. Luchini testified that the January 29, 2014 conversation was the first time he became aware that foils had been placed on the fentanyl vials.

Luchini did not take the vials out of circulation. Rather, he waited until Monday, February 3, 2014, which was his next day of work. After thinking about it for a long weekend, Luchini determined that the vials should be removed. On Monday, February 3, 2014, he and LeClair took the vials out of service.

Luchini called the Door County Sheriff's Department and Jeff Farley, the Field Service Lieutenant, came over to inspect. He directed Mark Hilsabeck, the Sheriff's Department's drug investigator, to take possession of the drugs. On February 4, 2014, Hilsabeck retrieved and secured the vials. He subsequently did a field test on the vials and believed they were missing the fentanyl. Hilsabeck did not have the ability to test with precision so he invited Luchini to bring a vial which he was sure had fentanyl in it for purposes of comparison. They concluded the foil covered vials were missing fentanyl and, on February 24, 2014, sent four of them to an independent lab for testing.

The Department suspected Jeanquart and, on February 5, 2014, Luchini, Farley and Kelly Hendee, Door County Human Resources Director, went to Jeanquart's home with a letter suspending him from work and directing him to be drug tested. Jeanquart drove himself

to the hospital, submitted to a drug test, and tested negative. LeClair was also tested. Luchini also submitted to a drug test. All tested negative.

On March 14, 2014, the lab report came back on the four vials sent for testing. Three came back showing a trace of fentanyl. They were filled with some other liquid. One came back showing a full measure of fentanyl. An investigation was conducted. All of the paramedics were interviewed during the month of February 2014. The Department concluded that Jeanquart had tampered with the fentanyl and terminated him on March 24, 2014, by the following letter:

> March 24, 2014
>
> Chris Jeanquart
> …
>
> RE: Disciplinary Action – Discharge from Employment
>
> Dear Mr. Jeanquart:
>
> Door County's investigation is judged complete. It has been determined that, by virtue of your acts and omissions from on or about January 9, 2014 – February 5, 2014, you engaged in conspicuously bad, and arguably flagrant and dishonest, misconduct.
>
> Grounds for this determination … include the following:
>
> A. Tampering with Fentanyl Vials.
>
> * * *
>
> 3. Sometime from January 9, 2014, through January 20, 2014, you tampered with Fentanyl vials. Specifically, you: retrieved the Fentanyl vials from the locked refrigerator situated at the Center Station; removed the protective caps from the vials and applied glue (not approved for medical use) to the underside of each protective cap and reinstalled the protective caps or injected glue (not approved for medical use) underneath the protective cap of each vial; placed a foil seal over the top of each vial; and returned the vials that you tampered with to the locked refrigerator.

4. By virtue of your tampering, you created an unacceptable risk that the vials of Fentanyl were contaminated and not sterile.

B. Diversion of Fentanyl from Vials that You tampered With.

1. Your misappropriation of Fentanyl from approved and/or legitimate patient usage, through substitution or theft.

* * *

3. The evidence indicates that it is highly probable, and we are reasonable [sic] certain, that you are the primary culprit with respect to the diversion of Fentanyl.

C. You Knowingly Placed these Tampered and/or Adulterated Vials of Fentanyl, Into Service.

1. By your actions, as described herein, you left these vials of Fentanyl in the system, to be used by unsuspecting EMT-Paramedics on unknowing patients (i.e., members of the general public).

2. In so doing, you exposed patients (i.e., members of the general public) to the unacceptable and adverse risk of being administered contaminated and/or compromised medication.

3. Two patients (and possibly more) actually received contaminated (not sterile) and / or adulterated / compromised medication …

* * *

N. Other factors judged to be aggravating include:

1. Your conduct, as described herein, was deliberate over a period of time, and not the result of a mere momentary lapse of judgment.

2. Your conduct, as described herein, has an element of dishonesty. This includes: constructing and perpetuating the myth that there was a significant issue with Fentanyl vial caps, and creating a "problem" to fit your "solution" (glue and foil); offering inaccurate explanations and assurances to co-workers to avoid suspicion and detection; and diversion and substitution, which involves representing the vials as containing a specified quantity of Fentanyl while knowing full well the vials do not.

* * *

O. Door County EMS Medical Director Dr. George Gorchynsky, MD has or will withdraw your credentials, consistent with Sec. DHS 110.52(6) Wis. Adm. Code.

1. Being credentialed, per DHS 110.52 Wis. Adm. Code, is a condition precedent to an individual providing emergency medical care as an EMT-Paramedic for a particular emergency medical services provider.

* * *

Just cause exists for disciplinary action. This letter is intended as a written notice of your discharge from employment with Door County effective March 24, 2014.

* * *

Dr. Gorchynsky withdrew Jeanquart's credentials to provide emergency medical services simultaneous with the termination.

Post discharge a number of employees approached the use of controlled substances with a heightened sense of concern. Employees filed more reports relative to concerns with the integrity of drugs. There were a variety of concerns brought forward. None of those concerns addressed caps coming off fentanyl vials. Following his discharge, Jeanquart researched and found a number of drug recalls, some involving fentanyl. The recalls involved crimps, under-filled vials and particulates found in packaging. None involved loose security caps coming off.

RELEVANT PROVISIONS OF THE COLLECTIVE BARGAINING AGREEMENT

ARTICLE 4 – GRIEVANCE PROCEDURE

* * *

D. Arbitration Award: The power of the Arbitrator is limited as follows: His or her function is limited to interpreting and applying the provisions of this Agreement. He or she has no power to add to, subtract from, or modify any of the terms of this Agreement.

* * *

ARTICLE 24 – DISCIPLINARY PROCEDURE

The following disciplinary procedure is intended as a legitimate management device to inform employees of work habits, etc. which are not consistent with the aims of the Employer's public function, and thereby to correct those deficiencies.

Any employee may be disciplined, demoted, suspended or discharged for just cause. It is understood that just cause for immediate discharge includes, but is not limited to being under the influence of intoxicants or controlled substance on duty, dishonesty, flagrant insubordination or flagrant misconduct. This expression of specific reasons for discharge shall not preclude discharge for other reasons normally considered just cause.

The normal sequence of disciplinary action for offenses shall be:

1. Letter of Criticism
2. Letter of Reprimand
3. Suspension
4. Termination

* * *

DISCUSSION

The collective bargaining agreement has a just cause provision. Article 24 outlines how discipline is to be applied. The provision contemplates progressive discipline. The second paragraph outlines certain conduct that can lead to immediate discharge without benefit of progressive discipline. Jeanquart was not given progressive discipline. The question in this proceeding is whether Jeanquart's conduct involved dishonesty, flagrant misconduct, or some similar behavior.

Jeanquart worked for the County for 19 years, had a good work record, no history of discipline, and exhibited the initiative to reach out and extend himself in a variety of ways that benefitted the County. His work history is such that he is entitled to consideration in the application of severe discipline involving a first offence.

The events of October 5 through 7, 2013, set the stage for what ultimately played out. A vial of fentanyl was identified as missing and was subsequently found by Jeanquart. The vial was broken. The accounts of Jeanquart and Luchini conflict in a meaningful way. If Jeanquart is to be credited, Luchini could not have seen the reference to the broken vial on Sunday, October 6, 2013. It would mean that Luchini misrepresented what he saw or reconstructed what he observed on October 6, 2013. If Luchini is to be credited, the reference to the broken vial was entered before the vial was discovered on October 7, 2013, which is when Jeanquart ostensibly found the vial and discovered it was broken.

Assuming Jeanquart's testimony to be accurate, there was good cause for Luchini and Christensen to proceed as they did. I observed the vials of fentanyl. The vial is described above. The managers in question have been around strictly controlled vials for years. If a vial that normally holds 2ml has 2½ ml of fluid, it would be obvious to the trained eye. The overage would jump out. They had just received a broken vial of fentanyl that had been missing for two days which appeared to be overfilled. They measured the content. The reaction to measure the content was natural. The failure to document the fact that they had removed the content is not explained in the record. Luchini in particular testified in detail and at length about the need to document the handling of controlled substances. As they emptied and refilled the vial, they had to assume that they may well be handling fentanyl. The Union makes much of the failure to document the measurement of the fluid and the failure of Luchini to testify that the measurement was taken. The Union's criticism has merit.

The vial was sent for testing and the results came back indicating there was no fentanyl. Cameras were set up. I think at this point the Department was reasonably concerned that something was going on. The Union objects to the focus on Jeanquart and points to Luchini as having failed in his supervisory role and as lacking credibility. As to the supervisory role, Luchini had only been serving as acting director since October 11, 2013. The October vial

disappeared and was found before he was named acting director. Luchini was the deputy director prior to that. He was hired by the Department on March 11, 2013, seven months before the October vial incident. The security shortcomings certainly predated his temporary appointment and likely predated his hire. It is difficult to see how Luchini had a role in the disappearance and diversion of the October vial. Bittorf worked the day before and logged the level of fentanyl for the outgoing shift. Jeanquart documented the level of fentanyl for the incoming shift.

There is a dispute as to whether or not Jeanquart talked with Luchini about the foils on January 20, 2014. LeClair corroborates Jeanquart's claim that the two men talked and that Luchini said okay to the foils. For purposes of this award, I have assumed that to be the case. Jeanquart affixed the foils to the vials and, when he struggled to do so, applied glue. It is uncontroverted that Jeanquart never advised Luchini that he was using glue.

In his investigatory interview, Jeanquart indicated he told everybody, including the next crew, about the foils. There was no record evidence to support the notion that coworkers were told by anyone of the existence and purpose of the foils. Jeanquart handled 20 vials of fentanyl alone. He did not record what he had done. At a minimum, he altered the appearance of a controlled substance and applied glue to a vial, the content of which was intended to be injected into the human bloodstream. I find the absence of notice of that fact to be unsettling. Using glue from a toolbox to glue foil to a vial of controlled substance, standing alone, is a very bad idea.

Luchini left the glued foils in service for several days. No one informed the staff as to why the fentanyl was appearing with blue foil and glue. The failure to notify staff is unexplained.

It is the Union's view that Jeanquart was a demonstrated problem solver. Once he identified a problem, he took the initiative to solve the problem and did so without direction. The record supports that description. However, the many initiative-based actions described in the record are distinguishable in two meaningful ways. First, this dispute involves a controlled substance which is heavily regulated. Unlike the various matters described above, the law and drug protocol bar the unauthorized and solitary modification of the containers. Jeanquart was well aware of that fact. Second, the various prior actions addressed real problems. The office files were a mess. The light system impeded the work of staff. The command car came without flashing lights, a siren or a radio. I do not believe a real problem existed with the fentanyl caps.

Jeanquart indicated that staff members complained that caps were coming off the fentanyl vials. When pressed, he identified two incidents involving him and one involving Schartner. Numerous witnesses testified that they did not experience the caps falling off. The Union points to the testimony of certain drugstore personnel. However, I believe the Union reads more into their testimony than is warranted. The Union points to the testimony of Kipp

for the proposition that the store had a problem with caps coming off. Kipp's testimony was that she accidentally knocked caps off a medication when attempting to open a box. The pharmacist, Amy Konop, testified that she had not experienced tops coming off fentanyl vials. As a part of the investigation, Luchini interviewed another pharmacist at the hospital and recorded the following exchange:

> Q: Do the caps ever fall off?
>
> A: Not typically, however some are loose and come off very easy.

I do not believe that any of the testimony from the pharmacy employees supports the claim that caps came off the fentanyl vials.

Jeanquart testified that he turned the vials upside down, placed two drops of glue on the side of the metal caps, and believed he turned the foil to secure the glue. He indicated that none of the caps came off. Jeanquart's testimony as to how the glue was applied is inconsistent with the testimony of every witness who observed the glue on the vials.

A number of individuals had the opportunity to handle or view the vials after the foils were attached. Hilsabeck indicated he opened all 15 of the vials he had in his possession. He testified that when he opened the tape the little green caps fell off. Hilsabeck indicated he saw adhesive on the silver tops of the vials located inside the caps. He indicated the majority was on top of the silver portion of the vials. Hilsabeck testified that in his opinion the caps had to be off to apply the glue and indicated that some glue was closer to the middle of the vials. Farley testified that the glue was carefully placed all the way around the top of the vials. He indicated that the glue held the tops to the vials. Farley further indicated that the glue circled the tops of the silver portion and that there was glue on the stoppers.

Luchini indicated that the glue was placed under the cap of the vial. He said the cap was off when the glue was placed on the vial. Luchini's report confirmed the testimony of Hilsabeck and Farley, that when they removed the seals the cap came off with it. Luchini reported none of the caps were attached; they fell off when the foil was removed.

When Luchini removed the vial from the sharps container, Schartner observed the vial. Schartner indicated she saw what appeared to be glue. She saw two clear, hard dots on top of the vial. Similarly, Bittorf used one of the foil wrapped vials. When Bittorf discarded the vial, she observed glue on the top of the metal ring that goes around the top of the vial.

The critical difference in the testimony is that Jeanquart described an application that was done without breaking the security provided by the green caps. All other witnesses described seeing a glue pattern that could only have occurred if the glue was applied under the green cap.

The Union sought to inspect the vials but was precluded from doing so. The parties were in the process of attempting to arrange for a visual inspection when the vials were seized by the Federal Drug Administration, which retained custody of the vials through the proceeding. Following a long postponement, the parties proceeded to hearing with the vials in the hands of the FDA. The record would have been improved had all parties been permitted to inspect the vials. That proved to be impossible. I am not willing to exclude or discount the testimony of the individuals who did see the vials. Five people testified as to what they saw. They had varying roles and relationships to Jeanquart. The Union has attacked Luchini's testimony, but his observations served only to corroborate what others saw.

The lab reports from the four vials that were tested could be read to indicate that some of the green caps were secure and that one vial lacked a foil. I have drawn no such implication from the reports, because I believe the foils were removed and the caps fell off while the vials were in the custody of law enforcement and before they were sent for testing.

The Union says anyone might have diverted the fentanyl. The security surrounding the drugs was inadequate. The drugs were accessible to a large number of people. However, the security caps were intact when the glue was applied. Law enforcement officers indicated that they removed the foils by breaking the glue.

I believe the County has established that Jeanquart engaged in the behaviors for which he was terminated. There was a level of dishonesty and flagrant misconduct involved. This is not the conduct that is traditionally addressed through progressive discipline.

AWARD

The grievance is denied.

Signed at the City of Madison, Wisconsin, this 19th day of February 2016.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

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William C. Houlihan, Arbitrator