

ARBITRATION

In the Matter of the Arbitration

Between	:	No.27-24-(92-07-20)-0123-01-04
THE STATE OF OHIO	:	GRIEVANCE OF REBECCA S. SPICER
and	:	
OCSEA/AFSCME-LOCAL 11, AFL-CIO	:	<u>DECISION AND AWARD</u>
	:	

This matter was heard on the 7th day of May, 1993
in Columbus, Ohio

Appearances:

For the State:

David Burrus, Labor Relations Officer
Lou Kitchen, OCB
R. G. Bower, Administrator DR&C
Ralph Coyle, Major, SCI
Greg Dennis, EMT, Berns Twp. Fire Department
Michael L. Buckley, Sergeant
Dr. Larry Mendel, Medical Director, OCRC
Rick Dean, Health Care Administrator

For the Union:

Floyd W. Gray, President SCI
Rebecca Spicer, Grievant
John Fisher, Staff Representative

I. INTRODUCTION AND BACKGROUND

The State of Ohio ("Employere") and OCSEA/AFSCME Local 11, AFL-CIO ("Union") are parties to a Collective Bargaining Agreement for the term of January 1, 1992 to January 31, 1994 ("Contract"). ARTICLE 25 of the Contract sets forth a multi-step grievance procedure leading to arbitration. The undersigned was selected as the Arbitrator pursuant to Section 25.04 of the Contract and the parties have stipulated that all procedural matters have been complied with and that this matter is properly before this Arbitrator for a decision.

The grievance in this case was filed as the result of the Employer terminating the Grievant from her position as a licensed practical nurse at the Southeast Correctional Facility of the Ohio Department of Rehabilitation and Correction. The Employer, pursuant to its management right as set forth in ARTICLE 5 of the Contract has issued various unilateral work rules which are called "Revised Standards of Employee Conduct Before the Department of Rehabilitation and Correction." Specifically, the Grievant is charged with violating Rule 9, the failure to carry out a work assignment or the exercise of poor judgment in carrying out an assignment; Rule 24, falsifying, altering, or removing any official document arising out of employment with DR&C; and, Rule 40, any act or commission not otherwise set forth herein which constitutes a threat to the security of the institution, its staff or inmates. Rule 9 contains a progressive disciplinary schedule starting with a reprimand for the first offense to a removal from

service for the fourth offense. Rule 24 starts with a three to five day suspension for the first offense leading to removal for the third offense and Rule 40 starts with a reprimand for the first offense leading to removal for the third offense. Page 15 of the Revised Standards of Employee Conduct issued by the ODR&C explains the concept of progressive discipline. That policy is set forth as follows:

Progressive Discipline

The purpose of this policy and procedure is to provide a measure of consistency. The consistency being sought does not require the Employer to administer the discipline indicated in the Standards of Employee Conduct exactly the same in every case. Every distinguishing fact must be considered first. Arbitrators are not bound by prior arbitration cases like the courts are bound by case law. They diligently adhere to the philosophy that "every case turns on its facts: and although they may be persuaded by prior decisions, they do so only if the facts are nearly indistinguishable.

The "consistency" that should be sought by the Department of Rehabilitation and Correction should be to strive for a consistently fair and thorough investigation prior to imposing discipline. The Department should also consider the offense being investigated and its relationship to prior disciplinary actions, if they exist. Prior disciplines should receive a two-pronged analysis in asking (1) whether they were of the same or similar nature, and (2) if they were committed in close proximity to each other or did a reasonable amount of time expire in between the offenses. Finally, a consistent application of discipline should take into account other relevant data such as work record or other unique circumstances surrounding the offense.

Corrective counseling is always an option and may be utilized prior to any disciplinary action as well as in between the various types of progressive discipline. Ultimately, the proper application of this Standards of Employee Conduct policy will satisfy the goal for which it was intended, and that is to assess a discipline commensurate to the offense.

Usage

It is paramount that each institution or facility centralize their disciplinary process to ensure as much consistency as possible. The ranges often allow for a great deal of discretion and as long as the facts are distinguishable, the disciplinary action may vary. However, when the facts are nearly the same, the disciplinary action taken should reflect consistency.

The Contract specifically addresses progressive discipline in Section 24.02 which states as follows:

24.02 - Progressive Discipline

The Employer will follow the principles of progressive discipline. Disciplinary action shall include:

- A. One or more oral reprimand(s) (with appropriate notation in employee's file);
- B. One or more written reprimand(s);
- C. One or more suspension(s);
- D. Termination.

Disciplinary action taken may not be referred to in an employee's performance evaluation report. The event or action giving rise to the disciplinary action may be referred to in an employee's performance evaluation report without indicating the fact that disciplinary action was taken.

Disciplinary action shall be initiated as soon as reasonably possible consistent with the requirements of the other provisions of this Article. An arbitrator deciding a discipline grievance must consider the timeliness of the Employer's decision to begin the disciplinary process.

II. ISSUE

The issue for determination in this case is whether or not the Grievant violated the standards of conduct issued by the Department by failing to perform her work duties and/or by falsifying or improperly completing her official reports of the subject incident. The Arbitrator must determine whether or not the Grievant was properly discharged for just cause as set forth in Section 24.01 of the Contract. If the Grievant was not discharged for just cause,

the Arbitrator shall sustain the grievance and fashion the appropriate remedy.

III. STIPULATED FACTS

The parties have stipulated the following facts:

1. The Grievant was employed on August 26, 1991 as a licensed practical nurse at the Southeast Correctional Institution.
2. The Grievant had no prior discipline before her termination from employment.
3. The Grievant signed for and acknowledged receipt of the Standards of Employee Conduct on August 26, 1991. The Union acknowledges the existence and receipt of the Standards but does not necessarily agree with the Standards.
4. The Grievant was removed from employment on July 8, 1992.
5. The Grievant was not disciplined for causing or contributing to the inmate's death.

IV. FACTS

The Grievant was employed as an LPN on the third shift (night shift) on April 3, 1992. The Grievant was the only "medical" person on duty in the facility. Shortly after midnight, the Grievant received a call that an inmate named Vanhandel had collapsed in his dormitory. Presumably, the inmate fell out of his bed and hit his head. The Grievant conversed with the guards who reported the incident and she was told that the inmate was still breathing and that he had a pulse. The Grievant requested the name and the prison ID number of the inmate so she could check the inmate's medical records to determine whether or not there was a

medical history of a seizure. The symptoms described by the guards were such that the Grievant thought that the inmate was having a seizure. The Grievant later received another telephone call from the guards in the dormitory informing her that the inmate's condition had worsened. The Grievant did not choose to attend to the inmate in the dormitory; but, instead, she called a captain to arrange for the inmate to be brought to the infirmary for treatment.

When the inmate was brought in, the Grievant began to attempt to diagnose the inmate's symptoms and render emergency treatment. The Grievant applied a nose cannula, a device which is placed over a patient's nose and which delivers oxygen into the nose cavity. The Grievant testified that she administered two quick mouth-to-mouth breaths, but this did not produce any breathing. The Grievant did not apply mouth-to-mouth resuscitation and she did not engage in compressing the inmate's chest to initiate breathing. The Grievant directed the guards to call the life squad and eventually the life squad arrived to administer CPR and other treatment. Apparently, inmates and guards at the dormitory attempted to administer CPR to the inmate before he was brought to the infirmary for examination by the Grievant. The inmate did not respond to treatment and eventually was pronounced dead.

The Grievant was required to complete two official reports about the incident. There are inconsistencies in the reports as to whether or not the Grievant actually performed CPR on the inmate. The Grievant was terminated from her employment because of the

manner in which she handled this emergency situation and because she provided conflicting reports about the incident.

V. POSITION OF THE EMPLOYER

The Employer believes that the Grievant should have immediately responded to the emergency by personally attending the inmate in the dormitory. Because the Grievant did not personally visit the dormitory, the other inmates became agitated and rebellious because they perceived that the Institution was not properly responding to the inmate who was in need of emergency care.

The Grievant stated in her report of April 3, 1992 that when the inmate arrived at the infirmary at 12:52 a.m., the inmate had no pulse, no blood pressure and no respiration. Under any standard of emergency care treatment, the inmate needed CPR performed upon him. The inmate's color turned a bluish gray from his head to his upper chest. Instead of administering CPR, the Grievant applied a nose cannula, which delivered oxygen into the nasal cavity but did not assist the inmate with breathing.

The second report completed by the Grievant on April 7, 1993 also states that the inmate was without any vital signs. However, in this report, the Grievant states that she continued CPR until the life squad arrived at approximately 1:25 a.m. None of the witnesses who observed the Grievant saw her administer any CPR to the inmate. The witnesses testified that the Grievant was distraught and was not under control.

The State employed the Grievant as a licensed practical nurse who would be expected to provide emergency treatment to inmates

when there is a need for such services. Instead of providing routine basic emergency services, the Grievant panicked and failed to provide CPR when the victim was in need of it. Moreover, the Grievant attempted to cover up her negligence by preparing a second report indicating that she had administered CPR when in fact she did not. Because of the Grievant's conduct in this situation, there is just cause to terminate her employment.

VI. POSITION OF THE UNION

The evidence does not support a finding that the Grievant neglected to perform her duties under the circumstances. When the inmate arrived at the infirmary, the Grievant detected that the inmate had a "thready pulse". This is a heartbeat which is very fast and very faint. According to her training, under these circumstances, a medical provider should not administer compression of the chest because the heart could become damaged. The Grievant treated the lack of breathing by administering oxygen through the nose cannula. Before she did that, she tilted the inmate's head back and administered two quick mouth to mouth breaths. She made arrangements to call for the life squad immediately. She was familiar with a device called an ambu bag which forces oxygen into the lungs. This was the device used by the life squad when it appeared. According to the Grievant, the infirmary had an ambu bag but no one in supervision informed her of that fact; and, as a result the device was not used by her in this instance.

The Grievant did not find it necessary to personally visit the inmate at the dormitory because she had received reports that the

inmate was breathing and that he had a pulse. She assumed that the Grievant would recover until she received the second telephone call informing her that the inmate's condition had declined.

The Grievant explained the inconsistencies in the two reports. Her supervisor advised her that the first report was satisfactory, but that she needed to include information in the second report about the CPR which was being administered. The Grievant testified that her supervisor requested that she put information about CPR in the second report. The second report is a more detailed report that requires specifics with respect to medical treatment. The first report is merely an incident report for administrative purposes.

Regardless of whether or not the Grievant performed her services in an acceptable manner; and, regardless of whether or not she properly completed her reporting requirements, the Grievant should not be discharged for these types of offenses. Each of the work rules or standards of conduct cited by the Employer calls for progressive discipline and none of the rules lists discharge as the appropriate penalty for the first offense. The Grievant was only an eleven month employee but she enjoyed a clean work record and she had received a satisfactory job evaluation relative to her work performance. The punishment under these circumstances did not fit the crime and the Employer acted in an arbitrary and unreasonable manner by terminating the Grievant from her employment.

VII. DISCUSSION

According to the evidence presented, the Grievant's conduct under the circumstances left something to be desired. Regardless of whether or not the Grievant should have personally attended to the inmate at the dormitory, for this is a judgment call, the Grievant did not properly attend to the inmate when he arrived at the infirmary. The inmate was without any vital signs. His eyes were closed and he was not responsive. His pupils were fixed and he was not breathing. The inmate's complexion was bluish gray in color and it was apparent that his body was not receiving oxygen. According to the expert witnesses who testified, CPR was called for under the circumstances but it was not administered by the Grievant. There was evidence that CPR was attempted by either the other inmates or the guards while the inmate was in the dormitory. It was necessary for the Grievant to administer CPR in order to deliver oxygen to the inmate's system. The Grievant's other concerns were secondary. It is true that there is a risk of secondary injury when the chest is compressed during the administration of CPR. There could be a heart injury or there could be damage to the ribs or sternum. Nevertheless, this is a judgment call and the first priority under these circumstances is to restore breathing by artificial respiration. Under the ABC's of CPR, first the airway must be cleared, second the breathing must be restored and third circulation must be restored. It was the Grievant's responsibility to address the inmate's lack of breathing before she needed to be concerned about the restoration of circulation.

The life squad employee testified that upon arrival he checked the inmate and found that he was not breathing. He could not find a pulse in either the arm or the neck. He immediately applied oxygen to the inmate's system by the use of an ambu bag. Because of the need to restore breathing, it was his opinion that chest compression should be instituted even with a thready heart beat under the circumstances when the inmate could not breath.

Another witness, Sgt. Buckley testified that the Grievant appeared disoriented and confused under the circumstances. She could not locate her stethoscope and, notwithstanding that the Grievant could not obtain any vital signs, he did not observe her administering any CPR.

Dr. Mendel, the medical director for the Ohio Department of Rehabilitation and Correction, corroborated the testimony of other witnesses. He stated that it was necessary for the Grievant to administer mouth-to-mouth respiration or CPR to address the inmate's lack of breathing. This is standard emergency medical treatment. The Grievant should have assessed and reassessed the inmate's symptoms and at some point she should have administered CPR.

The Grievant's supervisor, Mr. Dean contradicted the testimony of the Grievant with respect to the Grievant's completion of her reports. He advised the Grievant that her first report was not adequate because it did not contain an explanation of the medical treatment which was being administered. He denied that he told the Grievant to put information in the second report that she had

administered CPR. He advised her that management would look for information regarding the administration of CPR in the reports but he did not advise her to make out another report and indicate that the inmate had received CPR. The Grievant may have interpreted the supervisor's comments or directive that she should put CPR information into the second report; however, the evidence is clear that the Grievant did not administer CPR and the reference to that subject in the second report was inaccurate and misleading.

The supervisor testified that there was an ambu bag in the department and that it was available for the Grievant's use. The Grievant, however, testified that she was not made aware of the ambu bag and she was familiar with the use of an ambu bag and had the existence of the ambu bag been disclosed she would have used it. The Grievant cannot be faulted for not using medical equipment of which she was not aware, but the Grievant's statement that she would have used the ambu bag had she known of its whereabouts is illuminating. The fact that the Grievant would have used an ambu bag if one was available indicates that the Grievant knew that the nose cannula was not sufficient to assist the inmate to breathe. The only reasonable alternative to an ambu bag is the administering of CPR in order to provide oxygen to the inmate's system. This was not done and the Grievant clearly failed in this regard.

Accordingly, this Arbitrator finds from the evidence presented that the Grievant did not perform her job duties in a satisfactory manner and she provided misleading information in her second report. She violated the Standards of Conduct and there was just

cause for discipline. The question remains, however, as to whether or not discharge or termination is the appropriate discipline to be administered under the circumstances. Ordinarily, disciplinary decisions of an Employer will not be questioned or second guessed by an Arbitrator because an Employer is entitled to broad leeway with regard to the extent of discipline under its management rights. Disciplinary decisions will only be overturned when they are found to be arbitrary, discriminatory, or clearly unreasonable under the circumstances.

The Contract in this case specifically addresses the management principals of progressive discipline. Section 24.02 states that the Employer will follow the principals of progressive discipline. The guidelines for progressive discipline are more fully explained in the Standards of Employee Conduct for the Department. The Employer refers to the policy of providing consistent application of discipline. Like offenses should be disciplined in the same manner. No evidence was presented by the Employer in this case, however, as to similar instances of discharge for the same or similar offenses as those committed by the Grievant.

Each of the work rules violated by the Grievant calls for some type of reprimand or suspension short of discharge for a first offense. Nevertheless, because of the Employer's belief that the Grievant attempted to cover up her infraction by submitting a false and misleading report, the Employer believes that discharge is called for in this case.

This Arbitrator does not agree with this analysis. The Grievant was only an 11-month employee and was not as yet fully trained. She was not even familiar with all of the medical equipment available for her use within her department. She was the only medical person in charge on the shift and she was faced with a severe emergency. She was negligent and she did not properly respond to the situation. The misleading and inaccurate second report was an attempt at covering up her negligence but there is some question as to whether or not there was a communication problem with her supervisor insofar as the required contents of the report. The circumstances under which the Grievant responded were of the most serious nature - literally a life and death situation. The Grievant did not measure up to the circumstances and she did not properly report her activities. For this, the Grievant should receive a serious disciplinary penalty. However, it is unreasonable to suggest that when all the circumstances are taken into consideration, including the Grievant's inexperience and lack of training, the most severe penalty of discharge or termination should be applicable. The principals of progressive discipline which appear both in the Contract and in the Standards of Conduct require the issuance of a suspension instead of the ultimate penalty of discharge. The Grievant, therefore, should be restored to her job and her penalty should be converted to a suspension. The Grievant should be restored without any back pay or benefits.

VIII. AWARD

The Grievance is sustained. The Grievant should be restored to her former position without an award of back pay or benefits.

SO ORDERED:

Date: June 2, 1993

Mitchell B. Goldberg
Mitchell B. Goldberg, Arbitrator

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