#117

**Dr. David M. Pincus**
**Arbitrator**
**4026 Ellendale Drive**
**Moreland Hills, Ohio 44022**

December 27, 1996

Mr. Mike Duco
Chief of Arbitration Services
Office of Collective Bargaining
106 North High Street
Columbus, Ohio 43215-3019

-and-

Mr. John Porter
Dispute Resolution
OCSEA, Local 11, AFSCME
1680 Watermark Drive
Columbus, Ohio 43215

Re: State of Ohio, Department of Rehabilitation and Corrections and
Ohio Civil Service Employees Association, Local 11, AFSCME, AFL-CIO

Grievant: David Williams
Grievance Number: 27-16-950914-2309-01-04

Gentlemen:

Enclosed please find my Opinion and Award dealing with the above captioned matter.

I have enclosed a copy of my arbitration invoice for services rendered.

Sincerely,

Dr. David M. Pincus
Arbitrator
S.S. #276-46-4879
Purchase Order #7H0062

**THE STATE OF OHIO AND OHIO CIVIL SERVICE EMPLOYEES ASSOCIATION LABOR ARBITRATION PROCEEDING**

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In The Matter of the Arbitration Between:

The State of Ohio, Department of Rehabilitation and Corrections

-and-

Ohio Civil Service Employees Association, Local 11, AFSCME, AFL-CIO

Grievant: David Williams
Grievance No.: 27-16-950914-2309-01-04

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**Arbitrator's Opinion and Award**
**Arbitrator: David M. Pincus**
**Date: December 27, 1996**

Appearances

| For the Employer | |
|---|---|
| Guy Foraker | Inmate Witness |
| George Brehm | Inmate Witness |
| Alphonso Darden | Inmate Witness |
| Joe Jackson | Inmate Witness |
| Joe Cochran | Sergeant |
| Alice A. Cain | Health Care Administrator |
| Larry M. Yoder | Inspector |
| Kevin J. Smith | Investigator OSHP |
| Fran Reisinger | Labor Relations Officer |
| Christopher Finnegan | Correction Officer |
| Barbara Lustgarten | Physician |
| Vickie Burns | Dental Assistant |
| Randy L. Foy | Major |
| Wendy Clark | Observer |
| Colleen Wise | Second Chair |
| Cynthia Sovell | Advocate |

For the Union

| | |
|---|---|
| David Williams | Grievant |
| Mike Hill | Staff Representative |
| Susan McElheny | LPN |
| Gary Williams | LPN/Training Officer |
| Kathy Hawkins | LPN |
| George L. Yerkes | Second Chair |
| Butch Wylie | Advocate |

## Introduction

This is a proceeding under Article 25, entitled Grievance Procedure, Section 25.03 - Arbitration Procedures, Section 25.04 - Arbitration/Mediation Panels of the Agreement between The State of Ohio, Ohio Department of Rehabilitation and Corrections, hereinafter referred to as the "Employer," and Ohio Civil Service Employees Association, AFSCME, Local 11, hereinafter referred to as the "Union," for the period March 1, 1994-February 28, 1997. The arbitration hearing was held on May 16, 1996, July 26, 1996, and August 1, 1996. The parties had selected David M. Pincus as the Arbitrator.

At the hearing, the parties were given the opportunity to present their respective positions on the grievance, to offer evidence, to present witnesses and to cross-examine witnesses. At the conclusion of the hearing, the parties were asked by the Arbitrator if they planned to submit post hearing briefs. The parties submitted briefs in accordance with the guidelines agreed to at the hearing.

## Stipulated Issues

Was the Grievant, David Williams, removed for just cause?
If not, what shall the remedy be?

## Pertinent Contract Provisions

### Article 24 - Discipline

**24.01 - Standard**

Disciplinary action shall not be imposed upon an employee except for just cause. The Employer has the burden of proof to establish just cause for disciplinary action. In cases involving termination, if the arbitrator finds that there has been an abuse of a patient or another in the care or custody of the State of Ohio, the arbitrator does not have authority to modify the termination of an employee committing such abuse. Abuse cases which are processed through the Arbitration step of Article 25 shall be heard by an arbitrator selected from a separate panel of abuse case arbitrators established pursuant to Section 25.04. Employees of the Lottery Commission shall be governed by O.R.C. Section 3770.02.

**24.02- Progressive Discipline**

The employer will follow the principles of progressive discipline. Disciplinary action shall be commensurate with the offense.

Disciplinary action shall include:

A. One of more oral reprimand(s) (with appropriate notation in employee's file);
B. one or more written reprimand(s);
C. a fine in an amount not to exceed two (2) days pay for discipline related to attendance only; to be implemented only after approval from OCB;
D. one or more days(s) suspension(s);
E. 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 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.

The deduction of fines from an employee's wages shall not require the employee's authorization for withholding of fines.

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(Joint Exhibit 1, Pgs. 68-69)

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**24.04-Pre-Discipline**

An employee shall be entitled to the presence of a union steward at an investigatory interview upon request and if he/she has reasonable grounds to believe that the interview may be used to support disciplinary action against him/her.

An employee has the right to a meeting prior to the imposition of a suspension, a fine or termination. The employee may waive this meeting, which shall be scheduled no earlier than three (3) days following the notification to the employee. Absent any extenuating circumstances, failure to appear at the meeting will result in a waiver of the right to a meeting. An employee who is charged, or his/her representative, may make such a written request for a continuance of up to 48 hours. Such continuance shall not be unreasonably denied. A continuance may be longer than 48 hours if mutually agreed to by the parties. Prior to the meeting, the employee and his/her representative shall be informed in writing of the reasons for the contemplated discipline and the possible form of discipline. When the pre-disciplinary notice is sent, the Employer will provide a list of witnesses to the event or act known of at that time and documents known of at that time used to support the possible disciplinary action. If the Employer becomes aware of additional witnesses or documents that will be relied upon in imposing discipline, they shall also be provided to the Union and the employee. The Employer representative recommending discipline shall be present at the meeting unless inappropriate or if he/she is legitimately unable to attend. The Appointing Authority's designee shall conduct

the meeting. The Union and/or the employee shall be given the opportunity to ask questions, comment, refute or rebut.

At the discretion of the Employer, in cases where a criminal investigation may occur, the pre-discipline meeting may be delayed until after disposition of the criminal charges.

**24.05-Imposition of Discipline**

The Agency Head or, in the absence of the Agency Head, the Acting Agency Head shall make a final decision on the recommended disciplinary action as soon as reasonably possible but no more than forty-five (45) days after the conclusion of the pre-discipline meeting. At the discretion of the Employer, the forty-five (45) day requirement will not apply in cases where a criminal investigation may occur and the Employer decides not to make a decision on the discipline until after disposition of the criminal charges.

The employee and/or union representative may submit a written presentation to the Agency Head or Acting Agency Head.

If a final decision is made to impose discipline, the employee and Union shall be notified in writing. The OCSEA Chapter President shall notify the agency head in writing of the name and address of the Union representative to receive such notice. Once the employee has received written notification of the final decision to impose discipline, the disciplinary action shall not be increased.

Disciplinary measures imposed shall be reasonable and commensurate with the offense and shall not be used solely for punishment.

The Employer will not impose discipline in the presence of other employees, clients, residents, inmates or the public except in extraordinary situations which pose a serious, immediate threat to the safety, health or well-being of others.

An employee may be placed on administrative leave or reassigned while an investigation is being conducted except

that in cases of alleged abuse of patients or others in the care or custody of the State of Ohio, the employee may be reassigned only if he/she agrees to the reassignment.

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(Joint Exhibit 1, Pgs. 70-72)

**Joint Stipulations**

1. David Williams was employed at the Marion Correctional Institute as a Licensed Practical Nurse from October 22, 1990 to October 28, 1995.

2. David Williams was placed on Administrative Leave With Pay on February 27, 1995 until his termination on October 28, 1995.

3. Inmate Jackson was seen in the infirmary by the Grievant on February 2, 1995.

4. On February 27, 1995, Inmate Spears #283-747 suffered from a heart attack and was pronounced dead at 3:00 p.m. The Inmate was found next to his bed in #6 Dormitory in B-Row. When Dr. Lustgarden pronounced the inmate dead she stated lividity had set in.

5. On February 27, 1995, David Williams was working 2nd shift and on February 27, 1995 at 2:45 p.m. he was in the Treatment Room.

6. No criminal charges were filed against the Grievant.

7. The third shift nursing staff had the responsibility of stocking the medical box.

8. The grievant did not have the medical box on his gurney when he responded to the medical emergency on February 27, 1995.

## Case History

David Williams, the Grievant, was employed at the Marion Correctional Institution as a Licensed Practical Nurse (LPN) from October 22, 1990 to October 28, 1995. Two (2) incidents were cited in support of the removal.

On February 2, 1995, between the period of 6:30 p.m. and 8:00 p.m., Inmate Larry Jackson, presented himself at Nurses Sick Call which was manned by the Grievant. Jackson testified he raised a number of physical problems he was experiencing. He complained of: shortness of breath; excessive sweating; coughing up phlegm; a chest cold; a knee injury; and a shaving clipper request. Without engaging in any formal assessment and offering any advice, the Grievant purportedly noted the doctor would see his chart.

Jackson testified his condition did not stabilize nor improve following his initial visit to Nurse's Sick Call. Jackson, again, visited the infirmary on February 8, 1995. His complaints mirrored those provided the Grievant on February 2, 1995. The attending nurse, in this instance, did take some vital signs and was able to procure a breathing treatment.

On February 9, 1995, Jackson saw Barbara Lustgarten, the Medical Director. After evaluating the Grievant's condition, she determined he had bronchopneumonia. Treatment was initiated shortly after the diagnosis.

Lustgarten investigated the circumstances surrounding Jackson's condition. She authored an Inter Office Communication (Employer Exhibit 10) on February 10, 1995. She concluded:

***

> Proper assessment was not done. Proper treatment was not rendered at the time by the nurse, and not in a timely fashion by the doctor because of improper assessment by the nurse.

***

(Employer Exhibit 10)

Her findings were based on a number of observations. She determined that Jackson was a known asthmatic with a standing order since December of 1994 for a breathing treatment. With this documentation, the Grievant failed to provide any diagnostic intervention. He failed, more specifically, to: initiate a lung auscultation (use of stethoscope); provide a breathing treatment; flag the chart for immediate doctor's attention; advise Jackson concerning his condition; take a temperature; describe respiratory effort in terms of rate and sounds; and describe the phlegm as to color and amount.

The second incident raised by the Employer in support of the removal decision took place on February 27, 1995. The incident took place on 6-Dorm, and again, involved the Grievant and his performance of nurse-related responsibilities.

Christopher Finnegan, a Corrections Officer assigned to this particular location, reviewed what transpired at approximately 2:45 p.m. Inmate Garrett remarked that an Inmate Spears was laying motionless on his bed and appeared to be ill. Upon further observation, Garrett revised his remarks and noted Spears was not breathing and might be experiencing a heart attack.

Finnegan contacted the infirmary and spoke to the Grievant. He informed him that he had a medical emergency in 6-Dorm; an inmate was not breathing and may have experienced a heart attack; and to come immediately to 6-Dorm. Finnegan, then, left the dorm and waited for the medical team at the short hallway. No one arrived, but he did observe three inmates performing CPR on Spears. Finnegan testified he went out to the short hallway an additional time, and when he returned he, again, called the infirmary. Finnegan was advised that the Grievant was "on his way." He was motivated to call the infirmary because the inmates were getting a bit irritated, they felt no one was responding to the call. In fact, they urged him to trigger his "man down" alarm or Signal 3 button. He hesitated following this suggestion since he was trained to use this option under a different set of circumstances.

Finnegan, for the third time, walked to the short hallway hoping to see the Grievant and facilitate his entrance into 6-Dorm. He returned to the dorm after failing to see the Grievant. Again, the inmates in the dorm

were irritated, anxious about the inmate's condition and the tardy response by the medical staff to the medical emergency.

Finnegan eventually relented and called a Signal #3 in an attempt to reduce the tension in the dorm, and to get some type of response. This caused supervisory staff and others to converge on 6-Dorm. Throughout this entire episode inmates continued to provide Spears with CPR.

The Grievant eventually arrived on the scene with a gurney, but without any medical equipment other than a stethoscope. When he arrived, the inmates were still engaged in CPR efforts. One inmate and Sergeant Cochran allegedly asked him if he was going to continue CPR or if he wished them to continue CPR. He merely took a pulse and indicated that the inmate was dead. Other inmates pleaded with the Grievant to continue the process. He merely asked for help loading the inmate onto the gurney.

On August 31, 1995, the Employer issued a Notice of Disciplinary Action (Joint Exhibit 2) which caused the Grievant's removal. It contained the following relevant particulars:

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> You are to be removed for the following infractions:
>
> Violations of Ohio Department of Rehabilitation and Correction Standards of Employee Conduct #8 (failure to follow post orders, administrative regulations and/or written policies or procedures, and #9 (failure to carry out a work assignment or the exercise of poor judgment in carrying out an assignment).

> On February 2, 1995, an inmate reported to Nurse's Sick Call complaining of shortness of breath and having breathing difficulties. You did not engage proper procedures, no vital signs were taken, no breathing treatment was offered, an no ASAP reference to the doctor was made. On February 9, 1995, this same inmate was seen in Medical and as having bronchopneumonia. You had failed to make proper assessment of, and provide proper treatment for, this inmate's condition.
>
> You did respond to an emergency without the proper equipment on February 27, 1995. Your response to the emergency did not indicate that the situation was urgent. It is noted that you were informed that the inmate was not breathing, and that you were asked to come immediately. You did decide that CPR was unnecessary, and you did fail to follow sick call procedures resulting in an insufficient assessment of the inmate's medical concern. Your actions could have lead to, and did lead to a security threat to MCI and was detrimental to the health and well-being of an inmate.
>
> Your actions constitute violation of Ohio Department of Rehabilitation and Correction Standards of Employee Conduct #8 and #9. Therefore, you are hereby removed from your position of Licensed Practical Nurse.
>
> ***

(Joint Exhibit 2)

On September 14, 1995, the Grievant formally contested his removal. He filed a grievance which contained the following Statement of Facts:

> ***
>
> On September 8, 1995, Mr. Williams was removed from his position of licensed practical nurse at Marion Correctional

Institution. Management failed to show just cause for this discipline.

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(Joint Exhibit 3)

Neither party raised substantive nor procedural arbitrability concerns. As such, the grievance is properly before the Arbitrator.

**The Merits of the Case**

The Employer opined it had just cause to remove the Grievant for violating two work rules involving two different inmates. The incident on February 2, 1995 clearly evidenced a violation of work rule #8 which deals with failure to follow post orders, administrative regulations and/or written policies or procedures. The second incident on February 27, 1995, resulted in a violation of work rule #9. This guideline deals with failure to carry out a work assignment and exercising poor judgment in carrying out a work assignment.

The Employer argued the Grievant failed to comply with several known policies and procedures when dealing with Inmate Jackson's situation. The lack of positive attention to Jackson's condition was initially precipitated by the Grievant's unwillingness to access Jackson's medical file (Union Exhibit 2). This should have been done prior to any initial assessment. If this threshold undertaking had been initiated, the Grievant would have realized that Jackson was a severe asthmatic with a standing order for a nebulizer when experiencing asthmatic stress.

At the hearing, the Grievant attempted to mitigate his actions by emphasizing he could not legally write a prescription for the Grievant's condition. The record, however, discloses no prescription was necessarily based on a standing order in place since December 19, 1994. Obviously, the Grievant was never aware of this situation since he never reviewed Jackson's file prior to a formal assessment.

Policies and Procedures for Cold and Flu Symptom's (Joint Exhibit 5(A)) were also violated. The Grievant was obliged to obtain and record a full set of vital signs. On two occasions, October 22, 1990 and November 15, 1993, the Grievant was notified and acknowledged his obligations regarding these duties. He was never advised these responsibilities were discretionary. His knowledge of, and adherence to, the Employer's policies and procedures was documented in performance evaluations (Joint Exhibit 9). As such, the Grievant's confusion regarding the requirement of taking vitals appeared contrived and self-serving.

The Union attempted to discredit testimony provided by Alice Caine, the Health Care Administrator, regarding the vital sign taking requirement. Her evaluation of the Grievant's compliance was limited by an opportunity to observe. She was newly hired and only on board for seventeen days after the Jackson incident. Also, she only supervised the Grievant for twelve days prior to his placement on administrative leave with pay.

Lustgarten provided critical testimony which supported the allegation concerning the Grievant's inappropriate conduct. She asserted no vital signs were taken. Even more distressing was the Grievant's failure to provide a nebulizer considering the standing order in his file (Union Exhibit 2) for a nebulizer and his documented asthmatic condition. Not only was no treatment offered, but the Grievant failed to place an "ASAP" designation in Jackson's file. A referral status of this sort would have alerted Lustgarten that she needed to see Jackson immediately.

A former Inspector at the institution Larry M. Yoder, provided testimony suggesting the Grievant had exhibited a pattern of negligent inmate treatment. Several inmate grievances were introduced which evidenced uncaring and rude behavior toward inmates during Nurse's Sick Call.

Vicki Burns, a bargaining unit member, testified the Grievant held a certain animus against inmate patients. During one discussion the Grievant allegedly noted: "all inmates are low life scum and they deserve to die."

The second incident involves a work rule #9 violation because the Grievant failed to carry out a work assignment, and exercised poor judgment in carrying out required work assignments. These charges dealt with the Grievant's tardy response, lack of preparedness when arriving on the scene and improper conduct once arriving on the scene in terms of following proper protocols.

The record clearly indicates the Grievant failed to respond in a timely fashion to an emergency situation. Both inmate and staff witnesses testified it took him too long to arrive on the scene after Finnegan informed him about the emergency. In fact, Finnegan had to call the infirmary on more than one occasion to urge a prompt response to the emergency situation. The perceived inordinate delay, moreover, caused Finnegan to call a Signal #3; hoping to gain some assistance and to avoid a potential riot in the dorm.

Justifications for the tardy response were viewed as unpersuasive. The care he provided another inmate with a head injury did not justify the delayed response. His inability to get through the sally port in a timely fashion was also viewed as contrived. Fran Reisinger, a former Control Room Operator, maintained a Signal #3 normally causes a Control Room Operator to open the gates in a timely fashion. Also, convex mirrors at the sally port would have provided the operator with a clear and unobstructed view of the gurney; which would have expedited matters even further.

The Grievant admitted, and the record clearly supported, the notion that he arrived on the scene without the proper equipment. The only equipment the Grievant took with him was the gurney and a stethescope. He noted that medical equipment was not available, and it was not his responsibility to place the medical box on the gurney.

The Grievant's equipment arguments were rebutted by the Employer. It referenced the Emergency Equipment Check List (Joint Exhibit 5(g)) which requires that emergency equipment be kept available and fully operable. Caine and Lustgarten testified three (3) medical boxes were in the treatment room when the Grievant received the medical emergency call from Finnegan.

Once he arrived on the scene, the Grievant engaged in additional misconduct. He did not continue CPR; advise the inmates to continue the process they had initiated prior to his arrival; nor allow other staff members to take over the process upon his arrival. These inactions directly conflicted with a CPR policy (Employer Exhibit 14) which articulates conditions necessary for the termination of a CPR intervention. The Grievant was well aware of these necessary conditions since he was trained and certified in CPR at the facility (Employer Exhibit 16) and at the Tucson Fire Department (Joint Exhibit 4).

The Grievant also inappropriately pronounced the inmate dead. A diagnosis clearly outside the realm of his legal authority as evidenced by the attending physician, Health Care Administrator, and the Nursing Act (Joint Exhibit 11).

The totality of the Grievant's conduct placed himself, staff and inmates in a hazardous predicament. His inaction and attitude while handling the emergency situation virtually caused a riot in 6-Dorm.

As opposed to the accurate and credible portrait of these incidents by the Employer's witnesses, the Grievant's testimony lacked any semblance of credibility. The Grievant provided testimony which conflicted with his own written statements dealing with the number of inmates surrounding Spears when he arrived on the scene. At the hearing, he testified one inmate and one staff member were attending Spears. In his statement and incident report (Employer Exhibits 19 and 21), he mentioned that two inmates were around Spears. He gave another perspective as evidenced by contents contained in his EEO Charge of Discrimination (Employer Exhibit 22). In this document, he stated ninety inmates surrounded Spears.

The Grievant's credibility was further reduced when he testified about the State Highway Patrol's investigation involving the disputed matter. Under direct examination the Grievant alleged he was not interviewed by the State Highway Patrol and was never criminally convicted. This testimony was rebutted by testimony and evidence provided by K.J. Smith, Trooper, who had conducted an investigation of the incident by interviewing the Grievant. A report of investigation (Employer Exhibit 23) was introduced which was signed by the Grievant.

Another credibility issue was raised dealing with phone calls made during the period the Grievant enjoyed administrative leave with pay status. The parties stipulated the phone logs (Joint Exhibit 11) accurately

depicted the Grievant's phone calls to the institution. And yet, the Grievant, testified he never called the institution one time.

**The Union's Position**

The Union opined the Employer did not have just cause to remove the Grievant. In support of this premise, the Union posed a procedural defect claim, and refuted the essence of each imposed charge.

The pre-disciplinary hearing was not conducted in a timely fashion. The pre-disciplinary notice was dated July 21, 1995, and yet, the Employer did not issue the notice until August 25, 1995, while the hearing itself did not take place until August 28, 1995. As such, the Employer was in no hurry to discipline the Grievant, and took an unreasonable and inordinate amount of time to conclude the disciplinary process.

What makes the above summary even more suspect is a series of events which led to the eventual issuance of the pre-disciplinary notice. The record clearly indicated of the disputed incident ended on or about March 29, 1995. The warden, moreover, ordered a pre-disciplinary hearing on April 6, 1996 and indicated the investigation of the incident had concluded.

Nothing in the record indicates the Grievant was unavailable to attend a pre-disciplinary hearing upon his departure from the hospital on April 12, 1995 to July 21, 1995, the date the notice of pre-disciplinary hearing was issued. Throughout this period, the Grievant, as evidenced

by the call-in log (Joint Exhibit 12), called the control center and noted administrative leave as his reason for being absent.

The Employer's attempt to tarnish the Grievant's credibility regarding his call-in attempts proved to be unpersuasive. The Grievant never ceased making his required phone calls. He clarified his lapse of memory by distinguishing phone calls to Tom Wing, Business Administrator, or Odell Woods, Deputy Warden, as opposed to those made to the control center. Either individual told him not to call again, as such, his testimony was indeed consistent. He did not call them but continued to call the control center.

The Employer could have required the Grievant's presence at an earlier stage of the process; he was available. He picked up his paycheck at the facility every two weeks while on administrative leave. As such, the Employer could have left a message at the control center instructing that he contact a management representative.

Nothing in the record indicates the Grievant was not available. The Employer failed to present any evidence to support this contention. Neither the Employer nor the Grievant asked for any continuance.

The tardy initiation of the disciplinary process cannot be justified by any impediments to an investigation. The Employer never alleged there were any witness cooperation problems. Also, there was never an on-going criminal investigation to impede the disciplinary process. Trooper

Smith's report dated February 27, 1995 (Employer Exhibit 20) indicated further criminal investigation had been ruled out.

A number of arguments were presented as rebuttal to the Inmate Jackson incident. The Union claimed the fact the Grievant failed to take a full set of vitals was not the determining factor. Rather, the focus of the analysis should rest on the medical staff's past practice of taking less than a full set of vital signs. Once established, this practice clearly absolved the Grievant's actions as they related to the Jackson incident. It was alleged that LPN's observe an inmate and then determine what vitals are needed based on their best judgment of the situation.

The Union admitted that at one time prior to the incident in dispute, a full set of vitals was required. The Grievant and a former LPN at the facility, Gary Williams, testified the policy led to a backlog of inmates to be seen by the staff. Stephen Fleshman, the former Health Care Administrator, told the nurses to use their own judgment in deciding when to take vitals. This policy change was in direct violation of the Warden's direct order dealing with the taking of complete vital signs.

Testimony and documents (Union Exhibits 2 and 3) introduced at the hearing clearly support the view that a full set of vital signs was rarely deemed necessary. It, moreover, appears that physicians violated the formal policy as well as other staff members. A glaring example of this dual standard was evidenced by reviewing entries in charts authored by

Lustgarden, one of the Grievant's chief accusors. Her notes did not evidence that she took a full set of vital signs.

Interestingly, no other nursing professional had been disciplined for engaging in similar practices. If such an ironclad policy was, indeed, enforced, why were none of the other medical staff disciplined? Caine noted Lustgarden would have brought such a violation of policy and procedure to her attention. No one was ever able to justify Lustgarden's fixation on the Grievant's conduct.

The Grievant emphasized he used his best professional judgment when he handled Inmate Jackson's situation. He did not order an x-ray because this is an intervention outside of the scope of his professional authority. The Grievant, moreover, did not order a nebulizer because he was concerned about possible adverse drug interaction. Also, the existence of a standing order only provides authorization for treatment but does not necessarily require it.

Some of the charges contained in the pre-disciplinary notice seem to lack clarity regarding the roles played by RNs and LPNs at the facility. The Grievant merely took those actions he felt appropriate based on his professional judgment. He should not be held responsible for assessments or responsibilities outside his scope of authority.

Inmate complaints (Employer Exhibit 12) introduced to establish a pattern of negligent behavior were deficient and inappropriate. The number of complaints introduced do not represent a significant

percentage of the total number of inmates seen by the medical staff. The vintage of the complaints also raised some suspicion concerning their relevance. Some were written approximately four years prior to the incident under consideration. Complaints of this sort, moreover, are somewhat commonplace and are often denied upon further review.

With respect to Inmate Spears' incident; the Union argued the Employer failed to support the charges used to support the removal. Evidentiary shortcomings, failure to apply the proper standards of conduct and unequal treatment were used to rebut the Employer's assertions.

The Grievant responded within a reasonable period of time to the emergency call in 6-Dorm based on the circumstances surrounding the incident. Finnegan merely advised the Grievant that the inmate was non-responsive; and thus, was not told the nature of the medical emergency. At the time of the call, moreover, the Grievant was charting a head injury case.

The record clearly indicates the elapsed time was relatively brief from departure to eventual declaration of death. The Grievant, more specifically, left the infirmary at approximately 2:50 p.m. and Lustgarden announced the Grievant dead at 3:00 p.m. A relatively short period of time based on the circumstances.

While attempting to respond to the call, the Grievant faced a number of obstacles. He had difficulty maneuvering the gurney by

himself. This difficulty probably prompted the perception by some that the Grievant was "walking slow."

The Grievant's response time was further frustrated because Finnegan failed to trigger the normal medical emergency procedure. Instead, he triggered a Signal #3 which created confusion and caused a delay at the crash gate. The Grievant testified the control room attendant was occupied, and did not notice the Grievant was waiting to be let through. Finnegan's response, moreover, caused mass confusion because officers were responding to the Signal #3. The Signal #3 caused the Grievant additional difficulty. He approached 6-Dorm with some caution because his training taught him the situation had to be controlled prior to rendering medical attention.

The Grievant admitted he did not arrive on the scene with the proper equipment. He emphasized this circumstance was not his fault. When he grabbed the gurney, he assumed the third shift nurse had done the necessary inventory. This procedure was implemented to avoid searching for equipment during an emergency situation.

A similar situation was referenced in support of an unequal treatment charge. Judy Remy, an LPN, received a written reprimand for responding to a medical emergency without any equipment. The fact that she was ordered to respond did not cause her situation to be any different than the one realized by the Grievant.

The Grievant arrived on the scene without observing CPR being performed. As such, he was not obliged to initiate the process. This version of the incident was supported by a statement (Employer Exhibit 6) authored by Sergeant Cochran. In that statement, Sergeant Cochran asked the Grievant several times, "Do you want to start CPR?" He never asked the Grievant whether the Grievant wished that CPR should be continued. Cochran's statement and the fact the Grievant did not hear from anyone else that CPR was performed prior to his arrival, caused him to believe that CPR had never been initiated.

The Grievant based his judgment not to initiate CPR based on the totality of the circumstances he confronted upon his arrival onto 6-Dorm. Spears appeared to be cold, clammy to the touch, eyes were fixed and dilated, his skin was ashen or blush, and there was no pulse or respiration. His conclusion that Spears "was gone" was supported by Lustgarden's assessment that lividly had set in at 3:00 p.m. The Franklin County Coroner Report (Joint Exhibit 10) further supported the Grievant's judgment. It indicated the official cause of death was a massive heart attack which caused instant death.

Other medical staff involved in similar situations failed to administer CPR. And yet, none of them suffered similar forms of discipline.

The very contents of the removal order indicate the defective nature of the charges specified in support of removal. It states the

Grievant failed to make proper assessments in accordance with specified policies and procedures. And yet, the Nurse Practice Act (Joint Exhibit 11) requires LPNs to observe, unlike RNs sanctioned to make assessments. The Grievant, therefore, was removed for conduct he is not legally allowed to perform.

## The Arbitrator's Opinion and Award

From the evidence and testimony introduced at the hearing, a complete and impartial review of the record including pertinent contract provisions, it is this Arbitrator's opinion that the Employer had just cause to remove the Grievant. The Grievant clearly violated policies and procedures surrounding proper interventions and acted in a fashion which contradicted his role of providing proper inmate care in accordance with his professional nursing standards. (Joint Exhibit 11).

The incident involving Inmate Spears, when viewed independently of the Inmate Jackson charge, serves as a sufficient justification requiring removal. He clearly violated Standards of Employee Conduct #8 (failure to follow post orders, administrative regulations and/or written policies and procedures), and #9 (failure to carry out a work assignments or the exercise of poor judgment in carrying out an assignment).

The record exposes the Grievant's intentional unwillingness to urgently respond to a medical emergency. A number of pertinent sources lead to this conclusion. Finnegan had to make a number of calls prior to

the Grievant's eventual response. The situation became so critical, as a consequence of the Grievant's tardy response, that he eventually had to call a Signal "3. This approach was utilized to forestall a potential riot in 6-Dorm, and was initiated in a vain attempt to attain some form of response. None of these actions were refuted and were supported in statements authored by Finnegan and several inmate witnesses.

Finnegan's testimony regarding the duration of the episode is viewed as highly credible. His testimony was consistent and explicit in terms of the various actions he engaged in, when they took place and their duration. It appears it took the Grievant in excess of eight (8) minutes to respond to a known emergency call. Any attempt to mitigate the duration proposed by Finnegan by relying on activities engaged in to help the inmate with a head injury appears misplaced. The Grievant, himself, testified the total time it took to accomplish this task was minimal, at best.

This Arbitrator is somewhat troubled by several references contained in the brief regarding this segment of the dispute. Even if Finnegan only told the Grievant that the inmate was non-responsive, an assertion I do not agree with, it is as if such a comment would justify the Grievant's tardy response. An argument, in my view, which provides an unwarranted back drop to the entire sequence of events which followed Finnegan's initial call. A non-responsive inmate is viewed by any reasonable person, let alone a professional nurse, as requiring immediate

attention because of a potential life threatening episode. The Union, moreover, implied that any tardy response was due to the Grievant's problems of maneuvering the gurney. The Grievant never raised this argument himself; yet the question was posed to other witnesses.

Two fellow employees provided testimony which supported the Employer's tardy response hypothesis. Vickie Burns, a Dental Technician, and Finnegan both viewed the Grievant's response to the emergency call. They concluded the Grievant was not walking with an extreme sense of urgency.

The Grievant's response was not only tardy and non-responsive; his response was deficient because he failed to respond with the proper medical equipment. This inaction violated the Policy and Procedure dealing with the Emergency Equipment Checklist (Joint Exhibit 5(g)). He alleged the equipment was not available, but nothing in the record indicates he looked for any necessary equipment. The record, moreover, fails to provide any support for this assertion. Blame, in terms of mere allegations, was placed on different personnel which further subverts this claim. In the Investigatory Report (Joint Exhibit 2), the Grievant places blame on the Health Care Administrator, while in other portions of the record blame is placed on the third shift.

Not surprisingly, the Grievant never takes any responsibility for his share of the controversy. He implicates himself, however, during the following exchange contained in the Investigatory Report:

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Q: Did you take medical equipment to 6-Dorm for this medical emergency?

A: The equipment was supposed to be on the gurney but it was not. I didn't realize there was no medical equipment until I got to 6-Dorm. . .

***

His actions are clearly viewed by the Arbitrator as reprehensible and negligent. No one should depart for an emergency situation without securing the proper equipment even if someone failed to provide the proper inventoried goods.

This procedural flaw also provides potential insight regarding the lack of CPR intervention, or another intervention attempt, once the Grievant arrived in 6-Dorm. Obviously, the range of intervention alternatives becomes limited if requisite equipment is not taken to the scene.

The Grievant clearly exercised poor judgment and failed to follow policies and procedures when he arrived on the scene. He also failed to initiate CPR on his own and/or failed to allow staff and/or inmates to initiate and/or continue CPR. He failed to render proper emergency care in accordance with an existing policy (Joint Exhibit 5(b)). This policy

requires a nurse to maintain the ABC's utilizing BLS (Basic Life Support) when required to:

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1) establish and maintain a patent airway.
2) support pulmonary ventilation via artificial breathing.
3) support cardiac perfusion with proper chest compressions.

***

The emergency situation in question clearly calls for the above interventions. No judgment is necessary nor required. If the Grievant arrived on the scene and he did not perceive any ongoing CPR intervention, the previously described policy requires it. If the circumstances upon arrival indicated that CPR had been initiated and stopped, or was on-going, the Grievant, himself, indicated he was ethically, professionally and procedurally bound to continue the process. Failure to initiate CPR under either scenario, in my view, should lead to a severe disciplinary outcome.

Reliance on Sergeant Cochran's testimony in support of the Grievant's version is totally misplaced. Cochran clarified his written statement (Employer Exhibit 6) at the hearing. He asked the Grievant if CPR should be continued after a break had been taken for a pulse reading. He never asked the Grievant if he should start CPR. Cochran's version is supported by testimony provided by Finnegan and several inmate witnesses. The inmates attempting to revive the inmate asked

why he was not continuing the process. Once the inmate was placed on the gurney, an outburst of inmate torment regarding his superficial, or non-existent, attempt to revive the inmate flowed through the dorm. Thus should have sent the Grievant a clear signal regarding that some form of resuscitation effort had been engaged in prior to his arrival.

The Grievant, himself, indicated some confusion surrounding the inmate's condition. When he arrived he observed the inmate was on his side and had aspirated; a potential sign of death. Yet, he asked the inmates to place the inmate on his back "thinking he was still alive" (Employer Exhibit 23). If that was the case, he had every reason to initiate CPR.

Another devastating procedural and professional error dealt with the Grievant diagnosing the inmate's demise. An assessment clearly outside his legal and professional domain. Ironically, the Union attempted to minimize the charges levied against the Grievant by distinguishing between legal judgments as opposed to illegal assessments. Here, however, the Union was inclined to conclude that the Grievant's judgment was proper and authorized. An ill-advised conclusion neither supported by the record nor the Ohio Revised Code. He had no business prematurely rushing to "judgment" without engaging in prior authorized activities. This proposition should have been adhered to regardless of the subsequent validation made by Lustgarden and the Coronor. He clearly made an unauthorized assessment when he concluded the

Grievant "was gone." The other procedural requirements raised by the Employer were not assessments but judgments clearly within the Grievant's purview.

The various unequal treatment comparisons raised by the Union did not provide sufficient proofs regarding the similarity of circumstances. Hawkins did not initiate CPR but took vitals and may have been a contract employee. Remy did not know where to go and had one of the charges dropped for some unknown reason. Williams arrived on the scene after someone had already initiated CPR.

The procedural defect raised by the Union was not supported by the record. The Grievant's uncertain health condition and the uncertainty involving the criminal investigation justified the delay.

As I previously noted, this Opinion and Award regarding the Spears' portion of the case eliminates the necessity of an analysis regarding Inmate Jackson's episode. The matters identified are so thoroughly unjustified that they, on their own, clearly support the Grievant's removal.

**Award**

The grievance is denied.

December 27, 1996

Dr. David M. Pincus
Arbitrator