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Labor Arbitrator
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IN ARBITRATION PROCEEDINGS PURSUANT TO THE

COLLECTIVE BARGAINING AGREEMENT BETWEEN THE PARTIES

In the Matter of

SEIU DISTRICT 1199

and

OHIO DEPARTMENT OF YOUTH SERVICES

Case No. 35-04-20110528-0017-02-11

Grievant: Adrienne Welfle

ARBITRATOR'S OPINION AND AWARD

This Arbitration arises pursuant to the collective bargaining agreement ("the Agreement") between the Parties, SEIU District 1199 ("the Union") and Ohio Department of Youth Services ("the Department") under which Susan Grody Ruben was appointed to serve as sole, impartial Arbitrator. The Parties agreed there are no procedural or substantive impediments to a final and binding decision by the Arbitrator.

Hearing was held January 31, 2013 at the Indian River Juvenile Correctional Facility in Massillon, Ohio. Both Parties were represented by advocates who had full opportunity for the examination and cross-examination of witnesses, the introduction of exhibits, and for argument. Both Parties submitted post-hearing briefs.

APPEARANCES:

On behalf of the Union:

Casey Whitten-Amadon, Esq., Administrative Organizer, SEIU District 1199, 1395 Dublin Rd., Columbus, OH 43215.

On behalf of the Department:

Larry L. Blake, Labor Relations Officer, Ohio Department of Youth Services, 30 W. Spring St., Columbus, OH 43215.

ISSUE

Did the Department have just cause to terminate the Grievant's employment? If not, what is the appropriate remedy?

RELEVANT PORTIONS OF THE PARTIES' COLLECTIVE BARGAINING AGREEMENT

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ARTICLE 8 – DISCIPLINE

8.01 Standard

Disciplinary action may be imposed upon an employee only for just cause.

8.02 Progressive Discipline

The principles of progressive discipline shall be followed. These principles usually include:

A. Verbal Reprimand
B. Written Reprimand
C. A fine in an amount not to exceed five (5) days pay
D. Suspension
E. Removal

The application of these steps is contingent upon the type and occurrence of various disciplinary offenses.

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FACTS

The Grievant was employed with the Department since May 30, 1995. She was removed from her position as a Nurse I for allegedly failing to provide proper medical care to a youth inmate on February 11, 2011.

The April 6, 2011 Amended Notice of Pre-Disciplinary Conference provides in pertinent part:

> **During the course of the investigation, the allegation that Nurse Adrienne Welfle failed to provide proper medical care to Youth [S] by not having him transported to the hospital by ambulance is substantiated.**
>
> - ***Dr. Bradley stated that based upon Youth [S's] symptoms at the scene and clinic along with the severity of [S's] injuries, this warranted that he be transported to the hospital by an ambulance.***
> - ***Dr. Bradley stated that [S's] statement that he does not remember even the first punch [from another youth inmate] and that he "woke up" in the clinic with people asking him questions implies that there was a lost[sic] of consciousness. The fact that staff reported that [S] appeared to be disoriented, dazed, and unsteady on his feet given this degree of closed head injury could also imply a mild concussion.***
> - ***Charles Ford, Program Deputy indicated that the Emergency Room Doctor indicated that Youth [S] should have been sent out via squad due to him losing consciousness.***
> - ***YS Tersigni and APC Glennon stated that Nurse Welfle stated that she did not believe that an ambulance was necessary because***

Youth [S] was faking when he had an audience. Although during her interview she stated that she assessed that an ambulance was not necessary because [S] did not sustain life threatening injuries.

- ***Youth [S] stated in his interview that he lost consciousness during this incident.***
- ***Several staff and youth stated that Youth [S] appeared to be disoriented and dazed.***
- ***Principal Korzan and some youth reported that Youth [S] was unconscious because he was unresponsive.***
- ***Video evidence shows that while back in the intake area, Youth [S] has difficulty maintaining balance when he stood up and that Nurse Welfle had to assist him.***

During the course of the investigation, the allegation that Nurse Adrienne Welfle failed to provide proper medical care to Youth [S] by not properly assessing him at the scene is substantiated.

- ***Nurse Welfle admitted that she did not bring the emergency medical bag when she responded to the medical emergency.***
- ***Nurse Welfle admitted that she was limited in her assessment of Youth [S] because she did not have the emergency medical bag.***
- ***Jackie Carter stated that nurses are supposed to bring the emergency medical bag with them as they are responding to the scene. She stated that the bag has equipment that could assist the nurse. In addition, time is an important fact in an emergency situation and there might not be time for the nurse and/or someone else to go and get the bag and bring it to the scene.***
- ***Nurse Welfle admitted that she did not ask staff or youth at the scene for any information to aid in her assessment of Youth [S].***
- ***Jackie Carter stated that the nurse is supposed to survey the scene and then focus on the youth. If the youth appears to be dazed and/or disoriented then it is best nursing practice for the nurse to ask the staff or any other by-standers what happened and if the youth passed out.***

During the course of the investigation, the allegation that Nurse Adrienne Welfle falsified documentation on the Youth Injury Assessment Form (YIAF) is substantiated.

- ***Nurse Welfle admitted that she indicated on the YIAF that Youth [S] did not lose consciousness when in fact she had not asked Youth [S] if he lost consciousness. She stated that she didn't ask as him[sic] as she did not want to put words in his mouth.***

- ***Nurse Welfle admitted that she indicated on the Youth Injury Assessment form that Youth [S] did not lose consciousness when in fact she had not asked staff or youth at the scene if he lost consciousness. She stated that she thought that someone would approach her if he had indeed lost consciousness.***

The May 24, 2011 Order of Removal provides in pertinent part:

On or about February 11, 2011, you failed to provide medical care to a youth when you did not have the emergency medical bag in order to provide a thorough assessment of a youth at the scene, you did not assess the scene by asking pertinent questions from the youth and witnesses and you also did not have youth transported out by ambulance to the hospital.

Your actions are a violation of the following Policy 103.17 Rule(s) effective July 8, 2009, specifically:

Rule 5.01P	**Failure to follow policies and procedures**		
	Specifically:	**403.13 –**	**Dental Services**
		403.13.04 –	**Nursing Protocol for Screening, Assessment & Stabilization of Dental Conditions**
		403.20.01 --	**First Aid and Emergency Care**
		403.17 --	**Medical Consultation and Hospitalization Including Central Medical Facility (CMF)**
Rule 5.12P	**Actions that could harm or potential[sic] harm an employee, youth, or a member of the general public.**		
Rule 5.28P	**Failure to follow work assignment or the exercise in poor judgment in carrying out an assignment** **Failure to perform assigned duties in a specified amount of time or failure to adequately perform the duties of the position or the exercise in poor judgment in carrying out an assignment.**		

Due to the seriousness of the infraction, you are hereby removed from your position as a Nurse effective May 24, 2011.

The May 28, 2011 grievance provides in pertinent part:

> **Grievant was unjustly removed from her position as a Nurse I at IRJCF on 5/24/11. Management did [not] follow tenets of just cause nor apply principles of progressive discipline.**

POSITIONS OF THE PARTIES

Department Position

The Department had just cause to terminate the Grievant's employment. The actions of the Grievant during the February 11, 2011 incident involving Youth [S] were so egregious that it is evident she presents a liability to the Department and should no longer serve as a Nurse I.

The Grievant's actions and inactions constituted patient abuse and neglect. The Grievant failed to provide good patient care by failing to use standard nursing practices and technique. The Grievant's conduct endangered the health of a youth.

It was medically required that the youth be transported by ambulance. He had suffered a closed head injury, multiple jaw fractures, and was bleeding from the mouth and right ear. He needed ambulance transportation with monitoring equipment and staff to get him from the facility to the local emergency department. In using the institutional vehicle, had there been any traffic delay or if the youth experienced difficulty breathing or any additional trauma, the youth's medical condition would have been severely threatened.

The Grievant had the responsibility for the health of the youth. The Grievant was expected to use sound professional judgment in addressing the emergent needs of the youth. Given the fact the Grievant failed to maintain the required duty of care, the termination was neither arbitrary nor capricious.

The Grievant was removed for just cause pursuant to Article 8. The discipline imposed was commensurate with the offense and was progressive in keeping with the Department's rules and practice.

Union Position

The Department did not have just cause to terminate the Grievant. The Grievant acted quickly and professionally to diagnose and treat Youth [S] on February 11, 2011. The overreaction of nonmedical personnel led to the illogical and punitive decision to terminate the Grievant. The investigation was not fair or sufficient, the case against the Grievant was not proven, the Grievant did not have notice her actions were prohibited, and any alleged violations did not justify removal. The Department violated Article 8.01 – just cause; and Article 8.02 – progressive discipline.

Prior to this incident, the Grievant had never been investigated by the Board of Nursing; nor did she have any discipline on her personnel record. She had never been disciplined for an incorrect diagnosis during her sixteen years with the Department.

With regard to the Grievant's medical treatment of Youth [S] on February 11, 2011, Investigator Nina Belli interviewed eight staff members who had been

present during or shortly after Youth [S] was struck by Youth [D]. Seven did not see Youth [S] lose consciousness. Video evidence also never shows Youth [S] being unconscious. Three of four youths did state Youth [S] was knocked unconscious, but these statements cannot be adequately trusted because they were questioned almost a month after the incident and because they had been about ten feet away from Youth [S].

The only staff member who said he saw Youth [S] unconscious was Principal Tony Korzan, a former paramedic, who assessed Youth [S] as unconscious because "there was no movement" and Youth [S] did not respond to Principal Korzan's questions. There are a few problems with Principal Korzan's testimony, however. First, he did not roll over Youth [S] to look at him. He failed to help him up, look at his pupils, or take his pulse. Second, Principal Korzan's testimony may have been affected by the Department's subsequent investigation and findings. For example, in his March 7, 2011 interview, Principal Korzan stated he "might have informed Welfle that [Youth [S]] was unconscious for a short period of time. At the arbitration hearing almost two years later, Principal Korzan testified he definitely informed the Grievant. When questioned about this discrepancy, Principal Korzan testified he "disguised" the truth from the investigator to protect the Grievant's job. The bizarre conclusion the Principal asks us to draw was he came out of retirement to testify on management's behalf, he changed his testimony to the detriment of the Grievant, and that he had earlier lied to protect the Grievant's job.

It also is unclear whether Principal Korzan correctly remembered the events of February 11, 2011, even during his initial interview. For example, in his interview, he stated Youth [S] was "lifted up and taken to medical." However, in the video, it is clear the youth stood based on his own strength with the Grievant simply having a hand on the youth's arm. When questioned about this discrepancy, Principal Korzan had no answer. Also, he stated in his interview he "believed it was two Youth Specialists" that picked the youth off the ground. This statement is proven false by the video; no Youth Specialists were in proximity when the youth stood on his own strength. Principal Korzan's testimony cannot be trusted in determining whether the youth was uconscious.

Youth [S] stated in his February 24, 2011 interview that he was blacked out the entire time between the gym and the "medicare place," but it is uncertain whether this statement can be trusted. First, within ten or fifteen minutes of the assault, the youth told both the Grievant and Accident Prevention Coordinator Edward Glennon that he had been "jumped." He seemed coherent and responsive to both of them. Second, there was no concussion in the medical report that would explain a memory loss. Third, the youth is seen on the video talking, walking straight, and navigating curves with minimal assistance. Fourth, the youth seems to remember an inordinate amount about Youth Specialist Tersigni, including that Tersigni "knew [the youth] had blacked out." In the thirteen days between the incident and his interview, the youth could have adjusted his story to what was told to him. Many youth exaggerate injuries,

especially if they receive special treatment or pain medication due to their exaggeration.

The Grievant responded to the February 11, 2011 emergency in a quick, professional, and appropriate manner. When the Grievant arrived at the scene, she testified she saw Youth [S] on his hands and knees, as is corroborated by the video. He was moving around on the ground while Principal Korzan was standing over him with his hand on his back telling him to "stay down." The staff told the Grievant the youth "got punched," but otherwise were talking among themselves about whether it was gang related. Principal Korzan said he "might have told Nurse Welfle that Youth [S] lost consciousness for a short while," yet no one else standing in the area heard him say this.

After being told Youth [S] "got punched," the Grievant approached the youth on the ground and talked to him, as is corroborated on the video. First, she asked him what happened, and he responded he had been "f----- hit in the face," and that "he jumped me." Second, the Grievant asked him if he could stand, and he said, "yeah." Third, she lightly placed her hand on his back and arm and he then stood up on his own strength. Fourth, she placed his arm in her own where she could feel his pulse and looked briefly at his eyes. She was looking for unsteady pupils, which would indicate a concussion, but his eyes looked fine. Fifth, after assessing he could stand without difficulty and was responding satisfactorily, she decided to walk him to Medical, where she could assess him in more depth.

The Department has attempted to show that because only eighteen seconds passed between the Grievant arriving on the scene and Youth [S] standing up, she could not have made a proper diagnosis. This conclusion is illogical and unsupported. Instead of leaving the youth in the cold February mud, the Grievant decided to get him to the warm Medical office where she could diagnose him in a more medically conducive environment. Her diagnosis did not end when she asked if he could stand up; it continued as she watched how he stood. The diagnosis continued as she felt his pulse while he was standing, it continued while she checked his eyes after he stood, it continued as she asked him questions as they walked, and it continued as she stayed near him and monitored him until he left for the hospital.

During their walk, the youth never wavered or lost his balance. The Grievant conducted the Alert and Oriented ("A&Ox3") test on the youth. He answered correctly and began to show frustration with the repetition of questions. His quick responses showed the Grievant the youth was not concussed or suffering from brain injury.

When the youth reached the infirmary, the Grievant wiped the blood off his face. She noticed a swelling along his jaw line, as well as a divided tooth line, and correctly diagnosed his jaw may have been broken. She also noticed blood in his ear, which she did not clean out for fear he had a ruptured eardrum. She told Mr. Burns that the youth needed to go to the hospital for a possible fractured jaw and a potential ruptured eardrum.

After determining the youth needed to go to the hospital, the Grievant took him to intake to get him to a van. The youth navigated the stairwell to intake without any problem. During this time, the youth's pain seemed to increase, which the Grievant expected once his adrenaline had decreased from being punched. The youth began to yell whenever someone came near. The Grievant speculated the youth's yelling did not arise solely from his pain.

The intake video shows the Grievant cared for the youth the entire time he was there. She sat with him, rubbed his back, talked to him, and told him to catch his saliva in a shirt because spitting hurt his jaw. When the van was ready, the Grievant and Youth Specialist Tersigni helped the youth walk him to the van.

At all times between 11:16am and 11:49am, the Grievant's care was quick, careful, and professional. She reacted to what she saw, what she was told, and how the youth was acting. In the end, she was correct that the youth had a broken jaw and she correctly sent him to the hospital.

The over-reaction of non-medical personnel to the youth's injuries led to the harsh decision to terminate the Grievant. Youth Specialist Tersigni's over-reaction to the youth's condition began the second-guessing of the Grievant's judgment call to send the youth to the hospital by van instead of by ambulance. Youth Specialist Tersigni testified he was worried about the youth's "gurgling" and "screaming." Youth Specialist Tersigni admitted he is not medically educated, and his only medical training is related to CPR. Youth Specialist Tersigni testified he had heard from Youth Specialist Fite that the youth had blacked out. Youth Specialist Fite, however, stated he "did not see him lose

consciousness." The only staff person who claimed to observe the youth unconscious was Principal Korzan; Youth Specialist Tersigni never mentioned getting the information from Principal Korzan. Perhaps Youth Specialist Tersigni assumed the youth had been unconscious based on observing the youth's injuries.

The misinformation given to the ER doctor about the youth having been unconscious must have been given by Youth Specialist Tersigni. When asked at the arbitration, "Did you tell the ER doctor that Youth [S] was blacked out?" Tersigni answered, "I may have," with a sheepish grin. No other person was in contact with the ER doctor. The Grievant had written the youth had not lost consciousness and was A&Ox3. Whatever Tersigni told the ER doctor, it prompted the ER doctor to telephone the Grievant. The ER doctor was furious and asked why the youth had not been sent by ambulance if he had lost consciousness. The Grievant told the ER doctor the youth had not lost consciousness.

The fact that Investigator Belli never interviewed the ER doctor, the ER nurse, or anyone else who treated the youth at the hospital makes it difficult to determine what information gave the ER doctor a temper. The treatment given by the ER doctor was the same as the Grievant prescribed – jaw surgery and pain medication. The ER doctor's call, prompted by the uninformed YS, set off a punitive investigation with a pre-formed conclusion. The investigation attempts to portray the Grievant as nonchalant and uncaring, but the video evidence and the testimony show the opposite. The evidence shows a nurse who responded

quickly to diagnose, care for, and transport an injured youth to the hospital for quick treatment.

Neither Central Office Medical Director Dr. John Bradley nor Nursing Director Jacqueline Carter witnessed the injured youth. Dr. Bradley did not read the entire interview with the youth, even though he based his conclusion on the interview. He stated there was no reason to doubt the youth's statement about "waking up" in the clinic, yet he admitted patients will exaggerate pain and sickness for various reasons.

Investigator Belli concluded the Grievant "failed to provide proper care" partially on the basis that "Charles Ford, Program Deputy indicated that the Emergency Room Doctor indicated the youth should have been sent to the hospital in an ambulance due to him losing consciousness." Considering that this was one of the main prongs of her conclusion, it would have been a better idea to interview the ER doctor rather than report an "indication" of one person on the "indication" of another.

Seven of the eight staff people Investigator Belli interviewed said they had not seen the youth lose consciousness. Instead of crediting these seven, she chose to credit Principal Korzan, without pointing out that his memory of the incident was questionable. She never pointed out Principal Korzan's memory of the youth being "lifted up by two YS's" was inaccurate. She chose to discredit the Grievant by pointing out how the Grievant's statement about maintaining his balance conflicted with Operations Administrator Pritchard's statement about the youth staggering. Investigator Belli did not point out that the Grievant's

statement is consistent with the video evidence of the youth walking, while Operations Administrator Pritchard's statement is inconsistent with the video evidence.

Investigator Belli's interviews were untimely, and therefore, incredible. Her conclusion is partly based on her finding that "several youth" indicated Youth [S] had been knocked unconscious. These youths were interviewed nearly a month after the incident, however. Delaying investigatory interviews increases the likelihood that the interviews will be tainted by the biases of later gossip. Youth [S] was not interviewed until 13 days after the assault.

Investigator Belli was very selective with regard to choosing and interpreting the video evidence. She picked out a 3-second period that took place a half hour after the assault where she interprets the youth "having trouble maintaining his balance." Upon closer examination of the video, however, the youth simply is leaning toward the glass and turning his head toward the glass of an intake examination room. He clearly is looking at his reflection, which is readily apparent from the contrast of the bright intake room to the dark examination room. It is unsurprising the youth would want to look at his injuries in his reflection. The insufficiency and unfairness of the investigation violated Article 8.01 just cause.

The Department alleges the Grievant violated Emergency Dental Care Policy 403.13 and Nursing Protocol 403.13.04. Those policies do not require an ambulance to transport a youth in an emergency. The Grievant satisfied all conditions of 403.13 and 403.13.04.

The Department also alleges the Grievant violated 403.20.01 First Aid and Emergency Care, and 403.17, which states in pertinent part that "if a youth shall require emergency transport, the institution staff shall utilize '911.'" These policies do not contain criteria for requiring emergency transport. Accordingly, the Grievant did not violate these policies.

The Central Office witnesses admitted policy was not the driving factor behind the discipline. Nursing Administrator Carter testified a nurse is not mandated per policy to use an ambulance, but instead has discretion to make this decision. Dr. Bradley testified similarly.

The Grievant also did not violate Rules 5.12 and 5.28. Rule 5.12 forbids "actions that could harm or potentially harm an employee, youth, or a member of the general public." It is clear the Grievant took good care of the youth. She diagnosed his injuries correctly, recommended he go to the hospital, stayed with him, and cared for him the entire time. Her actions were not those that "could potentially harm a youth." In fact, her actions were the opposite of that. Rule 5.28 forbids "failure to follow a work assignment or the exercise of poor judgment in carrying out an assignment." Considering her observations, the Grievant's judgment and diagnosis were correct.

The Grievant had no notice her treatment of the youth and his transportation by van were forbidden. Nursing Administrator Carter testified many broken jaws had been transported by van, both to local hospitals and to the Central Medical Facility. These prior transportations were considered correct policy and were not disciplined.

Even if the Grievant had violated Rules 5.01, 5.12, or 5.28, the violations did not merit a termination. Central Office second-guessed the Grievant's judgment calls without any personal knowledge or observations. Two non-medical employees at the facility second-guessed her judgment calls regarding an ambulance. The youth was not harmed by the Grievant's care. Rather, he received good treatment from her, as well as a sound diagnosis.

It is easy to second-guess an employee in an emergency after the fact, but all of management's second-guessing comes with costs. Many of management's critiques would have slowed down the youth's diagnosis and treatment. If the Grievant had questioned all the staff around the youth, he would have been on his hands and knees in the mud longer. It is possible to argue an ambulance would have been better, but the Department can point to no specific policy or past practice that warned the Grievant of the consequences of exercising her judgment.

The Union requests the Grievant be made whole, including, but not limited to, full backpay, reasonable calculation of overtime, vacation, personal days, and sick days, and reimbursement of health care insurance costs. The Grievant should be offered the chance to retire as of September 2012 before the January 2013 changes to OPERS, as the Grievant would have been eligible. Her personnel file should be purged of all documents relating to her unjust termination.

ARBITRATOR'S OPINION

The Company has the burden of proving it had just cause to terminate the Grievant's employment. This consists of proving two criteria: 1) the Grievant did what she is accused of doing; and 2) termination is appropriate under all the circumstances.

1. <u>Whether the Grievant's Actions Violated Department Policy</u>

The core question is whether the Grievant violated Rule 5.12, which prohibits "actions that could harm or potentially harm…[a] youth…." Based on the record evidence, the Arbitrator finds that the Grievant's failure to determine if Youth [S] had lost consciousness after being punched by Youth [D] on February 11, 2011 violated Rule 5.12 because that failure could have "potentially harm[ed]" Youth [S] in a serious way.

The Grievant admits she did not question anyone who was on the scene at the time of the assault whether Youth [S] had fallen unconscious after being punched. She testified, "I didn't ask him or anybody if he'd lost consciousness." Rather, as she testified, Youth [S] "never said he was blacked out or unconscious." She also testified she did not ask anyone at the scene whether Youth [S] "had hit his head on the ground."

The Grievant further testified, "If a staff member told me [Youth S had] been knocked unconscious, I would've called an ambulance." The Grievant was the only medical staff person on the scene. She arrived at the scene shortly after Youth [S] was punched. By not asking any of the multiple staff persons on the scene when Youth [S] was punched whether he had hit his head and/or lost

consciousness after being punched, the Grievant did not have sufficient information to determine whether Youth [S] needed to be transported by ambulance when she sent him to the hospital.

The Grievant testified Youth [S] had a displaced jaw and blood "in his right ear" which she "couldn't tell if it was coming from his ear or his mouth." She testified there was "no possibility of him choking even though he had a broken jaw and misaligned teeth. He could breathe through his nose and mouth. You don't need your teeth to breathe." In contrast, Dr. John Bradley, Department Medical Director, testified the Grievant should have been concerned about Youth [S]'s "airway, and even if it's good now, how will it be in fifteen minutes?"

The Grievant further testified that "an ice pack would've been helpful; he could've gotten that in an ambulance." She did not give him an ice pack to take along with him in the van because "he couldn't have held it because he was in the belly chains." The van was staffed by only one Youth Specialist, who drove the van and was therefore unavailable to assist Youth [S] in any immediate way.

Finally, the Grievant testified she "made a medical decision" to send the Grievant to the emergency room by van, "and I stand by it."

Based on the record evidence, the Arbitrator finds the Grievant, by her actions and inactions on February 11, 2011 described above, violated Rule 5.12 – "Actions that could harm or potentially harm…[a] youth…."

2. <u>The Seriousness of the Offense</u>

The Grievant's failure to determine whether Youth [S] had fallen unconscious after being punched, which left her without the information to determine if an ambulance was needed, is a significant failure that put the youth in grave potential harm. Less-than-optimal split-second decisions made by Department staff in the middle of an active assault can be excusable. The situation, here, however, was not a less-than-optimal split-second decision made in the middle of an active assault. Rather, the Grievant arrived on the scene after the assault, and she spent approximately thirty minutes with the youth before placing him in the van. At no time during that thirty minutes did she make any attempt to gather the basic and fundamental information regarding whether he had lost consciousness after being punched.

The Union correctly points out the Grievant had no previous discipline, and therefore, should not be removed for this incident. The Arbitrator was disturbed, however, by the Grievant's failure to take any responsibility for her actions and inactions on February 11, 2011. Rather, she testified she stood by her decision to send the youth to the emergency room in a van. She stated this, despite her admission that if a staff member had told her the youth had fallen unconscious, she would have had him transported by ambulance.

The Grievant was the medical professional on duty. Part of her professional duty was to gather sufficient information to assess the seriousness of the youth's injuries. She failed to do this and has not acknowledged this failure. Accordingly, despite the Grievant's lack of disciplinary history, it was

within a zone of reasonableness for the Department to determine she should be removed from employment.

AWARD

For the reasons set out above, the grievance is denied. The Company had just cause to terminate the Grievant's employment.

DATED: May 1, 2013

Susan Grody Ruben
Susan Grody Ruben, Esq.
Arbitrator