ARBITRATION PROCEEDING PURSUANT TO
COLLECTIVE BARGAINING AGREEMENT BETWEEN THE PARTIES

In the Matter of	◆	
	◆	
SEIU DISTRICT 1199	◆	
	◆	Arbitrator's
and	◆	Opinion and Award
	◆	
OHIO DEPARTMENT OF REHABILITATION AND CORRECTIONS	◆	
	◆	
	◆	
Grievant: Gertrude Achankeng	◆	
Case No. DRC-2017-03544-11	◆	

This Arbitration arises pursuant to the collective bargaining agreement ("the Agreement") between the Parties, the SEIU DISTRICT 1199 ("the Union") and the OHIO DEPARTMENT OF REHABILITATION AND CORRECTIONS ("DRC" or "the State") under which Susan Grody Ruben was appointed to serve as sole, impartial Arbitrator. Her Award shall be final and binding pursuant to the Agreement and pursuant to stipulation of the Parties.

Hearing was held August 23, 2018. Both Parties had advocates who had full opportunity to introduce oral testimony and documentary evidence, cross-examine witnesses, and make argument. Both Parties filed post-hearing briefs on October 12, 2018.

APPEARANCES:

On behalf of the Union:

Peter J. Hanlon, SEIU District 1199 Representative, Columbus, OH.

On behalf of DRC:

Emily Paine, ODRC Labor Relations Officer 3, Columbus, OH.

ISSUE

Was the removal of the Grievant for just cause? If not, what shall the remedy be?

RELEVANT SECTIONS OF THE AGREEMENT

. . .

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

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

…

8.03 Pre-Discipline

Prior to the imposition of a suspension or fine of more than three (3) days, or a termination, the employee shall be afforded an opportunity to be confronted with the charges against him/her and offer his/her side of the story. This opportunity shall be offered in accordance with the "Loudermill Decision" or any subsequent court decisions that shall impact pre-discipline due process requirements.

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FACTS

The Grievant, Gertrude Achankeng, R.N., was hired by the State on February 2, 2009. At the time of her September 12, 2017 removal, her position was Nurse 1.

At the time of her removal, the Grievant had active discipline – a written reprimand issued August 31, 2016 for violation of Rule 8.[1]

[1] According to DRC, the Grievant failed to communicate information that caused a scissor count by the incoming shift to be inaccurate. The Grievant disputes this, but the written warning was not grieved.

The Grievant's Notice of Removal, dated August 15, 2017, provides in pertinent part:

> …you are being issued a Removal…for the following infractions:
>
> Rule 8 Failure to carry out a work assignment or the exercise of poor judgment in carrying out an assignment.
>
> Rule 38 Any act, or failure to act, or commission not otherwise set forth herein which constitutes a threat to the security of the facility, staff, any individual under the supervision of the Department, or a member of the general public.
>
> Rule 41 Unauthorized actions or a failure to act that could harm any individual under the supervision of the Department.
>
> Supporting Facts:
>
> On February 3rd, 2017, you failed to initiate or assist with the care of a patient that was suspected to have fallen. You delayed retrieval of privacy curtains and emergency equipment by remaining in the area after the initial fall occurred.

The Union filed the instant grievance on September 13, 2017. It provides in pertinent part:

> Statement of Grievance: Grievant was removed/terminated from her position as an RN at Pickaway Correctional Institution on September 12, 2017 without just cause.
>
> Resolution Requested: Make grievant whole in every way

including, but not limited to reinstating grievant back into her RN position at Pickaway Correctional Institution, removing all Discipline from her record, reimburse all back pay and benefits, with continuation of seniority, and reinstate grievant's good days and schedule.

POSITIONS OF THE PARTIES

DRC Position

DRC had just cause to terminate the Grievant's employment. The Grievant failed to provide basic nursing care to patient/inmate TW, who died on February 3, 2017 while under the care of the State. Though the Grievant found TW unresponsive, face down on the floor, she provided no treatment for nine minutes. The Grievant did not check TW's airway, breathing, or circulation. She did not check his vital signs and she did not start CPR. Instead, she verbally encouraged him to get up. She finally left the unit to retrieve an Automated External Defibrillator ("AED").

A Rule 8 violation carries recommended discipline of a 2-day fine, a Rule 38 violation a 5-day fine or removal, and a Rule 41 violation a 5-day fine or removal. Here, removal is appropriate because the Grievant failed to meet the nursing standard of care.

The Grievant offered no reasonable excuse for her failure to act. She testified she responded to TW as she had many times before, verbally requesting he get up from the floor.

Despite the Union's contention that the Grievant was assessing the scene to ensure it was safe, the Grievant offered no testimony in support of this theory. The Grievant provided no valid reason for her failure to check TW's vital signs.

To the extent the Grievant tried to excuse her failure to act during her arbitration testimony, she alleged there was insufficient room to assess the patient. The video evidence, however, belies this claim.

Warden Charles Bradley testified the Grievant was not fired for the death of TW. Rather, "[h]er response was what triggered the investigation, her response and action or lack of response."

To the extent the Union contends a corrections officer on the scene should have performed CPR, Warden Bradley explained a CO defers to medical staff when they are available.

DRC Director of Nursing Michelle Viets testified she "would certainly expect anyone coming to the scene to do something." She also testified

the AED should have been the first piece of equipment brought to the scene.

The Grievant's years of service to DRC do not mitigate the egregiousness of her failure. To the extent she contends she thought other staff had assessed TW – even though she saw no one with medical training assess him and asked no one if they had assessed him – she admits she failed to meet her obligations to the patient.

To the extent the Union now contends DRC somehow violated the Grievant's due process rights by not interviewing certain witnesses during the investigation, it has waived that argument. The Union did not raise any procedural objections at the pre-disciplinary hearing. Even if it was error to not interview certain individuals, the Union did not establish how the Grievant was harmed.

The Union also contends that because the Grievant was not immediately placed on administrative leave, her termination was not for just cause. The Agreement does not require administrative leave. Nor is it required by just cause or *Cleveland Board of Education v. Loudermill*.[2] The placement of an employee on administrative leave is left to the discretion

[2] 470 U.S. 532 (1985). *Loudermill* held certain public-sector employees can have a property interest in their employment.

of the Warden. Here, where the Warden did not have reason to believe the Grievant posed an immediate threat, he exercised his discretion to allow her to work through the investigation.

Ultimately, the investigation concluded the Grievant had failed to adhere to the nursing standard of care. Despite the Grievant's generally acceptable track record as a nurse, the Warden found her egregious failure to act on February 3, 2017 warranted removal.

The Grievant continues to believe she was not at fault. She fails to see a nurse's role is to treat every patient appropriately, even if there is reason to believe a particular patient may be crying wolf. The Grievant's failure to recognize she failed to provide basic care to a patient precludes her reinstatement.

Even if the Arbitrator reinstates the Grievant, she is not entitled to full back pay. First, unemployment should be set off from any back pay award. Second, any earned wages should be set off from any back pay award. Third, the Grievant failed to mitigate her damages by seeking full employment as a registered nurse. When asked about her job search, the Grievant said her depression during this period precluded a job search. She failed to provide any corroborating evidence on this subject, however.

The Grievant may generally be an adequate nurse. She may even be a good nurse. But on February 3, 2017, she ignored her professional obligations. This failure created just cause for her removal.

Union Position

DRC did not have just cause to terminate the Grievant's employment. The record shows the investigator, a nurse supervisor, did an inferior investigation. She testified she did not view the February 3, 2017 video because she did not have access to it. When shown her investigation summary report that stated she had viewed the video, she changed her recollection and testified she had viewed part of the video. The investigator admitted she did not interview all the employees shown in the video; nor did she interview other employees who could have provided essential information. Even with the few individuals the investigator spoke to, she did not ask them what the Grievant did or did not do during the incident. She also failed to examine the reasonableness of the Grievant's actions; she did not even ask the Grievant about the reasons for the actions she took.

Regarding the alleged Rule 8 violation, the pre-disciplinary hearing officer acknowledged during testimony that TW's head and chest were out of the frame of the video, making it difficult if not impossible to assess what was or was not done. He also acknowledged the Grievant did take action – she moved the bed to give other nurses access to TW, she got the privacy curtain, the oxygen tank, and the AED, and she working IV tubing. The Director of Nursing testified to the same actions taken by the Grievant. Both witnesses also acknowledged the Grievant was not assigned to TW's area that evening.

Regarding the alleged Rule 38 and Rule 41 violations, DRC did not provide substantial evidence of proof of guilt. Due to a flawed investigation, the pre-disciplinary hearing officer could not have adequately determined whether there was just cause for a Rule 38 or a Rule 41 violation.

DRC failed to assess the reasonableness of the Grievant's actions. The Grievant testified, and the video corroborates, that she arrived on the scene shortly after another RN and a CO. She had not been asked to respond to the scene. No mandown had been activated and no emergency code had been signaled. She became aware of the situation by overhearing

staff speak of it. She thought she could help because she had a rapport with TW.

Once the Grievant arrived on the scene, she was not alarmed to see TW on the floor because he had been known to lie down on the floor in an attempt to get Lasix or other medication to relieve distension and water retention. She did not believe TW to be in any distress. She did what she had done with TW in the past – she implored him to get back up into his wheelchair and she would get medication for him.

Based on the Grievant's assessment that this was not an emergency situation, she went to get the privacy curtain because other inmates were making fun of TW and were hurling insults at him. The Grievant then went to get the oxygen tank. When she returned with the oxygen tank, she realized TW's condition was deteriorating. She gave the oxygen tank to another nurse, told two other nurses to begin CPR, and told a third nurse to call 911. As she ran to get the AED, she told a nurse supervisor about TW's condition. She brought the AED and hooked TW up to it. She assisted another nurse with getting an IV line started. The paramedic arrived; the Grievant problem solved the best way to get TW on the gurney. She then escorted the gurney, holding the IV as TW left the unit. Sadly, TW was

pronounced dead less than an hour later at OSU Medical Center, but not due to any inaction on the Grievant's part.

Furthermore, DRC's actions after the incident undermines its claims of rule violations. After the incident, the Grievant continued to work the same shift, same assignment, and with the same patients for approximately 7 months. If she were truly a threat to anyone, she should have been placed on administrative leave. Additionally, approximately one month after the incident, the Grievant received a Meets Expectations performance review, with the comment, "Continue to do a great job." She was rated as Exceeds Expectations in the areas of Customer Focus and Communication with Supervisors/Peers/Subordinates.

DRC has failed to show the penalty it assessed was reasonably related to the seriousness of the alleged offenses and to the Grievant's past record. Even if the Arbitrator were to determine the Grievant is guilty of a Rule 8 violation, DRC's own disciplinary grid shows a second offense for a Rule 8 violation is a 2-day suspension or fine. There is no history here of a continued pattern of violating work rules. Indeed, the record shows the Grievant was eager to work with others, take on extra work, and assist in situations with patients other than her own.

If a thorough investigation had taken place, it would have concluded the Grievant acted in the best interest of the patient based on the Grievant's history with the patient and the Grievant's assessment of the gravity of the situation. When the Grievant's assessment of the situation was that the patient's condition had deteriorated, her level of action, pace, participation, and direction of others escalated.

The Union requests the Arbitrator to sustain the grievance and to enact the appropriate remedies to make the Grievant whole.

OPINION

DRC has the burden of proving it had just cause for the termination of the Grievant from her position. Just cause consists of: 1) whether the Grievant did what she is accused of doing; and 2) whether the level of discipline fits the charges under all the circumstances.[3]

1. The Charges

DRC charged the Grievant with three rule violations:

[3] *See* Board of Trustees of Miami Twp. v. FOP, Ohio Labor Council, Inc., 81 Ohio St.3d 269 (1998); *see also* City of Piqua v. FOP, Ohio Labor Council, 183 Ohio App. 3d 495 (2009).

Rule 8 Failure to carry out a work assignment or the exercise of poor judgment in carrying out an assignment.

Rule 38 Any act, or failure to act, or commission not otherwise set forth herein which constitutes a threat to the security of the facility, staff, any individual under the supervision of the Department, or a member of the general public.

Rule 41 Unauthorized actions or a failure to act that could harm any individual under the supervision of the Department.

In the August 15, 2017 Notice of Removal, the Supporting Facts are listed as:

> On February 3rd, 2017, you failed to initiate or assist with the care of a patient that was suspected to have fallen. You delayed retrieval of privacy curtains and emergency equipment by remaining in the area after the initial fall occurred.

Rule 8

The first question for the Arbitrator is whether the Grievant failed to initiate or assist with the care of a patient that was suspected to have fallen. The record, including the video, shows the Grievant both initiated and assisted with the care of the fallen TW. She did not act optimally, but she did both initiate and assist with the care of TW.

The second question for the Arbitrator is whether the Grievant delayed retrieval of privacy curtains and emergency equipment by remaining in the area after the initial fall occurred. The record, including the video, demonstrate the Grievant did delay the retrieval of privacy curtains and emergency equipment. This delay was not caused by the Grievant's indifference, however. Rather, the Grievant initially believed TW was not in medical danger.

The third question for the Arbitrator is whether the answers to the first two questions prove a Rule 8 violation – i.e., whether the Grievant failed to carry out a work assignment or exercise poor judgment in carrying out an assignment. It first should be noted the Grievant was not even assigned to the area or the patient that evening. She was assigned to another area and other patients. Yet upon overhearing that TW was involved in an incident, she went to where he was because she knew she had a good rapport with him. She went above and beyond her duties. Indeed, the record shows she often went the extra mile for staff and patients.

When the Grievant arrived on scene, she saw a familiar sight – TW on the ground. In her experience with TW, he often took himself out of his

wheelchair, and placed himself on the floor in an attempt to dramatize what he felt was a need for medication. In the past, the Grievant had successfully coaxed TW to get back in his wheelchair. That is what she attempted to do this time. TW did not respond to the Grievant on this occasion, however. The Arbitrator finds the Grievant's initial actions toward the Grievant did not constitute a failure to carry out a work assignment.

Once TW did not initially respond to the Grievant as he had in the past, however, is where the record, including the video, shows the Grievant did make an error in judgment. Once TW did not respond to the Grievant, she should have checked his vital signs and/or his airway, breathing, and circulation ("ABCs") to determine his medical state.

At this point of the incident, other inmates were jeering at TW on the floor. The Grievant's first instinct at this point was to go retrieve a privacy curtain to maintain TW's dignity. While this was an understandable action, if the Grievant had checked TW's vitals and/or his ABCs, she would have known that the first priority would have been to retrieve the AED, the Automated External Defibrillator. Accordingly, the Arbitrator finds the Grievant did exercise poor judgment in choosing not to check TW's vitals

and/or his ABCs once he did not respond to the Grievant's entreaties to get up off the floor.

Rule 38

In the context of this matter, the Rule 38 question is whether the Grievant's "failure to act…constitute[d] a threat to the security of…any individual under the supervision of the Department." The Arbitrator finds that any failure of the Grievant to act did not per se constitute a threat to TW's "security." Indeed, she protected his security by retrieving the privacy curtain. The Arbitrator finds that the appropriate question is whether any failure of the Grievant to act caused any "harm" to TW, which as a Rule 41 question, will be addressed below.

Rule 41

The Rule 41 question is whether the Grievant's "failure to act…could harm any individual under the supervision of the Department." As this incident was unfolding, the Grievant, in good faith, believed TW was doing his usual wheelchair flop to draw attention to himself. This had happened many times in the past. With 20-20 hindsight, we now know TW was in medical danger. By assuming he was ok, however, and therefore not immediately checking his vitals, airway, breathing, or circulation, it can be

concluded that this failure could "harm" TW. It must be said, however, that the record shows the Grievant was not responsible for TW's death.

2. The Appropriateness of the Penalty

As set out above, the Arbitrator has determined the Grievant:

a) Did violate Rule 8;

b) Did not violate Rule 38; and

c) Did violate Rule 41.

DRC's own disciplinary grid recommends a 2-day fine for the Rule 8 violation and a 5-day fine or removal for the Rule 41 violation.

There are a number of record facts that affect the appropriateness of the penalty. First, the record shows the Grievant generally is a good nurse. Her initial treatment of TW on the evening in question was based on successful interactions she had had with him in the past. Second, the investigation of this matter was incomplete – the investigator admitted she did not even watch the complete video, let alone interview pertinent witnesses, or ask the Grievant why she did what she did. Third, the Grievant was permitted to work with patients for approximately 7 months after the incident. This certainly suggests the Grievant's conduct on the evening in question did not merit removal. Based on these mitigating

factors, the Arbitrator finds the appropriate penalty under all the circumstances is a 5-day fine.

AWARD

For the reasons set out above, the grievance is sustained in part and denied in part.

The Grievant is to be reinstated to her position with continuation of seniority, good days, and schedule.

The Grievant is to be given lost backpay and benefits, including any lost retirement contributions, with the following setoffs made to backpay:

1. A 5-day fine;
2. Any overall unemployment benefits received by the Grievant;[4]
3. Any wages earned by the Grievant; and
4. Given the Grievant's testimony that she was depressed after her removal, but due to the lack of any documentation regarding such depression, the Grievant shall be given only a 6-week grace period before she was required to mitigate her damages by seeking employment. I.e., after such 6-week grace period, if the Grievant did not seek and/or obtain employment, she is not entitled to lost wages and benefits for the period of unemployment after the 6-week grace period.[5]

[4] "Overall" unemployment benefits received means the total of any unemployment benefits received. I.e., any unemployment benefits received will not be correlated with a particular week in terms of determining setoffs.

[5] The Arbitrator is aware that the backpay setoffs could result in a backpay award of zero.

The Arbitrator shall retain jurisdiction until February 28, 2019 regarding implementation of remedy only.

December 20, 2018 *Susan Grody Ruben*
Arbitrator