IN ARBITRATION BEFORE MICHAEL D. GORDON, NEUTRAL

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

and

DANLEY SUSPENSION GRIEVANCE
FMCS No. 17-54509

DEPARTMENT OF VETERANS AFFAIRS

ARBITRATOR'S DECISION AND AWARD

This grievance challenges the 30 day suspension of Barbara Danley("Grievant"). It arises under a master collective bargaining contract ("Agreement") between American Federation of Government Employees ("Union") and the Department of Veterans Affairs ("Agency") covering certain employees at its Truman Memorial Veterans Hospital in Columbia, Missouri ("Hospital").

A hearing was held May 24, 2018, in Columbia, Missouri. Akua Laplanche appeared for the Union. Beth K. Chesney represented the Agency. The hearing was officially reported. The parties received full opportunity to examine and cross-examine witnesses, to introduce relevant exhibits and to argue. The record closed with receipt of written briefs on or before June 29, 2018.

ISSUE

Did the Agency suspend Grievant for just and sufficient cause; and, if not, what should the remedy be?

SELECTED PORTIONS OF AGREEMENT

ARTICLE 14 - DISCIPLINE AND ADVERSE ACTION

Section 1 - General

The Department and the Union recognize that the public interest requires the maintenance of high standards of conduct. No bargaining unit employees will be subject to disciplinary action except for just and sufficient cause. Disciplinary actions will be taken only for such cause as will promote the efficiency of the service. Actions based upon substantively unacceptable performance should be taken in accordance with Title 5, Chapter 43 and will be covered in Article 27 - Performance Appraisal System.

* * *

Section 6 - Fairness and Timeliness

Disciplinary actions must be consistent with applicable laws, regulations, policy, and accepted practice within the Department. Discipline will be applied fairly and equitably and will not be used to harass employees. Disciplinary actions will be timely based upon the circumstances and complexity of each case.

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Section 10 - Investigation of Disciplinary Actions

A. The Department will investigate an incident or situation as soon as possible to determine whether or not discipline is warranted. Ordinarily this inquiry will be made by the appropriate line supervisor. The employee who is the subject of the investigation will be informed of his/her right to representation before any questioning takes places or signed statements are obtained. Other employees questioned in connection with the incident who reasonably believe they may be subject to disciplinary action have the right to Union representation upon request.

B. Disciplinary investigations will be conducted fairly and impartially, and a reasonable effort will be made to reconcile conflicting statements by developing additional evidence. In all cases, the information obtained will be documented. Supervisory notes may be used to support an action detrimental to an employee only when the notes have been shown to the employee in a timely manner after the occurrence of the act and a copy provided to an employee as provided for in Article 24 - Official Records.

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ARTICLE 22 - INVESTIGATIONS

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SECTION 2 - INVESTIGATIONS

A. The Department agrees that before employees conduct a formal investigation, they shall be properly trained.

SELECTED PORTIONS OF APPENDIX A. Title 38 - TABLE OF PENALTIES

1. INSTRUCTIONS FOR USE OF TABLE

a. General. This appendix will be used as a guide in the administration of discipline and major adverse actions to help ensure that like actions are taken for like offenses. The table is designed to be sufficiently broad to include most types of offenses, but is not intended to be exhaustive listing of all offenses. For other offenses, appropriate penalties may be prescribed by decision officials for application within their jurisdiction, consistent with the range of penalties for comparable offenses listed in the table. Disciplinary penalties will generally fall between the ranges indicated in the guide, but in unusual circumstances greater or lesser penalties may be imposed. In determining action to be taken in a specific case, mitigating and aggravating factors should be considered such as length of service, past employment record, the potential for improve behavior, etc.

b. Application of Table

* * *

(5) Discharge action will be taken whenever required by law or regulation or whenever warranted by the facts in the individual case. Usually progressively more severe penalties will be administered before the discharge action is initiated, unless the offense is so serious that it warrants discharge action.

2. RANGE OF PENALTIES FOR STATED OFFENSES [Days are calendar days]

. . .

Safety and Health

. . .

9. Endangering the safety of or causing injury to anyone on VA premises: 1st Offense; Admonishment to Removal.

10. Abuse of patients or beneficiaries: 1st Offense; Reprimand to Removal.

. . .

General Misconduct

. . .

16. Carelessness or negligent workmanship resulting in waste or delay: 1st Offense; Admonishment to Reprimand

. . .

19. Deliberate failure or unreasonable delay in carrying out instructions: 1st Offense; Admonishment to Reprimand;

FACTS

On January 16, 2016, the Agency published a single spaced six page document entitled "Abuse of Patients By Employees, HPM 589A4-271" ("HPM"). In part, it reads:

. . .

3. POLICY

a. It is the policy of the Department of Veterans Affairs and this medical center that no patient will be mistreated or exploited physically, verbally, emotionally, psychologically, sexually or financially, regardless of any temptation or provocation. Any employee or volunteer who commits any of the above, or witnesses such acts by another employee or volunteer, and does not promptly report it to the proper authority; will be subject to disciplinary action. All instances of alleged abuse or mistreatment of patient will be reviewed by the Quality Manager (QM) and when it is deemed appropriate by the Medical Center Director, an Administrative Investigation Board (AIB) will be conducted.

* * *

4. DEFINITION:

. . .

b. Patient abuse includes acts of physical, psychological, sexual or verbal abuse. Examples include intentional omission of care, willful violation of a patient's privacy, willful physical injury, and intimidation, harassment or ridicule, and any action or behavior that conflicts with a patient's rights, as defined in VA regulations found at 38 C.F.R 17.33. Intent to abuse is not necessary. The patient's perception of how he or she was treated is an essential component of the determination as to whether abuse occurred. However, the fact that a patient has limited or no cognitive ability, or may not allege abuse, does not exclude the possibility that a patient was abused.

5. PROCEDURES:

a. Employees and volunteers who witness patient abuse or who receive a report of such abuse from a visitor or a patient will intervene in the act if appropriate.. . Employees will immediately report the incident to his/her supervisor. . . The supervisor who receives a report concerning patient abuse will ensure that VAF 10-2633, Report of Special Incident is completed or submit an electronic Patient Incident Report Form on the VA SharePoint. Only facts, not opinions, should be recorded on the form. The Service Chief and/or QM will notify the MCD as soon as possible, but not later than 24 hours of becoming aware of allegations of patient abuse.

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e. Based on the Table of Penalties for a first offense, the minimum penalty is a reprimand, and the maximum is removal. The level of punishment should be commensurate with the severity of the offense. The following acts are generally minor abuses although they may be considered as major abuses under certain circumstances: teasing a patient, speaking harshly, rudely or irritably to a patient; laughing at or ridiculing a patient; scolding a patient; indifference, although in certain instances such acts can be considered major abuse.

* * *

g. Any employee who is identified as having knowledge of such abuse and does not take appropriate action, may be subject to disciplinary action.

6. RESPONSIBILITY:

a. Employees and volunteers are responsible for treating patients with dignity, compassion, excellence and respect. Any employee who witnesses patient abuse, or who receives a report of such abuse from a visitor or patient, or who has reason to believe that patient abuse has occurred is responsible for promptly reporting it to his or her immediate supervisor, and if necessary, to the Service Chief, QM, Chief of Staff, or to an Executive Leadership Team member.. . .

* * *

e. In carrying out this policy, managers will adhere to all applicable collective bargaining agreements that effect bargaining unit employees.

. . .

Grievant, a Certified Respiratory Therapist, began employment at the Hospital on February 23, 2003. She received substantial training. She had good performance evaluations although she had been disciplined in 2010 for disrespecting a co-worker.[1]

On May 12, 2017, Grievant was involved in an incident at the core of this grievance. It is undisputed that while she

[1] The Agency purposefully did not use the 2010 incident in assessing Grievant's discipline here.

was on duty in the Step Down Unit ("SDU"),[2] a patient, RW, became physically unruly and experienced breathing difficulties and low oxygen saturation levels. A Sitter, Aston Burks, called for help after RW attempted to hit her and get out of his bed. Registered nurses, Julie Samp, Amanda Boggs, Mattie Sharp and, perhaps, Julie Dunseith, arrived at RW's room. They restrained a thrashing and non-compliant RW. A nurse applied a non-breather mask ("NRM") to RW.[3] At some point, Grievant became present. What else happened in RW's room thereafter is disputed. The differences appear in more detail below.

On March 12, Samp filed a patient safety incident report with first line supervisor, Jimmie Riggins, Chief Respiratory Care.[4] On March 15, Grievant was reassigned temporarily to Sterile Processing Section ("SPS") until the investigation was

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[2] The SDU is a fairly small area, maybe 30-50 feet from one end to the other. It consists of 10 patient beds, 4 in individual rooms with glass doors and 3 within one doorless area with 2 walls, each bed divided by a curtain. The 10 beds encircle two nursing stations that can see all beds and attendant equipment.

[3] Like Grievant, all nurses present are qualified to apply the device.

[4] The incident report was not forwarded to HR or presented at the arbitration hearing. It apparently now is regarded as confidential. Its precise contents are unknown.

complete. She may have lost premium and night differential pay she would have earned had she not been transferred.

After Riggins finished his investigation, he consulted the *Douglas Factors*, 5 M.S.P.R. 280 (1981). On March 27, he decided Grievant warranted a charge of patient abandonment and failure to act in the patient's best interest by not acting within the scope of practice of a respiratory therapist. Removal was recommended.

On May 31, Grievant received notice of proposed dismissal. Specifically, the notice charged:

> . . . you demonstrated a careless performance of duty by endangering the safety of a patient (R.W.) by failing to respond to a patient (R.W.)in severe distress with critically low oxygen saturation level. By your own admission, you "stood by" in the room and did not do anything to assist the patient (R.W.). You violated policy [HPM] Abuse of Patients by Employees, by your intentional commission of care to a Veteran in severe distress.

On June 23. Director David Isaacks presided over Grievant's oral response. As she essentially testified at the arbitration, she said that, under the circumstances, there was nothing she could have done for RW that was not being done already. Isaacks, saying the words seemed negative to him,

asked about what she meant during her interview with Riggins that she "stood by" during the incident. Grievant replied:

> That means that you're assessing what's going on; that you're evaluating the patient status. And if what you're doing isn't effective then you're going to move on to the next step.

After considering the *Douglas Factors*, On June 10, Isaacks assessed a 30 day suspension against Grievant for patient abandonment.[5] Chief of Staff Lana Zerrer affirmed the suspension. This grievance followed and on August 24, the Union invoked arbitration. Upon her return from a July 24-August 23 suspension, Grievant returned to her normal duties.

AGENCY POSITION

Grievant's 30 day suspension was for just and sufficient cause. The Agency proved Grievant abused a patient in violation of the HPM when she abandoned RW. Her 30 day suspension is fair and reasonable. The grievance should be denied.

Grievant acknowledged that she "stood by" and did nothing to assist. "Patient Abandonment" is defined and discussed in

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[5] Grievant's tenure counted against her because, Isaacks reasoned, someone with her lengthy service should know better.

the *Respiratory Therapists Legal Answer Book* and the *Journal of Emergency Medical Services*. It is a subject of the HPM.

Intent to abuse is not necessary under 38 C.F.R §17.33(a)(2). Grievant knew that her omission of care to RW violated generally known and reasonable work rules and expectations.

Grievant's statements have been contradictory. There is abundant proof she stood by and did nothing to assist RW and she left while he remained in distress. She put him in danger.

Patient abandonment is patient abuse. A nexus existed between Grievant's misconduct and the efficiency of the service. Isaacks' decision to mitigate the penalty shows her actions strike the heart of her direct and indirect duties and responsibilities and are contrary to the Agency's mission and reputation.

Isaacks considered mere rehabilitation unlikely because Grievant believes she did nothing wrong. He considered her lengthy experience as an aggravating factor because long tenure means an employee should be aware of the duties and expectations of a job. His reduction of removal to a 30 day suspension resulted from careful consideration of the *Douglas Factors* and the facts.

UNION POSITION

The Agency did not prove Grievant's 30 day suspension was for just cause. She should be awarded resulting loss of pay and benefits, plus interest and reasonable attorney fees.

The Agency did not present preponderant evidence of Grievant's misconduct, the reasonableness of her penalty or the nexus between her discipline and the efficiency of the federal service. It did not properly assess and apply the *Douglas Factors*. It denied Grievant due process under the Agreement. Any one deficiency violates the Agreement. She should be awarded any resulting lost pay and benefits, plus interest and attorney fees under the Backpay Act.

The Agency failed its proof. The Agency does not know what happened on May 12. Its witnesses are unreliable. At the hearing, they were forgetful and contradictory. Stamp testified she did not remember and her time log is inconsistent with her explanation and the testimony of other witnesses who, also, contradicted themselves. Riggins never asked Grievant what she meant and then misinterpreted her "stood by" comment.

There is no one universally accepted definition of "patient abandonment." Authorities differ but no definition fits here.

No policy or training required Grievant to take a NRM from a qualified nurse and place it on RW. Grievant's explanation is that such action would complicate an already crowded and chaotic situation.

Isaacks did not consult the Agreement. So the suspension could not have been for cause.

Grievant's due process rights were violated. Contrary to Article 14 §10 (B), no full and fair investigation occurred and the investigation that was done is deficient.

Grievant was not provided evidence used against her. The incident report, reports of contact and list of similar disciplinary comparisons were not furnished despite Isaacks' testimony he considered and relied on all of them and despite numerous Union specific requests for them.

The Agency violated Article 22 §2(A) because it did not prove Riggins was properly trained regarding investigations. Thus, the investigation was sub-par.

Also, Grievant's discipline was untimely under Article 14 §6. This matter is not complex enough to justify the long period between the May 12 incident and Grievant's discipline. The Agency offers no explanation.

Even if Agency charges are proven, Grievant's penalty was excessive and punitive. The *Douglas Factors* were misapplied. Use of her length of service, job performance, dependability and ability to get along with others were improperly treated as aggravating, rather than, mitigating, factors.

Any misconduct was minor regarding her ability to perform satisfactorily and maintain supervisory confidence in her ability to perform. Neither before nor after May 12, was guidance given about how to perform under the circumstances that occurred on May 12. The incident generated no notoriety or negative impact on the Agency's reputation. Grievant was not on notice of any alleged Agency NRM policy. Grievant's lengthy service and good performance record show she was a good candidate for rehabilitation.

David Bach, an employee who abandoned a patient was not disciplined, but rewarded. This disparate treatment is

inconsistent with the law and Article 14 §6 which require similar treatment of similarly situated employees.

Grievant was charged with patient abandonment but disciplined for patient abuse under the Table of Penalties. Those are two significantly different offenses, patient abuse being more serious. Finally, there was no consideration of mitigating circumstances involved in the May 12 incident, such as job tensions, personality conflicts, etc.

DECISION

The Agency shoulders the burden of proving "just and sufficient cause." This phrase is purposefully ambiguous so relevant facts about each particular discipline can be weighed and balanced. Progressive discipline normally applies but it does not have to occur in any fixed order and egregious misconduct may warrant termination for a first offense. Corrective action is favored over punitive discipline. Prior treatment of similar situations, if any, is very important if those incidents are truly comparable.

Essentially, under the test, the Agency must establish by adequate evidence that (1) all required procedures and due process was followed; (2) the employee engaged in wrongdoing

and, under the totality of circumstances, (3) the penalty it imposed is proportionate to the offense. In the federal sector these analyses are informed by the 12 well-known *Douglas Factors*.

For several reasons, the Agency did not satisfy the Agreement or properly apply its rules. Therefore, the grievance will be sustained.[6]

First, the exact charge against Grievant is vague, contradictory and, probably inapplicable. The charge against her is abandonment. Abandonment is a serious offense warranting substantial discipline, perhaps termination, for a first offense. But important differences exist between abandonment, abuse and negligent or sub-par performance.

Originally developed for doctors, the concept of abandonment is frequently, if sometimes imprecisely, applied to nurses. Some definitions cited by the Agency (Br. 4-5) and Union (Br. 10) are potentially excessive to the extent they permit after-the-fact review of the ultimate care that might

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[6] The Union raises various defenses, including allegations of disparate treatment of Bach and instances of personality conflicts and job tensions. There is insufficient support for these claims. Since the dispute can be resolved without them, no exegesis is required.

have been provided rather than appropriate care under circumstances known at the time. They are difficult to reconcile with the "admonishment to reprimand" discipline suggested in the Table of Penalties for "careless or negligent workmanship" and "deliberate failure or unreasonable delay."

It is unnecessary to definitively define "abandonment" now. For present purposes, it occurred if Grievant left RW when she knew, or should have known, he was not receiving adequate, timely and competent care from others at the time.

Thus, distinctions must be drawn between negligent/ careless performance and deliberate actions. On this record, the key requires wrongful intent because, if for no other reason, Grievant's initial notice of discipline cited the HPM and alleged an "intentional commission of care" and the same standards were used thereafter.

Second, the HPM has little, if any, application here.[7] While the it broadly mentions "professional" conduct, the word *abandon* nowhere appears. Its prohibitions seem directed

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[7] Notably, none of the two or three nurses present in RW's room were criticized for not reporting misconduct despite HPM provisions 3a, 5, a, g, and 6 that discipline "may"/"will" result from non-disclosure. This suggests disparity in enforcement or that the events of May 12 were not immediately recognized by these qualified nurses as significant.

almost exclusively at sexual and non-professional personal, emotional, social, or financial relationships with patients and their families. To the extent it may apply, its basic elements are difficult to reconcile. So, although it says "intent to abuse is not necessary", its previous sentence lists as an example of abuse, "intentional commission of care."

Third, it is unclear what Grievant did not do or should have done. There was no order made. No request demanded immediate attention. Repeated reference was made to an ABG. But, as the Agency correctly noted in an objection at the hearing, Grievant was not charged with any failures related to an ABG; the test is not mentioned in any specification of misconduct; and, occurred "after the entire incident in question."

Fourth, the Agency's factual predicate is fatally weak. Riggins' March 16 notes of an interview with Samp said, in part, that Samp said Grievant:

> . . . was asked to assess a patient. Dr. Welschmeyer notified and reported to bedside, orders received for EKG, ABG and Haldol and restraints. [Grievant] was informed of the orders, and, per Julie's statement, "flipped out" and stated that she was not going to do the ABG, and . . . knew what was wrong, he is hypoxic.

> [Grievant] then left the SDU with no communication as to where she was going or why she was leaving. Julie informed the physician of RT's refusal to draw the ABG and Dr. Welschmeyer asked Julie to call the ICU respiratory therapist, [who] was notified and advised Julie that she had a couple of things to finish in the ICU but would be down.

At the arbitration hearing, Samp testified, in part, on direct that she absolutely had no knowledge if she worked on March 12 and then "I just know there was an issue with the patient with [Grievant], but honestly I don't remember the details or whatnot." She said she wrote one or more incident reports but was uncertain what happened on March 12 without looking at her report (which was unavailable, see FN 4.) She did recall an incident where she requested Grievant's assistance which was not forthcoming. She was unable to say if Grievant entered RW's room. When asked the facts she remembered, she responded:

> Again, everything was in my charting. Without looking at that, I would just be, I could not give you an accurate account because I just do not remember that far back.

Riggins took notes of his March 17 interview with Boggs. They said Boggs stated, "everyone responded to patients room; A NRM was applied, Physician arrived and orders were given for ABG. [Grievant] was informed of this order and stated, "we

don't need an ABG, we know what is wrong", the [Grievant] left the unit with no communication as to why she was leaving. [Samp] then called the ICU respiratory therapist (Kessa Plachte) to do the ABG." Boggs did not testify at the hearing. No explanation was given for her absence.[8]

Riggins' noted that during his March 21 interview, Dunseith said she could not remember if Grievant was present and "does not recall any interaction between [Grievant] and nursing or physician." At arbitration, Dunseith testified that, although she remembers Grievant being asked to help, she could not otherwise describe the events of March 12. She said ". . . I was not in the patient's room at all at the same time [Grievant] was. I didn't hear anything she said to the patient or that any of the other nurses said."

Riggins talked to Sharp on March 22. His notes indicates she told him:

> "[Grievant] stood outside of SDU 4" "Patient was in distress, HR increased Sp02 decreased" "I (Mattie) retrieved the Non-rebreather mask (NRB) and placed it on the patient" "Julie (Samp) notified the physician (Welschmeyer) who ordered the ABG" "[Grievant] was notified of the ABG order, and her . . . reply was He's

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[8] Also, Burkes and/or Plachte did not testify and were not interviewed.

> hypoxic, confused the NRB is not helping "during the incident patient was clearly not stable and [Grievant] just walked out of the unit" [Samp] called [Grievant] back about the ABG and was told (by [Grievant]) that she was not going to do the ABG until the patient had calmed down, "[Samp] informed [Grievant] that the patient was calm but [Grievant] never returned to do the ABG" "[Grievant] never helped nursing during this incident."

At arbitration Sharp recalled (1) Grievant was in RW's room while he was in distress; (2) she did not go to the head of the bed or monitor oxygen; (3) an NRM was applied by another nurse; and (4) at some point Grievant stood outside RW's room. When asked if Grievant attended RW at all, Sharp said, "not that I am aware of, I cannot say 100 percent." She also said Grievant left the room while her assistance still was needed. She believes she asked Samp to file the May 12 incident report. According to Sharp, Samp was out of RW's room while Grievant was present.

Riggins' notes of a March 22 meeting with Grievant shows she said she (1) entered RW's room when she heard a commotion, (2) noted that RW's oxygen saturation was in the 70's (low from the normal 90+), and (3) heard a nurse say she was going to get an NRM and that several nurses were needed to put it on RW. According to the notes, "Per [Grievant's] admission she 'stood by' in that room, and then went back to

finish her other treatment, then left the SDU to finish her other rounds."

At the conclusion of his investigation, Riggins reasoned:

> Given her statement of admission that she "stood-by in that room, and then went back to finish her other rounds". Clearly demonstrates an intentional omission of care. With her lack on engagement during a critical incident, and her leaving the unit without providing care as a Respiratory Therapist.[9]

All Agency evidence falls far short of proving abandonment. Its witnesses disagree or can not remember if Grievant actually entered RW's room and/or remained in the SDU. Their individual independent recollection virtually is non-existent. This is not to say misconduct can not be based on solid evidence from one person or a reliable source. It can. But when, as here, there are important missing documents, conflicting memories and material differences between percipient neutral witnesses, there must be a satisfactory explanation for the Agency's factual choices.

The Agency relies heavily - - perhaps exclusively - - on Grievant's statement that she "stood by" after seeing RW at the time of his distress. Yet no convincing evidence proves

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[9] Riggins also disagreed with Grievant's statement that the SDU was understaffed at the time.

she purposefully left RW knowing her action deprived him of proper care. The record just as likely shows she left RW's room after concluding at least 3 other qualified nurses were providing immediate, necessary and appropriate care so that there was nothing her presence or participation would immediately add to it; and, she could return if the situation changed. This may or may not constitute some form of negligence or similar substandard performance. It is not abandonment.

Finally, Grievant's discipline involved some misreading of the *Douglas Factors*. For example, using Grievant's seniority as an aggravating factor turns that factor on its head.

While not necessarily determinative, seniority is a plus in the disciplinary calculus. It militates toward a lesser penalty than otherwise might be imposed. Thus, "Long service with the company, particularly if unblemished, is a definite factor in favor of the employee whose discharge is reviewed through arbitration." Elkouri & Elkouri, *How Arbitration Works*, May Editor, BNA, 7th Ed., 2012, Ch. 15.3.F.ix. "Arbitrators generally believe that an employee with long,

satisfactory service deserves some additional consideration, especially if the penalty is discharge", Brand and Biren, *Discipline and Discharge in Arbitration,* BNA, 3rd Ed., 2015, Ch. 2.IV.B.3. Also, St. Antoine, *The Common Law of the Shop,* 2nd Ed., BNA, 2005, § 5.10.

AWARD

1. Grievant was not suspended for just and sufficient cause.

2. The record of her suspension shall be removed from her file and the events of March 12, 2017, shall not be used against her in the future.

3. Grievant shall be made whole for monetary losses, if any, caused by her suspension.

4. This record shall remain open for an appropriate and timely claim for attorney fees and other costs, if any.

5. The Arbitrator shall retain jurisdiction, for the sole and exclusive purpose of resolving questions, if any, arising from the remedy described above.

July 15, 2018
Date

MICHAEL D. GORDON, ARBITRATOR