

**BEFORE MARTIN HENNER, ARBITRATOR  
AMERICAN ARBITRATION ASSOCIATION**

**IN THE MATTER OF AN ARBITRATION BETWEEN** )  
 ) **OPINION**  
 ) **and**  
**STATE OF WASHINGTON FEDERATION** ) **AWARD**  
**DEPARTMENT OF SOCIAL AND HEALTH SERVICES )**  
 ) **AAA CASE No.**  
 ) **75-390-00066-09**  
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 )  
**and** )  
 )  
**WASHINGTON FEDERATION OF STATE EMPLOYEES** )  
**(LaShonda Mitchell Grievance)** )  
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**REPRESENTING THE UNION:** **ANITA L. HUNTER, ATTORNEY**  
**WASHINGTON FEDERATION OF STATE EMPLOYEES**

**REPRESENTING THE EMPLOYER:** **ANDREW F. SCOTT**  
**ASSISTANT ATTORNEY GENERAL**  
**STATE OF WASHINGTON**

**HEARING HELD ON:** **APRIL 26 27 & 28, 2010**

**AT:** **SEATTLE, WASHINGTON**

**DATE OF AWARD** **AUGUST 9, 2010**

## INTRODUCTION

This arbitration arises out of a grievance filed by the Washington Federation of State Employees (Union), on behalf of LaShonda Mitchell (Grievant) against the State of Washington's Department of Social and Health Services (Department). The Union asserted that the Department had violated the parties' Collective Bargaining Agreement (Agreement) when it discharged the Grievant from his employment without just cause.

The Grievant and another employee had served as professional caregivers for a developmentally delayed adult client. The client was found in the bathtub with her head underwater and not breathing. She never regained consciousness. A few days later, life support was removed, and the client died.

The Department contended that failures on the part of these caregivers in the performance of their duties contributed to the death of that client, leading to their being discharged. Accordingly, the termination of their employment was proper. (The other employee has also grieved her termination; that matter was heard by a different arbitrator.)

When the parties were unable to come to a satisfactory resolution of the grievance, they proceeded to arbitration before the undersigned, who was selected from a panel furnished by the American Arbitration Association.

The matter was heard on April 26, 27 & 28, 2010, in Seattle, Washington, at which time the matter was concluded, with written briefs to be filed subsequently by the parties. The briefs were timely filed, and received with a slight delay because of a

misaddressed envelope. The record was closed upon receipt of the final brief on July 9, 2010.

At the commencement of the hearing the parties stipulated that there were no procedural impediments to the arbitration being heard. The matter was properly before the Arbitrator.

The parties further stipulated that the Arbitrator was authorized to retain jurisdiction for a period of 90 days from the date of the Award to resolve any issues which might arise regarding the implementation of any remedy which might be ordered.

The Union was represented by Anita L. Hunter, Attorney, Washington Federation of State Employees, and the Department by Andrew F. Scott, Assistant Attorney General, State of Washington.

Both parties were afforded a full opportunity to offer written evidence, examine and cross examine witnesses, and submit written arguments in support of their positions.

In fact, both advocates made excellent presentations at the hearing and in their written closing arguments in support of their client's positions.

## ISSUE

The parties agreed that the issue presented for determination by the arbitrator is:

Did the Employer violate the parties' Collective Bargaining Agreement when it terminated the Grievant's employment without just cause?

If so, what is the remedy?

## RELEVANT CONTRACT LANGUAGE

### **ARTICLE 27 DISCIPLINE**

- 27.1 The Employer will not discipline any permanent employee without just cause.
- 27.2 Discipline includes oral and written reprimands, reductions in pay, suspensions, demotions, and discharges. Oral reprimands will be identified as such.
- 27.3 When disciplining an employee, the Employer will make a reasonable effort to protect the privacy of the employee.
- 27.4 All agency policies regarding investigatory procedures relating to alleged staff misconduct are superseded. The Employer has the authority to determine the method of conducting investigations.

## POSITIONS OF THE PARTIES

### THE DEPARTMENT

The Department argues that its decision to terminate the Grievant's employment is supported because of her conduct as a care provider to the client who died and her responses during the investigations which then occurred. Specifically, the Department asserts that:

1. The Grievant failed in the performance of her duties when she and her colleague failed to properly monitor the client during her bathing period, to assure her safety.
2. The Grievant failed in her duty to properly administer Cardio Pulmonary Resuscitation (CPR) to the Client when she was found not breathing.
3. The Department reasonably believed that the Grievant's responses to questioning during investigations into the client's death gave evidence of untruthfulness.

The Department further argues that, under the circumstances presented in this case, the appropriate discipline was termination, rather than a lesser discipline which might have been imposed under concepts of progressive discipline. The critical failures of the Grievant and her colleague led to the death of a dependent client. It is unreasonable to place another dependent client at serious risk by retaining the Grievant as a professional caregiver.

#### THE UNION

The Union claims that the Grievant acted properly in monitoring the client's bathing. Specifically, the Grievant regularly checked on the client's status at appropriate intervals. The accident which happened cannot be ascribed to a fault of the Grievant.

The Grievant also actively participated in providing CPR to the client after she was discovered in the bathtub not breathing.

The Union denies that there is any evidence to support a finding that the Grievant was not completely truthful during the investigations of the incident.

Affirmatively, the Union claims that the Department's investigation was flawed, in violation of standards of just cause, and led to faulty conclusions.

The Union further asserts that, in light of the Grievant's exemplary record, if any discipline was warranted in this matter, standards of progressive discipline should have been invoked, and lesser, corrective discipline should have been imposed. But instead, the Department elected to discharge the Grievant and her colleague as a response to a lawsuit for damages being filed against it.

#### BURDEN OF PROOF

As is usual in cases involving employee discipline, the Department has the burden of proof to establish that there was just cause to support the discipline imposed.

The Union argues that the required quantum of evidence needed to meet this burden is that of 'clear and convincing evidence.' It notes that many arbitrators have applied this standard in cases where an employee has been accused of serious criminal misconduct or dishonorable behavior, because of the stigma that attaches to an employee who has been subject to such accusations.

The Department claims that the 'preponderance of the evidence' standard is the one to be applied in this case. That is the standard traditionally applied by arbitrators in discipline and discharge cases.

In support of its position, the Department notes that the preponderance of the evidence standard is applied by statute in federal sector cases before the Merit System Protection Board. It is also used in State of Washington cases for non-represented employees whose cases go before the Washington State Personnel Resources Board (PRB).

Finally, that quantum of proof standard was the one applied by the arbitrator who heard the grievance filed by the discharged coworker of the Grievant in this case. While that arbitrator's determination is not binding, the Department claims it deserves special consideration, since the two discharged employees should not have their cases measured by different standards.

It is my practice to apply the generally accepted preponderance of the evidence standard in labor arbitrations, including those involving discipline and discharge, unless the employee has been charged with the kind of serious offense that carries the kind of

stigma which would severely impact possibilities of future employment. Embezzlement or theft from an employer would be such an offense for some job categories involving money or security. A pedophilia related act would be such an offense for employees employed in the care or teaching of children.

But in this case, the basis of the Grievant's discharge is, essentially, negligence. She is accused of not having been properly attentive while the client was bathing. She is accused of failing to properly assist in administering CPR to the client, which I also consider to be a charge of negligent failure. And she is accused of not being completely truthful in answering questions about her activities on the day of the incident.

I cannot find that charges of negligence, or of denial and evasion in answering an investigator's questions, to be the kind of serious misconduct requiring the application of a higher than normal standard. Accordingly, I will be applying the usual 'preponderance of the evidence' quantum of proof requirement in this case.

## FACTUAL FRAMEWORK

The Grievant was a professional adult caregiver, employed by in the Department's State Operated Living Alternative (SOLA) program for developmentally disabled adults. She had worked for the Department approximately 14 years at the time of the incident (16 years at the time of her termination). She had no prior discipline and a good performance history.

At times pertinent to this case, she worked as a caregiver in a small home for four adult residents. On the night of October 10, 2006, she was one of two caregivers on duty.

One of the clients resident in this home was a developmentally delayed woman, approximately 30 years old, who had limited cognitive ability. The client was described to be functioning only at the level of a 6 year old child mentally.

This client had a severe seizure related condition. She suffered seizures on a daily basis, some of which were silent and momentary and some more severe. A seizure log was maintained for this client, for use by her physician.

Because of the risk of seizures occurring while this client was taking baths, and the possibilities of her hitting her head on the tub or suffering other injuries, staff attention had been given to her bathing routines. In a previous home for this client, a sound monitor was located in the bathroom during her baths, so staff could listen to sounds of distress or danger. She had been given a helmet to wear during her baths. Staff was alerted to be watchful during her baths.

When this client moved to the smaller home where she lived at the time of this incident, it was determined that the house was sufficiently small so that a sound monitor in the bathroom was no longer required. Activity from the bathroom could easily be heard in all of the other rooms.

At this time the client was refusing to wear a helmet while bathing. Since she was an adult, the agency determined that she had the right to refuse, and that requirement had been discontinued.

Staff monitored the client during her baths by discretely observing her and listening to her activities at regular intervals through the open bathroom door, and, if necessary, by entering the bathroom to observe her. At the same time, an effort was made so that she would not feel that her privacy was being invaded.

Staff also monitored the water level in the bathtub, to assure it was not so high that a risk of her drowning during a seizure was being created.

However, it is noted that the Department had adopted no written bathing protocols for people who suffered from seizures until after the incident in this case. And some testimony indicates that formal instructions to staff on how to monitor the client during her baths had never been given.

On the evening of October 10, 2006, the client was directed by the other caregiver to begin her bath at approximately 8:00 pm. She was discovered in the bathtub, with her mouth and nose partially immersed in water, at approximately 8:20 pm. She was removed from the tub, CPR was initiated, and an emergency telephone call to 911 was made at 8:23 pm.

The client was ultimately taken to the hospital but never regained consciousness. A few days later, life support was withdrawn and she was permitted to die.

It is assumed that the client likely had a seizure while bathing and drowned in the bathtub. However, the results of the client's autopsy were never made available to the Department, so that assumption has not been definitely verified. She could also have suffered a stroke or heart attack. As there is evidence that the client's medication had been changed only days prior to the incident, there remains the possibility that the death may have been medication related and not caused by a seizure.

## FINDINGS

The only witnesses who were present in the house at the time of the incident were the two caregivers: the Grievant and her colleague. The Grievant gave numerous

statements and interviews. There is no independent way of testing the veracity of the answers and testimony which she provided.

The Sheriff's investigating detective did not believe her and, in fact, recommended that she be prosecuted for criminal negligence: manslaughter. After some months of consideration, the King County Prosecutor declined the case.

The Department's lead investigator refrained from making any conclusions, but he submitted a report to the regional administrator highlighting discrepancies he found between the various statements made by the Grievant.

The regional administrator ultimately concluded that she did not believe that the Grievant and her colleague were being truthful about their activities on the night the client drowned, and she determined to terminate their employment.

I must now make findings of the truthfulness of the Grievant, or lack thereof. I must decide if I believe her version of what she and her colleague did and of what transpired. I can only use prior experience, logic, common sense, and my assessment of the witnesses' demeanor as they testified.

In doing so, I have carefully reviewed the entire hearing transcript and exhibits while considering the written closing arguments submitted by the parties,

#### Failure to Monitor Client's Bathing

I am convinced that the Grievant, who was well aware of the client's seizure disorder, understood the need for constant monitoring of her while she took baths. Based on their responses, I have no doubt that the Grievant also understood the need to monitor the water level in the bathtub, to minimize any risk of drowning.

I have considered the claim that the caregivers checked on the client's bathing at 8:12, 8:16 and 8:20 pm, the regular 4 minute intervals claimed. I do not believe it.

I accept the testimony that the Grievant, her colleague, and the two other residents were watching television during the time of the client's bath. And that they were likely watching a game show. Both caregivers were seated on the couch for at least some of the time.

Importantly, I do not believe their statements and testimony that the TV sound was muted. People do not watch muted game shows, and to make such an assertion strains credibility. My conclusion is supported by testimony that one of the residents who was watching TV, Beth, liked game shows and would have been upset if the sound had been muted. She likely would have protested.

I also believe that the TV program and its sound would have made it difficult for the caregivers to hear noises from the bathroom. This noise interference would have been made even worse if the TV volume was set high enough so that the Grievant and another resident could continue to listen to the show when they went into the kitchen so the Grievant could give the resident her medications, some yoghurt, and later a slice of pie.

In addition to the noise factor, the program itself would have been a distraction to the caregivers. Multitasking has been shown to be more difficult than people expect. Interesting guests, funny remarks from the host, and puzzling questions can easily temporarily capture the focus of viewers, leading them to lose track of time and of their other responsibilities. A minute here, a minute there. It adds up. That is what I believe happened on this tragic evening.

While no one can ever know positively, I do not believe that the bathing client received the regular monitoring which was required, at the time intervals claimed by the Grievant and her colleague.

Such negligence would support the imposition of discipline.

I have also considered the further allegation that the water in the bathtub was permitted to exceed a safe level. I cannot make a finding supporting that allegation as (1) the evidence of the water level is inconclusive and (2) it appears that the tub was filled while the Grievant was administering medication to another resident, and the level was being monitored by the other caregiver, not by the Grievant.

#### Failure to Adequately Administer CPR to Client

Upon being called to the bathroom by the other caregiver, the Grievant assisted in dragging the client out of the tub, and helped position her so that CPR could be administered. It is not completely clear which caregiver commenced CPR, since the testimony is conflicting. But both caregivers were then working as a team, and CPR appears to have been initiated.

The Grievant then went to call 911, asking for an ambulance to be sent to the house. This was appropriate.

She brought the phone back to the bathroom where the other caregiver was doing CPR, and appears to have taken over, doing chest compressions, etc. The 911 operator kept her on the line and asked to have the counting done out loud.

It is at this point that what occurred becomes questionable. The 911 tape, as listened to by the detective, was not found by her to have sounds typical of CPR. Moreover, the Grievant at some point terminated the 911 call in order to call Department

management to report the incident, rather than giving her attention to assisting the other caregiver in providing CPR.

At a later point, the Grievant abandoned the other caregiver to go into another resident's room, apparently to escape the stress of the situation. Finally, she again left her colleague in the bathroom while she waited at the front door so that she could signal to the ambulance when it arrived.

Reviewing the testimony of her caregiver colleague, I believe the evidence would support a finding that the Grievant simply panicked.

Taken together, these actions constituted a failure by the Grievant to fully assist in the administering of CPR to the client.

#### Findings of Untruthfulness

My findings regarding the television watching and my disbelief in the times of monitoring the client which were reported by the Grievant also support the charge of untruthfulness.

### UNION'S AFFIRMATIVE ARGUMENTS

#### Improper Investigation

The Union claims that the investigation conducted by the Department was flawed, as one member of the investigatory team was the Region 4 administrator of the SOLA program. Since the death of the resident occurred in her Region, the Union argues that she had an incentive to shift blame down to the caregiver staff and to deflect any personal responsibility.

I reject this claim, since the investigation was headed up by the Region 5 SOLA administrator who had no personal connection and could be presumed to be impartial. He was the team leader, and it was he who led the investigation and drafted the actual report to the regional administrator. The Region 4 administrator was merely a helper on the team.

Importantly, the Region 4 SOLA administrator's function was administrative. She performed functions of budgeting, fiscal oversight, personnel and labor relations, etc. She was not responsible for program management and suffered no risk of discipline in this matter. Another employee, a program manager who was supervised by her, was involved in day-to-day activities and could possibly have been held responsible. However this was not the case for the Region 4 SOLA administrator.

Finally, the contract between the parties grants management broad latitude in deciding how to conduct investigations, and the Union appears to have waived the right to object:

27.4 All agency policies regarding investigatory procedures relating to alleged staff misconduct are superseded. The Employer has the authority to determine the method of conducting investigations.

#### Department's Failure to Have Written Protocols

The Union appears to try to shift the blame for the client's drowning to the Agency, since, at the time of the incident, it had not adopted written protocols governing how clients with seizure disorders would be monitored while bathing. I reject this claim, as I believe ample evidence in the record supports the conclusion that all staff realized that such clients required special monitoring while bathing.

The caregivers of the client in this case certainly knew that she formerly required a sound monitor and even the wearing of a helmet for protection. Even in the new, smaller residence, continual observations of her were acknowledged to be required. That is the reason why the caregivers claimed to have observed her at 4 minute intervals.

### Unequal Discipline

The Union claims that the Department is punishing the Grievant for the same kind of client bath monitoring that many other caregivers also practiced without having been disciplined. The Department response has been that these caregivers had not caused harm as the Grievant did.

This is a question that arbitrators have struggled with. Should the misconduct be punished, or the resulting harm? Logically, if I back up my car without looking and run over a child's bicycle, and you back up your car without looking and run over a child, we have both committed the same misconduct; we made the same error.

But on reflection that is not how our legal system views it. In the real world, I would have to pay for a new bicycle and you would be in prison for manslaughter. There are, in fact, many cases in which the level of discipline imposed on an employee varied with the monetary value of the damage caused.

In this case, however, the question is moot. I do not believe that the Grievant and her colleague actually did perform the same kind of monitoring as done by other caregivers. Thus no question of unequal treatment is presented.

### Suspicious Timing of Discipline

The Union observes that the drowning incident occurred on October 10, 2006. The Department's investigation was completed on October 31, 2007. But there was no attempt to impose any discipline on the Grievant until after June 13, 2008, when the mother of the client filed a lawsuit against the State. Then, less than a month later on July 7, 2008, a notice of intent to discipline was issued.

This claim is answered by the regional administrator. She testified that, notwithstanding the submission of the investigative report on October 31, 2007, she was not satisfied that she had all the facts she needed.

She then made a request to the Washington State Patrol for a further investigation. Apparently, her request was ignored for some time. Finally, through a protest using the channels of the State Attorney General's office, she was able to get action. She met with a State Patrol investigator.

She was seeking the autopsy report, as she wished to ascertain with certainty the cause of the client's death before she made any disciplinary decision.

In May, 2008, she was informed by the Patrol that the autopsy report was the property of the family of the decedent and they were not agreeable to its release to her.

She then proceeded to work with human resources to prepare to impose discipline, leading to the Notice of Intent to Discipline on July 7, 2008.

While I might have chosen to proceed more expeditiously, I cannot complain about the delay that occurred here. The administrator had that discretion.

I note that some unions have negotiated provisions in their collective bargaining agreements which provide that any discipline must be imposed within a certain time

period after the violation occurred or was discovered. Such a provision is not in these parties' Agreement.

### Progressive Discipline

For a long term employee such as the Grievant, with 16 years of service at the time of her termination and an apparent exemplary record, I would normally be inclined to hold that discharge for a first offense, even one as serious as this one, was excessive. People do panic. Errors get made.

I might have considered a demotion to the Adult Caregiver 1 classification, a level where there is supervision rather than the independence the Grievant enjoyed as an Adult Caregiver 2. This might have been coupled with a suspension.

But in this case, I am troubled by my assessment that the Grievant has not been truthful about her failures in monitoring the client's bathing and in administering CPR. Under such circumstances, the imposition of a lesser penalty does not seem appropriate.

### General Findings

Just cause for the discharge of the Grievant has been shown.

### AWARD

The grievance is DENIED.

Respectfully submitted, at Eugene, Oregon, August 9, 2010.

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Martin Henner, Arbitrator