ARBITRATION BETWEEN

Washington Federation of State Employees, Murine McGenty, Grievant

Arbitrators Opinion and Award
AAA Case No. 75-390-00471-08
Richard W. Croll, Arbitrator
February 3, 2010

And

Washington Department of Social and Health Services

PROCEDURE

This grievance is between the State of Washington, Department of Social and Health Services (DSHS) and the Washington Federation of State Employees (Union), Murine McGenty, Grievant. The grievance was filed August 6, 2008 when the DSHS, State Operated Living Alternative (SOLA) program terminated the Grievant. The parties were unable to settle the grievance and it was processed to arbitration under the terms of the Parties Collective Bargaining Contract (CBA) and the rules of the American Arbitration Association (AAA). The Arbitrator was properly selected under the above terms and is authorized to hear and decide this grievance.

A hearing was held on October 29, October 30 and November 2, 2009 before the Arbitrator at the DSHS, Children's Administrative Office, Office of Indian Child Welfare, 4045 Delridge Way SW, Seattle, Washington. A verbatim transcript of the hearing was made by Dixie Cattell & Associates, Terri L. Averill CSR, and supplied to the parties and the Arbitrator. The parties agreed to file written argument and those briefs were filed and received electronically by the Arbitrator on January 4, 2010. The Arbitrator adjourned the hearing with the receipt of the briefs and under the rules of the AAA he has until February 4, 2010 to submit the decision and award to the AAA.

ISSUES

The issues are (1) Did the Employer have just cause to discipline the Grievant for her role in the events of October 10, 2006, which took place at her work location, the 105th Street SOLA Home; and (2) if so was termination the appropriate discipline under the circumstances?

APPEARANCES

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EXHIBITS

Ex. A	Letter of termination, July 16, 2008.
Ex. B	Step One Grievance Hearing , Aug. 28, 2008.
Ex. C	Step One Grievance Form, August 6, 2008.
Ex. D	Alternate assignment for Grievant, October 11, 2006.
Ex. E	Alternate assignment for Grievant, January 4, 2007.
Ex. F	Complaint Investigation by Residential Care Services, SOLA.
Ex. G	Response of SOLA to Residential Care Services.
Ex. H	Sola Incident Report by Grievant, 10/10/06.

Ex. I	Incident report by LaShonda Mitchell
Ex. J	PSP Report for Justine, 10/07/06 through 10/10/06, 2:10 PM.
Ex. K	Justine's PSP, August 28, 2001.
Ex. L	Justine's PSP, August 29, 2002.
Ex. M	Justine's PSP, October 28, 2003.
Ex. N	Justine's PSP, October 15, 2004.
Ex. O	Justine's PSP, August 29, 2005.
Ex. P	Justine's PSP, August 17, 2006.
Ex. Q	Kent Fire Department Incident Report, October 10, 2006
Ex. R	Joleen Spellman Report, October 11, 2006.
Ex. S	Joleen Spellman, 06/11/07 D. Davis & M. Bauchman.
Ex. T	Sonja Pate, 10/23/06, M. Buchman.
Ex.U	Sonja Pate, 05/29/07, M. Buchman.
Ex. V	Justine's seizure reports, 06/09/06 through10/09/06.
Ex. W	KCS Polygraph report of Grievant, 11/07/06.
Ex. X	Grievant's Performance Reports, 08/01/98 through 08/25/06.
Ex.AA	Snapshot, Justine, Undated.
Ex.BB	Det. Bartlett interview of EMT James Medema, 10/19/06.
Ex. CC	Det. Bartlett interview of Grievant, 10/20/06.
Ex. DD	Det. Bartlett interview of Grievant, 11/07/06.
Ex. FF	Det. Do interview of LaShonda Mitchell, 10/20/06.
Ex. GG	105th St. House floor plan and bathroom plan, KSO.
Ex. HH	Bathroom and tub pictures w/model.
Ex. JJ	DSHS Policy, #513.
Ex. KK	Grievant's AC2 Position Description, 08/02/06.
Ex. II	Davis/Bauchman Report, 08/31/07.
Ex. NN	105th St. House Daily Log, 10/10/06, 1st entry 7:20 – 5:30.

BACKGROUND

The Department of Social and Health Services (DSHS) is charged by the State to assist and to provide for the State's disadvantaged and developmentally disabled citizens; the State Operated Living Alternative program (SOLA) is the venue for the arbitration in this case. The SOLA program is designed to allow developmentally disabled adults to live a relatively normal life in a group home located in the community and assisted by staff employed and trained by DSHS.

The SOLA home which is the focus of this arbitration was located at 22814 S.E. 105th Place, Kent, Washington, and was referred to as the 105th Street Home. At all times pertinent to this arbitration, the 105th St. Home housed three developmentally disabled adults and two caregivers per shift. The caregivers worked shifts of: 7 AM – 3 PM, 3 PM – 11 PM and 11 PM – 7 AM. The shift in question was the 3 PM – 11 PM shift and it was staffed by Murine and Lashonda, two experienced caregivers. Their DSHS employment classification was Attendant Counselor 2 (AC2).[1]

The incident which triggered this arbitration occurred on October 10, 2006. On that date one of the residents, Justine, was discovered by the Grievant and Lashonda unconscious and not breathing in the tub while taking a bath. Emergency measures were implemented, including a 911 call. The emergency personnel were able to restore breathing and a heartbeat and they then transported Justine to the hospital where she was placed on life support. A week later, life support was discontinued and within a few hours Justine died.
The Grievant and Lashonda were terminated on July 16, 2008, for their roles in the death of Justine. This arbitration only deals with the termination of the Grievant as a separate grievance is being processed for LaShonda.

DISCUSSION

Caregivers Murine and LaShonda were the only persons present at the 105th St. Home on the evening in question who were capable of relating the happenings of that entire evening. Both caregivers have been interviewed extensively about what took place on October 10, 2006. The Grievant wrote an incident report at 9:45 PM on the above date. Her report contained the following information: Justine went into the bathroom at 8:00 PM to take a bath. The staff checked on Justine at 8:12 PM, 8:16 PM and at 8:20 PM when Justine was found lying in the tub, head sidewise partially under water.[2] The two staff took Justine out of the tub, started CPR and called 911. Staff performed CPR until 911 arrived. 911 got Justine's heart to beat and restored her blood pressure, then transported her to the hospital. The Grievant's report then repeated that Justine was checked at 8:12 PM, at 8:16

[1] It was stated that the SOLA program was developed around the AC2 classification, a person with this classification was expected to do the job without supervision. This is in contrast to the AC1 classification which was designated for people who worked in institutions with supervision.
[2] At this time Justine was unconscious and not breathing.

PM by LaShonda and at 8:20 PM when the incident was discovered, they started CPR and called 911. In this report the Grievant related that she had used the toilet between 8:12 PM and 8:16 PM and had talked to Justine during that time. (Ex. H)

Joleen Spellman, a SOLA staff member who lived in close proximity to the 105th St. Home, was asked by her supervisor, Michelle Bauchman, to go to the above house on the night of the incident. She reviewed the incident with the two caregivers together for about forty-five minutes, requested the Grievant's incident report and went to the hospital. LaShonda went to the hospital at the same time as Spellman.

While they were in Justine's room, Spellman requested LaShonda write an incident report. She delivered LaShonda and the Grievant's reports to her supervisor the next day.

LaShonda's report, in the main, outlined her recollection of the incident of October 10, 2006. She wrote that around 8:00 PM the Grievant asked Justine to take her bath and a few minutes later, while at the kitchen table, she heard the bathwater running. A few minutes later the Grievant went into the bathroom and told Justine to start her bath. The Grievant left the bathroom, then turned and went back in and used the bathroom. LaShonda then said that she went into the bathroom and told Justine to bathe herself which she started to do. LaShonda left the bathroom and said that she gave another resident, Lisa, some pie and that had to be around 8:16 PM. A couple of minutes later, around 8:20 PM the Grievant went into the bathroom and found Justine non-responsive, slumped in the tub. She summoned LaShonda, they pulled her out, LaShonda said she went to the phone and called 911 and they performed CPR until the medics arrived. She then went on to report that she notified Tanya, Michelle and staff. (Ex. I)

The Employer -- after numerous interviews of the Grievant and LaShonda, many other staff, and the first responders -- determined that the "near drowning" of Justine resulting in her death was the fault of the Grievant and LaShonda and they were terminated from employment on July 16, 2008. The termination letter was single spaced and thirteen pages. All of the charges against the Grievant were explained in detail in the letter and many of them will be discussed in this award. The capsule charges from the letter are as follows: (1) in violation of DSHS policy, Grievant's failure to monitor and supervise client Justine B. during her bath on October 10, 2006

resulting in her death by "near drowning"; (2) Grievant's failure to properly and adequately administer cardiopulmonary resuscitation (CPR) to Justine on October 10, 2006; and (3) Grievant's inconsistent statements and lack of honesty during the investigation into the events of October 10, 2006. (Ex. A)

Burden of proof:
The Employer and Union both emphasized that the Employer has the responsibility to prove that the Grievant is guilty of the charges above. The hearing in this matter consumed two and one half days. The transcript is 516 pages and there are 34 exhibits, some of which run 30 to 50 pages. The Arbitrator's responsibility is to determine whether the Employer's decision to terminate the Grievant was for just cause. The just cause standard will be discussed presently; the burden of proof will first be established. The only persons in attendance during the incident were the Grievant and Lashonda; they are the only first person witnesses. Arbitrators use a number of standards to determine the effectiveness of evidence: (1) beyond a reasonable doubt, (2) clear and convincing evidence, (3) evidence sufficient to convince a reasonable mind of guilt, (4) preponderance of the evidence. *Elkouri & Elkouri,* Fifth Ed., p. 606. The Employer argues that the proper standard should be preponderance of the evidence. His argument is that both State and Federal law use that standard in comparable cases. (Emp. Br. P. 6.) The Employer's argument continues, "That standard places on the Employer an obligation to convince the arbitrator that the existence of facts alleged against the Grievant have been proven by the greater weight of evidence, or that its contentions are more probable than not." (Emp. Br. P. 6)

The Union's position regarding burden of proof is for the arbitrator to use clear and convincing evidence. (Un. Br. P. 6)

> "The imposition of a lesser burden than clear and convincing proof fails to give consideration to the harsh effect of summary discharge upon the employee in terms of future employment"[3]

Even though the Employer does not have any eye witnesses to directly conflict the Grievant's version of the incident, the Employer, through the use of witnesses and the documents created by various interviewers, has established reasonable doubt about the Grievant's description of the incident which resulted in the death of a young disabled woman.

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[3] *General Telephone Co. of California, 73 LA 531 (Richman, 1979).*

The parties did not establish in the contract the burden of proof for the arbitrator to use in deciding a Grievant's guilt or innocence; this is true in most contracts. Arbitrators are left basically to their own devices to establish the proof standard. It may occur that an arbitrator may use one standard in one case and a different standard in another case.[4] The standard to be used in this case will fit the unusual circumstances surrounding the case. The standard for deciding the above question will be the preponderance of the evidence.

The parties, both the Employer and the Union, assured the witnesses and the Grievant that they do not believe there was any intentional abuse that caused Justine's "near drowning" and subsequent death. The rule that the Employer cited to justify its charges against the Grievant is Policy 5.13, Protection From Abuse. This policy specifically refers to "vulnerable adults". The portions of this policy that the Employer cites are found on pages 2 and 9.

> *Page 2. A. Abuse of vulnerable adults is prohibited by law and will not be tolerated.*
> *Page 9. D. Neglect: Abandoning a client in situations where other persons, objects or the environment may injure the client.*

While the policy specifically refers to abuse, the type of abuse the Grievant is charged with in her care of Justine is neglect.

Just cause:
As in many labor contracts the parties' agreement provides for just cause,

> "The Employer will not discipline any permanent employee without just cause."[5]

This agreement, like many other agreements that provide for just cause, does not contain a definition or an explanation of what is meant by just cause. This then requires that the arbitrators come up with a working definition or explanation of just cause and apply it to the case before them. Again, as in the burden of proof, the arbitrator might alter the application of just cause, from case to case; based on the particular nature of the matter with which he

[4] Elkouri & Elkouri, Fifth Ed., pp. 906 – 907.
[5] Agreement, Article 27.1, Discipline

is presented. A standard for just cause was developed many decades ago by Arbitrator Carroll Daugherty. While in the intervening time arbitrators have tweaked Daugherty's work, basically they have used all or part of his proposals to measure whether the Employer followed the tenants of just cause in discipline and/or discharge cases. The Union and the Employer have both offered in their written arguments their proposals for how the Arbitrator should apply just cause.

The Union offered the following definition of just cause:

> It is generally accepted that any "just cause" analysis involves an examination of seven mutually exclusive tests.[6] These tests include, but are not necessarily limited to, notice, reasonable rules and orders, investigation, fair investigation, proof of equal treatment and penalty.[7] However, because typically there is no definition of "just cause" contained within the CBA, an arbitrator utilizes his or her own definition and/or factors when determining if just cause for a particular discipline existed, and applies it to the facts. (Un. Br. p. 7)

The Employer offered the following definition of just cause:

> Different treatises offer different, but substantially similar, elements to be considered when considering what constitutes just cause. These elements in Washington state arbitration practice have commonly been reduced to these four questions for the arbitrator: (1) was notice provided to the grievant of the rules to be followed and the consequences of non-compliance? (2) is there proof that the grievant engaged in misconduct? (3) was the investigation of the misconduct procedurally sound?; and (4) was the discipline administered reasonable and even handed including consideration of progressive discipline when appropriate?[8] (Emp. Br. p 25)

The Union and the Employer's suggestions of just cause closely parallel the seven questions by Arbitrator Daugherty who claimed that affirmative answers to the following questions ensured that the Employer had provided just cause for the discipline/discharge of an employee.

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[6] Koven, Adolph M. and Susan L. Smith "Just Cause: The Seven Tests." P. 10, Coloracre Pub. Inc., San Francisco, CA 1985.
[7] Id.
[8] *See Wash. Fed' of State Employees v. DSHS, AAA No. 75-390-00549-05 (2006).*

> (1) Employee was forewarned of consequences of his actions; (2) company's rules are reasonably related to business efficiency and performance employer might expect from employee; (3) effort was made before discharge to determine whether employee was guilty as charged; (4) investigation was conducted fairly and objectively; (5) substantial evidence of employee's guilt was obtained; (6) rules were applied fairly and without discrimination; and (7) degree of discipline was reasonably related to seriousness of employee's offense and employee's past record.[9]

These questions will serve as the guide against which the Arbitrator will decide if the Employer has followed the tenets of just cause in the Grievant's termination. Due to the seriousness of the charges,[10] the just cause questions as applied to the whole case need to be answered positively, but not every charge against the Grievant needs to be sustained as being the individual cause of Justine's death.

Charge of negligence:
Employer claims the Grievant was negligent in the care of Justine on the evening of October 10, 2006 resulting in near drowning and Justine's eventual death. Charging the Grievant with negligence in her care of Justine is cited by the Employer as a violation of DSHS Policy 5.13. (Ex. JJ, pp. 2 & 9). The seriousness of the charges is argued by the Employer: "The harsh reality of this personnel action is that the best evidence of employee misconduct is the tragic fact that Justine is dead." The employer continued: " … Justine's death on Grievant's watch cannot merely be a reduced to a coincidence. Something must have happened that caused her caregivers to lose touch with her. (Emp. Br. p. 7)

Policy 5.13 states that neglect of vulnerable adults is against the law and will not be tolerated Policy 5.13 defines neglect as:

- *Allowing the physical environment to deteriorate to the point that a client is subject to hazardous situations, such as electrical, water and structural Hazards*
- *Failure to provide care within acceptable standards*

[9] *Enterprise Wire Co., 46 LA 359,(1966).*
[10] The Grievant's actions or inactions caused the near drowning and resultant death of Justine.

- *Failure to promptly respond to medical emergencies or requests for medical treatment* (Ex. JJ p. 10)

Opposing the negligence issue the Union raised several arguments; they said the Grievant and/or LaShonda did not leave Justine alone in the tub with out periodic and appropriate checks. The Union pointed out that there were no protocols in place regarding Justine's bath. In fact, because of SOLA's failure to maintain bathing protocols, a finding was made against SOLA Region 4 by Residential Care Services.

Despite the lack of bathing protocols for Justine, there is no question that all of Justine's caregivers knew of her seizure disorder. One of the records the caregivers were required to keep was of Justine's seizures; from June 9, 2006 to October 9, 2006 there were eighty seizures recorded in this report. The last seizure in the report was dated October 9, 2006, 2:50 AM, the seizure prior to this one was recorded by LaShonda on October 8, 2006, 10:56 PM and the seizure lasted for 2 min. (Ex. V)

Each year the staff worked with relatives, friends, medical personnel, and the client to develop a multi-page Personal Support Plan (PSP) for the client. The plans entered into the record were from 2001 through 2006. (Ex. K, L, M, N, O, P) The PSP from 2001 contained the following entry:

> Non-Negotiables – Things I (Justine) Must Have:
> A monitor so staff can hear me if I have a seizure when I am in my room or in the bathtub. I will usually carry my monitor to the bathroom; if I forget remind me and I will get it. (Ex. K, p. 2)

This theme, sometimes in different words, was repeated in each of Justine's PSP's through the PSP in place when she died.

> "I might need support to have the things I want and to do the things I want to do. The ways I'd like you to support me reach my goals are: Help me with my seizure – make sure I take my medication, track my seizures, and make sure I go see my doctor when I need to" (Ex. P, p. 4).

It was established that Justine had been to her neurologist the week prior to the near drowning incident and her medicine was changed because of an increase in seizures.

The Employer, while accepting that there was not a written bath protocol for clients with seizures such as Justine's, offered the following testimony through Sonja Pate, the Grievant's supervisor.[11] She was asked if there was a risk in leaving Justine alone in the bathtub for any period of time and she responded: "It was always a risk to leave Justine." (Tr. p. 56) When questioned about why there wasn't a written bath protocol for Justine she responded that "It was verbal. It was understood." (Tr. p.50) When Sonja was asked if leaving Justine alone in the bathtub for three minutes would be allowed, she said unequivocally, 'No – one or two minutes was the maximum." (Tr. p. 51).

In addition to having personal knowledge of Justine's seizures and the admonition to watch her closely in all of Justine's PSP's, the following information was also included in Justine's care giving folder kept at home for all caregivers to review**:**

> ***"MEDICAL CONCERNS/NEEDS:***
> Justine has severe seizures and needs to be watched closely"[12]

Several of Justine's SOLA caregivers testified at the hearing that Justine desired privacy when she took her bath and they respected her privacy. It appeared that in all instances the bathroom door would remain open and the shower curtain pushed aside. All of the caregivers, including the Grievant, said that they were always in a location where they could hear Justine in the bathtub; they also said that when they could not hear Justine in the bathtub they peeked in or went into the bathroom.[13] Thus it is well established through the testimony of Justine's regular caregivers who testified that if they were not directly watching Justine in the bath, then they were in a position to hear her. This indicates they were listening for noise from the bathroom - or for the lack of noise, if they did not hear any noise they would also look in on Justine.

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[11] It was disclosed that Supervisor Sonja Pate was given a reprimand because of the near drowning incident at the 105th St. Home on October 10, 2006. The reprimand was never presented to the arbitrator, nor was there specific testimony as to exactly what the reprimand was for. Based on this almost total lack of specifics regarding the reprimand it did not impact the just cause portion of the Arbitrator's decision.

[12] This folder, called a snapshot, was available in the home for all of Justine's caregivers.

[13] The witnesses testified that ordinarily Justine made noise in the bathtub. Conversation such as "now I am washing my leg, etc." There were two reasons given by the witnesses to account for Justine's silences; when she was soaking in the tub and when she was masturbating.

Bob Patterson, AC2 on the 7 AM to 3 PM shift explained how he monitored Justine who had been in his care for three years. He testified that he and his co-worker constantly monitored Justine. He said that when she was in the bathtub he or his co-worker would stand outside the bathroom door so he could hear her or see her if she had a seizure or went to sleep. He indicated he had not seen Justine have a seizure in the bathtub but she had gone to sleep; in those instances he pulled the plug. (Tr. pp. 84 – 86) Patterson related how he and his co-worker would monitor Justine when she was bathing:

> Q What was your routine, when Justine was in the bath and you were her caregiver, about how you monitored her situation while she was in the bath?
> A Well, when – Justine used to take baths in the day shift. And what we would – and when I say "we," I'm speaking of my other co-worker – it would be one of us would be by the bathroom door.
> Q How close to the bathroom door?
> A Right outside the bathroom door
> Q Why?
> A Justine didn't want anybody in there to watch her, so we respected her privacy. (Tr. p. 85)

Bob Patterson's testimony continued:

> Q And would you be able to hear what Justine was saying while she was in the tub?
> A Yeah.
> Q Was she generally talking while she was in the tub?
> A She might talk sometimes, but there was splashing. I mean, I myself, if I didn't hear splashing, I would check. I would look in. (Tr. p. 85)

Ms. Evelena Robinson and Ms. Viletta Douglas, both AC2s and caregivers who had cared for Justine in the 105th Street Home and were familiar with the Grievant, were called by the Union to testify in this case. While Viletta did not give an example of how often she would check on Justine during her bath she put in the following direct testimony:

> Q Is it possible she (Justine) would be in the tub for upwards of five to ten minutes without being checked?

> A I don't remember that, but there wasn't a time to go and check, no. (Tr. p. 484)

Again, all of the caregivers who testified at the hearing or were interviewed by staff indicated that even though they respected Justine's privacy during her bath they were always in a position to hear what was going on or not going on in the bathroom. When they did not hear sounds of bathing, they would check on Justine.

The Grievant testified at the hearing that she asked Justine to take her bath at 7:56 PM; between then and 8:12 the Grievant checked the water level and Justine got into the bathtub, she then checked on Justine at 8:12 PM. She said that the next check on Justine was by LaShonda at 8:16 PM. The Grievant then checked Justine at 8:20 PM:

> I saw Justine lying in the tub, her head was kind of slumped down and to the side. Her lips looked a little bluish and her eyes were closed. When I was calling her, she wasn't responding. (Tr. p. 381)

The Employer raised an issue concerning the times from the Grievant's testimony above and the identical times found in the Grievant's first written report. (Ex. H) The Employer points out that while LaShonda was not as sure of the times as the Grievant, she has come to repeat those times also. The inference is that the Grievant and LaShonda rehearsed the times from the time the emergency personnel left until Ms. Spellman's arrival. Ms. Spellman said the Grievant and LaShonda together verbally related the details of the incident to her. Ms. Spellman further said that although the Grievant did most of the talking the caregivers exchanged "validating" looks with each other during their initial report of the incident. (Ex. S, p. 3)

Detective Bartlett:

The Grievant was interviewed about the incident at least six times; twice by the Sheriff's Department, (three times if you count the polygraph[14]) and four times by DSHS employees. Detective Bartlett[15] of the King County Sheriff's Office was the lead criminal investigator and conducted her first interview of the Grievant on October 20, 2006, ten days after the incident.

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[14] The Grievant voluntarily took the polygraph which turned out to be inconclusive.

[15] Detective Bartlett, a detective with 23 years of police experience was the lead criminal investigator. The Sheriff investigates deaths of children and developmentally delayed adults.

Detective Bartlett's testimony left no doubt that she felt Justine's death was a result of negligence on the part of the caregivers.

> I did the follow up interview because, upon further investigation of this case, my suspicions were that Justine was left unattended by both employees. (Tr. p. 108)

The Detective expressed concern over the fact the Grievant and LaShonda related precisely the same times when discussing the events surrounding the incident; 7:56, 8:12, 8:16, and 8:20. When relating the events of the day up until bath time they used approximate times; examples were, "about 4:00 or so", "a little after five", Oh about 10 after 7:00." and "…closer to 7:00." (Ex. CC, p.p. 10 & 11)

> Det: Okay. Did you (and LaShonda) talk about the time of events?
> Wit: We might of.
> Det: In your experience of a couple of years working with her (LaShonda), do you know her to be a clock watcher?
> Wit: No.
> Det: Okay. So if she gives us those times, is it possible she got those times from you?
> Wit: Yes.[16]

LaShonda confirmed that she had talked to the Grievant prior to her interview on October 20, 2006 by Detective Thien Do. Detective Bartlett was present for LaShonda's interview.

> Det B: Have you talked about this with (Grievant)?
> Wit: Yeah, I've called her, see how she's doing, she if she's hurting again. (Ex. FF, p. 40)

Detective Bartlett testified that there were factors other than the times which made her suspicious of the Grievant and LaShonda's accounts of the incident as she testified during her direct examination by Mr. Scott.

> A: Well, my suspicion was that Justine was left unattended and that, when they did find her, that CPR was not initiated.
> Q: Why do you say that?

[16] Detective Bartlett's second interview of the Grievant on 11/09/06, p. 6.

A: I say it for a couple of reasons. During the search warrant, I found a CPR mask that was unused, which was odd since they were care providers. When I listened to the 911
(After argument the direct testimony continued.)
Q: Do you have an opinion, based on your investigation, as to whether or not CPR was conducted in the manner or to the degree that the two women related to you, Detective Bartlett?
A: My opinion still was that CPR was not initiated. And outside of the 911 tape, when I interviewed the firemen, one of the women was outside and the fireman that came in first, when he responded, he stated that Justine was alone in the bathroom. My experience, having gone through CPR training myself, is that, once you initiate CPR, you don't stop until the fire department arrives." (Tr. pp. 116 -118) (Emphasis added)

Detective Bartlett was questioned further about the 911 tape in cross examination:

Q It's true on the 911 tape that we do not have in the record that CPR could be heard in the background; is that true? Or do you know?
A Well, my opinion was that it wasn't being done.
Q That wasn't – I guess that wasn't my question. You indicated you listened to the 911 tape.
A I did.
Q And is it your testimony that CPR process was heard in the background?
A No, it isn't. (Tr. p. 125)

James Medema, EMT Kent Fire Department:
James Medema was the first firefighter to enter the 105th Street Home in response to the 911 call about the near drowning incident with Justine. He related in his interview on 11/01/06 with Detective Bartlett that there was no one else in the bathroom when he entered except Justine. He said that the bathroom was too small to perform CPR and the EMT needs a lot of room to work. Justine was moved into the living room and the EMT commenced their medical protocol. EMT Medema also told Detective Bartlett during her interview of him:

Det: Were you the first person into the bathroom?
Wit: Yes, I was, first from the Department.

> Det: When you arrived, was CPR initiated?
> Wit: Um, I don't know if they had initiated some kind of resuscitative efforts, but there was nothing ongoing when, when I went into the bathroom.
> Det: Is that, would that be standard to what you see on a CPR in progress call?
> Wit: Um, not typically. Typically there's somebody with the patient trying to do something. (Ex. BB, p. 4)

Medema testified that the 911 call was logged at 20:23:36 (8:23) on October 10, 2006 and they arrived at the 105th Street House at 20:28:47(8:28). (Ex. Q) He further testified that Justine's hair was wet but her body was dry and there was not a lot of water on the bathroom floor. In regard to the treatment provided for Justine, EMT Medema testified that he did CPR, the Medics did drug IV therapy and they intubated her. He also testified a defibrillator was used on Justine and she was transported to the Hospital when her vital signs were stable.

Failure to monitor and supervise client Justine B. during her bath on October 10, 2006:

If one assumes the times related by the two caregivers are accurate, we have the Grievant asking Justine to bathe at 7:56 PM. Justine had a ritual about getting ready to bathe and also a ritual while bathing. The caregivers all referred to the ritual when they were questioned by the Sheriff's Detectives and supervisors. Often it would take 15 – 20 minutes for Justine to prepare for her bath; disrobing in the bathroom, laying out her towels and wash cloths, sitting on the toilet and drawing her water. The Grievant said that when she heard the water shut off, she would enter the bathroom and check the water depth, and on the date in question she stated she went into the bathroom to perform this check at 8:06 PM. The Grievant testified that on the evening of October 10, 2006 Justine was much speedier than usual. (Ex. DD, p. 11) The Grievant said she next went into the bathroom at 8:12 PM and suggested that Justine, who was just soaking in the tub, start her bath. She then left the bathroom but immediately returned to use the toilet. She closed the curtain while she used the toilet and then reopened it when she left. It is also evident that at some point while Justine was in the bathroom the Grievant sat on the couch in the living room and was joined there by LaShonda. During her interview with Detective Do, LaShonda related the events of the evening as follows:

> Det: And it was you and the (Grievant) and Lisa sitting on the couch watching TV?
> Wit: Un-huh, well Lisa wasn't sit … excuse me, Lisa was sitting at the table.
> Det: Okay, kitchen table?
> Wit: Un-huh.
> Det: Is there a kitchen table and a dining room table or … cause I haven't been there?
> Wit: Its pretty much like this except smaller
> Det: Okay and you guys don't remember what you were watching?
> Wit: No, it was between … (unintelligible). It was Jeopardy cause we watched Wheel of Fortune and Jeopardy. Oh what comes on Channel 13? I don't remember.
> Det: Okay, that's all the questions I had. (Ex. FF)

LaShonda and the Grievant agreed that it was 8:16 PM when LaShonda went into the bathroom and told Justine to start her bath. LaShonda said that Justine picked up her wash cloth and reached behind her for the soap and began to wash. Lashonda then returned to the couch where the Grievant was sitting and resumed watching TV. The Grievant then said that at 8:20 she went into the bathroom and found Justine.

The Grievant and LaShonda's testimony indicate there was a <u>four minute</u> window between the time LaShonda checked Justine and when the Grievant found her not breathing. Justine's caregivers said that when Justine took a bath, they would listen for noises from the bathroom and also for the lack of noise. The Grievant claims that she was in a position, in this very small house, where she could hear everything in the bathroom; knowing that LaShonda had just told Justine to bathe, it seems improbable that she would not have been listening for sounds of bathing from the bathroom, or the lack thereof. But the Grievant apparently did not hear anything from the bathroom, and that did not alarm her. It is evident that something distracted the Grievant from her main task of the moment, monitoring Justine's bath. It is equally obvious there had to have been adequate warning of a problem, *i.e.,* no noise of Justine bathing, which should have sounded an alarm to a person who had worked with Justine for years.

The Grievant and LaShonda's recollection of the events and times of that tragic evening strains credulity; while the check times of 8:12, 8:16 and 8:20 were exact, other times were "around" or "ish" much less than the exact

times of the bathroom checks related by both caregivers. There is no way to determine that these times were correct or incorrect. However, even using the times the caregivers supplied, LaShonda's 8:16 check-in with Justine and admonition to start bathing, and the Grievant's 8:20 re-check seem to have been enough time for the client to have a near drowning accident resulting in brain function damage leading to her death.

The Employer charged the caregivers with collusion regarding the specific time of checking Justine in the bath. Ms. Spellman related that when she first went to the 105th Street Home she asked for a verbal report about the incident. According to Ms. Spellman's written report, although both caregivers were present the Grievant did most of the talking regarding the incident. (Ex. R. p. 1) The Grievant, during the October 20, 2006 interview with Detective Bartlett, was asked if she had talked with LaShonda since the incident and she indicated she had not. (CC. p. 47) Upon further questioning by the Detective, the Grievant admitted to having talked with LaShonda since the incident. (CC p. 48)

The Grievant's October 20, 2006 recollection to Detective Bartlett of what she was doing while Justine was taking her bath does not add to her credibility. She first said she was writing in the Log Book (CC. p. 7) In response to another question about what she was doing she said she was: (1) working on the log book and: (2) working on information about an appointment for energy assistance. (CC. p. 15) Then in response to a third question about what she was doing, she said she was doing the energy assistance and the Log Book. (CC. p. 16) Her final response was: "Um, I don't know what all I was doing. I'm sorry." (Ex. CC. p. 16)

The Grievant's statement about what she was doing on the couch while Justine was in her bath is not the whole story. For instance, the Log Book for the date in question 10/10/06, does not have any entries after 5:30 PM. (Ex. NN, p.2) She may have been doing some energy assistance. The energy assistance, while not offered as an exhibit, was characterized as something that was very minimal. If the Grievant's primary duty was to ensure Justine's safety while she was bathing, doing work which could have been done later is incomprehensible.

While both caregivers admit they were sitting on the couch watching TV during Justine's bath, only the Grievant said the TV was muted. LaShonda, who did not say the TV was muted, actually gave the names of the programs

they were watching at that time. While one could conjecture about what distracted the Grievant from her prime duty of the minute (monitoring Justine's bath), it is not important in the grand scheme of the evening's events; what is important is that Justine had a near drowning experience that resulted in her death while under the Grievant's care. The Employer decided they had just cause to terminate the Grievant for negligence and the record supports that finding.

Failure to properly and adequately administer CPR to Justine B. on the evening of October 10, 2006:

The Grievant said that after she found Justine unresponsive in the tub, she called LaShonda and they removed her from the tub.[17] There seems to be differing descriptions of the physical removal of Justine from the tub[18] and what the caregivers did immediately thereafter. For instance, both caregivers claim they were the one to initiate CPR. But more important discrepancies than who started CPR exist. The drawings and measurements of the bathroom show that it is a relatively small space. The open space by the side of the tub was approximately 3' by 5'. (Ex. GG) The caregiver's describe Justine lying with her head by the vanity with one leg and her mid-section by the toilet, and the other leg up on the side of the tub. CPR was started with one caregiver performing the compressions and the other the breaths. It was shortly after CPR was started that LaShonda left for the living room where the phone was located to call 911.[19] There was confusion at this time as LaShonda brought the phone into the bathroom and tried to give it to the Grievant who according to her rendition of events was doing CPR; obviously, she could not do CPR and talk on the phone. They reported that the 911 operator asked the caregivers to count out loud, which they did for one series. But during this period of time LaShonda did not stay continuously in the bathroom; she reported she went to the front door, into the living room, into one of the client's bedrooms and into the driveway.

The Grievant maintained that she continued CPR until the EMTs arrived. But this is not consistent with the Fire Department's testimony. EMT Medema was the first to arrive on the scene and he said there was no one in the bathroom with Justine when he arrived. He also said there was not

[17] The Grievant said she pulled the stopper to let the water out as they were removing Justine from the tub.
[18] Due to the stress of the moment and the need to get Justine out of the tub, this conflicting story is not considered major.
[19] Critical times that surround the 911 call are 8:20 PM discovery of Justine, 8:23 PM 911 call received by the fire department and 8:28 PM arrival of the EMTs to the 105th Street Home.

enough space in the bathroom for the EMTs to practice their lifesaving techniques on Justime and they immediately moved her into the living room.[20] Medema's description of Justine as he found her in the bathroom, with wet hair but a dry body, and the fact there was little water on the floor and no noticeable wetness on the caregiver's clothes provides more confusing information.

The 911 calls were recorded and made available to the authorities. Unfortunately, the 911 recording was subsequently lost and was not available at the hearing. Detective Bartlett, however, did have access to the 911 recording during her investigation and prior to its loss and she was asked by Union counsel during cross-examination if she heard CPR on the tape and her unequivocal answer was, "No."[21]

Inconsistencies and less than honest responses during the investigation: The Grievant's explanation of her activities while sitting on the living room couch during Justine's bath is not credible. Her response to the three separate questions about her activities was that she was doing the logs; yet there is no entry in the logs after 5:30 PM. She also said she was working on the energy application but this was described as minimal and unnecessary at that time.[22] The time factors used by the caregivers to indicate when they checked on Justine from the start of the bath until she was found in the tub are the same and exact, yet other times for the day of the events in question are less exact.[23] In the interviews of the Grievant, she said she did not talk to LaShonda about the near drowning death of Justine; the Grievant herself later repudiated this information. (Ex. CC, p. 47)

There were inconsistencies in the Grievant's description of the amount of water in the tub, how long it took to get the water to reach the level described by the Grievant, and the emptying of the tub. Both caregivers and other SOLA personnel emphasized that after the bathwater was drawn they checked to see that it was not too deep; and on the date in question the Grievant said she checked the water about 8:05- 8:06 PM. But the investigation conducted by Michelle Bauchman, Region 4 SOLA Program Administrator, Nancy Hammil, AC Manager and Debra DeKruif, AC Manager of the bathtub, demonstrates some inconsistencies that make the

[20] EMT Medema's testimony is found above.
[21] See testimony above.
[22] See testimony above, (Ex. KK).
[23] See testimony above.

Grievant's description of the bath difficult to accept. The above SOLA investigators went to the 105th Street Home and measured the tub, they measured to the depth the Grievant testified she would allow the water. There was also a soap ring at that depth. (Tr. p. 406) The SOLA investigators took eleven pictures of the tub, both empty and with Ms. Hammil as a model. The Grievant described Justine's posture and position in the tub when she discovered her at 8:20 PM as laying flat in the tub with her feet touching the end, with her head tilted to the right and her mouth under water. (Ex. CC, p. 7) The SOLA investigators asked Ms. Hammil to model the Grievant's description of Justine above. Ms. Hammil is two inches shorter then Justine, 5'3'' to 5'5''and about ten pounds lighter 145 pounds to 155 pounds. When the Grievant was asked by the Employer attorney to identify which picture of Ms. Hammil most closely represented Justine, she identified number six. (Ex HH, #6) Again, while Ms. Hammil was two inches shorter and 10 pounds lighter, her mouth and nose were not under water in the picture identified by the Grievant as the most characteristic picture of Justine. There is no argument that Justine suffered a near drowning death due to the above described incident. Looking at the smaller Ms. Hammil in the same amount of water described by the Grievant as causing Justine's near drowning does not make sense. At least one of the factors described by the Grievant must have been different.

JUST CAUSE

1) Employee was forewarned of consequences of her actions? The Grievant reviewed and signed her position description approximately two months prior to the incident. (Ex. KK) The position description clearly spells out the duties and obligations required by an AC2. At the time of the incident, Justine's near drowning and death, the Grievant had worked as an AC2 for DSHS since 1999 and privately since 1990; she was an experienced professional caregiver. It is abundantly clear that Developmental Disabilities Policy 5.13 establishes that any neglect of vulnerable adults "will not be tolerated." (Ex. JJ, p. 2) The preceding language clearly spells out the intent of the policy. Even without policy or forewarning, there are some employee activities that are so egregious that the employment related penalty is termination. The negligent death of a client fits this category. The answer to this question is yes.

2) Company's rules are reasonably related to business efficiency and performance employer might expect from employee? The employer specifically charged the Grievant with violating Policy 5.13 of the DSHS, Division of Developmental Disabilities, Protection From Abuse, Policy 5.13. The answer to this question is yes.

3) Effort was made before discharge to determine whether employee was guilty as charged? The Employer implemented an extensive, intensive and detailed investigation of the Grievant's activities or lack thereof regarding the incident. Again, the only persons who have on the scene knowledge of the incident as it occurred are the Grievant and LaShonda. The Employer's task is to demonstrate that the termination of the Grievant was based on reliable and significant evidence. The mere fact that a young vulnerable woman died on the Grievant's shift is not adequate to support a finding of neglect and form the basis of the termination; there must be more.

   There was a plethora of investigations by the Sherriff's Department, Grievant's supervisors and the extensive investigation of Bauchman and Davis which included a synopsis of all the other investigations. In each and every one of the investigations, the investigators concluded that there were unanswered questions and incomplete explanations of how Justine's near drowning occurred without anyone hearing her; she near drown in a tub with less than enough water to cover her model who was two inches shorter and 10 pounds lighter. The record of these proceedings demonstrates that the amount of water the Grievant said was in the tub was not adequate to have a near drowning and no one in that very small house heard any noise from the bathroom.

   EMT Medema said that when he arrived at the bathroom that only Justine was there and he did not see anyone leave the bathroom. He further said it was unusual to arrive on a CPR scene and to not see anyone helping the victim.

   Detective Bartlett, a twenty plus year veteran detective of the Sheriffs Department that the events surrounding the incident raised unanswered questions. Further, she also concluded that the Grievant and Lashonda removed Justine from the tub and did not do CPR.

When questioned by the Union Attorney as to whether she heard CPR on the 911 tape, she said "No."

There are still unanswered questions surrounding the incident; why was Justine's hair wet and her body dry, why wasn't there more water on the bathroom floor, why weren't the caregivers wet from pulling Justine out of the tub, why couldn't the detective hear CPR being administered on the 911 tape, why didn't the Grievant or LaShonda check when they did not hear any noise from the bathroom after LaShonda said Justine began to wash at her 8:16 check, why didn't the caregivers attempt to move Justine to the living room where they would have had more room to work on her? The preponderance of the evidence supports a finding that the Employer had just cause to terminate the Grievant. The answer to this question is yes.

4) Investigation was conducted fairly and objectively? The Employer assigned two supervisors, one from the Grievant's area, Ms. Bauchman and one from another SOLA area, Mr. Davis, to conduct the investigation. Mr. Davis, who had conducted many investigations during his tenure in DSHS, is currently the program manager of statewide investigations for DSHS Division of Developmental Disabilities. The investigators reviewed and utilized the interrogations by the King County Sheriff's Department, Detective Christina Bartlett, a Detective with 23 years police work and her partner Detective Do. The answer to this question is yes.

5) Substantial evidence of employee's guilt was obtained? As was stated earlier, only the Grievant and LaShonda know for sure what happened in the 105th Street Home on October 10, 2006. The near drowning and subsequent death of Justine, a young developmentally disabled woman took place while her two professional caregivers were within a few feet of the bathroom. The Grievant maintained that she was in a position to hear Justine in her bath; it was previously established that upon not hearing noise from the bathroom the caregivers would visually check Justine. The Grievant said during the time Justine was in the bathroom, she checked the water level when Justine turned off the water at 8:05 PM or 8:06 PM, she then checked on Justine at 8:12 PM and before returning to the couch, she used the bathroom, and then returned to the couch, she said that at 8:16 PM LaShonda checked on Justine in the bath and then she also sat on the

couch, the Grievant said while sitting on the couch she was filling in the Log Book, and clarifying some notes for energy assistance. Now there are some notes in the log about energy assistance, but the last time entry is 5:30. (NN, p. 2) If one is to accept that the Grievant was making log entries about the energy assistance between 8:00 PM and 8:20 PM, it could not have taken more than a minute or two to write the following:

> "Made appt. for energy ass. Nov 8 11AM
> Only Lisa needs to go, but bring
> Enjo on all three ladies" (Ex. NN, p. 2).

The question remains, what was she doing the rest of the time? That is a very serious question for which no answer has been provided. There is no doubt that Justine died due to the Grievant's negligence.[24] The answer to this question is yes.

6) Rules were applied fairly and without discrimination? The Union has not contended unfairness or discrimination in this matter. In addition the Employer twice offered to discuss previous disciplinary cases but the Union objected and the offers were dropped. The answer to this question is yes.

7) Degree of discipline was reasonably related to seriousness of employee's offense and employee's past record? While the Grievant's record was very good, the finding of negligence resulting in the near drowning and subsequent death of a developmentally disabled adult in the Grievant's care is so serious as not to allow for mitigation. The answer to this question is yes.

[24] See number 3) above.

AWARD

The Employer had just cause to terminate the Grievant, Murine McGenty, from her position as an AC2 in the Washington State DSHS SOLA program. Grievance AAA # 75 390 00471 08 is denied.

Richard W. Croll — February 3, 2010

Richard W. Croll, Arbitrator — Date