#1146

IN THE MATTER OF ARBITRATION

BETWEEN

STATE OF OHIO
DEPARTMENT OF REHABILITATION & CORRECTIONS
OHIO REFORMATORY FOR WOMEN

AND

OHIO CIVIL SERVICE EMPLOYEES ASSOCIATION
LOCAL 11
AFSCME. AFL-CIO

Arbitration Date: September 29, 2015

Grievant Dennis Johnson: #27-19-(2013-11-22)-0261-01-04

BEFORE: Arbitrator Craig A. Allen

Advocate for the Employer:

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GENERAL COUNSEL

I. HEARING

The hearing was held September 29, 2015 at the Ohio Reformatory for Women. The hearing commenced at 9:20 A.M.

The stipulated issue before the Arbitrator is "Was the grievant removed for Just Cause? If not, what shall the remedy be?"

II. STATEMENT OF THE CASE

The Grievant was removed November 20, 2013 for violations of the Code of Conduct and General Work Rules: Rule 8, failure to carry out a work assignment or the exercise of poor judgment in carrying out an assignment; Rule 41, unauthorized actions or a failure to act that could harm any individual under the supervision of the Department.

The Grievant has a written reprimand for Rule 8 and 1-DWS Rule 8 on his record.

On November 22, 2013 the Union filed a Grievance and the matter is properly before the Arbitrator.

PRELIMINARY MATTER

The Arbitrator inquired as to the status of this Case as the Union filed an action in the Union County Common Pleas Court after the last hearing.

Jessica Doogan, Associate General Counsel, said the Employer contended that certain documents requested by the Union were prohibited by the Ohio Revised Code. The Arbitrator had ruled that the documents were to be provided to the Union. The Union dismissed part of its action concerning subpoenas and the Court found that the Arbitrator's Award was not an award because removal was the issue.

III. THE EMPLOYER'S CASE

The Employer's first witness was David Pennington. Mr. Pennington is a Registered Nurse and has twenty-one (21) years with the Department. He is now the Health Service Administrator at Franklin Medical Center.

Mr. Pennington was at ORW for three (3) years and was Medical Operations Manager. He worked with the Grievant all three (3) years but was not his direct supervisor. The medical operation is in a separate building and provides all health care for the inmates. Mr. Pennington said ORW has the largest medical staff in the state. Mr. Pennington testified that ORW has two thousand five hundred (2500) inmates. One way inmates request medical attention is to put letters in the mail. Mr. Pennington testified that there are six or seven practitioners here and a staff of fifty (50).

Mr. Pennington testified that some inmates carry their own meds and some inmates come to Operations. The inmates go to the window to get their meds and are observed until they swallow them.

Mr. Pennington then said that JX 71 was Policy B-10. This is the Policy of guidelines for the safe administration of medication. Mr. Pennington testified that failure to follow policy can cause harm to the inmate or even death.

Mr. Pennington then read JX 74 which is Section E-1 of the Policy Guidelines. It says: "Medications are to be administered to the patient by a nurse in accordance with the following: a) Right person (patient) and right inmate number; b) Right Drug; c) Right dosage; d) Right route; e) Right time. Mr. Pennington said on June 25, 2013 Inmate 1 came to the window to get meds. The Officer watched her swallow the Meds. The Inmate came back saying she wasn't feeling

well and was seen as a medical emergency by an RN. The RN referred the Inmate to the Practitioners. He said the Inmate then went to the infirmary.

Mr. Pennington then watched the video and testified that Inmate 1 was there and the Grievant was in window 1 preparing meds. He testified that the Grievant was looking through medical records. The video shows Inmate 1 swallowing the meds.

Mr. Pennington then looked at JX 99 and said it was a photograph of Inmate 1. Mr. Pennington testified that he talked to Inmate 1. Mr. Pennington said that after Inmate 1 goes into the infirmary she said she got the wrong meds. The Nurse told him Inmate 1 had questioned the meds at the window.

Mr. Pennington read JX 98 and said it was the statement of Inmate 1 taken July 23, 2013 at 1:50 P.M. Inmate 1 says it didn't look like my meds. The Nurse said it was pain medication and to talk to the Dr. about it. Inmate 1 said her chart said she wasn't there for her meds.

Mr. Pennington testified that he called the Grievant and told the Grievant that Inmate 1 said she took four (4) pills not prescribed for her. Mr. Pennington said the Grievant displayed no shock or remorse.

Mr. Pennington then read JX 51 and said it was his Investigatory Interview. Mr. Pennington read JX52 of the Interview and read Question 5, "Which inmate was run in medical on 6/25/13 for being "higher than a kite" and had difficulty walking?" His answer was Inmate 1, upon eval. she needed to be admitted to the infirmary for evaluation.

Mr. Pennington read JX 53 of his statement: Question 6 "What did Inmate 1 indicate to you was the reason for her apparent drugged condition?" His answer was, "She stated that she took 4 pills from Nurse Johnson from window 1 that she did not believe were hers. She stated

that she asked Nurse Johnson about it and he told her that it was just her pain med and she needed to take it." Mr. Pennington then read Question 7: "Did you check the MARS for Inmate 1's prescribed med?" He answered: "Yes and she was only due Altrum and it was not signed out."

Mr. Pennington read Question 8: "Did you ask N Johnson about this medication issue? His answer: "Yes and he said he did not give her Altrum and he verified she was not due for any other medication."

Mr. Pennington then read JX 131 and said it was the Medical Accountability Record (MAR). This is a list of all meds. He testified that the June 2013 MAR shows a negative symbol for June 25, 2013 that Inmate 1 did not receive medication. Mr. Pennington testified that the video shows the Grievant giving med to Inmate 1.

Mr. Pennington then went back to JX 53 Question 10: Was Inmate 1 able to identify any of the meds she received that morning? He said: "Yes, according to N Eirch's documentation she ID Thorazen 50 mg. And Neurontin 300 mg. Tablets which are not prescribed to her and could potentially create the sp. she described."

Mr. Pennington then testified I think Inmate 1 says she took 3 or 4 pills at the window. Symptoms could be for one not use to meds. He said the Grievant was removed from Pill Call Duty after the incident. The Grievant's action was not consistent with Policy and Procedures. Mr. Pennington testified that the Grievant cannot be trusted to do the job.

On Cross-Examination Mr. Pennington was referred to JX 99 and said it was a photograph of Inmate 1. Mr. Pennington was asked: "Can an Inmate change hair style or color?" He said: "Yes the hairstyle was similar to the video." He said he was not present at the A.M. Pill

Call on June 25 as he was at the infirmary. He also said he was not present at Inmate 1/s evaluation.

Mr. Pennington then viewed the video and JX 99 which is the photograph of Inmate 1. He testified that Inmate 1 has her hair up in the video at 6:50 A.M. June 25, 2013. Mr. Pennington then went back to JX 53 Question 9: "Was there anyway to verify the Inmate's statement about taking the 4 pills?" He said, "Yes, it is on video per Mr. Elins that Inmate 1 did receive some medication at 7:58 A.M. on 6/25/13." Mr. Pennington did not see 4 pills but he saw Inmate 1 take some meds on the video. He testified Nurse Eirch got description of drugs from Inmate 1.

Mr. Pennington read JX 130 and testified that Inmate 1 did not get the med she was supposed to get. He was then referred back to JX 99 and asked what was Inmate 1's most serious offense. Sale of counterfeit drugs.

On Re-Direct Mr. Pennington was asked if inmates could have plastic surgery and he said not as an elective.

Mr. Pennington testified that inmates are to present a photo ID to get meds. If a Nurse questioned the ID they were to pull up the inmates photo and call the Captain's Office.

On Re-Cross Examination Mr. Pennington was asked if he knew of any incidents of an inmate using another inmates ID. He said he didn't know of a case like that. Mr. Pennington was then asked if an inmate could change her hair style to pass as another inmate. He said he didn't know.

The next witness was Angela Embaugh. She is a first shift Relief CO. CO Embaugh read JX 56 which is her witness statement taken July 9, 2013 about the incident June 25, 2013. CO Embaugh was shown JX 99 and said that is the inmate in her statement.

CO Embaugh read JX 57 of her statement and said the Nurse notified her that Inmate 1 was having trouble breathing. She read Question 2: "How did the inmate appear to you , upon arriving in the infirmary?" She answered: "She looked drunk or over medicated. She could not walk without assistance. The Nurse and I helped her back to the room. It took two people".

CO Embaugh read Question 3, "Did you witness any conversations among staff and inmates regarding this situation? " She said "The inmate was accused of not showing up for her meds by Nurse Johnson. When the Emergency Nurse was assessing her the nurse asked Nurse Johnson what did the inmate take. He told her several medications by name. Then the inmate spoke up and stated I was ordered new medication so what he gave me this morning did not look right but I took it anyway because I thought it was the new medication the Dr. had ordered. Nurse Johnson held up his paperwork to the window stating she will not come in which we signed off as a refusal. The inmate then gave a description of every pill she took and said don't you remember. I then escorted her back with the help of a nurse to put her on observation."

Upon Cross-Examination CO Embaugh was asked: "Was it possible that the Nurse asked the Grievant what was prescribed, not taken?" CO Embaugh replied: "That was a long time ago. I can only say what's in the Interview."

The Employer's next witness was Dr. Karen Dapper. Dr. Dapper has a Ph D in clinical psychology and is also a Registered Nurse.

Dr. Dapper read JX 95 which is the Incident Report of the June 25, 2013 Incident. The report was of a phone call from CO Embaugh to Lieutenant Carper. CO Embaugh advised that an inmate was coming back to the infirmary because she was "higher than a kite" to the point where she needed assistance to walk to the infirmary........ The story she gave was that she went to the

infirmary, got her meds which she said did not look like her normal meds. She asked Nurse Johnson what they were and he told her it was just her pain meds. She took them, went back to her Unit, and began to feel funny. She stated she didn't like the way she felt so she took a nap. She complained of dizziness and feeling loopy. Appearance wise, the inmates eyes were dilated, her speech was slurred and she was acting funny. A "Just Cause" urine test was administered and the inmate was placed in the infirmary for observation.

Dr. Dapper then read JX 25, 26 and 27 which is the conclusion of her Investigation Report. Dr. Dapper read that CO Embaugh said Inmate 1 was being brought over to the infirmary by another inmate as she was having difficulty walking. She stated that upon arrival the inmate appeared "drunk or over medicated". The inmate was accused by Nurse Johnson of not showing up for meds, but the inmate did show up. Inmate 1 asked the Grievant if he did not remember her. Inmate 1 said it was not her fault.

Dr. Dapper next read JX 98 which is Inmate's statement. Inmate 1 said: "one morning I went to take my meds and the Nurse gave me some pills they didn't look like my meds I normally take so I asked he said its my pain med to talk to the doc about it so I took them left later they made me fill racey dizzy shakey so I told a CO they sent me to the hospital then told me they think I took somebody else meds and my chart said I wasn't there for meds ...."

Dr. Dapper then looked at the video and identified Inmate 1 and the Grievant. Dr. Dapper looked at JX 99 and said that is Inmate 1 on the video.

Dr. Dapper then read JX 30 and said that is the Investigatory Interview of the Grievant. She read JX 36 Question 7 "Showed video of N Johnson and Inmate 1, - Is this you and Inmate 1? He answered: "It is me. I don't know if it is Inmate 1."

Dr. Dapper then read JX 28: Nurse Johnson said that he did not remember administering medication to Inmate 1 on 6/25/13. He reported that he only remembers that his supervisor approached him about the situation. He stated he did not remember seeing Inmate 1 that morning. He also stated that he would have checked her ID as she holds it up to the window.

Dr. Dapper next read JX 131 which is the MARS report for Inmate 1 for June 2013. The report says meds not given and the Grievant says those are his initials.

Dr. Dapper read JX 28 and 29 which says the video shows Inmate 1 receiving meds from the Grievant. She also read JX 129 which is the Lab Report on Inmate 1's Urine Test June 26, 2013 which shows "No Drugs."

Dr. Dapper next read JX 29 items 4 - 10 which are her conclusions: 4) In regards to the situation involving Inmate 1 "drugged" condition, it appears that the inmate was administered the incorrect medication. She was apparently administered medications which the inmate reportedly told Nurse Johnson did not look like her medication but was instructed by him to take it. 5) Furthermore, she did not apparently receive the medication she was supposed to take (Ultram) as it was signed out as a refusal per the MARS. 6) Upon investigation it appears that Inmate 1 was probably administered Thorazine and Neurontin which are not part of her medication regime and could potentially result in the symptoms she displayed. 7) It is expected that medication errors can occur in the practice of nursing however, if a patient tells the nurse that the medication is incorrect the nurse should stop and recheck the medication orders at a minimum to assure patient safety. 8) Inmate 1 did experience a negative medical outcome due to being given the incorrect medication as evidenced by her drugged appearance and condition. 9) The video of medication administration shows Nurse Johnson administering some unidentified medications to Inmate 1 on

the morning of 6/25/2013. 10) The "Just Cause" urine screen came back with no illicit drugs noted.

Dr. Dapper read JX 36 and said the Grievant said the MARS signature was his. The Grievant also said he had not looked at Med Policy in a long time. Dr. Dapper read JX 71 which is the Medical Administration Protocol B-10. It sets forth at JX 74 E-1 the 5 rights of patients.

Dr. Dapper said her conclusion was that Inmate 1 got the wrong meds June 25, 2013.

On Cross-Examination Dr. Dapper testified that inmates can change their hair style. Dr. Dapper read JX 99 and said the photograph and the video have different hairstyles. Inmate 1/s hair is pulled back in the video.

Dr. Dapper next read JX 29 and testified there was no medical diagnosis made. Inmate 1 was not tested for Thorazine and Neurotin. Dr. Dapper read JX 129. She said prescription drugs may be illicit. Dr. Dapper testified that amphetamines without a prescription is illicit. With a prescription it is not illicit. She was asked if "Thorazine gives a false positive for one of these drugs?" Dr. Dapper said: "Not sure."

Dr. Dapper read JX 27 and JX 98 where the inmate said it was the fault of staff. Dr. Dapper then read JX 64 which is the Investigatory Interview with Nurse Brown. Nurse Brown said she did not remember a conversation between the Grievant and Inmate 1.

Dr. Dapper then read JX 60 the Investigatory Interview with CO Comer. CO Comer said he doesn't recall this incident specifically. CO Comer said it is common for inmates to ask about their medication because colors and sizes of medications change.

On Re-Direct Examination Dr. Dapper read JX 27 where Inmate 1 says it was staff's fault. She also looked at JX 99 and testified Inmate 1's hair color is the same as in the video.

On Re-Cross Examination Dr. Dapper looked at video. She testified that the Nurse should check MARS and identify the inmate. The Nurse should include all 5 rights.

The next witness was Athena Brown. Ms. Brown is a Union witness called out of order. Ms. Brown is an LPN. She works at the Pill Call Window. Ms. Brown read JX 64 which is her Investigatory Interview concerning the incident of June 25, 2013. Ms. Brown then read JX 66 of her statement which says "I have worked with Mr. Johnson for 6 years and when a patient has asked to verify a med in the past he will alway check med with patient to ensure a patient is given the right med."

Upon Cross-Examination Ms. Brown said she worked with the Grievant in the afternoon.

The Employer's next witness was Kristel Hurtt. Ms. Hurtt is an LPN who has been at ORW for 5 years. She also has 10 months ATC time. She has worked with the Grievant for about 4 years.

Ms. Hurtt then read JX 127 which is her Incident Report dated July 28, 2013. The Incident date was July 24, 2013. Ms. Hurtt testified that on July 24, Nurse Ritter called to verify a medication given to Inmate 2 who is in ARN4, noon medication Lamictal 100 mg. Ms Hurtt looked in the ARN4 medication MAR book for ARN4 and read the dates that had initials of nurses in the spaces provided for the noon doses. Nurse Ritter said Inmate 2 has said she is not receiving her Noon dose of Lamictal. On the date stated above the ARN4 book was initialed in the square for Noon on the 23rd of July, 2013. When Nurse Hurtt opened up the ARN noon medication envelopes that meds are put into to take over to ARN4 there was 1 pill in the envelope for Inmate 2. The finding was reported to Nurse Ritter.

Ms. Hurtt then read JX 117 Question 12 and said she checked the pill envelope and

found a pill in the pill envelope of Inmate 2. Ms. Hurtt then testified this suggests Inmate 2 never got the noon dose of ARN4 meds. The meds are put in an envelope with the inmates name and med. When Ms. Hurtt checked the meds had not been dispensed as the envelope was not empty.

Ms. Hurtt then read JX 74 E-1 which is the patients 5 rights. She then read JX 79 and said ARN4 is a segregation Unit.

Ms. Hurtt next read JX 132 for July 23 and it shows Lamictal dispensed.

Upon Cross-Examination Ms. Hurtt testified that JX 132 had no record for July 13 and July 20. She said when the inmate moves the MARS is moved also. Ms. Hurtt testified there should be some indication of the 13th and the 20th.

Ms. Hurtt next read JX 119 and testified that Nurse Ritter called her and asked if Inmate 2 had taken Lamictal. She said she looked and found the medicine. Her supervisor sent her an E-Mail and told her to do an incident report. Ms. Hurtt testified she had never reported this before. She said after this she went through MARS reports and found at least ten med reports.

Ms. Hurtt then read JX 119 and said meds have to be in the ARN4 box. When the patient returns from solitary the meds come with them.

On Re-Direct Examination Ms. Hurtt was referred to JX 132 and testified there were no notes for July 13 and 30.

On Re-Cross Examination she said there was no investigation of July 13 and 20.

The Employer's next witness was Alice Chambly. Ms. Chambly is now a Psychology Supervisor at DYS. She held the same job at ORW for 1 ½ years part time and 1 ½ years full time. Ms. Chambly was the Investigator for the Inmate 2 incident.

Ms. Chambly read JX 126 which is the Incident report from Nurse Ritter. "On July 23, 2013 at 2:30 P.M. I went to ARN4 in response to an inmate stating she was not getting her mental health medication per her report to Ms. Nickle doing reg. rounds. The inmate stated she had not received her Lamictal since she came to the hole on Friday. I told the inmate I would contact medical and find out what is going but I also encouraged the inmate to write an informal if she felt her medication was not being given to her. I spoke to Nurse Hughes who stated the inmate's medication was in the ARN4 meds and on the kardex. The kardex showed she refused the medication over the weekend and took it today. I then went back to ARN4 to tell the inmate the outcome. The inmate stated she had not been offered her medication at noon; which her roommate verified. I then went and called medical again and spoke to Nurse Hurtt who said the kardex does say she took her medication today and then she found the inmate's envelope with the medication still in it.

Ms. Chambly read JX 101 which is the Investigation Summary Report of Dennis Johnson. The Report says at JX 106 that Inmate 2 was not given her noon July 23 med. The Grievant had initialed MARS that the medicine was given. The medicine was found in the Pill envelope.

Ms. Chambly next read JX 132 and testified that it is the MARS report for Inmate 2 July 13, 2013. The Grievant initialed Lamictal as given. Ms. Chambly also read JX 102 which is Grievant's Investigatory Interview where Grievant admitted he initialed the MARS for July 23rd . She then read JX 104 and said he initialed the MARS as medicine given.

On Cross Examination Ms. Chambly testified that she had only investigated July 23.

The Employer's last witness was Kelly Storm. Ms. Storm is a Mental Health

Administrator 4 and has been at ORW six years. Ms. Storm was the Pre-Disciplinary Hearing Officer. She read JX 1 which is the Notice of Removal.

Ms. Storm next read JX 6, her Pre-Disciplinary Report and on JX 9 & 10 she found Just Cause.

There was no Cross-Examination.

III. THE UNION'S CASE

The Union renewed all of its' Objections.

The Union's first witness was Gary Comer. Mr. Comer is a CO. CO Comer read JX 60 which is his Investigatory Interview. CO Comer was the Medical Officer at the infirmary on June 25, 2013.

CO Comer looked at the video and JX 99. CO Comer testified that he is in the video by the Pill Window. He identified Inmate 1. CO Comer said he sees that the inmates take their meds. CO Comer testified that there is nothing unusual in this video. CO Comer testified that Inmate 1 has her hands to her mouth and may be hiding pills. CO Comer also said the Inmate may have been taking other meds.

On Cross-Examination CO Comer said he cannot say what the 5 rights are. CO Comer testified that Inmate 1 put the pills in her mouth and took water. CO Comer said after he checked her mouth she had nothing in her hands.

The Union's next witness was James Adkins. Mr. Adkins is a Plumber 2 and Chief Steward. He is also a member of the Board of Directors of the Union. Mr. Adkins testified that he went to Management 3 times for an EAP. Mr. Adkins read JX 3 which is Grievant's Discipline History. The Grievant has a Written Reprimand for Rule 8 and 1 - DWS for Rule 8. Mr. Adkins asked for a reduction to one day and EAP and Management said No.

There was no Cross-Examination.

The Union's last witness was Dennis Johnson, the Grievant. The Grievant looked at JX 99 and testified that he didn't recognize her.

The Grievant looked at the video and said he was in Window 1. The Grievant testified that he checks ID, goes to the Med Book. He then gets meds, puts in a cup and gives it to her. The MARS is on the counter. Inmate 1 may have asked about meds then he would go back to MARS.

The Grievant testified that inmates can refuse meds unless Court ordered or life sustaining. He said the inmate could refuse this medicine. The Grievant said he double checked the MARS. The Grievant looked at JX 99 and said her hair style was different.

The Grievant read JX 35 and 36 and testified that he cannot remember what was said. He said he saw the video and it was him but couldn't say it was Inmate 1.

The Grievant was shown JX 132. The MARS shows he did not dispense medicine to Inmate 1. The Grievant testified that Inmate 1 may not have been her. It may be a false ID. He said the MARS would show a "no show". The Grievant was asked: "Why would an inmate try to deceive in order to get a drug?" He said: "They want that specific drug."

The Grievant read JX 132 and said he passed meds. He said the infirmary has its own MARS book. The Grievant said he puts the meds in small cups. The Grievant testified that the initials on the MARS show the Inmate got the drugs. If the Inmate didn't get the drugs this would be marked.

The Grievant testified that he could have missed Inmate for meds. It was Count Time and he got phone calls. He said he was overloaded with stuff. The Grievant said he had to do med pick up and he was in charge of all wheel chairs. No other LPN had this big a load.

The Grievant testified that his 28 year old son was diagnosed with cancer in March and died in September. None of his duties were reassigned and he was off most of August. The medical inventory was not reassigned. The Grievant testified that errors are usually written up as Medical Error Reports. He said he is treated differently as others had Medical Error Reports.

On Cross-Examination the Grievant testified that he does not admit to doing something wrong. He admits to not marking it when he got back from infirmary.

On Re-Direct he testified that Management does not have to agree to an EAP. The Grievant testified that he went to a psychologist at EAP until he lost his insurance.

The hearing adjourned at 4:10 P.M. The Employer ordered a transcript. The parties agreed to file written closing arguments by close of business November 13, 2015.

OPINION AND AWARD

The Arbitrator has reviewed all the testimony and Exhibits. This is a difficult case and the Advocates for both parties have done an excellent job presenting their cases.

This case has been, in part, a toe to toe slugfest between the Union and the Employer concerning subpoenas filed by the Union for medical records of two Inmates.

The Arbitrator ruled that the Union could subpoena the records with safeguards to protect the Inmates' Identity. This part of the case was litigated in the Union County Common Pleas Court. Jessica Doogon, Associate General Counsel reported that the Employer contended to the Court that certain documents requested by the Union were prohibited by the Ohio Revised Code. The Union dismissed part of its action concerning the subpoenas and the Court found the Arbitrator's Award was not an Award because removal was the issue.

The first day of hearings on August 5, 2014 focused on the stipulated records and documents protected by statute. The Arbitrator decided that the information was to be disclosed

as indicated supra and the Employer's Advocate informed the parties he would seek legal assistance. The hearing was recessed until September 17, 2014.

Subpoenas were served on the Employer's Advocate for production of "Health Care Occurrences", "Medical Error Reports" and certain medical records. During the second day of hearings September 17, 2014 the Employer's Advocate declined to honor the subpoenas on advice of Counsel. The Union advised the Arbitrator and the Employer it would seek relief in another forum and the case was recessed.

The case was then set for September 29, 2015. The Union then subpoenaed "health care occurrances", "medical error reports" and medical records of a certain Inmate. The Employer again refused to provide the Documents. The Employer says the records are not public records and cites O.R.C. 211 (B) (2) which prohibits use of the records in discovery or in Judicial or Administrative proceedings.

The Employer argues that an Inmate's medical records cannot be released without a release signed by the Inmate and the Union failed to get a release.

The Employer argues that DR&C employees would be subject to fines if they provided the Union with the records. The burden was upon the Union to secure a wavier and it failed to do so.

The Employer then argues that the Collective Bargaining Agreement (CBA) does not give the Union the right to have any confidential records. The CBA specifies in Article 25.09 says the parties may make discovery requests which will not be unreasonably denied. The Employer argues that the Employer and the Union did not intend to supersede the statutory confidentiality of O.R.C. 5120.21 or 5120.211.

The Employer then argues that it acted reasonably in denying access to the subpoenaed

records based upon statutory prohibitions.

The Employer says the CBA specifies "to the extent this Agreement addresses matters covered by conflicting State statutes, administrative rules, regulations or directives in effect at the time of the signing of this Agreement, except for O.R.C. Chapter 4117, this Agreement shall take precedence and supersede all Conflicting State Laws".

The Employer also argues that the CBA does not address documents protected by statutory prohibitions against disclosure specified in O.R.C. 5120.21 and 5120.211 and penalties outlined in O.R.C. 5120.99. Therefore the denial was reasonable.

The Employer then argues that the Union had other means in which to gain the information. The Employer cites as examples: all disciplines, supervisory notes and interviews with medical employees and managers. The Union did not elect to pursue other avenues for which they had recourse.

The Employer asserts that the Union Advocate secured a modification of the stipulations agreed to by the previous Union Advocate who had retired. The parties agreed to remove the stipulation that the "grievant has a written reprimand a 1-DWS on file for rule 8 violations". The Employer says the Union admitted the discipline "but had an argument about it". The first offense was a written reprimand for Rule 8 by providing insulin to an Inmate without medical follow up and the Inmate had to be sent to the hospital. The second offense was two violations of Rule 8: and leaving a syringe and an insulin vial in a cuff port.

The Employer then says this case is not about protected documents but the careless, reckless behavior of the Grievant. The Grievant is a Licensed Practical Nurse.

The Employer also argues that the Grievant has consistently engaged in reckless, egregious, life threatening behavior. He is a liability to the Department and we cannot afford to

have a nurse disregard medical protocols and be reckless in the administration of medication to patients harming their lives.

The Union would like you to believe that management misinterpreted the facts of the June 30, 2013 incident during which Inmate 1 claims that the Grievant gave Inmate 1 the wrong medication. The Employer says the evidence clearly shows she received medication yet the Grievant documented that she did not show up to get the medication.

The Union says " Incident 2 was no more than a clerical error". The Employer argues that Inmate 2 did not receive medication even though the Grievant documented that he administered the medication.

The Employer contends the behavior of the Grievant cannot be simply written off as misinterpretations or clerical errors. The Grievant has shown a continual pattern of reckless disregard of protocols and carelessness as shown in his progressive disciplines.

The Employer argues that the evidence and testimony clearly show that the Grievant did administer the wrong medication to Inmate 1, yet documented that she did not receive any medication because she was a no show. The evidence and testimony clearly show Inmate 1 was seriously harmed when she returned to the infirmary in an altered state of euphoria caused by the Grievant.

The Employer also argues that the evidence and testimony also clearly show that the Grievant did document that he administered medication to Inmate 2, yet it was found by another LPN undistributed the following day.

The Employer argues that the Grievant violated DR&C Standards of Employee Conduct Rule 8: Failure to carry out a work assignment or the exercise of poor judgment in carrying out an assignment.

The Grievant failed to carry out his work assignment during pill call on June 25, 2013 to ensure that Inmate 1 was in fact who she was and administer the correct medication as outlined in her Medical Administration Record (MAR) and document correctly that she did in fact show up for her medications as required. The Grievant on this day decided to give Inmate 1 a handful of pills that she had no medical order to receive, and document that she was a no show for her medication.

The Employer further argues that on July 23, 2013 the Grievant again failed to carry out his work assignment to distribute medication to Inmate 2 in the segregation (ARN-4) Unit. On this day he elects to document on Inmate 2's MAR records that he did in fact administer the medication to Inmate 2. It was found the next day undistributed by Kristel Hurtt, LPN, after Inmate 2 questioned the nursing supervisor, Brittany Ritter, why she was not receiving her medication.

The Employer also asserts that the Grievant violated Rule 41: Unauthorized actions or a failure to act that could harm any individual under the supervision of the Department.

The Grievant caused serious harm and placed the life of Inmate 1 in jeopardy by giving her a handful of pills that she had no right to receive. Inmate 1 returned to the infirmary "higher than a kite" appearing drunk or over medicated" as described by Officer Embaugh in her investigatory interview and testimony. Officer Embaugh testified that Inmate 1 could not walk without assistance taking two people to help her move.

The Employer argues that Inmate 1 did not receive her prescribed medication (Ultram) and the Grievant documented that she was a no show. The Employer further argues that the Grievant attempted to cover up his wrong doing, his disregard for protocols and dangerous behavior by distributing a handful of medication to Inmate 1 with no idea of the effects on her

well being.

The Employer also contends that the Grievant placed Inmate 2's life in jeopardy by not administering her medication. Since the medication was not administered to Inmate 2, it placed her in a state of harm to herself and others around her since she did not have the medication to control her mental illness.

The Employer points out that Mr. Pennington testified that the Grievant did not follow Medical Protocol B-10 wherein he did not ensure the industry standards of the "5 rights". He also testified the Grievant documented on Inmate 1's MARS record that she did not receive her prescribed medication June 25, 2013.

Mr. Pennington clearly identified Inmate 1 in the video taking medication received from the Grievant. Mr. Pennington spoke to Inmate 1 after she was admitted to the infirmary and she said she questioned the Grievant about the medication given to her.

The Employer says Mr. Pennington spoke to the emergency nurse who told him Inmate 1 could visually identify the two pills given to her as nuerontin and thorazine. Mr. Pennington said Inmate 1's behaviors were consistent with taking the aforementioned drugs.

Mr. Pennington spoke with the Grievant June 25, 2013 about the medication administered to Inmate 1. He said the Grievant showed no remorse or shock.

Mr. Pennington testified that the MAR record permitted Inmate 1 to receive Ultram. The Grievant documented that Inmate 1 did not receive her medication.

Mr. Pennington testified that in his professional opinion the Grievant cannot be trusted to carry out his duties.

The Employer says the Union questioned Mr. Pennington about whether the video showed Inmate 1 as it relates to her picture in the joint exhibits. Mr. Pennington noted Inmate 1's

hair was up.

The Employer says Mr. Pennington outlined the established procedures for identifying an Inmate. First, the Inmate is required to show her ID; second, if there is a question to the validity of her identity, the nurse is required to pull up her picture on the computer; lastly, if positive identification cannot be made, the nurse is required to contact security to ID the Inmate.

The Employer says the Union questioned Mr. Pennington about the ability to identify in the video the amount of pills Inmate 1 took. The Employer argues that it was Inmate 1's statement that she took four (4) pills. It was Nurse Erich's, RN Emergency Nurse, assessment that she was able to physically identify tow pills that Inmate 1 ingested: Nuerontin and Thorazine.

The Employer next reviewed the testimony of its witnesses. Angela Embaugh, CO, was on the scene on June 25, 2013 when Inmate 1 came to the Infirmary. She testified that Inmate 1 appeared "drunk or over medicated and that it took two (2) people to help the Inmate walk. CO Embaugh was also present when the emergency nurse questioned the Inmate. The Employer points out that CO Embaugh's investigatory statement was given only 14 days after the incident.

The Employer contends that Dr. Dapper, the investigating official, concluded the Grievant administered the wrong medication to Inmate 1. The Grievant documented on Inmate 1's MAR record that she refused her medication. Dr. Dapper said the Grievant acknowledged those were his initials on Inmate 1's MAR record for June 25, 2013. She said the Grievant identified himself on the video. Dr. Dapper also identified Inmate 1 in the video. In response to Union questions about Inmate 1's toxicology report she said the drugs tested for could be non-llicit. She said Inmate 1's prescription was only for Ultram. The drugs noted on the toxicology report are those typically abused and are common contraband. The Employer argues that Inmate

1 did not test positive for these drugs so her altered state was caused by the Grievant. The Employer argues that Kristel Hurtt, LPN testified that on July 23, 2013 she found medication for Inmate 2 undistributed by Grievant even though he documented on her MAR record that she received it. Nurse Hurtt found the medication in the coin envelope in the infirmary and was instructed by a supervisor to write up an incident report. Nurse Hurtt testified that this was not a normal practice and a medication error report should have been written. Nurse Hurtt alleges she did another incident report the same day listing all missed medications. The Employer argues that no evidence of this report was introduced. Nurse Hurtt said she has never written a med error report but felt it was appropriate. She also said she did an incident report for all missed meds on July 23, 2013 to "prove a point". The Employer argues that it is not her call to write a med error report as she was instructed to do so by her supervisor.

Dr. Alice Chambly, Ph D was the investigating official concerning Inmate 2 not receiving her medication. She said on July 23, 2013 the Grievant marked Inmate 2's MAR record that she received the medication. Her conclusion was the Grievant had marked Inmate 2's MAR report that Inmate 2 had received her medication when in fact she did not. Dr. Chambly testified that she only investigated July 23, 2013. There was no reported wrongdoing on the other dates the Union notes were not marked on Inmate 2's MAR record.

Ms. Kelly Storm was the Pre-Disciplinary Conference Hearing Officer. She testified that she found just cause that the Grievant did violate rules 8 and 41.

The Employer then reviewed the Union's witnesses. Athena Brown, LPN was called to question the quality of the video and the inability to identify anyone for the June 25, 2013 incident. The Employer argues that this is irrelevant as the Grievant had identified himself in the

video. Nurse Brown testified that she did not remember working with the Grievant and the video "does not look like me".

Gary Comer, CO testified that he was the infirmary officer June 25, 2013. He identified himself in the video. CO Comer testifies that Inmate 1 is the one receiving the medicine. He said that often Inmate 1 puts her hand to her mouth to take the medication and drinks water, he checks their mouths with a flashlight to ensure they ingested the medicine. CO Comer testifies that Inmate 1, after she left him, makes a motion as if wiping her mouth but she could have taken the medicine out of her mouth. He said the video quality is poor and it may be questionable she took the medicine from her mouth. The Employer argues that the Union has no evidence to substantiate this claim and all the evidence is to the contrary. CO Comer testified he is not exactly sure if she took the medicine out of her mouth. He is speculating. The Employer argues the video shows CO Comer checking her hands and using a flashlight to check her mouth. CO Comer is now trying to introduce doubt that the Inmate took her medicine. The Employer says the testimony of two (2) RNs and a Doctor who reviewed the video clearly show Inmate 1 receiving and ingesting the wrong medication.

James Adkins, Plumber, testified he asked David Lundberg three (3) times about Grievant seeking an Employee Assistance Program (EAP) grant,: Twice during the one day and 2 day working suspensions and for this discipline. He said he sought the EAP Agreements because Grievant lost his son. The Employer says there is nothing in the CBA that says management needs to give approval for an employee to participate in an EAP.

The Employer says Article 24.10 of the CBA does not require management to approve an EAP request.

The Employer argues that when the Grievant testified, he identified himself in the video

but said Inmate 1 is not clear in the video. The Employer argues that since the Grievant claims Inmate 1 may have deceived him by a false ID he should have contacted custody supervisors for a positive identification. The Grievant said sometimes Inmate IDs are not updated for ten (10) years but the Employer argues there is no evidence of this. The Employer says Inmate 1 was admitted to ORW May 3, 2013, two months prior to June 25, 2013. The Employer consistently stated she questioned Grievant about her medication. Inmate 1 stated this to Mr. Pennington, overheard by CO Embaugh. Inmate 1 also said this in her statement. The Grievant testified that Inmate 1 could have refused the medication. The Employer argues that this may be true but she trusted Grievant as a medical professional that was administering medicine the Dr. told her she would be receiving. The Employer says Grievant attempted to cover up his wrongdoing by documenting on Inmate 1's MAR record that she did not show up.

The Employer points out that the Grievant does not dispute the events that took place on July 23, 2013 with Inmate 2 but excuses this as a clerical error. The Grievant says this is a common mistake that occurs when things get hectic and he may have been called away from documenting Inmate 2's MAR record.

The Employer argues that if the Grievant had followed the medical protocol he likely would not have made the error.

The Employer says the Grievant testified his son was diagnosed with cancer in March of 2012 and died in September 2012. The Employer argues that the incidents that gave rise to this case happened on June 25, 2013 and July 23, 2013 some ten (10) months later. The Employer argues that if the Grievant was still having difficulties ten (10) months later he should have excused himself from his profession and sought help. The Employer points out that as a State employee the Grievant had benefits such as disability insurance.

The Employer says the Grievant was asked if he was treated differently than other LPNs. The Grievant said: "there's some that made a lot worse errors than I did".

The Employer asked the Grievant: "You're admitting to what you did". The Grievant said: "I might have said it wrong. I didn't admit to it". The Employer says the Grievant eventually admitted the error of not passing medicine to Inmate 2. The Employer argues that this calls into question the Grievant's credibility.

The Employer concludes by arguing that the Grievant engaged in reckless, harmful behavior towards Inmates 1 and 2 and the discipline is progressive.

The Union states in its' closing argument that the Grievant, a 20 plus year employee, was removed from his position as a Licensed Practical Nurse without Just Cause. The Union argues that the Employer has refused to produce documents necessary for the Union to present an adequate affirmative defense, has failed to lay the foundation for multiple references to documents, assumptions reached in the investigations and brought out in testimony during the hearing; and has failed to prove any of its allegations.

The Union then renewed its objections to the lack of foundation for documents and the testimony they elicited. These objections were also made at the end of the hearing. The Union objects to the lack of foundation for the Employer's contention that two of the pills taken by Inmate 1 were Neurontin and Thorazine. The Union argues that there was no evidence as to how these pills were identified or by whom, and in fact the Inmate's statement that is referenced in relation to these two drugs states that four (4) pills were taken, yet they only speculate as to two (2). The Union argues there was no evidence presented as to how this identification was made (by photograph, description, etc.) no evidence presented to support their contention that those drugs were given (such as pill counts, missing pills from pill counts, etc.). The Union argues

there was no medical testimony given by the Employer's witnesses that these drugs would cause the type of reaction that was observed in the Inmate after Incident One. The Union argues that those references be stricken as the necessary foundation was never presented.

The Union contends that reference to the names of the drugs is prejudicial. The Union says it caused questions to be asked of Mr. Pennington based on the name of the drug. Dr. Dapper also testified to the effect of these drugs despite not having the foundation laid.

The Union argues in reference to Incident two that the Grievant had been subjected to disparate treatment in relation to the charge of a clerical error made during pill pass. The Union elicited evidence in the form of testimony from the Employer's own witness, Nurse Hurtt, proving that no other LPN had been subjected to this sort of discipline over similar mistakes.

The Union requested the healthcare occurrence forms to provide more evidence at Arbitration that other nurses had made similar errors in paperwork, and that the process was handled differently for everyone except the Grievant. The Union says Nurse Hurtt's testimony specifically lays this out, even without the documents. She testified that in fact, every other time a similar error occurred, which is often: the nurses "would put them in a Sharps container, any leftover pills". She also testified that after she was instructed to record the error this way, she took it upon herself to file an incident report naming other nurses that had made similar mistakes, and stating there that she believed Grievant was being singled out for a common error.

The Union says it found the Healthcare Occurrence form necessary to paint a full picture of the disparate treatment the Grievant experienced, and those documents were necessary to present a full affirmative defense. The Union says that despite its efforts and the Arbitrator's ruling that the documents be produced with the identity of the Inmates redacted the documents were not produced. The Arbitrator also affirmed the Ohio Revised Code did not prohibit the

Employer from producing these documents.

The Union believes that the written statements and testimony of Nurse Krystal Hurtt, and others, coupled with the Union's request for the Arbitrator's negative inference surrounding the Employer's refusal to produce the documents in question is sufficient to prove that the Grievant was treated disparately. The Union argues that the Employer has not proved its case and the charge related to Inmate 2 should be dismissed.

The Union argues the Employer has insufficient evidence to prove this charge as to Inmate 1.

The Union argues that there are two probable explanations concerning Inmate 1. The first scenario is the Grievant was just simply inattentive in his duties and issued the wrong medications to Inmate 1. The second scenario is that the inmate intentionally deceived the Grievant to create an opportunity to get "high" and when she was caught blamed the Grievant as a way to escape the consequences.

The Union contends that the video of June 25, 2013 pill call proves six things: 1) Inmate 1 was at the June 25, 2013 A.M. pill call; 2) the Inmate's hair was done in a dramatically different style than the hairstyle on her ID picture; 3) the Grievant was working the window that Inmate 1 got her medications from; 4) the Grievant checked the Medical Administration Record (MAR) at least once if not twice; 5) the Inmate turned from the CO checking if the pills had been taken, immediately swipe her left hand across her mouth; 6) her left hand that she used to swipe her mouth, remains clinched for the remainder of the video. What you can't verify with the video is what medication or how many medications Inmate 1 receives. There is also no way to identify if Inmate 1 had altered her identification, was wearing a fake identification or was indeed wearing the correct identification.

The Union argues that the Employer presupposed the cause was the Grievant's inattention to duty. This is not supported by the video evidence. The Union says the Grievant clearly checked the MAR during the video and this was confirmed by witnesses.

The Union contends that Inmate 1's statement shows clear bias and the Employer's belief that the medication error was Grievant's fault. The Union says neither the drug test nor the video support this conclusion. The Union contends that the Employer made a conclusion even before all the interviews of the investigation were completed. The Union says this conclusion resulted in the Employer's failure to investigate the role of Inmate 1.

The Union claims the Employer's investigation was riddled with errors. The people questioned about the incident were the noon pill pass staff and not the A.M. pill pass staff.

The Inmate claims she took four (4) pills but the Union argues there are not witnesses to this fact. The Union says the Employer only theoretically identified two of the alleged drugs from the Inmates description. The Union argues that the Employer never described or produced evidence that led to the conclusion that two (2) of the pills the Inmate took were Neurontin and Thorazine. The Union says the Employer presented no medical professional who interacted with Inmate 1. Therefore, there is no evidence of over medication.

The Union says the evidence presented by the Employer provides three different versions of Inmate 1's incapacitation. In fact without medical evidence we don't even know that the Inmate's incapacitation was caused by drugs. There was no definitive diagnosis of Inmate 1's incapacitation. While Inmate 1 tested negative for intoxicants, it is possible she did not ingest enough to test positive. It is also possible that the drugs the Employer claims were identified by Inmate 1 would have caused a positive drug screen.

The Union asserts that Inmate 1 intentionally created a false pill call record to enable to

get "high" surreptitiously and not face punishment by presenting an ID that did not belong to her. The Union says this is actually supported by video and evidence. Inmate 1 is an inmate because of a drug offence, "Sale of Counterfeit Drugs". It is also supported by the MAR from the June 25, 2013 A.M. pill call and the video. The Grievant can be seen in the video checking the MAR possibly even twice, and yet the MAR for Inmate 1 was marked that the inmate refused medication or that she didn't come to pill call. The Inmate was to receive the medication Ultram which was not signed out on a separate log for medications. Inmate 1 even claimed she questioned the Grievant about the medicine she was being given. The Union argues that the evidence is consistent with its' conclusion.

The Union further argues that Inmate 1 turned from the CO checking if the pills had been taken and immediately swiped her left hand across her mouth. Her left hand remained clinched for the remainder of the video. The Union says the Inmate could have been responsible for the incorrect medication being given.

The Union cites the testimony of CO Comer. CO Comer said there was nothing unusual in Inmate 1's transaction of pill call. He said there was no hesitation as far as her taking her medication. CO Comer testified that "the Inmate putting her hand up to her mouth like she did, that's questionable. She may have just been wiping away a crumb or it may have been a pill she was placing in her hand. It's hard to watch four (4) windows at one time. This is after she walks away from seeing me." CO said it was very possible Inmate 1 removed something from her mouth.

As to Inmate 2, the Union argues that the incident was caused by a bad work process creating errors in paperwork. Nor are other nurses treated in the same way as the Grievant. By the testimony of the Employer's own witness, Ms. Hurtt, a Healthcare Occurrence Form was filled

out instead of an incident report. The Union said it could have shown this more clearly if the Employer had produced the Healthcare Occurrence Forms. The Grievant admitted he didn't correctly mark the MAR for ARN4. It is highly improbable that Grievant actually missed Inmate 2 as she claims. The Union argues that Nurse Hurtt's statement and testimony demonstrate the disparate treatment of the Grievant. The Grievant's paperwork error was written on an incident report and forwarded for further action. All other Nurses identical errors were ordered documented on Healthcare Occurrence Forms. The Union says Nurse Hurtt, as creator of these documents, was the best evidence the Union could produce to prove the disparate treatment of the Grievant. Nurse Hurtt was very clear that no one else was treated in this manor for their errors and the Grievant was being singled out. The Union also points out that the Employer's own witness states that other nurses made similar errors during her investigation and did not receive discipline.

The Union says the discipline concerning Inmate 2 should be dismissed.

The Union asks for reinstatement with back pay, benefits, seniority and to be made whole.

As to Inmate 1, the Union's argument is very clever but not supported by the evidence. Inmate 1 says she received the drugs from the Grievant, and questioned him at the time. CO Comer's testimony, at best, is conjecture. He was supposed to see that the Inmate ingested the pills. The Inmate obviously ingested some medicine as she had a reaction. Contrary to the Union's argument there were medical professionals involved. Emergency Nurse, Erich assessed the Inmate and had the Inmate verify at least two of the pills that she took. Mr. Pennington, RN verified the medicine as Neurontin and Thorazine and said the medicine was the cause of the Inmate's reaction. It is clear that the Grievant marked the records as if Inmate 1 refused

medication for the pill call.

The Union argues that it may have been another Inmate. The evidence is that Inmate 1 is in the video. If it was another Inmate the Grievant should have secured proper identification. The fact is that Inmate 1 received the wrong medication from the Grievant. This is the Inmate's statement and the effects of the medicine are documented by medical professionals and the lay witness who helped Inmate 1 to the infirmary.

The Union says the Grievant can be seen checking the MAR in the video. If he was really checking the MAR why did Inmate 1 receive the wrong medication?

The Grievant has clearly violated Rule 8 and Rule 41.

As to Inmate 2 the Grievant admits that he didn't correctly mark the MAR for ARN4. The Union then bases its argument upon disparate treatment. The Union says the failure of the Employer to provide Healthcare Occurrence Forms has hindered its case. As was indicated above the Arbitrator ordered the subpoena to be honored. The Union filed suit in the Common Pleas Court and then dismissed its claims concerning the subpoenas. The Court also declined to enforce the Arbitrator's Order. The Arbitrator has no authority to over rule a Court decision.

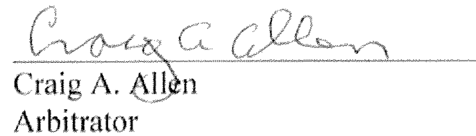
The Employer has argued that the Union had other avenues to get the information, such as requesting disciplines, corrective counseling, supervisory notes, personnel files, etc. The Union elected to proceed primarily upon the testimony of Nurse Hurtt. Nurse Hurtt filed an unsolicited Incident Report in which she said she found at least ten (10) medication errors. The Employer says she had no authority to do this. Nurse Hurtt says she did it as the Grievant was being singled out. Nurse Hurtt's testimony is disturbing. However, no copy of the Incident Report was presented. Without the Incident Report the Arbitrator cannot judge the severity of the mistakes Nurse Hurtt refers to.

James Adkins, Chief Steward, did not testify as to disparate treatment. The Union's own record of grievances filed, or lack thereof, should show disparate treatment. If the Union's records do not show grievances filed for other LPNs or RNs for discipline, much less removal, for a similar fact pattern it would clearly be disparate treatment of the Grievant. Disparate treatment is an Affirmative Defense which requires some corroboration.

The Arbitrator finds the discipline is progressive.

The grievance is denied.

Issued at Ironton, Ohio this 2nd day of December, 2015.



Craig A. Allen
Arbitrator