67 FLRA No. 143

UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS
MEDICAL CENTER
KANSAS CITY, MISSOURI
(Agency)

and

AMERICAN FEDERATION
OF GOVERNMENT EMPLOYEES
LOCAL 2663
(Union)

0-AR-5028

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DECISION

September 4, 2014

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Before the Authority: Carol Waller Pope, Chairman, and Ernest DuBester and Patrick Pizzella, Members
(Member Pizzella concurring)

This matter is before the Authority on exceptions to an award of Arbitrator Archie E. Robbins filed by the Agency under § 7122(a) of the Federal Service Labor-Management Relations Statute (the Statute)[1] and part 2425 of the Authority's Regulations.[2] The Union filed an opposition to the Agency's exceptions.

We have determined that this case is appropriate for issuance as an expedited, abbreviated decision under § 2425.7 of the Authority's Regulations.[3]

Under § 7122(a) of the Statute,[4] an award is deficient if it is contrary to any law, rule, or regulation, or it is deficient on other grounds similar to those applied by federal courts in private sector labor-management relations. Upon careful consideration of the entire record in this case and Authority precedent, we conclude that the award is not deficient on the grounds raised in the exceptions and set forth in § 7122(a).[5] Accordingly, we deny the Agency's exceptions.

[1] 5 U.S.C. § 7122(a).
[2] 5 C.F.R. pt. 2425.
[3] *Id.* § 2425.7 ("Even absent a [party's] request, the Authority may issue expedited, abbreviated decisions in appropriate cases.").
[4] 5 U.S.C. § 7122(a).
[5] *U.S. Dep't of the Navy, Long Beach Naval Shipyard, Long Beach, Cal.*, 48 FLRA 612, 618-19 (1993) (award not deficient as contrary to public policy where excepting party fails to establish that the award violates an explicit public policy based on well-defined and dominant laws and legal precedents); *U.S. Dep't of the Air Force, Lowry Air Force Base, Denver, Colo.*, 48 FLRA 589, 593-94 (1993) (award not deficient as based on a nonfact where excepting party either challenges a factual matter that the parties disputed at arbitration or fails to demonstrate that a central fact underlying the award is clearly erroneous, but for which the arbitrator would have reached a different result).

Member Pizzella, concurring:

Alfred Hitchcock would probably have referred to this case as "The Case of the Vanishing Patients." A patient in the secure acute inpatient psychiatry unit, at the Veterans Affairs Medical Facility in Kansas City, Missouri (VAMC Kansas City), vanished and no one noticed that he was missing for over two hours.

The patients in this particular unit are maintained in a secured environment because of their treatment for "drugs, hostile nature, and mental problems" and "[t]hus it is imp[e]rative that patients not be allowed to leave the unit on a voluntary basis."[1] Therefore, the employees rotate the duty of checking that patients are actually present. A "[p]atient [o]bservation [r]ecord" (POR) is maintained and the responsible employee checks and verifies that each patient is present every fifteen minutes.[2] After the patient had already vanished from the unit, at least three employees marked on the POR that they had seen him, even though a security camera had recorded the patient walking out of the unit through an unlocked security door earlier that afternoon. Afolabi Olubo, the grievant, marked the patient present (in other words, indicating that he had seen him) *four times*, each purported sighting at least fifteen minutes apart. From the time the patient disappeared, until it was noticed that he was missing, an undetermined number of VAMC Kansas City employees went through the security door and not one of them even noticed that it was not locked. Fortunately, the patient was discovered later the same evening at his brother's house (but not until he had first wandered to, and left, his step-father's house without being detected by anyone).

To this day, it is still a mystery whether the security door was left unlocked because of mechanical defect, negligence, or deliberate "manipulat[ion]."[3] It is also undisputed that other "patients ha[d] escaped" from this unit before.[4] In one case, the patient "was gone for two . . . days before it was discovered he was gone."[5] One might presume, therefore, that solving the mystery of the unlocked door would be a priority shared by the managers and union officers at AFGE, Local 2663 (Local 2663) in order to ensure that no other patients are lost in the future.

To make the circumstances of this case even more harrowing, within two months of VAMC Kansas City losing the patient in this case, VA medical facilities in Cleveland, Ohio[6] and Pittsburgh, Pennsylvania[7] lost patients of their own. Following the Pittsburgh incident, a reporter for the CBS affiliate in Pittsburgh noted laconically that: "Let's be honest[,] the patient could only 'go missing' if the people who were supposed to be watching him *weren't doing their job*."[8]

I could not agree more. The employees clearly were not doing their job. It is equally obvious, however, that the managers at VAMC Kansas City and the union officers at Local 2663 did not act in a manner that "contribute[d] to the effective conduct of [government] business"[9] or that "utilized the [Federal Service Labor-Management Relations] Statute to create positive working relationships and resolve good-faith disputes."[10] Rather, all of the parties involved in this case – VAMC Kansas City, Local 2663, and Arbitrator Archie Robbins – treated this case as if losing a patient is no more serious than losing one's office key.

The managers initially proposed that Olubo (and another caregiver who had marked the missing patient present three times) should be fired. But, then, they unilaterally reduced the penalty to a fourteen-day suspension[11] and later to a one-day suspension,[12] without the Union having to do anything at all.

The union officers at Local 2663 knew that its bargaining unit employees had lost patients before and, at the time they filed the grievance on behalf of Olubo, they were most certainly aware of the missing patient incidents that had occurred in Cleveland and Pittsburgh. Rather than focusing their efforts on working with management to solve the mystery of the unlocked door that led to the escape in the first place and working with management to ensure that nothing like this happened again, Local 2663 argued that no suspension was "appropriate"[13] for Olubo because he "had just returned from . . . vacation" and mistakenly thought he saw "[an]other patient [that] look[ed] like [the missing] patient."[14]

[1] Award at 6.
[2] *Id.* at 7.
[3] *Id.*
[4] *Id.* at 6.
[5] *Id.* at 7.
[6] "Cleveland Police Search for Man Missing from VA Hospital," http://vamalpractice.info/?p-2194 (last visited August 14, 2014).
[7] "Police Searching for a Veteran who the Pittsburgh VA Lost," http://vamalpractice.info/?p=2271 (last visited August 14, 2014).
[8] *Id.* (emphasis added).
[9] *U.S. Dep't of VA, VA Med. Ctr. Martinsburg, W.Va.*, 67 FLRA 400, 405 n.17 (2014) (Dissenting Opinion of Member Pizzella) (citing *U.S. DHS, CBP*, 67 FLRA 107, 113 (2013) (*CBP*) (Concurring Opinion of Member Pizzella)).
[10] *CBP*, 67 FLRA at 113 (Concurring Opinion of Member Pizzella).
[11] Opp'n, Joint Ex. 3.
[12] Opp'n, Joint Ex. 4.
[13] Award at 2.
[14] *Id.* at 8.

Then Arbitrator Archie Robbins got involved. He determined that Olubo's negligence was nothing more than a "shortcoming[]," and thought it was prudent to lecture VAMC Kansas City that it should have used the disciplinary process "to inspire [Olubo] to be a better worker in the future."[15] In the end, the Arbitrator "revo[]ked" the suspension and ordered the Agency to pay Olubo backpay.[16] Even though Arbitrator Robbins conceded that VAMC Kansas City should be able to verbally reprimand Olubo for his "faults and errors," he directed that VAMC Kansas City could not place any evidence of the reprimand "into [Olubo's] work record[] or utilize[] [it] in any future disciplinary action[]."[17]

In summary, the penalty here went from a proposed firing of the employee most at fault to an order by the Arbitrator to award him backpay. One cannot just make this stuff up!

As I noted in *AFGE, Local 1897*, it is inconceivable that any set of factors "could mitigate against the gravity of this offense."[18] The safety of the public and the well-being of the patient himself were put at risk by the confluent negligence of these employees. It is apparent to me that their misconduct is inexcusable and must have violated many written and unwritten policies pertaining to the public health and welfare. But, inexplicably, the Veterans Administration could not be bothered to name even one public policy that was implicated by the Arbitrator's mitigation of the Agency's extraordinarily lenient one-day suspension.

Therefore, I have no choice, under these circumstances, but to join my colleagues and deny the Agency's contrary to public policy exception. Our precedent, which relies upon well-established rulings of the Supreme Court, clearly establishes that in order to find an arbitrator's award contrary to public policy, the public policy must be "'explicit,' 'well[-]defined, and dominant.'"[19] In other words, the Agency must specifically "reference to the laws and legal precedents and not from general considerations of supposed public interests."[20]

Thank you.

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[15] *Id.* at 11.
[16] *Id*. at 12.
[17] *Id*. In *U.S. DOD, Defense Logistics Agency, Defense Distribution Depot, Red River, Texarkana, Tex*., 67 FLRA 609, 615-16 (2014) (Dissenting Opinion of Member Pizzella), Arbitrator Robbins similarly ignored the Anti-Nepotism Act, and the standards of conduct, when he ordered the agency to return an employee to a post of duty that placed him directly under the chain of command of his nephew.
[18] 67 FLRA 239, 243 (2014) (Concurring Opinion of Member Pizzella).
[19] *SSA*, 32 FLRA 765, 767-68 (1988) (citing *W.R. Grace & Co. v. Rubber Workers*, 461 U.S. 757, 766 (1983) (*W.R. Grace*).
[20] *Id*. at 768 (citing *W.R. Grace*, 461 U.S. at 766).