UNITED STATES OF AMERICA
FEDERAL LABOR RELATIONS AUTHORITY
OFFICE OF ADMINISTRATIVE LAW JUDGES
WASHINGTON, D.C. 20424

DEPARTMENT OF VETERANS AFFAIRS, WASHINGTON, D.C. AND DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, CANANDAIGUA, NEW YORK Respondent	
and	Case Nos. 1-CA-00107 1-CA-00161
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO, LOCAL 3306 Charging Party	

James F. Mietlicki
Counsel for the Respondent

Martin R. Cohen
Counsel for the Charging Party

Peter F. Dow
Counsel for the General Counsel, FLRA

Before: GARVIN LEE OLIVER
Administrative Law Judge

DECISION

Statement of the Case

The unfair labor practice complaint alleges that Respondent violated section 7116(a)(1), (2) and (4) of the Federal Service Labor-Management Relations Statute (the Statute), 5 U.S.C. §§ 7116(a)(1), (2) and (4), by issuing proposed notices of discharge to Registered Nurse William Ward, President of the Charging Party (Union), and Registered

Nurse David Bellomo, Vice President of the Union, because they were involved in filing unfair labor practice charges against the Respondent and because of their activities for and on behalf of the Union.

Respondent denies these allegations and asserts (1) that the proposed notices of discharge were issued to Ward and Bellomo as part of disciplinary proceedings initiated against them as nurses under 38 U.S.C. § 4110; (2) these disciplinary proceedings are exclusive under the provisions of 38 U.S.C. § 4119 and bar action under Title 5 which would effect this disciplinary process; (3) the issues raised in the complaint have been, or may be, raised under the appeals procedure of 38 U.S.C. § 4110 and, therefore, may not be raised in this proceeding by operation of 5 U.S.C. § 7116(d); (4) the Authority while having jurisdiction to examine the issue of causal connection between the employees' non-bargaining union activity and the disciplinary action is prohibited from reviewing the clinical and professional judgment of activity management; and (5) the disciplinary proposals against Ward and Bellomo would have been taken whether or not such individuals engaged in Union activity under the Statute.

For the reasons discussed below, I find that Respondent's proposals to discharge Ward and Bellomo are not substantively reviewable in this proceeding. Therefore, it is recommended that the case be dismissed. If, however, Ward and Bellomo were deemed to be protected by the Statute, I would find that Respondent's conduct violated the Statute.

A hearing was held in Canandaigua, New York. The Respondent, Union, and the General Counsel were represented by counsel and afforded full opportunity to be heard, adduce relevant evidence, examine and cross-examine witnesses, and file post-hearing briefs.1/ The Respondent and General Counsel filed helpful briefs and the proposed findings have been adopted where found supported by the record as a whole. Based on the entire record, including my observation

---

1/ The General Counsel's unopposed motion to strike all references and argument in the Respondent's post-hearing brief relating to the alleged removal of "P.B." is granted. Nothing in the record relates to this matter.

of the witnesses and their demeanor, I make the following findings of fact, conclusions of law, and recommendations.

Findings of Fact

The Parties

The Respondent is an agency within the meaning of 5 U.S.C. § 7103(a)(3), and the Union is a labor organization within the meaning of 5 U.S.C. § 7103(a)(4).

At all times material herein, the American Federation of Government Employees, AFL-CIO, has been and is now the certified exclusive representative of separate nationwide consolidated units of professional and nonprofessional employees employed by the Department of Veterans Affairs which includes professional employees at the Department of Veterans Affairs Medical Center in Canandaigua, New York.

At all times material herein, the Respondent has recognized the Charging Party, Local 3306, as the agent and representative of the American Federation of Government Employees, AFL-CIO, for the purpose of representing bargaining unit employees at the Department of Veterans Affairs Medical Center in Canandaigua, New York.

The Department of Medicine and Surgery Statute

In 1946 Congress established the Department of Medicine and Surgery (DM&S) within the Veterans Administration, Ch. 658, 59 Stat. 652 (1945) (codified as amended at 38 U.S.C. § 4101 et seq. (1988)) (DM&S statute). The DM&S was established "to provide a complete medical and hospital service . . . for the medical care and treatment of veterans." 38 U.S.C. § 4104(a).

In enacting and amending the DM&S statute, Congress established an extensive personnel system, independent of the civil service system, to cover the professional medical employees at DM&S.[2/] Appointments to positions in the DM&S are made "only after qualifications have been established in accordance with regulations prescribed by the Administrator,

---

2/ Health care professionals covered under the personnel system established include physicians, dentists, nurses, dental auxiliaries, physical therapists, and pharmacists. See 38 U.S.C. § 4104.

without regard to civil-service requirements."[3/] 38 U.S.C. § 4106(a). Employees appointed to the DM&S must serve a two year probationary period. 38 U.S.C. § 4106(b). Promotions for the professionals are based on the qualifications established by the Administrator. 38 U.S.C. § 4106(c).

The DM&S statute provides that the working conditions for these professionals be established almost exclusively without regard to the civil service laws of title 5.[4/] Section 4107 establishes the grade and pay scales for these employees. Particularly relevant here, the Administrator is directed to prescribe by regulation the conditions of employment of the professional medical employees. 38 U.S.C. § 4108(a). Internal disciplinary boards are to be established to handle performance or misconduct problems. 38 U.S.C. § 4110. Finally, the agency has the authority to promulgate any remaining regulations necessary for the administration of DM&S. 38 U.S.C. § 4115. In 1980 an amendment was added to the DM&S statute which mandated that the provisions of the DM&S statute will override any inconsistent provisions of title 5 or other laws pertaining to the civil service system. 38 U.S.C. § 4119.

The Respondent's Published Policy Concerning Patient Abuse

Respondent defines patient abuse as including assault upon or injury to a patient; teasing a patient; speaking harshly, rudely or irritably to a patient; laughing at or ridiculing a patient; and indifference. A primary requirement of the Respondent's patient abuse policy is that all employees, supervisors and managers must make prompt, timely and accurate reports of alleged patient abuse to their superiors. The Respondent's prompt reporting rule requires the professional employee in charge at the time of the alleged abuse to make a written report (VA Form 10-2633) of the incident by the end of the work shift. The reason

---

3/ The DM&S statute also provides for employment of additional personnel, other than the professionals covered under the provisions of the statute, who are necessary for the proper maintenance of DM&S. These employees are covered under the provisions of the civil service laws, rules and regulations. 38 U.S.C. § 4111.

4/ The retirement benefits of these professionals are the only aspect of their working conditions remaining under the civil service system. 38 U.S.C. § 4109.

for this rule is (1) to insure prompt examination of the patient by a physician for evidence of physical and/or mental abuse; (2) to provide for the prompt treatment of patients who have suffered physical and/or mental abuse; and (3) to provide timely notice of the allegations to the accused employee and provide an opportunity for that employee to preserve evidence to defend against the charges.

The requirement for reporting patient abuse is not conditioned upon whether an employee witnessing an incident wants to fill out a VA Form 10-2633. Rather, a report must be filed once an employee, supervisor or manager either witnesses patient abuse or receives a report of an incident involving abuse. The Respondent's policy provides for disciplinary action whenever an employee, supervisor or manager fails to promptly report alleged patient abuse.

Respondent's policy provides that the administrative penalty for patient abuse is removal. A lesser disciplinary action may be imposed only when the abuse is considered to be of a minor nature and is not a repeated offense, or where there are mitigating or extenuating circumstances. Intent to abuse a patient is not an element of patient abuse and absence of intent is not a valid consideration in determining whether patient abuse has occurred. The Respondent considers repeat instances of patient abuse as a very important factor when applying its policy. The Respondent has provided written guidance to its employees concerning the nature of the mitigating or extenuating circumstances which will serve to excuse an employee's application of force against a patient. This guidance permits an employee to use reasonable force directed at a patient only in instances involving an assaultive patient. Reasonableness is determined from the circumstances including the patient's age, physical size, condition, weight and health.

The Case of Registered Nurse William Ward

William Ward was at all times relevant employed by the Respondent in the position of nurse at the Department of Veterans Affairs Medical Center, Canandaigua, New York. He was appointed to such position for the medical care of veterans pursuant to the provisions of 38 U.S.C. § 4104.

William Ward has worked as a registered nurse at the Respondent's Canandaigua, New York facility since 1981. He has served as an official of the Union since 1986, initially as Executive Vice President and since October 1989 as President.

From November 1987 until April 1988 Ward was the acting head nurse on ward 37-B. Ward agreed with Chief Nurse Gregory Skomra that he would take a leave of absence from his Union office while serving as the acting head nurse. In mid-March 1988 Skomra selected Barbara Jones, R.N., for the permanent head nurse position. When Skomra told Ward of Jones' selection, Skomra asked Ward what he was going to do about his position with the Union. Ward replied that he planned to return to his Union duties. Skomra asked whether Ward considered that to be in the best interests of his career.

In early April 1988, just after Barbara Jones became head nurse on 37-B, Ward, on behalf of the Union, represented a registered nurse at a meeting with Jones. At this meeting Jones counseled the nurse regarding the performance of his duties during an incident which resulted in a patient's death. Ward insisted during the meeting that Jones shared responsibility for the incident.

On October 17, 1988 Ward filed a grievance on behalf of a registered nurse, John Britton, and other nurses which challenged the assignment of a new employee to a position vacancy instead of to a nurse with seniority. When Chief Nurse Skomra failed to respond at the second step, Ward moved the grievance to the third step where it was adjusted by the Respondent's Center Director.

In August 1988, after some of the registered nurses had come to Ward with questions pertaining to the application of the collective bargaining agreement to seniority rights, overtime, and possible disciplinary action, Jones told Ward that she resented his interference with her supervisory authority. On another occasion in November 1988, Jones overheard a nurse's conversation with Ward about the propriety of a doctor's orders and whether the Union would support the nurse's proposed action. Jones told Ward that she was getting tired of his interfering with matters; that he was no longer the head nurse; that he and the Union were not expert on everything; and it was about time people found out for themselves that he was "not the Brittanica of 37-B."

On March 3, 1989 Ward served Jones with an unfair labor practice charge. The charge alleged that Jones had bypassed the Union on February 7, 1989 by bargaining directly with unit employees concerning a change in the nurses' working hours. The charge was resolved at a meeting between Ward, Skomra, and representatives of the personnel office.

On March 8 and 9, 1989 Ward filed grievances on behalf of the staff nurses on 37-B complaining of violations of the contract concerning staffing shortages and security measures which allegedly led to a nurse being injured. Jones told Ward during a first step grievance meeting that he had overstepped his authority in telling a nurse which forms to fill out after the incident; that she was sick of his interfering with her authority; and this was the last time she was going to put up with it. Ward replied that the nurse had asked him which forms to fill out, but he was at this meeting only to discuss the grievance. Jones replied that she did not want to talk about it. The grievance was moved to the second step through Chief Nurse Skomra and was resolved there.

On March 22, 1989 Ward filed a grievance charging that Jones had falsely accused him of inappropriate nursing documentation. Ward requested reassignment to another psychiatric unit as a remedy. When Jones failed to respond, Ward moved the grievance to the second step where, on April 11, 1989 he and his Union representative, David Bellomo, met with Skomra. Skomra wanted Jones present at this meeting, but excluded her when Ward objected that she had not responded to his grievance and should not be allowed to participate. Skomra proceeded to adjust Ward's grievance by agreeing to transfer him off of 37-B. Ward was advised later that day by telephone and by memorandum dated April 11 that his reassignment would be effective April 30, 1989.5/

5/ As noted, the record reflects that Ward was granted the reassignment on April 11, 1989 as an adjustment of a grievance. However, Skomra acknowledged that he testified at Ward's hearing before the Nurse's Professional Disciplinary Board that the transfer was not made at Ward's request (Tr. 52). Skomra testified that the transfer was made only after he had received incident reports of Ward's alleged patient abuse and then requested and reviewed reports from the staff involved and met with the Chief of Staff. (Tr. 53-54). Skomra could not recall receiving any reports of alleged patient abuse by Ward prior to April 12, 1989 (Tr. 65) and the actual reports were dated and reviewed between April 12-14, 1989 (Tr. 57; G.C. Ex. 8). Thus, the record does not support the impact of Skomra's testimony before the Board which was that the transfer was designed to remove Ward from patient care in light of the alleged abuse (Tr. 65-66). As noted, Ward's transfer was approved April 11, 1989.

Application of Patient Abuse Policy To Ward

On April 12, 1989 Jones submitted three VA Forms 10-2633, "Report of Special Incident Involving A Beneficiary," reporting on three instances of alleged patient abuse by Ward which had occurred nearly two weeks earlier on March 31, 1989. Jones reported that she witnessed one of the incidents and the other two were reported to her earlier on March 31. Jones was in charge of the ward. The allegations were:

> 1. Ward ordered a patient to strip, wash, and remake the bed of a second patient which the first patient had soiled.
>
> 2. Ward repeatedly asked a patient if he wanted to fight and told the patient a lot of other patients had hard feelings against him and he would be put in ambulatory cuff and belts and other patients could get even with him. The Respondent's diagnosis of this patient was schizo chronic paranoid with a history of assaultive behavior. He had been admitted for chronic psychosis and at the time of this incident was in ambulatory cuff and belt and was very agitated.
>
> 3. Ward allegedly told an agitated patient whom Ward and an assistant had placed in ambulatory cuff and belt that he would not be able to smoke or lie down and would be "on hold" all weekend. This patient was 30 years old, diagnosed as schizo affective disorder, multi substance abuse, with a history of swallowing foreign objects.

Between March 31 1989 and April 12, 1989 Ward worked the same schedule as Jones. They had daily contact at work and during that entire period Ward performed all of his regular nursing duties on 37-B. Skomra was also at work throughout this period. At no time in that period did Jones or any other representative of the Respondent mention anything to Ward concerning the allegations of patient abuse on March 31st. Jones' delay of 12 days in reporting the alleged abuse was improper under the Respondent's patient abuse policy. Respondent has taken no action to investigate or discipline Jones for the delay or Chief Nurse Skomra for failing to investigate the delay.

As a result of these allegations, the Medical Center Director appointed a 3-member Investigation Team to investigate the allegations. The team submitted its report on July 7, 1989 finding that the alleged acts constituted abuse.

On July 25, 1989 Chief Nurse Skomra recommended Ward's removal. Dr. Tao Brondum, the Chief of Staff, and Gary W. Devansky, Acting Medical Center Director, concurred with that recommendation. The Respondent was well aware at that time of Ward's activities as an official of the Union.

The recommendation to remove Ward was forwarded to Respondent Central Office in Washington, D.C. The recommendation was adopted and on September 25, 1989 the Respondent's Central Office issued a proposed notice of discharge to Ward for the three instances of patient abuse on March 31st.

The proposed notice of discharge advised Ward of his rights to submit a written explanation and to request a hearing before a Disciplinary Board appointed by the Chief Medical Director. The Disciplinary Board would recommend to the Chief Medical Director whether the charges should be sustained and the final action to be taken. The notice stated that the Chief Medical Director would make the final decision.

The proposed notice of discharge of Ward was issued pursuant to procedures promulgated by the Secretary of Veterans Affairs under authority of 38 U.S.C. § 4110, relative to appointment of disciplinary boards to determine, upon notice and fair hearing, charges of inaptitude, inefficiency, or misconduct of any person employed in a position provided in paragraph (1) of 38 U.S.C. 4104.

Ward submitted a written request for a hearing before the Disciplinary Board on October 4, 1989. On October 10, 1989 he also submitted a written explanation. His statement included the position that the credibility of the nursing assistants who reportedly witnessed his alleged abuse should be doubted as he had, among other things, reprimanded them earlier that morning when they neglected their duties.

The unfair labor practice charge relating to the issuance of the proposed discharge of Ward was filed on December 26, 1989, with amendments thereto filed on January 29, 1990 and February 7, 1990.

Effective December 31, 1989 the Respondent denied Ward's within grade step increase because it had proposed his discharge for patient abuse.

Ward's Disciplinary Board hearing was held on March 19-21, 1990. Ward submitted by way of defense to such charges documentary and testimonial evidence concerning his activity in the pursuit of grievances and unfair labor practice charges against management officials of the Department of Veterans Affairs and argued that such charges were brought against him as retaliation for his activity as an official of the Union.

Prior to this incident, Ward had not been disciplined by the Respondent for any reason.

The Case of Registered Nurse David Bellomo

David Bellomo was at all times relevant employed by the Respondent in the position of nurse at the Department of Veterans Affairs Medical Center, Canandaigua, New York. He was appointed to such position for medical care of veterans pursuant to the provisions of paragraph (1) of 38 U.S.C. 4104.

Bellomo has worked for 13 years as a registered nurse at the Respondent's Canandaigua facility. He has served as a Union official for over four years and has been active in his role as a Union representative since July 1987. In both his July 1987-July 1988 and July 1988-July 1989 evaluations Bellomo's supervisor, Joyce Lasner, Head Nurse, noted that he was an "active member of AFGE" and had requested official time as appropriate to attend to Union needs away from the unit.

During the period February 16, 1989 to April 17, 1989 Bellomo processed grievances for two registered nurses who complained that they had been counseled by their head nurse in an improper manner. The grievance was resolved at the second step by Gregory Skomra, Chief, Nursing Service.

During the period February 25, 1989 to April 17, 1989 Bellomo processed a grievance for a registered nurse who complained that she was forced to perform overtime in violation of the contract. In presenting the grievance at step one the head nurse merely presented Bellomo with a previously prepared denial as she had done on two other occasions. The grievance was resolved at the second step by Mr. Skomra.

On June 10, 1989 Bellomo was working on an acute psychiatric ward when as agitated schizo-paranoid patient struck Bellomo on the head several times with his fist. The patient was highly volatile and had a history of becoming easily agitated and assaulting staff members. At the time of this incident the patient was: 41 years old, over 6 feet tall, in good physical health, solidly build, with no physical infirmities, very strong, and capable of inflicting serious injury on himself and others. The nearest staff members who could have assisted Bellomo were over 100 yards away, behind a series of locked doors. Bellomo wrestled the patient to the floor and eventually subdued him by holding one of the patient's hands between his legs. Bellomo and a nursing assistant, who had just arrived, took the patient to his room in this fashion. According to Bellomo, if, instead of subduing the patient, Bellomo had evaded the patient's assault and gone off looking for help, as suggested after the fact by Skomra, he would have exposed the 50 year old female nursing assistant on duty to the full brunt of the assault. Bellomo promptly reported the incident in accordance with Respondent's regulations.

On June 16, 1989 the patient alleged that he had been abused by Bellomo during the incident. As a result, the Medical Center Director appointed a 3-member team to investigate the allegation.

On June 19, 1989 Bellomo was reassigned from direct patient care to the nursing home care unit where he began working for Head Nurse Elizabeth Maio. Shortly after this assignment, the Union, on June 30 and July 7, 1989, filed three grievances concerning Maio's actions. Bellomo asked Ward to process the grievances. They concerned failure to orient new nurses and failure to adhere to posted times for nurses as provided by the contract. On July 7, 1989 Maio complained to Bellomo, "My God, David, before you came over here I had no problems with the Union. Since you've been here, I'm having nothing but problems."

The investigating team appointed by the Medical Center Director submitted its report on July 14, 1989 finding that Bellomo's actions on June 10, 1989 constituted patient abuse. The team recommended unspecified disciplinary action.

Around the end of August, Bellomo's assignment was changed again. He was transferred to ward 9-A where three of the five Union officials were assigned by the Respondent.

On August 24, 1989 Bellomo initiated an unfair labor practice charge alleging that Chief Nurse Skomra failed to

meet with him as a designated representative of the Union concerning the matter of another nurse who was also reportedly assigned out of direct patient care. On August 29th Bellomo met with Skomra to attempt resolution of his charge. Bellomo complained that Skomra had not subjected (Nurse "D", infra.) to the same sort of restrictions on patient contact as those imposed on him, after she had abused a patient on May 28, 1989. Bellomo argued that those restrictions placed him in a difficult position should an emergency arise with a patient. Skomra responded, "We could put you off on a non-duty status without pay."

On September 1, 1989 Chief Nurse Skomra reviewed the report of the investigating team concerning Bellomo's alleged patient abuse and recommended that Bellomo's "continued retention" be reviewed. Dr. Tao Brondum, the Chief of Staff, concurred. On September 27, 1989 Gary W. Devansky, Acting Medical Center Director, decided that Bellomo should be removed from the service. The Respondent was well aware at the time that Bellomo had been an active Union official. The recommendation to remove Bellomo was forwarded to the Respondent's Central Office in Washington, D.C.

On December 5, 1989 Bellomo personally served the Respondent's agents at Canandaigua, including Skomra, Brondum and Acting Center Director Devansky, with an unfair labor practice charge. The charge alleged that the Respondent had changed working conditions by opening a previously locked ward without negotiating with the Union on the impact and implementation of the change.

On December 6, 1989 the Respondent Central Office in Washington, D.C. issued a proposed notice of discharge to Bellomo for alleged patient abuse on June 10, 1989. The notice alleged, in part, that Bellomo had conducted himself "in an unprofessional manner in providing care to a patient in that you used excessive force and an inappropriate technique to subdue and restrain a patient."

The proposed notice of discharge advised Bellomo of his rights to, within five days, submit a written explanation and/or to request a hearing before a Disciplinary Board appointed by the Chief Medical Director. The Disciplinary Board would recommend to the Chief Medical Director whether the charges should be sustained and the final action to be taken. The notice stated that the Chief Medical Director would make the final decision.

The proposed notice of discharge of Bellomo was issued pursuant to procedures promulgated by the Secretary of

Veterans Affairs under authority of 38 U.S.C. 4110, relative to appointment of disciplinary boards to determine, upon notice and fair hearing, charges of inaptitude, inefficiency, or misconduct of any person employed in a position provided in paragraph (1) of 38 U.S.C. 4104.

Bellomo requested a hearing on the proposed removal in December 1989, and a hearing was held on May 16 and 17, 1990.

The unfair labor practice charge alleging unfair labor practices in the issuance of the proposed discharge of David Bellomo was filed in Case No. 1-CA-00161 on February 7, 1990.

Respondent's History Of Applying Its Patient Abuse Policy To Other Registered Nurses Employed At Its Canandaigua, New York Facility

The Case of Registered Nurse - "A"

Patient Abuse Incident #1 - In approximately May or June 1983, the Respondent entrusted Nurse A with the care of a patient who was then in his late fifties or early sixties. The patient had a tracheotomy, a permanent breathing hole in his throat, as he could not breathe through his mouth or nose. He was also diagnosed with a psychiatric illness, and was very strong and easily agitated. As a result, he frequently had to be physically restrained. At the time of this incident, the patient was secured to a tray chair. Nurse A had just given the patient some oral medication when the patient threw the remaining water in his cup onto the floor. As a nursing assistant mopped the spilled water, Nurse A yelled at the patient and struck a forceful, side-arm blow to the back of his head with a hard, rubber-soled slipper. The blow was audible, sounding like a "real hard slap." The nursing assistant made a written report of Nurse A's abuse of this patient. The Respondent transferred Nurse A to another ward, but there is no record of any disciplinary action against her for patient abuse.

Patient Abuse Incident #2 - The next recorded instance when Nurse A abused a patient was on or about September 11, 1985. The patient was 58 years old and suffering from organic brain damage. The incident was investigated by Dr. Brondum. The only competent eyewitness to Nurse A's abuse was a licensed practical nurse (LPN) since the patient's mental infirmity rendered him incapable of providing an account of what Nurse A had done to him. The Respondent's record of this case of patient abuse makes

clear the following points: The LPN had a good view of the incident. Nurse A failed to observe the necessary routine for getting an elderly patient out of bed in the middle of the night to change Attends (diapers) and bed linens. She struggled with the patient and pushed or struck him in the area of his chest. The patient was bruised and Nurse A had bits of his hair in her hand following the struggle. Nurse A was frustrated and angry at the patient. She had prior training in handling combative patients and should have known the correct manner for dealing with this patient. She threatened the LPN with reprisal for reporting her abuse of this patient.

Because of Nurse A's low frustration level and easily aroused anger, Dr. Brondum and the other members of the Respondent Investigation Panel recommended that she be referred to the Respondent employee assistance program. Nurse A declined that assistance. The Respondent concluded that Nurse A had indeed abused the patient and that she should be disciplined. The report made no reference to the fact that she had previously assaulted and abused a patient. She was transferred to still another shift and received a written reprimand and additional training on how to deal with difficult patients. A month after the reprimand was issued, the Respondent's Center Director notified the Union in response to a grievance by the nurse that it was being removed from her file because, although the nurse was involved in a previous patient abuse incident, she was currently performing satisfactorily and the reprimand had served its purpose.

Patient Abuse Incident #3 - Six months later Nurse A was accused for a third time of abusing patients who were placed in her care by the Respondent. This time, two co-workers reported to their head nurse on July 22, 1986 that Nurse A had abused four patients. The head nurse did not report this alleged patient abuse until October 3, 1986 when she filed a VA Form 10-2633 and a Report of Contact outlining three of the four incidents. The Respondent's Investigation Panel considered only two of the four incidents. The Panel concluded in its report of October 31, 1986 that no evidence was found to support the co-workers allegations; that no dates or times could be established.

Notwithstanding these conclusions, the Panel had evidence in the form of memoranda from Nurse A's co-workers concerning their charges that she had physically abused the

four patients. One charge contains a detailed description of her alleged abuse of a patient. The co-workers reported that on June 7, 1986, at 6:30 p.m., in the day room on the North end of ward 36-A, the patient had gotten out of control. Nurse A allegedly twisted his arm behind his back, lowered him to the floor, choked him, placed her hand over his mouth in an attempt to shut it and applied excessive pressure to his jaw, forcing his head backwards. The more the patient tried to scream, the tighter she allegedly gripped him. When an aide appeared with a cuff and belt for the patient, Nurse A allegedly quickly removed her hands from the patient's neck and jaw. The Panel did not consider that allegation and the Respondent offered no explanation for its failure to do so. The other charges included allegations that Nurse A had slapped a patient when he wouldn't eat; squeezed a patient's cheeks when he wouldn't take his medication; and slapped a patient in the head and pushed him into walls for no apparent reason. The Respondent noted some apparent "personality conflicts" between Nurse A and the two co-workers and speculated that these conflicts "could have attributed (sic)" to the critical way in which the co-workers had observed her actions. It does not appear from the record that the Panel took testimony from these two eye witnesses.

Dr. Brondum concurred in the recommendation that no action be taken against Nurse A, and the Canandaigua Center Director reported to the Respondent's Central Office in Washington, D.C. that the incident was closed.

In a follow-up to the handling of these matters, the Respondent's Central Office noted the deficiencies in Canandaigua's investigation, including whether the staff were asked to testify or were interviewed. The Central Office also recommended training be provided to the nursing staff at Canandaigua regarding the Respondent's requirement for immediate reporting of all allegations of patient abuse. Finally, the Central Office demanded information on what actions had been taken against the head nurse for failing to report the alleged abuse in a timely manner. The record does not show any response from Canandaigua.

The Case of Registered Nurse - "B"

On July 12, 1986 a nursing assistant reported that a patient on the Respondent nursing home care unit had been treated roughly by employees. The incident arose after a patient who was on a toilet stool bit the nursing assistant who was attending him. The assistant left the patient and

went to the nurses' station where he reported the matter. Nurse B returned with the assistant to the bathroom where the patient was still on the stool. Nurse B grabbed the patient's chin and in a rough and punitive manner forced his head back against the wall while at the same time asking the patient why he'd bitten the assistant and was he going to bite her? Nurse B then allowed the nursing assistant to roughly transfer the patient to a chair where he was restrained with his pants down and without Attends. The patient was returned in this condition to his room where he was kept with the door closed for two hours. Nurse B also failed to report the patient's allegation that the nursing assistant had hurt him.

The Respondent Investigation Team concluded that Nurse B had abused this patient and recommended she be disciplined. Chief of Staff Brondum concurred with the recommendation to reprimand Nurse B. On September 3, 1986 the Respondent's Center Director concurred and recommended closing the case.

On October 14, 1986 the Respondent's Central Office commented in a memo to the Center Director at Canandaigua that Nurse B should have been removed for abusing this patient, but the fact that disciplinary action had already been taken precluded further action other than monitoring her future behavior.

The Case of Registered Nurse "C"

On August 17, 1986 a 58 year old patient died as a result of "blood loss into the intestine secondary to a laceration of the intestine due to over distending a foley catheter balloon in attempting to remove the foley catheter." Nurse C had burst a foley catheter balloon by over filling it with water when it could not be removed in the usual way. Dr. Brondum commented at the time that this particular procedure is safe and acceptable when the balloon is in the urinary bladder or within the stomach, but is hazardous and should not be used when the balloon is in a confined space such as in the small bowel. The Investigation Team concluded that Nurse C's action "was based on his previous experience and O.D. instruction in two other instances. There was no intent to harm the patient and he performed his duty in the usual manner considered appropriate for his nursing position and experience." No disciplinary action was recommended. According to the Respondent's patient abuse policy, however, intent to cause injury to a patient is not an element of patient abuse and the absence of intent is not a valid foundation for a finding that abuse has not occurred.

The Case of Registered Nurse - "D"

On May 28, 1989 Nurse D was providing care for a 75 year old partially paralyzed patient. The patient had a history of being non-cooperative when taking his medications, a not uncommon situation among the Respondent's elderly, infirm patients. The Respondent expects its registered nurses to react in a professional manner when confronted with such behavior. On this occasion, as Nurse D gave the patient some milk of magnesia, the patient spat it at her. Nurse D responded angrily, throwing a milk shake in the patient's face. She did not report the incident and did not complete the requisite VA Form 10-2633. When Nurse D was confronted with this allegation of patient abuse she denied it. Nevertheless, the Respondent found that the evidence established she had thrown the milk shake on the patient and concluded that her actions constituted patient abuse although an "instinctive reflex action" and "without deliberate malice or intent to harm."

Chief Nurse Skomra, in recommending a one day suspension for Nurse D, wrote, in part, "Based on the occurrence of this singular incident, the nature of which I do not expect to reoccur, I recommend the return of [Nurse D] to her full-duty responsibilities [following her suspension]."

Notwithstanding Skomra's characterization of Nurse D's patient abuse as a "singular incident" the Respondent's investigation of her abuse of this patient revealed that a week or two before the milk shake incident, a co-worker had reported that Nurse D abused another patient. The co-worker told her supervisor on May 15th or 16th that she saw Nurse D repeatedly and forcefully shove a patient back into his seat when the patient attempted to rise. When the co-worker made her initial report, her supervisor asked if she "wished" to file a complaint. The co-worker declined. The Respondent's policy makes it mandatory to report every instance of patient abuse. Reporting abuse is not a matter that is left to the discretion of an employee who may witness abuse. The Respondent never investigated that earlier allegation and it did not consider it when determining Nurse D's discipline for abusing the patient on May 28th. Moreover it did not discipline the personnel responsible for failing to report the earlier incident.

On August 3, 1989 Skomra recommended Nurse D's suspension for one day. Chief of Staff Brondum signed off on that recommendation. On October 4, 1989 the Respondent's Central Office in Washington, D.C. proposed to suspend Nurse D for

five days for her action of throwing a glass of liquid into a patient's face.

Chief Nurse Skomra testified that the actions of Mr. Bellomo, particularly the hold applied on the patient and his actions in taking the patient to the floor, demonstrated more of an intent to abuse than did the acts of Nurse D, which was more of a reaction to the patient. Skomra testified that the three separate incidents attributed to Mr. Ward also demonstrated an intent to abuse the patients which warranted the recommendation of removal.

No Other Removals

Nurses A, B, C, and D have never been officials of the Union. Other than Ward and Bellomo, the Respondent has not proposed to fire any registered nurse for patient abuse at its Canandaigua facility during at least the past five years. Moreover, the Respondent has presented no evidence that it has ever made such a proposal in the case of a registered nurse to the date of the hearing.

Discussion and Conclusions

I. Respondent's Proposals To Discharge Are Not Substantively Reviewable In This Proceeding.

The proposed notices of discharge to Ward and Bellomo were issued pursuant to procedures promulgated by the Secretary of Veterans Affairs under authority of 38 U.S.C. § 4110, relative to the appointment of disciplinary boards to determine, upon notice and fair hear, charges of inaptitude, inefficiency, or misconduct. It is well established that those procedures are the exclusive procedures available to title 38 professional medical employees for handling disputes regarding discipline for alleged professional misconduct. Veterans Administration Central Office, Washington, D.C. and Veterans Administration Medical and Regional Office Center, Fargo, North Dakota, 27 FLRA 835, 839 (1987) (VA, Fargo), aff'd. sub nom. American Federation of Government Employees v. FLRA, 850 F.2d 782 (D.C. Cir., 1988; U.S. Department of Veterans Affairs, Veterans Affairs Medical Center, San Francisco, California, 40 FLRA No. 30 (1991) (VA San Francisco).

The General Counsel alleges that the proposed notices were issued in violation of 5 U.S.C. § 7116(a)(1), (2), and (4). Counsel for the General Counsel urges, in part, that to remedy these violations, pursuant to 5 U.S.C. § 7118 the

proposed notices of discharge should be rescinded. However, 38 U.S.C. § 4119, enacted in 1980, provides that no provision of title 5 which is "inconsistent" with a provision of title 38 "shall be considered to supersede, override or otherwise modify" the title 38 provision unless title 5 specifically so provides by specific reference to the title 38 provision.6/ See Veterans Administration, Washington, D.C. and Veterans Administration Medical Center, Minneapolis, Minnesota, 15 FLRA 948, 951-2 (1984) (VA, Minneapolis). There is nothing in the Federal Service Labor-Management Relations Statute, enacted as section 701 of the Civil Service Reform Act of 1978, Pub. L. No. 95-454, 92 Stat. 1111 (1978) and codified in title 5 along with other civil service and personnel laws, 5 U.S.C. §§ 7101 et seq., which even refers to title 38, much less specifically provides that the unfair labor practice provisions of the Statute were intended to supersede, override, or otherwise modify the provisions of the DM&S Statute. For the Authority to find a violation of section 7116(a) of the Statute and order the Agency to rescind the proposed notices of discharge pursuant to section 7118(a)(7)(D) would be to apply the Statute so as to supersede, override, or otherwise modify the provisions of 38 U.S.C. § 4110. Such a result is barred by 38 U.S.C. § 4119. Cf. VA, Fargo, 27 FLRA at 840; VA, Minneapolis, 15 FLRA at 952.

Since the law is somewhat unsettled in this area, and this case involves proposed removals rather that the final determinations by the agency addressed in VA San Francisco, the record as developed by the parties will be considered further to avoid the possible necessity of a remand.

II. Section 7116(d) Does Not Bar The Complaint

Respondent contends that under section 7116(d) of the Statute the charges at issue may not be raised in an unfair

---

6/ § 4119. Relationship between this subchapter and other provisions of law

Notwithstanding any other provision of law, no provision of title 5 or any other law pertaining to the civil service system which is inconsistent with any provision of this subchapter shall be considered to supersede, override, or otherwise modify such provision of this subchapter except to the extent that such provision of title 5 or of such other law specifically provides, by specific reference to a provision of this subchapter, for such provision to be superseded, overridden, or otherwise modified.

labor practice hearing. Section 7116(d) of the Statute provides that "Issues which can properly be raised under an appeals procedure may not be raised as unfair labor practices prohibited under this section."

Respondent argues that both Ward and Bellomo requested hearings upon the proposed notices of discharge before disciplinary boards established pursuant to 38 U.S.C. § 4110 "to determine charges of inaptitude, inefficiency, or misconduct" and have proceeded through that process. Ward submitted into evidence before the disciplinary board, as part of his of defense to such charges, documentary and testimonial evidence concerning his activity in pursuit of grievances and unfair labor practice charges against management officials and alleged that such charges were brought against him as retaliation for such activity. Respondent argues that Bellomo had the some opportunity.

As held above, the personnel system established by 38 U.S.C. §§ 4104-4119 for DM&S professional employees is intended to operate apart from the personnel system which is applicable to general Federal civil service employees under title 5,7/ and for that reason may be beyond the reach of the unfair labor practices prohibited by the Statute. However, there has been no showing that the issues involved in the instant complaint "can properly be raised" under the appeals procedure cited by Respondent and are separately barred by section 7116(d). The jurisdiction of Respondent's internal peer disciplinary boards is limited to determining "charges of inaptitude, inefficiency, or misconduct." Cf. Department of Health and Human Services, Social Security Administration, Baltimore, Maryland and Wilkes-Barre Data Operation Center, 17 FLRA 435, 443 (1985) (Applicant's handicap discrimination complaint and limited right to appeal to the Merit Systems Protection Board did not require dismissal of unfair labor practice complaint pursuant to section 7116(d)); Veterans Administration Regional Office, Denver, Colorado, 7 FLRA 629, 639 (1982) ("appeals procedures" in section 7116(d) does not encompass an intra-agency appeal to the head of an agency which does not provide for third-party review of an agency action).

7/ See U.S. Small Business Administration and Local 2532 of National Council of Small Business Administration Locals of the American Federation of Government Employees, AFL-CIO, 33 FLRA 28, 34-5 (1988).

III. Ward and Bellomo Were Engaged In Activity Protected By The Statute

In Letterkenny Army Depot, 35 FLRA 113 (1990), the Authority set forth various factors it deemed applicable in evaluating cases alleging violations of section 7116(a)(2) and (1) of the Statute. After noting that the General Counsel always has the burden of proving the allegations of the complaint by a preponderance of the evidence, the Authority stated that in all cases of alleged discrimination, the General Counsel must establish that: (1) the employee against whom the alleged discriminatory action was taken was engaged in protected activity; and (2) such activity was a motivating factor in the agency's treatment of the employee in connection with hiring, tenure, promotion, or other conditions of employment. The Authority stated that if the General Counsel fails to make the required prima facie showing, the case ends without further inquiry. Id. at 118.

The General Counsel contends that the termination of Ward and Bellomo was proposed because they engaged in activities protected by the Statute. The activity of Ward allegedly protected under the Statute includes his serving as a Union representative and filing three grievances concerning nurses' working conditions, furnishing advice to nurses concerning their rights under the agreement, being present on behalf of the Union at the counseling of a nurse, and filing an unfair labor practice charge regarding an alleged bypass of the Union when management consulted only with nurses concerning a change in their working hours. The alleged protected activity of Bellomo under the Statute includes his serving as a Union representative and filing three grievances regarding nurses' working conditions and two unfair labor practice charges regarding management's alleged refusal to meet with the Union regarding differences in the assignments of two nurses and a change in working conditions by opening a locked ward. There is no indication in the record that Ward or Bellomo represented any nonprofessional employees.

In Colorado Nurses Association v. FLRA, 851 F.2d 1486 (D.C. Cir. 1988), the court reversed the Authority's ruling that the VA is obligated to bargain over conditions of employment for professional medical employees of the Department of Medicine and Surgery (DM&S) appointed under title 38 of the United States Code. The court stated that under 38 U.S.C. § 4108, the authority of the VA Administrator "is exempt from all laws governing the terms and conditions of federal employment except as otherwise explicitly provided

in the DM&S Statute [.]" Based on the court's decision in Colorado Nurses Association, the Authority found that the VA has no obligation to bargain over the conditions of employment of professional medical employees of the DM&S which are within the discretion of the VA Administrator under 38 U.S.C. § 4108 and "may be determined unilaterally by the Agency." Veterans Administration, Washington, D.C., 33 FLRA 600, 602-03 (1988).

In U.S. Department of Veterans Affairs, Medical Center, Danville, Illinois, 34 FLRA 131 (1990), aff'd. sub nom. American Federation of Government Employees, Local 1963 v. FLRA, No. 90-2080 (C.D. Ill., Aug. 14, 1990), the Authority held that the parties' negotiations do not constitute "collective bargaining" under the Statute, and any agreement entered into as a result of those negotiations does not constitute a "collective bargaining agreement" within the meaning of the Statute. The Authority held, for the same reasons, that a grievance procedure contained in an agreement resulting from the parties' negotiations does not constitute a negotiated grievance procedure under section 7121 of the Statute.

The Authority expanded on this holding in U.S. Department of Veterans Affairs, Washington, D.C. and U.S. Department of Veterans Affairs, Medical and Regional Office Center, Fargo, North Dakota, 34 FLRA 182 (1990), (VA, Fargo II) reversed sub nom. American Federation of Government Employees, AFL-CIO, Local 3884 v. Federal Labor Relations Authority, No. 90-1379 (8th Cir., April 16, 1991). The Authority held that the VA did not violate the Statute by refusing to furnish the Union with information pursuant to section 7114(b)(4) of the Statute which the Union had requested in order to process a grievance. The Authority stated, in part, as follows:

> Because the parties' agreement results from an exercise of the Administrator's discretion under 38 U.S.C. § 4108(a) rather than from collective bargaining under the Statute, it falls outside the framework of rights and obligations established by the Statute and is not covered by the Statute's mechanics for the enforcement of those rights and obligations. A collective bargaining relationship under the Statute does not exist between the parties in this case. Consequently, the Union has no right under the Statute to information for the

> processing of a grievance under the parties' agreement and recourse to the Statute's unfair labor practice procedures is not available for the enforcement of the Union's claim to that information. Id. at 188.

Based on these decisions, it could be argued that the activity of Ward and Bellomo of filing and processing grievances on behalf of nurses, otherwise counseling and advising them of rights under the parties' agreement, and filing unfair labor practices against the Agency for failure to negotiate or meet with the Union concerning the nurses' working conditions also was not activity protected by the Statute. It could be argued, as the Authority held in VA, Fargo II, that the parties' agreement "falls outside the framework of rights and obligations established by the Statute and is not covered by the Statute's mechanisms for the enforcement of those rights and obligations."

However, the Authority in U.S. Department of Veterans Affairs, VA Medical Center, San Francisco, California, 40 FLRA No. 30 (1991) recently stated as follows:

> In sum, we conclude that the Charging Party, and other professional medical employees, are entitled to exercise rights pursuant to section 7102 of the Statute, including the right to form, join, or assist a labor organization without fear of penalty or reprisal. Unlawful interference with such rights constitutes a violation of section 7116(a)(1) and, in certain circumstances, section 7116(a)(2) of the Statute. The Authority has, and will exercise, statutory jurisdiction to resolve complaints alleging such violations.
>
> In resolving such complaints, however, the Agency's exclusive authority to determine working conditions and make decisions regarding inaptitude, inefficient, and misconduct under title 38 must be observed. If as here, a respondent asserts a lawful reason for a disputed action, and such assertion is consistent with action taken pursuant to its exclusive authority under title 38 of the United States Code and is final, the determination made pursuant to that authority is not substantively

> reviewable in an unfair labor practice proceeding. If, however, a respondent does not make such assertion, the respondent will be found to have violated the Statute./ [_/We express no view on what remedies may be appropriate or permissible in such cases.]

Accordingly, it is concluded that the activities of Ward and Bellomo were protected by the Statute. Cf. AFGE, Local 3884 v. FLRA, No. 90-1379 (8th Cir., April 16, 1991) (FLRA has jurisdiction over unfair labor practices arising under collective bargaining agreements the VA has voluntarily agreed to abide by.)

III. If The Proceeding Is Not Barred By The Provisions Of Title 38 And The Activities Of Ward And Bellomo Are Protected By The Statute, Respondent Violated The Statute.

Should the Authority determine that this proceeding is not barred by the provisions of title 38 and the activities of Ward and Bellomo are deemed to be activity protected by section 7102 of the Statute, the record, as set forth in detail above, demonstrates that Ward and Bellomo's activity was known to management. Some supervisors and officials involved in reporting or recommending action concerning their alleged patient abuse demonstrated anti-union animus toward them, particularly Head Nurse Barbara Jones and Chief Nurse Skomra in the case of Ward and Chief Nurse Skomra in the case of Bellomo. Where evidence of improper motivation has been presented, the existence of a causal relationship between such animus and the discharge can properly be inferred by the fact finder. Pension Benefit Guaranty Corporation, 39 FLRA No. 80 (1991) (Pension Benefit) slip opinion at 26. Accordingly, it is concluded that Union animus motivated in some part the decision to propose their dismissal.

Even assuming that the Respondent established that it had a legitimate justification for taking some form of disciplinary action against Ward and Bellomo, the Respondent has failed to demonstrate by a preponderance of the evidence that it would have proposed the same action -- discharge of the employees -- in the absence of protected activity. Pension Benefit, slip opinion at 27. Contrary to the position of Respondent, the alleged patient abuse of Ward and Bellomo was not sufficiently distinguishable from that of other nurses to merit the harsher discipline of proposed discharge.

Respondent's announced policy is understandably directed at insuring patients' safety and preserving their human dignity. This policy provides severe disciplinary penalties for violating patients' rights or for failing to report violations of the Respondent's published patient abuse policy. The disciplinary penalties provided by this policy are clear and unambiguous; patient abuse is punishable by removal unless (a) it is of a minor nature and is not a repeat offense, of (b) mitigating or extenuating circumstances are present. Under that policy the only instance when use of force against a patient is condoned is to repel the assault of a patient. Even then, the circumstances must be examined to determine the reasonableness of a nurse's application of force. However, as demonstrated by the facts in this case, the only registered nurses to whom the Respondent has invoked its published policy and proposed the maximum penalty of termination at Canandaigua are Ward and Bellomo. Discipline, if imposed at all on other nurses, who are not Union officials, has been minimal.

As set forth in detail above, Nurse A was transferred to another ward, but not otherwise disciplined after striking a restrained patient in the back of the head with a slipper in 1983. In 1985 she merely received a transfer once again along with a written reprimand and additional training after she was found to have bruised an elderly patient during a struggle. Six months later Nurse A was accused for a third time of patient abuse. Despite her record of prior abuse and notwithstanding the existence of detailed eye witness accounts, the Respondent recommended no disciplinary action citing lack of evidence. Unlike its handling of Ward's case, the Respondent noted that the co-workers' animosity towards Nurse A could have affected their observations of these incidents.

Similarly, Nurse B was merely reprimanded in 1986 after having been found to have abused a patient. Nurse B forced the patient's head back against a wall and allowed a nursing assistant to roughly transfer the patient to a chair where he was restrained with his pants down and without Attends. He was kept in this condition in a closed room for two hours. Nurse B had also failed to report the patients' allegation of abuse by the nursing assistant.

Finally, in a case of patient abuse arising at the same time as Ward's and Bellomo's, Nurse D angrily threw a milk shake in the face of an elderly, partially paralyzed patient. The Respondent's investigation disclosed that Nurse D's response was an "angry," "gut reaction", not the "learned,

educated reaction" the Respondents expects from its registered nurses. In Bellomo's case the exact same description was applied to his conduct in responding to and subduing the assault of a young, virile, psychotic patient. Indeed, the Respondent relied heavily upon the reflexive nature of Bellomo's response when it proposed to fire him. Notwithstanding these identical policy considerations, the Respondent proposed only a brief suspension of Nurse D and ignored another allegation regarding Nurse D's abuse of a second patient.

Based on the foregoing, if this proceeding were not barred by the provisions of title 38 and the activities of Ward and Bellomo were deemed protected by section 7102 of the Statute, I would conclude that the General Counsel has established by a preponderance of the evidence that the proposed discharges of Ward and Bellomo were motivated by their protected activity. Further, even assuming that the Respondent had a legitimate justification for taking some form of disciplinary action against Ward and Bellomo, I would conclude that the Respondent has failed to demonstrate by a preponderance of the evidence that it would have proposed the same action -- discharge of the employees -- in the absence of protected activity. Accordingly, if these circumstances had prevailed, violations of section 7116(a)(1), (2) and (4) would have been found.

Based on the foregoing findings and conclusions, it is recommended that the Authority issue the following Order:

Order

The complaint is dismissed.

Issued, Washington, DC, April 25, 1991

GARVIN LEE OLIVER
Administrative Law Judge