DEPARTMENT OF VETERANS AFFAIRS
UNDER SECRETARY FOR HEALTH
WASHINGTON DC 20420

JUN 0 3 2008

Dennis H. Smith
Director, VA Maryland Health Care System
10 North Greene Street
Baltimore, MD 21201

Edward Elder
Counsel, NAGE
601 North Fairfax Street, Suite 125
Alexandria, VA 22314

Dear Mr. Smith and Mr. Elder:

I am responding to the issue raised in your memorandum of January 25, 2008, and *Statement Supporting Arbitrability* of December 21, 2007, respectively, concerning the grievance and request for arbitration filed by NAGE Local R3-19 regarding the one-day suspension of , RN.

Pursuant to delegated authority, I have decided on the basis of the enclosed decision paper that there is insufficient information to make a determination that the issue presented by this grievance is a matter concerning or arising out of the professional conduct or competence within the meaning of 38 U.S.C. § 7422(b). As a result, the issue presented by this grievance is within the scope of collective bargaining.

Sincerely yours,

Michael J. Kussman

Michael J. Kussman, MD, MS, MACP
Under Secretary for Health

Enclosure

Title 38 Decision Paper
VAMC Baltimore, Maryland
VA 08-0

FACTS

, a registered nurse (RN) on Psychiatric Unit 6A at the Baltimore VA Medical Center (VAMC), was suspended for one day for "careless workmanship", due to an incident that occurred during the evening and early morning of September 7 and 8, 2006. NAGE Local R3-19 filed a grievance on behalf of Mr. alleging a number of violations of the VA/NAGE Master Agreement. The grievance was denied and the union moved to invoke arbitration. Thereafter, management at the Baltimore VAMC requested that the issue be declared non-grievable pursuant to 38 U.S.C. § 7422.

Mr. 's suspension and the union's subsequent grievance stem from an incident that allegedly took place on September 8, 2006. Based on an investigation conducted by an Administrative Board of Investigation (ABI)[1], a veteran arrived at the Washington, DC VAMC on the afternoon of September 7, 2006, experiencing "suicidal ideation to overdose on multiple medications." (Attachment A) No beds were available at the DC VAMC and the patient was transferred to the Baltimore VAMC. However, it is not clear who accepted the patient transfer at the Baltimore VAMC. Ms. , PA, POD testified that she did not have access to the patient's electronic medical record and declined acceptance of the patient until records could be reviewed and a signed Maryland Voluntary Admission form could be obtained. The patient arrived by ambulance at approximately 12:15 a.m. on September 8, 2006. Mr. was the charge nurse at Psychiatric Unit 6A at the Baltimore VAMC at the time the patient was transferred. It is alleged that , Administrative Officer of the Day (AOD), spoke with Mr. on the day of the incident and Mr. instructed Ms. to send the patient back to the DC VAMC because the procedures for transferring a patient were not followed.

The ABI made the following relevant conclusions:

> Uncoordinated and inadequate communication between administrative staff and clinical staff within each facility and between facilities resulted in the incident listed above. The absence of official documentation of the communication between facilities is a systems failure that permitted this error to occur. There is no evidence of patient abuse or dereliction of duties. It is the opinion of this board that further action by the

[1] ABI 2006-08 was conducted on October 23, 2006.