UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF LOUISIANA
ALEXANDRIA DIVISION

DENISE VEAL	**CIVIL ACTION NO. 1:19-CV-00089**
VERSUS	**JUDGE DAVID C. JOSEPH**
RAPIDES REGIONAL MEDICAL CENTER	**MAGISTRATE JUDGE PEREZ-MONTES**

MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT BY DEFENDANT, RAPIDES HEALTHCARE SYSTEM, LLC, D/B/A RAPIDES REGIONAL MEDICAL CENTER

Respectfully submitted,

GOLD, WEEMS, BRUSER, SUES & RUNDELL

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This memorandum is submitted on behalf of defendant, RAPIDES HEALTHCARE SYSTEM, LLC, d/b/a RAPIDES REGIONAL MEDICAL CENTER ("RRMC" or the "Hospital"). For the reasons set forth below, RRMC's Motion for Summary Judgment should be granted, denying and dismissing the claims of plaintiff, Denise Veal ("Veal"), with prejudice.

I. BACKGROUND

This matter arises from the Hospital's April 27, 2017 termination of Veal as a telemetry technician. (Doc. 10, Amended Complaint, ¶¶ 5, 25). As shown below, Veal failed in the performance of her vital job duties, thus resulting in her discharge from employment after a patient's death. Veal, however, claims racial discrimination was the basis for her termination (*Id.,* ¶ 30). At her deposition, Veal referenced her supervisor, Deborah L. Bullock ("Bullock"), and testified, "Debbie Bullock fired me. She fired me because I was black." (Ex. 18, Veal Depo., p. 151/19-21).

A. The Telemetry Technician Position

Telemetry technicians are an important part of the Hospital's cardiology care services; they work in a department known as "Central Monitoring Station/Heart Central" (hereafter "Heart Central"), which observes patients requiring telemetry monitoring outside of the Intensive Care Unit and Emergency Department settings. (Ex. B, Bullock Affidavit, ¶ 4). Telemetry technicians are responsible for observing monitors that show patients' cardiac rhythms; among other things, they are required to report any heart rhythm irregularities to a nurse, who then takes whatever action is necessary in relation to the irregularity. (*Id.*, ¶ 6; Ex. 3, RRMC Policy #225 - Central Monitoring Station/Heart Central). The Hospital's "Job Summary" for the telemetry technician position provides:

> The Telemetry Monitor Tech assists the nursing staff by continuously monitoring cardiac rhythms and performing various patient care activities as related to cardiac telemetry monitoring. Detect and document arrhythmias [irregular or abnormal rhythm] and notifies the nursing staff as needed.

(Ex. 1, Job Description, p. 1, bracketed material added). A telemetry technician's "Major Tasks, Duties and Responsibilities" include:

> Assists the nurses by continually assessing the patient's cardiac rhythm, rate and any significant changes in these, documenting strips every shift and with any changes.
>
> * * *
>
> Visually and audibly monitors and analyzes patient's cardiac rhythm. Accurately identifies basic cardiac rhythm and any dysrhythmias [disturbance of rhythm]. Immediately reports all significant changes to the patient's nurse or charge nurse.
>
> Maintains accurate and current records of telemetry patients. Documents patient's rhythm strip at the beginning of the shift and any changes that occur. ...

(*Id.,* p. 2, Nos. 1, 11, 12, bracketed material added). Patients requiring telemetry at RRMC are connected to a telemetry transmitter via leads attached to electrode pads placed on the patient's chest; the leads are attached to the transmitter which sends cardiac rhythms to a computer monitor screen in Heart Central; the cardiac activity is monitored on the screen, and recorded strips ("telemetry strips") can be printed out as needed showing heart rhythms through specific waveforms which appear as vertical "jumps" between horizontal lines; "flatline" or asystole indicates no heart rhythm whatsoever. (Ex. B, Bullock Affidavit, ¶ 5). More specifically, asystole is a cardiac arrest rhythm in which there is no discernible electrical activity on the ECG monitor; as indicated above, asystole is sometimes referred to as "flatline." (*Id.,* ¶ 5). In addition to *immediately* notifying a patient's nurse of telemetry rhythm abnormalities, each telemetry technician (during his or her shift) is required to (1) record rhythm abnormalities as they occur on a "Flow Sheet" log of events; (2) print out the telemetry strip(s) reflecting the abnormality; and (3) attach the telemetry strips to

the Flow Sheet. (*Id.,* ¶ 7 ; *see also* Ex. 3, RRMC Policy #225; Ex. 18, Veal Depo, p. 38/20-23; p. 42/6-9; p. 44/16-20). "The Flow Sheet is intended as a record of events as they occur, in chronological order." (Ex. B, Bullock Affidavit, ¶ 7). As to this point, Veal testified:

> Q. ...when you were completing flow sheets, was it the general rule that you did things in chronological order as they happened?
> A. Yes.

(Ex. 18, Veal Depo., p. 44/17-20). Telemetry technician Kimberly B. Gruehl ("Gruehl"), who is also licensed as an LPN (Ex. 19, Gruehl Depo., pp. 15/17-16/12), testified:

> A. Well, we fill out the flow sheet as the occurrences happen. It's in – it's a line by line. It's usually done in an orderly fashion. *** ... it's supposed to be done step by step, as far as the clock is ticking. It's usually done in a chronological fashion. If you have to make a late entry, I'm assuming it's ok to make a late entry ... I mean, we're writing as we're talking on the phone sometimes, so it's usually done chronological.

(*Id.,* p. 33/2-5, 9-17). Gruehl was unable to explain any circumstances justifying the Flow Sheet entry of an event out of sequence:

> Q. ... What are the circumstances ... that could occur that would justify a telemetry tech entering an event out of sequence?
> A. I don't really know how to describe a circumstance. I can't even think of a circumstance. I mean ... if we make a late entry it's usually a couple lines down that we might say something about something that happened two lines ago. If we forgot to mention something we wanted to say about that, we might write it on the third line down. I don't know how you would generate – make a late entry. *** I can't think of any circumstances off the top of my head. I mean, I don't know how to explain that.

(*Id.,* pp. 33/23-34/11; p. 34/15-17). Playing a role in Veal's firing was an out of sequence Flow Sheet entry on the night a telemetry patient died. As further addressed below, Veal was terminated after she failed to call any nurse regarding a monitored cardiac abnormality (progressing to asystole/flatline and patient death) which she should have observed and reported, but failed to do. (*See* Ex. 22, Bullock Depo., p. 20/6-25; p. 21/7-12; p. 22/5-20; pp. 36/16-37/12; Ex. 14, Clark

Report; Ex. 20, Clark Depo., p. 100/1-21; pp. 101/13-103/16; Ex. 8, Denise Veal Disciplinary/Corrective Action Form [4/27/17]).

B. Veal's Employment History/Disciplinary Actions Prior to Termination

1. Hiring/Evaluations --Veal was hired as a telemetry technician in September of 2011. (Doc. 10, Amended Complaint, ¶ 5). Plaintiff's 2011 Evaluation Form (Ex. 4, at Bates Nos. 00042-44) reflects an overall score of "2" (*Id.,* Bates No. 00044), which signifies "[w]ork is fully satisfactory; employee successfully meets all performance expectations." (*Id.,* Bates No. 00042). Plaintiff's "Evaluator" – Clara Wiley – commented, "Denise is developing appropriately as new telemetry tech. She is learning to apply facility policies, practices, and expectations into her role as a telemetry." (*Id.,* at 00044). Veal's 2012 Evaluation Form (Ex. 4, at Bates Nos. 00045-49), includes scores of "2" and "3" – which show "[w]ork is fully satisfactory and often exceeds performance expectations." (*Id.,* Bates Nos. 00045-47). The 2012 Form is signed by "Evaluator" Deborah L. Bullock, RN, who comments: "Denise is well liked by her co-workers and seems to do her job well & quietly without complaint." (*Id.,* Bates No. 00047). Deborah L. Bullock ("Bullock") is the Unit Manager of 3-South and Heart Central, a position Bullock has held since 2012. (Ex. B, Bullock Affidavit, ¶ 2). ["3-South" is Heart Central's location in the East wing of the Hospital's South tower, *see* Ex. 22, Bullock Depo., p. 58/4-17]. Veal's 2013 Evaluation Form (Ex. 4, at Bates Nos. 00050-55) also shows scores of "2" – and several scores of "2.5" (*Id.,* Bates Nos. 00051-52). Bullock again signed as Veal's "Evaluator" (on 3/12/14) and noted, "Denise is very quiet and rarely gives any feedback on how things are going in the department. She seems to get along well with her co-workers and perform her job well." (*Id.,* Bates No. 00052). The 2014 Evaluation Form (Ex. 4, at Bates Nos. 00056-00059) primarily reflects scores of "2" – although Veal received a low score of

"1" for the category reflecting:

> Assists the nurse by continually assessing the patient's cardiac rhythm, rate and any significant changes in these, documenting strips every shift and with any changes.

(*Id.,* Bates No. 00057). The score of "1" shows: "[e]xpectations are not fully achieved; employee needs to improve performance during the next three-month period" (*Id.,* Bates No. 00056). Again signing as "Evaluator" (on 4/10/15), Bullock commented:

> Denise needs to improve her skills of cardiac rhythm interpretation this year. She also needs to show more accountability for monitoring patients and notifying nursing staff of issues and charges.

(*Id.,* Bates No. 00058). Veal's 2015 Evaluation Form (Ex. 4, at Bates Nos. 00060-62) reflects an overall score of "2" (*Id.,* Bates No. 00062), with Bullock again signing as "Evaluator" (on 3/16/16), and commenting:

> ... Our goal for this year is to show improvement in cardiac rhythm interpretation and proper record keeping of patient rhythm changes.

(*Id.,* Bates No. 00062). The 2015 Evaluation shows a continuing need for Veal to improve her cardiac rhythm and record keeping skills. Bullock's 2015 comments also state:

> Denise missed a great deal of work this year due to a family medical leave (and the loss of her son for which I am truly sorry).

(*Id.,* Bates No. 00062). Although Veal testified Bullock fired her because Veal "was black" (Ex. 18, Veal Depo., p. 151/19-21), Veal admitted Bullock helped her get extra FMLA leave in 2015:

> Q. I know that 2015 was a tough year for you.
> A. Yes.
> Q. Didn't Miss Bullock help you get extra FMLA leave time for the family emergency you had to deal with?
> A. Yes.

(*Id.,* p. 61/3-9). Veal was terminated prior to the completion of an Evaluation Form for 2016.

2. Discipline – Prior to her termination, Veal was disciplined three (3) times for improper job performance. RRMC does not have a "progressive discipline" policy; instead, discipline is based solely on the circumstances surrounding the conduct involved. (Ex. B, Bullock Affidavit, ¶ 8). The Hospital seeks to work with employees who may have violated RRMC policies and procedures, but it uses no "tiers" of discipline; an employee may be counseled and/or suspended; the employee can also be terminated outright for a significant employee offense, regardless of his or her past disciplinary record. (*Id.,* ¶ 8). A telemetry technician's actions involving Performance, Patient Safety and Hospital Policy are of paramount importance in the discipline of telemetry technicians, inasmuch as patient's lives are at stake in regard to the critical duties and responsibilities of a telemetry technician. (*Id.,* ¶ 9). As to discipline, Veal herself acknowledged it was possible to have good yearly Evaluations, and still be disciplined. ("Q. ... you can get ... written up and still do well in your actual evaluation, couldn't you? A. Yes.") (Ex. 18, Veal Depo., p. 50/13-16). Her employment records reveal as much.

a) 2/20/15 - Veal's Employee Counseling Form for 2/20/15 shows Veal received a two-day suspension relating to "communication between co-workers, not following processes for patients on telemetry." (Ex. 5). The Counseling Form states, "[i]f no improvement of communication on co-workers & following processes will ensure further suspension or termination." (*Id.,* emphasis added).

b) 4/22/15 - A second Employee Counseling Form for 4/22/15 reflects another two-day suspension relating to "Performance" (Ex. 6). Importantly, the "Reason for Action" shows:

> Patient off telemetry for more than three hours. No documentation of staff notified – patient not placed back on telemetry

(*Id*.). The "Plan of Action" requires the following:

> Immediate improvement. Will notify nursing staff of patient's being off monitor or dead batteries as well as rhythm changes & lethal arrhythmias. Notification & attempts to notify nursing staff will be documented.

(Id.). The "Time Frame" is "Immediately" (*Id.*). The form's "Counseling History" notes Veal's above discussed 2/20/15 "not following policy" infraction, as well as an earlier 12/23/14 "Meeting individually with staff - reinforcing job duties" counseling. (*Id.*).

c) 10/11/16 - Of importance to claims in the instant matter, Veal's disciplinary record also contains a Disciplinary/Corrective Action Form dated 10/11/16, showing a suspension relating to "Performance" and "Patient Safety" issues. (Ex. 7, p. 1). The Disciplinary Form's "Detailed Description of Offense(s) Leading to This Action" states:

> Failed to report dead battery on patient on 4S - Patient Expired while Battery on telemetry was dead - off at 20:22 [8:20 p.m.] - Resumed at 2108 [9:08 p.m.] - See attached

(*Id.,* p. 1, bracketed material added). As stated for the "Required Corrective Action and Expectations Going Forward":

> Denise will follow hospital policy to notify nursing staff when patients are off the telemetry monitor.

(*Id.,* p. 1). Of particular note, the "Next Steps If The Employee Does Not Meet The Required Improvements/Expectations" states:

> Failure to demonstrate immediate, significant and sustained improvement will result in additional disciplinary action, up to and possibly including termination of employment.

(*Id.,* p. 1). The telemetry strips and "Flow Sheet" documenting Veal's employment offense are attached to the Disciplinary Form. (*See* Ex. 7, pp. 2-3). Veal testified she had no recollection of the 10/11/16 incident involving the patient's death – and which led to her discipline and suspension regarding that event:

> Q. Let's go th the next write-up ... on October 11, 2016. *** Do you remember this incident?
> A. No, I do not. I do not recall this incident.
> Q. You don't recall when a patient actually died on –
> A. No, I do not.

(Ex. 18, Veal Depo., p. 82/3, 5-6; pp. 82/23-83/3).

C. Second Patient Death and Veal's Termination

As discussed more fully *infra,* Veal's April 16, 2017 inactions relating to the death of a second patient led to her termination. RRMC records reflect that while Veal was on-duty – and responsible for monitoring and responding to telemetry readings – the subject patient's severe bradycardia (*i.e.,* abnormally slow heart action) progressed to asystole (*i.e.,* no heartbeat/flatline) without any action by Veal. (Ex. B, Bullock Affidavit, ¶ 11; Ex. 8, Disciplinary/Corrective Action Form; Ex. 14, Clark Report).Veal's Disciplinary/Corrective Action Form dated 4/27/17 (Ex. 8) reflects "Performance" and "Policy Violation" issues leading to "Termination" for the 4/16/17 incident. (*Id.,* p. 1). As explained in the "Detailed Summary of Offense(s) Leading to This Action":

> Pt. in 5406 had episode of severe bradycardia which progressed to asystole at 2117 [9:17 p.m.] on 4/16/17 - No code called until 2153 [9:53 p.m.] - Denise did not make any calls to Nurse to advise of Rhythm change or asystole or leads off. Last call regarding patient was at 2045 [8:45 p.m.] Policy not followed - No escalation.

(*Id.,* p. 1). RRMC Director of Emergency Services, Dominique J. Boney (Ex. 21, Boney Depo., p. 44/8-10), who had served as Unit Manager/Direct Supervisor for the Fourth Floor South Tower (*Id*., p. 25/11, 16-22), and who is an African-American (*Id.,* p. 95/12-14), explained the "Escalation Policy" (that was not followed by Veal):

> Q. What is that policy?
> A. The telemetry tech should call the nurse caring for that person first. ... the second method of escalation is the charge nurse, and then the third is the nurse supervisor on shift.

(*Id.,* p. 23/23-25; p. 24/2-4). Telemetry technician Kimberly Gruehl confirmed Boney's description

of the Escalation Policy (Ex. 19, Gruehl Depo., p. 39/5-23); Veal testified to the same order of escalation. (Ex. 18, pp. 38/20-39/11). Veal's Disciplinary Form further states:

> This is the second documented occurrence of not following proper policy. Employee is terminated.

(Ex. 8, Disciplinary/Corrective Action Form, p. 1). The cited Form was signed by Deborah Bullock RN; Veal elected not to sign the Disciplinary/Corrective Action Form. (*Id.,* p. 1). Bullock also wrote and initialed the "Employee Comments" section of the Form, stating:

> Denise claims manager was plotting against her and stated she had been suspended in the past for what other people had done wrong. Accepted no responsibility for any wrongdoing.

(*Id.,* p. 1). Veal's "Flow Sheet" and telemetry strips for her 4/16/17 work shift are attached to the Disciplinary Form. (*See* Ex. 8, pp. 2-4). As further addressed below, these attachments show – **in chronological order** - no reporting by Veal of the severe, abnormally slow heart rhythm of the patient in Room 5406, or his subsequent lack of any heart rhythm whatsoever (flatline) – neither of which were reported by Veal in accordance with the Escalation Policy. The attachments also show Veal's claimed - and highly unusual - out of chronological order purported "call" to a nurse regarding the telemetry abnormalities, which out of chronological order entry on the Flow Sheet only raised suspicion as to Veal's claim of having properly performed her job.

D. <u>RRMC Review of Actions Relating to Deceased Patient</u>

Contrary to Veal's unsupported "on information and belief" assertion that RRMC "never conducted in investigation into the events surrounding the death of Patient B" (Doc. 10, Amended Complaint, ¶ 23), the events leading to Veal's termination were investigated. Prior to issuance of the 4/27/17 Disciplinary/Corrective Form, the Hospital sought information relating to the April 16, 2017 patient death during Veal's shift. Nurse Martha Clark ("Clark"), who became involved with the

unresponsive patient during her rounds (Ex. 14, Clark Report, p. 1), and called a "Code Blue"on the patient (Ex. 20, Clark Depo., p. 103/11-16), testified "[a]nytime there is an event in which there's a death that occurs that is unusual, we review it with risk management." (*Id.,* p. 20/16-18). As acknowledged by Veal, "[t]he nursing supervisor for the nights was Martha Clark." (Ex. 18, Veal Depo., p. 31/1-2). RRMC Director of Emergency Services, Dominique J. Boney, confirmed that personnel from RRMC's Office of Risk Management "convened a meeting" regarding the events of April 16, 2017. (Ex. 21, Boney Depo., p. 66/19-24). Boney recalled being present at the meeting (*Id.,* pp. 66/25-67/6), along with his Risk Manager, the Assistant Risk Manager, Nurse Kandie Batiste, Bullock, and Veal. (*Id.,* p. 67/7-13). Nurse Martha Clark was also in attendance, and provided Risk Manager Julie Fontenot with at typed statement of events she witnessed and matters she observed on April 16, 2017. (Ex. 20, Clark Depo., pp. 21/2-22/22; p. 100/1-21; Ex. 14, Clark Report). Clark was alerted by a respiratory clerk to the patient's possible lack of a pulse, testifying, "[a]nd I ran in and checked, and certainly he didn't. And I called the code blue or a quick step at that time." (*See* Ex. 20, Clark Depo., p. 103/9-16). Explaining the unusual nature of the events (*Id.,* p. 102/21-24), Clark testified:

> A. ... there was some inconsistencies in the monitoring and there was an event, a cardiac event, that went unnoticed. *** After ... the man was a code blue ... I went back to the telemetry monitors and I looked back at the history as I usually do whenever I get the chance to see if there was any event prior to the code to see what happened. I did see he had ST elevations on his monitor. Then he went bradycardia, which means ST elevations can mean an occurrence of a myocardial infarction.

(*Id.,* pp. 101/25-102/2, 10, 12-19). Clark further testified as to the telemetry record of the patient's condition, after she noted the showing of a possible myocardial infarction (*i.e.,* heart attack):

> ... Then he went bradycardic, which means his heart rate slowed down. Then he went asystole, and then the code was called at sometime after when a respiratory tech went into

> the room and saw that – didn't think he had a pulse. So I felt that was really an event that required reviewing because there was a period of time when this man had been in asystole and it wasn't noted or called in. Also the ST elevations were classic, which should have been known that he was a myocardial infarction. Something was happening to this gentleman, and it was not caught. ...

(*Id.,* pp. 102/19-103/7). Clark's Report of her interactions with the patient, and her review of the telemetry history [with attached RRMC Records and telemetry strips] (Ex. 14, Clark Report), shows the following cardiac events (using the "monitor times" of the telemetry strips which were four minutes faster than "actual time," as per Clark Report):

2103 [9:03 p.m.] – First signs of ST Elevation [indicating lack of blood flow to heart];
2116 [9:16 p.m.] – Bradycardia, BBB [Bundle-Branch Blockage], Flipped T Wave;
2117 [9:17 p.m.] – Patient goes into Asystole;
2154 [9:54 p.m.] – Code Blue called;
2211 [10:11 p.m.] – Death

(*See* Ex. 14, Clark Report, p. 1, bracketed material added). As noted above, the chronological order of entries on Veal's 4/16/17 Flow Sheet reveals Veal's last call regarding the deceased patient was at 2045 [8:45 p.m.] (Ex. 8 , p. 2). Veal's out of chronological order notation and attached telemetry strip, *if believed*, would indicate an earlier call by Veal as to the patient. (*See Id.,* p. 2). With reference to Veal's "flow sheet printout" (Ex. 21, Boney Depo., p. 72/4-19), Emergency Services Director Boney testified, "I found it odd that the times were not in chronological order." (*Id.,* p. 72/8-9). Additional evidence (addressed *infra*) supported the determination that Veal failed in her job responsibilities, violated Hospital policy, and should be terminated.

II. PLAINTIFF'S LITIGATION CLAIMS

Following her termination, Veal completed an EEOC Intake Questionnaire (Ex. 12), listing the discriminatory action against her as "Terminated for Failing To Perform Job Duties," and naming "Debbie Bullock Unit Manager" as the Person Responsible for her firing. (*Id.,* p. 2, ¶ 5A). Veal also

filed an EEOC Charge of Discrimination (Ex. 13), stating in part, as to "Particulars":

> I believe I have been discriminated against based on my race, Black, in violation of Title VII of the Civil Rights Act of 1964, as amended, in that, in May 2017, after I was discharged, the exact incident happened, which had led to my discharge, but with a White Employee who was not suspended or discharged.

(*Id.,* p. 1). Asserting her claim in this Court, Veal avers she was "subjected ... to deliberate racially discriminatory treatment" (Doc. 10, First Amended Complaint, ¶ 9), and thereafter alleges disparate treatment discrimination relating *solely* to "The April 16, 2017 Incident." (*Id.,* at p. 3; ¶¶ 10-15). As to the cited "Incident" – plaintiff claims that during her "7 p.m. until 7 a.m." shift – on which "Two Telemetry technicians were scheduled to work" (*Id.,* ¶ 10) – the second telemetry technician working with her, "Kim Gruel [sic] ... a Caucasian female" (*Id.,* ¶ 11), "left the telemetry station" to check on the monitor of a patient (identified by Veal as "Patient A"). (*Id.,* ¶ 12). Plaintiff further alleges that while the second telemetry technician "was gone, Ms. Veal was responsible for monitoring more than 100 patients connected to Defendant's telemetry system ..." (*Id.* ¶ 12); that she noticed a patient (designated by Veal as "Patient B") "was ... improperly connected to the telemetry system" and that Veal "called Patient B's nurse, Kandie, to make her aware that Patient B's telemetry monitor was offline," and further, "Nurse Kandie indicated that she was going to check." (*Id.,* ¶ 13). Plaintiff alleges a "code blue" was shortly thereafter called for Patient B, who then "passed away." (*Id.,* ¶ 14). Veal claims the Hospital "never conducted an investigation into the events surrounding the death of Patient B" (*Id.,* ¶ 23). However, Veal alleges she presented her version of the April 16, 2017 facts at a Risk Management Meeting conducted at the end of her April 18, 2017 shift (*Id.,* ¶¶ 16-20), and further avers "Nurse Kandie misrepresented the factual details of the events leading up to Patient B's death" at the Meeting. (*Id.,* ¶ 21). Veal cites *her* suspension and termination (*Id.,* ¶¶ 22, 25), and

avers, "Nurse Kandie, a Caucasian female, was neither suspended nor terminated." (*Id.,* ¶ 26). Continuing her disparate treatment allegations, Veal claims that after her firing, another patient died (in or around May of 2017) when Caucasian telemetry technicians purportedly failed to alert the patent's assigned nurse of the patient's faulty telemetry connection; that the patient was thus "never assessed or checked on" by any nurse; and that no Caucasian telemetry technician was suspended or fired. (*Id.,* ¶¶ 27, 28, 29). Citing her EEOC claim "that she was discriminated against on the basis of her race, African American" (*Id.,* ¶ 30), plaintiff claims entitlement to damages, interest, costs and attorney fees. (*Id.,* ¶¶ 35, 36). At her deposition, and as reflected in her EEOC Charge of Discrimination (Ex. 13), Veal made clear her discrimination claim related *only* to her termination:

> Q. Why did you file this lawsuit against the hospital?
> A. Because I felt that I was wrongfully fired because I was black.
> Q. Any other reason?
> A. That was the reason.

(Ex. 18, Veal Depo., p. 19/17-22). Plaintiff's claims under Louisiana law were earlier dismissed (Doc. 22, Judgment). As shown below, plaintiff's remaining Title VII claim should likewise be dismissed, at plaintiff's cost.

III. LAW AND ARGUMENT

A. Summary Judgment Standard – As provided by Fed. R. Civ. P. 56(a), in pertinent part, "[a] party may move for summary judgment identifying each claim ... on which summary judgment is sought. The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." The evidence submitted herewith, viewed in light of applicable law, shows summary judgment should be granted, dismissing plaintiff's demands under Title VII, with prejudice.

B. Requirements for Plaintiff's Title VII Claim – Particularly pertinent here are the legal requirements for a Title VII "disparate treatment" claim. As explained in *Givs v. City of Eunice,* 512 F.Supp.2d 522 (W.D. La. 2007), *affirmed,* 268 Fed.Appx. 305 (5th Cir. 2008):

> ... plaintiff establishes a prima facie case of racial discrimination by proving (1) that he is a member of a protected class, (2) that he was qualified for the position, (3) that he suffered adverse employment action, and (4) that, in the case of disparate treatment, others similarly situated were treated more favorably. *Bouie v. Equistar Chemicals LP,* 2006 WL 1736557 [188 Fed.Appx. 233](5th Cir. 2006); *Shackelford v. Deloitte & Touche, LLP,* 190 F.3d 398, 404 (5th Cir. 1999).

(*Id.,* at 537, emphasis and bracketed cite added). Veal asserts a disparate treatment termination claim, alleging Caucasian employees were treated more favorably under the same circumstances. (Doc. 10, Amended Complaint, ¶¶ 26, 27-29; Ex. 13, EEOC Charge of Discrimination). Plaintiff does not meet the requirements for showing disparate treatment.

C. Veal Has No Proper Comparator for Her Claim – As shown below, not only does Veal have no comparator who was treated better than she was, but the only telemetry technician who engaged in similar actions received the same treatment as Veal. In *Turner v. Kansas City Southern Ry. Co.,* 675 F.3d 887 (5th Cir. 2012), the Fifth Circuit addressed proof of disparate treatment in Title VII actions. (*Id.,* at 892-893). As to establishing "white employees who engaged in similar acts were not punished similarly" (*Id.,* at 893), the *Turner* Court said:

> " ... [the plaintiff] must show that ... employees [who were not members of the plaintiff's protected class] were treated differently under circumstances 'nearly identical' to his." ... "The employment actions being compared will be deemed to have been taken under nearly identical circumstances when the employees being compared held the same job or responsibilities, shared the same supervisor or had their employment status determined by the same person, and have essentially comparable violation histories.

(*Id.,* at 893, internal citations omitted). The *Turner* Court said further:

> Moreover, "the plaintiff's conduct that drew the adverse employment decision must have been 'nearly identical' to that of the proffered comparator who allegedly drew dissimilar employment decisions ..."

(*Id.,* at 893). The Fifth Circuit explained that, if differing conduct of the plaintiff and the comparator "*accounts* for the difference in treatment ... the employees are not similarly situated for the purposes of an employment discrimination analysis." (*Id.,* at 893, italics in Opinion).

More recently, the Fifth Circuit reiterated its position, stating the same requirements for the "similarly situated" prong of a Title VII claim. *See Alkhawaldeh v. Dow Chemical Company,* 851 F.3d 422, 426 (5th Cir. 2017). These requirements are not met here.

1. <u>Nurse Kandie Batiste</u> – As further discussed below, this RRMC employee did not have the same job as Veal; she did not have the same responsibilities as Veal; she did not have the same supervisor as Veal, and she is not a proper comparator. Nevertheless, Veal offers "Nurse Kandie" as a Caucasian comparator employee who was "neither suspended nor terminated" in relation to the April 16, 2017 patient death. (Doc. 10, ¶ 26; Ex. 18, Veal Depo., p. 20/1-6, 18-12). "Nurse Kandie" is former RRMC Registered Nurse Kandie Batiste ("Batiste"), who resigned from the Hospital after giving two-weeks notice on March 22, 2019. (Ex. A, Stokes Affidavit, ¶ 9; Ex. 15, Batiste Personnel Records, pp 1-3). As earlier noted, plaintiff alleges she notified Batiste "that Patient B's telemetry monitor was offline" and Batiste failed to address the problem, after Batiste allegedly "indicated" she "was going to check." (Doc. 10, Amended Complaint, ¶¶ 13, 15). As discussed *infra*, plaintiff's assertions regarding Batiste were not believed, leading to plaintiff's termination for "Performance" and "Policy Violation" issues. (Ex. 8, Disciplinary/Corrective Action Form). At her deposition, Veal at one point indicated she did not feel Batiste was treated more favorably (Ex. 18, Veal Depo., p. 109/3-10), but nevertheless testified on the "comparator" issue

as follows:

> Q. ...You're saying that because the hospital did not discharge Miss Batiste, Nurse Batiste, that they treated you – discriminated against you because you're black?
> A. Yes.
>
> * * *
>
> Q. So you're saying because the hospital neither terminated nor suspended Nurse Kandie, you were treated differently because you're black?
> MR. BERNARD:
> Yes.
> THE WITNESS:
> Yes.

(*Id.,* p. 106/ 9-13; p. 111/12-19). Veal knew Batiste was either a Registered Nurse (RN) or a Louisiana Practical Nurse (LPN), and agreed that, in either event, Batiste's nursing job was not the same as Veal's job as a telemetry technician:

> Q. Now you referred to Nurse Kandie. We know that that is Kandie Batiste. Is Nurse Kandie an LPN or a registered nurse? ...
> A. I do not know.
> Q. But she is either an LPN or a registered nurse, right?
> A. Yes
> Q. And her job as a registered nurse or LPN we already agreed is different from your job as a telemetry technician?
> A. Yes.

(*Id*., pp. 89/16-90/1). As noted above, Batiste was, in fact, a Registered Nurse. (Ex. A, Stokes Affidavit, ¶ 9; Ex. 15, Batiste Personnel Records). The first consideration for a "comparator employee" is not met, in that Registered Nurse Kandie Batiste did not have the same job as Telemetry Technician Denise Veal. The "Job Description" for a Registered Nurse is completely different from that of Telemetry Technician. (*See* Ex. 2 [RN], and Ex. 1 [Telemetry Technician]). The duties and responsibilities are also completely different for each position. (Ex. 2, pp. 2-3 [RN], and Ex. 1, p. 2 [Telemetry Technician]; *see also* Ex. B, Bullock Affidavit, ¶ 14). Also, because Batiste was not employed as a telemetry technician, she and Veal could not have "essentially

comparable violation histories" *Turner, supra,* in that Batiste could never have been disciplined for failing to properly perform the duties of a telemetry technician. This requirement for a "comparator employee" is also missing. Further, Veal and Batiste did not have the same supervisor; Veal's EEOC Intake Questionnaire names "Debbie Bullock" as Veal's "Immediate Supervisor" (Ex. 12, p. 1, ¶ 3); Veal admitted Deborah Bullock was her supervisor:

> Q. During your tenure at the hospital, Deborah Bullock was your supervisor or appeared to be from 2014 until the end of your employment; is that about right?
> A. Correct.

(Ex. 18, Veal Depo., p. 16/10-14). Also, Bullock attested she was Veal's direct supervisor. (Ex. B, Bullock Affidavit, ¶ 10). Conversely, Batiste's supervisor was Dominique Boney, who testified he was at RRMC's April 16, 2017 Risk Management Meeting (regarding the patient's death) because he was Batiste's supervisor:

> Q. Now, why were you involved in this meeting?
> A. I was the supervisor of Candy Batiste.

(Ex. 21, Boney Depo., p. 69/7-8). At that time, Boney was Unit Manager of 4-South (Ex. B, Bullock Affidavit, ¶ 13); Boney further testified "I've never been a supervisor over telemetry techs" (*Id.,* p. 23/16-17), but was Direct Supervisor for the Fourth Floor South Tower (Ex. 21, Boney Depo., p. 25/16-23), and supervised "[n]urses, patient care techs and secretaries, both registered nurses and ... licensed practical nurses." (*See Id.,* at p. 26/11-13). Boney, rather than Bullock, would determine disciplinary action – including termination – for nurses under his supervision. (Ex. B, Bullock Affidavit, ¶ 13). Clearly, Veal and Batiste did not share "the same supervisor" or have "their employment status determined by the same person." *Turner, supra.* This element of the "comparator employee" test is also missing. Thus, the absence of any disciplinary action against Batiste does not

show "racial discrimination" as to Veal. Registered Nurse Kandie Batiste is simply not a proper comparator for the disparate treatment discrimination claim of telemetry technician Denise Veal.

2. Telemetry Technician [redacted] – As with Veal, and directly contrary to Veal's baseless assertions, this individual was terminated for improper telemetry job performance and violation of Hospital Policy. Although nowhere mentioned in relation to plaintiff's firing for the events of April 16, 2017 (*See* Doc. 10, Amended Complaint), former RRMC telemetry technician [redacted]") is cited by Veal as a Caucasian comparator in her EEOC Intake Questionnaire (Ex. 12), and in her below discussed deposition testimony; these references show [redacted] is the Caucasian telemetry technician *Veal claims* is responsible for a patient's death in May of 2017, and who *allegedly* was never disciplined. (*See* Doc. 10, Amended Complaint, ¶¶ 27-29). Veal's above cited EEOC filing states:

> After I Was Terminated - The Exact Incident Happened In May 2017 With A White Employee Who Wasn't Suspended Nor Terminated.

(Ex. 12, EEOC Intake Questionnaire, p. 2, ¶ 6). In response to that part of the EEOC Questionnaire asking: "Of the persons in the same or similar situation as you, who was treated *better* than you?" (*Id.,* p. 2, ¶ 8), Veal identified [redacted] as the "White Employee" who *supposedly* was not suspended or terminated; Veal's answer states:

> [redacted], White, Telemetry Technician, Failure To Perform Job Duties And Resulted In A Patient's Death.

(*Id.,* p. 2, ¶ 8A, emphasis added). Veal was terminated on April 27, 2017 (Doc. 10, Amended Complaint, ¶ 25), so any assertions as to [redacted]'s alleged work performance in May of 2017 (*Id.,* ¶¶ 27, 28, 29) would be hearsay (which Veal admitted, as shown below).

a) No Evidence to Prove Allegations – Although [redacted] and Veal were both Hospital telemetry technicians with the same duties, Veal's "comparator" assertions fail because plaintiff has no evidence to show [redacted] was responsible for any patient's death in May of 2017, and further, RRMC records reflect [redacted] was disciplined on May 11, 2017 for "Performance," "Patient Safety," and "Policy Violation" issues (Ex. 9, Disciplinary/Corrective Action Form), and ultimately terminated on January 24, 2019 for "Performance," "Patient Safety," "Attendance," and "Policy Violation" issues. (Ex. 11, Disciplinary/Corrective Action Form [1/24/19]). Veal's "similar situation" assertions begins with Paragraph 27 of her Amended Complaint, alleging "Patient C" "was improperly connected to the telemetry system," and "no Telemetry Technician called from the station to alert the nurse ... about the faulty connection." (Doc. 10, ¶ 27). Paragraphs 28 and 29 aver Patient C was subsequently found dead, after never having been checked by any nurse, and the on-duty Caucasian telemetry technicians were not suspended or fired. (*Id.,* ¶¶ 28, 29). Veal testified as to her lack of evidence and personal knowledge regarding the above referenced May 2017 patient death allegations as follows:

> Q: ... following your termination you speak about Miss [redacted] in your paragraph 28, and then 27 and 28 and 29. In number 28 you say:
>
> > "Patient was found dead in his room and upon information and belief patient C was never assessed or checked on by any nurse during the shift which patient C died."
>
> Do you have any proof about that other than what you write? Do you nave any evidence to show that... patient C was never assessed or checked on by any nurse during the shift?
> A. No.

(Ex. 18, Veal Depo., p. 125/13-24). When questioned as to the "information and belief" allegations of her Amended Complaint ¶ 29, Veal admitted she had no personal knowledge of the assertions:

> Q. And on number 29, "*Upon information and belief* no telemetry technician was either suspended or fired as a result of the events leading up to the death of patient C." Because you had already been discharged from the hospital, right?
> A. Yes, I had been discharged.
> Q. So you did not have any personal knowledge of anything going on other than what other people told, correct?
> A. Correct.

(Ex. 18, Veal Depo., pp. 125/25-126/10). Veal also clarified her "May of 2017" patient death/no telemetry technician discipline allegations related solely to [redacted]; regarding ¶¶ 27-29 of the Amended Complaint, Veal testified:

> Q. 27 through 29, which telemetry technicians are you talking about as far as nothing happening to this person?
> A. Vivian Vidrine.
> Q. Anybody else?
> A. No.

(*Id.,* p. 126/11-16). As noted above, [redacted] was disciplined regarding a patient's death in May of 2017. (*See* Ex. B, Bullock Affidavit, ¶ 12; Ex. 9, Disciplinary/Corrective Action Form [5/11/17]). The cited Disciplinary Form shows [redacted] received a Final Written Warning for these offenses:

> Failure to follow policy by escalating calls for telemetry off; Not getting telemetry on in timely manner; Patient off monitor at 0129 am - code called at approx 6:30am- telemetry off for five hours. Unable to verify calls were made as recorded on call log ... checked Cisco phones of nursing staff on 3-South and 4 South and could not find calls from 4060 as listed on attached log with the exception of one call to 3-South "D.J." at 0355 for 2.5 second pause. Nursing staff deny receiving calls from Heart Central.

(Ex. 9, Disciplinary/Corrective Action Form, pp. 1-2). The Disciplinary Form further shows "Performance," "Patient Safety," and "Policy Violation" as the "Category of Disciplinary Action" (*Id.,* p.1), and states: "Policy will be followed to maintain telemetry monitoring as ordered. Any further incident will result in immediate termination." (*Id.,* p. 1). The Disciplinary Form was signed by Deborah Bullock, R.N., on 5/11/17. (*Id.,* p. 1). [redacted]'s subsequent violations regarding

"Performance," "Attendance," "Patient Safety" and "Policy Violation" resulted in her termination on 1/24/19. (Ex. B, Bullock Affidavit, ¶ 12; Ex. 11, Disciplinary/Corrective Action Form [1/24/19]). [redacted]'s Disciplinary Form cites her offenses as:

> Failure to follow Heart Central Policy and processes to safely care for patients. Failure to recognize heart rhythm changes on deteriorating patient during cardiac event. Continued severe tardiness without proper notification of supervisor.

(Ex. 11). The Disciplinary Form shows "Termination" as the "Level of Discipline." (*Id.*). Deborah Bullock testified, "I ... terminated [redacted] ..." (Ex. 22, Bullock Depo., p. 88/10). Plaintiff's unsupported, inaccurate, hearsay assertions regarding [redacted] (Doc. 10, ¶¶ 27, 28, 29) are directly refuted by the evidence, and provide no basis for plaintiff's "comparator" claims regarding the discipline of [redacted].

b) <u>No Evidence for Unalleged Claim</u> – Although not alleged in Veal's Amended Complaint, another "comparator" claim against [redacted] was asserted at plaintiff' deposition. There, Veal averred [redacted] should have been disciplined for the 4/16/17 event resulting in Veal's termination, stating the deceased patient's telemetry connections were not properly attached during [redacted]'s immediately preceding shift, and RRMC supposedly knew of the improper connection when Veal thereafter reported for duty:

> A. That patient was off ... strip at 6:00 pm. I was not on. A white employee was on. Nothing happened to that person, nothing. I was black. 7:00 pm I came on and called. I got fired.
> Q. Who worked before you?
> A. [redacted]. She was a white employee.

(Ex. 18, Veal Depo., p. 108/14-21). When asked how her disparate treatment discrimination claims involved [redacted] (*Id.,* pp. 111/12-112/6), Veal answered, "[b]ecause the hospital knowingly knew that the patient was off at 6:00 pm." (*Id.,* p, 112/7-8). Veal was then shown her "Flow Sheet" from

her 4/16/17 shift (Ex. 8, Disciplinary/Corrective Action Form [4/27/17], p. 2), which did not reflect the telemetry leads for "Patient B" (in Room 5406) were "off at 6:pm" or at 7:p.m. when Veal started her shift, but showed only an 8:45 p.m. entry that the patient's leads "may" need attention:

> Q. Let's look at the remainder of the second page of your discharge paperwork. Is this your flow sheet from April 16, 0217?
> A. Yes, it is.
> * * *
> Q. Wasn't this patient B in 5406?
> A. 5406, yes.
> Q. So you started your shift at 1900? **[7:00 p.m.]**
> A. Yes, I did.
> Q. At 2045 **[8:45 p.m.]** it says, "Leads may need to be checked." It doesn't say that the leads were off in 5406. Why not?
> A. Because of the possibility that they probably had actually something that – they probably had actually something on the thing squiggly.
> * * *
> Q. Where is it in here that you noted that the patient was off the monitor?
> A. At the beginning of my shift, again, I put what I could on this flow sheet ... I was by myself watching a hundred patients and I tried to write down any chance I could as much as I could. I'm not going to say I put everything. I put as much as I could. ...

(Ex. 18, Veal Depo., p. 112/9-12; pp. 112/19-113/3; p. 113/7-15, bracketed material added). Veal's own testimony fails to support her claim the Hospital "knew" the subsequently deceased patient's leads were "off" during [redacted]'s shift, or the [redacted] should have been disciplined for anything.

3. <u>Telemetry Technician Kimberly Gruehl</u> – This employee did not engage in any conduct remotely similar to Veal's, and she too, is not a proper comparator. As noted above, Veal's First Amended Complaint alleges Gruehl left the telemetry station on April 16, 2017, to check on "Patient A" – and Veal was then "responsible for monitoring" the telemetry patients. (Doc. 10, ¶¶ 11, 12). Veal further alleges "Ms. Gruel [sic] was required to attend" the RRMC Risk Management Meeting of April 18, 2017, but "Ms. Gruel [sic] did not attend the meeting." (Doc. 10, ¶ 16). The Amended Complaint makes no "comparator" allegations regarding any deficiencies in Gruehl's

telemetry monitoring of any patient, and the Hospital's failure to discipline her for such deficiencies. However, in Veal's deposition testimony, Veal claims Gruehl should have been terminated for not being present while Veal was monitoring the telemetry patients (in Gruehl's absence):

> Q. How was Kim Gruel treated better than you because of her race?
> A. She would actually leave the station for long periods of time.
> Q. Why is that – why is that treating her better?
> A. Her leaving the station and nothing was done, being the only one person in the station.
> * * *
> A. She wasn't terminated on the incident ... the incident that happened with me, supposedly happened with me.
> * * *
> Q. So how was she involved in that incident?
> A. She was working. Where was she? *** ... We are both supposed to care for all of the patients. *** ... We both cared for all of those patients.
> * * *
> A. I believe ... I feel I was discriminatory, yeah, for me being terminated because Kim Gruel was not. She was working there ...

(Ex. 18, Veal Depo., pp. 136/25-137/8; p. 137/10-12, 16-18; p. 138/3-4, 7-8; p. 140/12-15). First, there is no allegation in plaintiff's Amended Complaint that Gruehl's absence was improper; second, plaintiff can present no evidence that Gruehl's absence *was* improper; third, Veal was not accused of being absent from her telemetry station, and she was not terminated for that reason; fourth, a "comparator" claim of purported absence from the telemetry station is completely different from *and not comparable to* the specific telemetry performance issues cited as the reasons for Veal's termination. (*See* Ex. 8, Disciplinary/Corrective Action Form [4/27/17]). Again, "[a]nd, critically, the plaintiff's conduct that drew the adverse employment decision must have been 'nearly identical' to that of the proffered comparator who allegedly drew dissimilar employment decisions." *Lee v. Kansas City Southern Ry. Co.,* 574 F.3d 253, 260 (5th Cir. 2009)(emphasis added, internal citation omitted). Further, engaging in activities outside the room with telemetry monitors was part of

Kimberly Gruehl's job as a telemetry technician; when questioned regarding the duties of a telemetry technician at the time of the "incident" involving Veal (Ex. 22, Bullock Depo., p. 73/2-23), Heart Central Unit Manager Deborah Bullock testified, in part:

> A. And at that time they were also responsible for delivering and picking up telemetry monitors from the floors. Like if they get a new admit, they would clean them – they would take a clean monitor to that patient's room. They may or may not actually put it on the patient depending on if the patient was already in the room. ... And when the patients were discharged they'd go to the floors and pick up the monitors and take them back to the Heart Central area and clean them and put them back on the wall.

(Ex. 22, Bullock Depo., p. 74/16-23; p. 75/1-5). From personal experience, Gruehl herself testified as to the responsibilities of a telemetry technician acting alone in monitoring patients:

> Q. And if she is in the heart-monitoring station by herself, then she would necessarily be responsible for looking at all of the screens to make sure – or to ensure that – or to find out whether or not there's a problem with the patient. Would that be accurate?
> A. Yes.
>
> * * *
>
> Q. Have you ever been in a situation when you were in the heart station where you had multiple – that's more than one – incident occurring at the same time?
> A. Yes.
> Q. But you were still responsible for contacting the nurse or contacting the nurse of the – or following the escalation policy ... in addition to recording the events on a flow sheet; isn't that accurate?
> A. Correct.

(Ex. 19, Gruehl Depo., p. 37/11-17; p. 40/2-12). Veal failed to perform her job responsibilities; Gruehl's absence from the telemetry station is not "nearly identical" to Veal's conduct. *Turner, supra; Lee, supra; Alkhawaldeh, supra.* Accordingly, Kimberly Gruehl is not a proper comparator, and absence of disciplinary action for Gruehl shows no disparate treatment as to plaintiff.

In total, Veal's baseless, unsupported, inaccurate and unproven "comparator" claims do not establish – and fail to make a prima facie showing – of disparate treatment. Plaintiff's Title VII disparate treatment claim should therefore be dismissed.

D. Veal Was Fired for Legitimate, Nondiscriminatory Reasons – *Even if* Veal could make a *prima facie* case of disparate treatment, RRMC would have no liability because Veal was terminated for legitimate, nondiscriminatory reasons. As explained in *Cargo v. Kansas City Southern Ry. Co.,* No. 05-2010, 2012 WL 4596757 (W.D. La. Oct. 1, 2012):

> Even if Stanley were able to establish a *prima facie* case of discrimination, KCS has provided a legitimate and non-discriminatory reason for his discharge. ... Rule violations are legitimate non-discriminatory reasons for discharging an employee. *Mayberry v. Vaught Aircraft Co.,* 55 F.3d 1086, 1090-91 (5th Cir. 1995). ... Stanley has presented no evidence that his termination was motivated by anything other than his repeated and serious violations of KCS policies.

(*Id.,* at *5). *See also Patrick v. Ridge,* 394 F.3d 311, 316 (5th Cir. 2004) ("An employer may avoid liability for charges of ... discrimination ... by producing evidence tending to show that it had a legitimate, nondiscriminatory reason for its disputed decision"). More recently, in affirming the summary judgment dismissal of a Title VII discrimination claim, the Fifth Circuit said, in *Samani v. Beechnut Academy,* 740 Fed.Appx. 445 (5th Cir. 2018):

> Sami was terminated ... Samani sued Beechnut under Title VII ... alleging racial and religious discrimination ... The court found that even if Samani had made a prima facie case of discrimination, the school had proffered legitimate, non-discriminatory reasons for its actions, which Samani had not been able to rebut. ... *** We AFFIRM the district court's grant of summary judgment.

(*Id.,* at 446, 447). The same is true here.

1. Veal's Termination – The below addressed evidence shows Veal's claim of having alerted Nurse Kandie Batiste of a telemetry problem (regarding the deceased patient) was contradicted by Batiste; no call from Veal was shown on Batiste's phone; Veal's out-of-chronological order Flow Sheet entry (regarding supposed calling of Batiste) was suspect; the Charge Nurse said she received no call regarding a telemetry problem with the deceased patient, and Veal's

claims were simply not believed by those investigating the patient's death, and Veal's actions.

RRMC reiterates and incorporates herein by reference its "BACKGROUND" discussion of this memorandum. Additionally, the evidence shows Veal's claims of having contacted Nurse Kandie Batiste were not believed. Emergency Services Director Dominique Boney heard Veal's claims at the April 18, 2017 Risk Management Meeting, and did not believe them. (*See* Ex. 21, Boney Depo., pp. 66/19-67/4; pp. 69/7-91/11). As earlier noted, Boney found Veal's out of chronological order entry suspicious; also, Kandie Batiste provided Boney evidence of not having been called by Veal. Regarding the claimed call, Boney testified in part:

> Q. Okay. And what did Miss Candy [Kandie] say? What was her side of the story?
> A. That she didn't receive any calls stating that the patient was off the monitor.
> * * *
> A. ... I don't believe she was called.
> Q. You don't believe she was called?
> A. No, I don't
> Q. Why is that?
> A. The day after the incident indeed happened, Candy [Kandie] showed me her call log from her phone. ***... There's no log that you can print from the hone. It was just the phone itself, it was an older phone. It was old technology, and there was no reports that can be ran on the phone. It was just the screen from the phone itself.
> Q. Did you see any calls from Ms. Veal to or from the telemetry tech or room or health heart center, heart station – I'm sorry.
> A. No, I didn't.

(*Id.,* p. 69/14-17; p. 70/6-11,16-25, bracketed material added). Regarding the odd nature of Veal's out of chronological order entry on the Flow Sheet (*Id.,* p. 72/4-19), Boney testified:

> Q. And the reason why you say that there's a problem with that is why?
> A. Because it was – it's roughly two hours later, and it just so happened it was put in between the events that transpired that night.
> Q. But what does that indicate, though?
> * * *
> A. Well, it indicates not a cover-up, but someone just trying to protect themselves.

(*Id.,* p. 81/18-23; p. 82/1-2). Boney's position was summarized at the deposition:

> Q. And when you say something that looks suspicious, you determined that the telemetry tech, Denise Veal, did not contact Nurse Candy [Kandie]; is that accurate?
> A. I believe she didn't.
> Q. And you believe she didn't based upon two points that you pointed out. Number one, that this flow chart or this flow sheet has some entries out of order; and, number two, that Nurse Candy [Kandie] showed you her phone, and that there was no indication that she had been contacted by Nurse Veal; is that accurate?
> A. In **the investigation**, yes, that's accurate. ...

(*Id.,* pp. 88/23-89/10, bracketed material added). Of note, Boney addresses the inquiry into the patient's death as "the investigation" – an investigation which Veal alleges "*[u]pon information and belief"* never occurred. (*See* Doc. 10, Amended Complaint, ¶ 23, emphasis added). Boney also believed Kandie Batiste – and not Veal – due to statements from the charge nurse [working the night of the patient's death]. (Ex. 22, Boney Depo.*,* p. 89/12-24). Boney testified:

> Q. So the charge nurse – what did the charge nurse tell you?
> A. That she didn't receive – she doesn't remember receiving a call until the events happened.

(*Id.,* p. 89/20-24). Boney's stated reasons for disbelieving plaintiff provide additional support for Deborah Bullock's reasonable termination decision as to Veal; Bullock's testimony makes her position clear:

> A. There was a meeting in risk management the following morning or the next morning, I think regarding this incident.
>
> * * *
>
> Q. Did the telemetry technician contribute to the death of the patient?
> A. Yes. In my opinion, yes.
>
> * * *
>
> A. As far as my part, we put Denise on leave temporarily until they finished their investigation. And when they completed it, it was determined that she had failed to perform her duties properly so she was terminated because this was not her first offense of this happening.

(Ex. 22, Bullock Depo., p. 35/9-11; p. 36/16-18; pp. 36/21-372). Bullock further stated:

> A. Whether or not the patient was checked on by the staff has nothing to do with Denise's failure to perform her duties.

(*Id.,* p. 42/6-8). Bullock explained her reasons for issuing the Disciplinary/Corrective Action Form documenting Veal's termination:

> Q. Why did you write this corrective action?
> A. Because Denise failed to follow the correct policy in notifying nursing staff about a patient that was having a problem on the telemetry. *** ... her log that's attached indicates that she did not do the proper escalation and she didn't notify the nurse when the patient got in trouble. There's no documentation of that. *** There is no documentation on Denise's log that's attached here that she notified the nurse at the time the patient started having issues.
> Q. Okay. So if it's not on her log, that means it didn't happen?
> A. Correct.

(*Id.,* p. 20/6-1-, 13-17, 19-25). Bullock, like Boney, did not believe Veal's claim to have contacted Nurse Kandie Batiste:

> A. The policy that we've reviewed with them says that they are to document all of the calls that they make to the nursing staff including the escalation of those calls on their log, and there's no documentation of that on her log.
> * * *
> Q. So it is your understanding that if the call or if certain events are not listed on the flow sheet then they didn't occur?
> A. Correct.
> Q. And ... how do you make sure that that is the case?
> A. ... I would check with the nurse too to ask her if she received any calls ...
> * * *
> A. The nurse said she had not received any calls from the Heart Central from Denise.
> Q. And how did you verify that?
> A. Through Dom her supervisor.
> Q. You verified it through Dom?
> A. And – and through her testimony, her – her word that she said she didn't get any calls.
> Q. So she told you she didn't get any calls and you verified it through Dom that she didn't get any calls and *** thus you determined that she didn't get any calls?
> A. Yes.

(*Id.,* p. 21/7-12, 16-23; p. 22/5-16, 18-20). The "nurse" referred to in Bullock's testimony is Kandie Batiste; the referenced supervisor – "Dom" – is Dominique Boney. (*See* Ex. B, Bullock Affidavit, ¶ 15). As to the unusual nature of placing events out of sequential order on a Flow Sheet, Bullock, like other RRMC personnel who addressed this issue, testified the same way:

> Q. ... Ms. Bullock ... is it unusual for a telemetry tech to not place matters in sequential order in terms of how they happened on the flow chart when they're on duty?
> A. It would be unusual for them to be out of order. Out of sequential order. *** ... I mean I think it is unusual for it to be out of order. *** I know it is unusual.

(Ex. 22, Bullock Depo., pp. 25/25-26/6; p. 28/20-22, 24). Bullock testified she was not working the night of the April 16, 2017 incident (*Id.,* p. 33/2-5), and was required to perform her own investigation of the events:

> Q. ... So in other words you had to, in order to figure out or find out what happened, you had to initiate an investigation; is that accurate?
> A. Yes.

(*Id.,* p. 33/15-19). When asked to describe the investigation protocol she followed "in this particular case involving Ms. Veal" (*Id.* p. 34/8-9) Bullock testified:

> A. I would have gone and looked at that patient's history and the monitor to see what was going on with them to see if there were any changes in the rhythm and at what time that happened, and what does her log indicate she called about and when she called. *** Might would possibly check with the nurse or – if – if that's warranted. *** That would be all in this situation.

(*Id.,* p. 34/12-18, 20-21, 23). Bullock further testified she was involved in the investigation conducted by RRMC's Office of Risk Management. (*Id.,* p. 35/6-11), explaining, "Risk would get involved if there was ... a major event and they just needed to investigate what happened." (*Id.,* p. 36/2-4). Bullock's findings, her conclusions regarding Veal's improper job performance, and Veal's prior disciplinary action involving another patient death let Bullock to determine that Veal should be separated from her employment as a telemetry technician. (Ex. B, Bullock Affidavit, ¶ 16; Ex. 8, Disciplinary/Corrective Action Form). Veal can show no racial discrimination in Bullock's action. Importantly, as addressed below, the law does not require an employer to be correct in terminating employment; the employer is only required to be non-discriminatory.

2. Jurisprudence – In affirming a Title VII disparate treatment termination claim for an employee's purported theft, the Fifth Circuit (using language particularly pertinent here) said, in *Lawson v. AT&T Mobility Services, L.L.C.,* 800 Fed.Appx. 272 (5th Cir. 2020):

> Theft is legitimate rationale for termination ... and AT&T offered nondiscriminatory reasons for concluding that Lawson committed the theft in question. ...Accordingly, AT&T's proffered explanation is not false or unworthy of credence, even if AT&T might be mistaken. *See Amezquita v. Beneficial Tex., Inc.,* 264 F. App'x 379, 386 (5th Cir. 2008)("[E]ven an employer's incorrect belief in the underlying facts – or an improper decision based on those facts – can constitute a legitimate, nondiscriminatory reason for termination." (citing *Bryant v. Compass Grp. USA, Inc*., 413 F.3d 471, 478 (5th Cir. 2005))); *see also Bryant*, 413 F.3d at 478 ("Management does not have to make proper decisions, only nondiscriminatory ones.").

(*Id.,* at 273, emphasis added). The quoted *Bryant* decision involved a claim for, *inter alia,* improper, racially motivated termination. (*See* 413 F.3d at 473-474). There, the Court also pointed out:

> ... evidence that the employer's investigation merely came to an incorrect conclusion does not establish a racial motivation behind an adverse employment decision. ... Employment discrimination laws are "not intended to be a vehicle for judicial second-guessing of business decisions, nor ... to transform the courts into personnel managers." *Bienkowski v. Am. Airlines, Inc.,* 851 F.2d 1503, 1507-08 (5th Cir. 1988).

(*Bryant,* 413 F.3d at 478, emphasis added). In *Cervantez v. KMGP Services Co. Inc.,* 349 Fed.Appx. 4 (5th Cir. 2009), the Fifth Circuit said, "we emphasize ... that a fired employee's actual innocence of his employer's proffered accusation is irrelevant as long as the employer reasonably believed it and acted on it in good faith."(*Id.,* at *10, emphasis added). Pertinent to Veal's lack of a proper investigation claim (Doc. 10, Amended Complaint, ¶¶ 23-24) – as well as her discrimination assertions – is *Arey v. Watkins,* 385 Fed.Appx. 401 (5th Cir. 2010). There, a Caucasian prosecutor in the Dallas County District Attorney's Office "for almost thirty-three years" was terminated and replaced by an African-American following the election of a new District Attorney, Craig Watkins (*Id.,* at 402, emphasis added). In affirming summary judgment for defendant Watkins, the Fifth

Circuit said:

> ... our precedents require Arey to do more than show that Watkin's investigation would have shown Arey's good qualities. Discrimination law addresses only discrimination, not general unfairness in employment relationships. *See LeMaire v. La. Dep't of Transp. & Dev. ex rel Louisiana,* 480 F.3d 383, 391 (5th Cir. 2007). Indeed, " '[e]ven an incorrect belief that an employee's performance is inadequate constitutes a legitimate, non-discriminatory reason' " for termination. *See Mayberry*, 55 F.3d at 1091 (" '[A] dispute in the evidence concerning ... job performance does not provide a sufficient basis for a reasonable factfinder to infer that [a] proffered justification is unworthy of credence.' " (quoting *Little,* 924 F.2d at 97) (first and second alterations in original)); *see also Sandstad v. CB Richard Ellis, Inc.,* 309 F.3d 893, 899 (5th Cir. 2002) ("Merely disputing [the employer's] assessment of [the employee's] performance will not create an issue of fact").

(*Id.,* at 403-404, emphasis added). Further regarding Veal's challenge to adequacy of RRMC's investigation, the Fifth Circuit in *Medlock v. Ace Cash Exp., Inc.,* 589 Fed.Appx. 707 (5th Cir. 2014), specifically found, "evidence of an improper investigation does not establish a discriminatory motive." (*Id.,* at 710, emphasis added). *See also, Hatfield v. Bio-Medical Life Applications of Louisiana, LLC,* No. 16-1307, 2017 WL 4976801 (W.D. La. Oct. 31, 2017), where an "inadequate investigation" assertion was rejected in the plaintiff's Title VII improper termination claim. (*Id.,* at *6). There, a patient care technician was fired, in part on the basis of a patient's complaint. (*Id.,* at *1, *2). As noted by the court, "Plaintiff claims ... Defendant did not properly investigate and confirm Patient A's complaint before terminating Plaintiff. ... Specifically, Plaintiff argues that Defendant discharged her without first interviewing a nurse, Karla Parks ... who witnessed the incident." (*Id.,* at *6, emphasis added). The court then cited evidence showing (as in the instant matter) the defendant "did investigate the incident before terminating Plaintiff." (*Id.,* at *6). Applicable here, the court said further, "[e]ven if Defendant did not interview Parks, the adequacy of Defendant's investigation ... does not establish a genuine dispute surrounding pretext." (*Id.,* at *6). As authority, the court quoted *Medlock, supra*, and cited *Arey, supra,* as "(holding that to create

a fact issue a plaintiff must do more than show that the employer's investigation was inadequate)." (*Id.,* at *6). Citing additional authority, the court said:

> *See also Gallow v. Autozone, Inc.,* 952 F.Supp. 441, 448 n.6. (S.D. Tex. 1996) (observing that the failure to investigate does not establish pretext); *Bissett v. Beau Rivage Resorts, Inc.,* 2011 WL 915790, at *7 (S.D. Miss. Mar. 16, 2011) (observing, "that the investigation into the employee's conduct was inadequate is insufficient to demonstrate pretext ...."); *Sherrod v. AIG Health Mgmt. Servs., Inc.,* 2000 WL 140746, at *7 (N.D. Tex. Feb. 4, 2000) ("Title VII does not guarantee plaintiffs that they may only be terminated after a completely thorough, accurate, and fair investigation into the circumstances around a termination.").

(*Id.,* at *6, FN 11, emphasis added). RRMC's legitimate, non-discriminatory reasons for terminating plaintiff preclude her Title VII disparate treatment discrimination claim.

3. <u>The April 16, 2017 Incident Was Investigated</u> – As shown above, Deborah Bullock conducted her own investigation into the events leading to Veal's termination, and she also participated in an investigation conducted by RRMC's Office of Risk Management. (*See* Ex. 22, Bullock Depo., p. 33/15-19; p. 34/8-23; p. 35/6-11; p. 36/2-4). Defendant reiterates and incorporates herein by reference its above investigation discussion, *i.e.,* Sec. I. D. "RRMC Review of Actions Relating to Deceased Patient" (Memorandum, pp. 9-11). There is no support for plaintiff's "investigation" challenge, and in any event, plaintiff's "investigation" assertions do not establish a pretext for Title VII discrimination. *See Arey, supra; Medlock, supra; Hatfield, supra; Sherrod, supra.*

4. <u>Bullock Has Hired Multiple African-American Telemetry Technicians</u>; <u>She Has Fired Only Three Employees, Including Veal</u>

Deborah Bullock's history of hiring African-American telemetry technicians demonstrates her lack of any racial animus. At her deposition, Bullock testified:

Q. ... What employees work in Heart Central?

> A. We have telemetry technicians; I have currently eight of those. Just to say, I've hired all but one of them and currently I have seven black employees and one white employee of telemetry technicians and I hired all but one of those. ...

(Ex. 22, Bullock Depo., p. 67/8-15). Bullock's testimony shows only three employment terminations by her, including Veal's:

> A. I have terminated [redacted] is one of them. And there was another one, I can't even remember, it was a long time ago. ...
>
> * * *
>
> Q. So would it be accurate to say that from the time you have become the unit manager ... You can only recall three techs that you've had terminated?
> A. Yes, that's correct. I'm trying to think
> Q. And one of those being Denise Veal –
> A. Right.

(*Id.,* p. 88/10-12, 18-25). The Affidavit of RRMC Vice-President of Human Resources, Sara Stokes ("Stokes") (Ex. A), confirms Bullock's testimony. As attested by Stokes, RRMC records reflect the Hospital currently has a total of eight (8) telemetry technicians, and all but one (1) were hired by Deborah Bullock. (*Id.,* ¶ 5). The telemetry technician not hired by Bullock, is Vera Alexander, an African-American who was hired by Clara Wiley in 2011 – before Bullock became a Unit Manager for Heart Central. (*Id.,* ¶ 5). Stokes further attests that during the years 2014 through 2020, Bullock hired the following African-American telemetry technicians: [1] Maurice Slaughter; [2] Brittney Pantallion; [3] Coretta Hannon; [4] Erica Llorance; [5] Quantaye Washington; and [6] Marion Merenivitch. (*Id.,* ¶ 6). *See also* Ex. 16 (in globo), reflecting RRMC employment of the referenced telemetry technicians. Although not referenced in Bullock's deposition testimony, Stokes attests Bullock also hired African-American telemetry technician Felicia Simon, who resigned in 2018. (*See* Ex. A, Stokes Affidavit, ¶ 7). Stokes further attests RRMC Personnel Records reflect Bullock has terminated only three (3) employees: Denise Veal, [redacted], and [redacted] who is

Caucasian. (*Id.*, ¶ 8). Quite clearly, Bullock's hiring and termination record shows a complete lack of *any* discriminatory animus against African-Americans. As shown above, the evidence establishes race played no part in Bullock's employment decision regarding Veal.

IV. CONCLUSION

Plaintiff's disparate treatment discrimination claim is not supported by any facts or applicable law. Moreover, the facts and law show the propriety of defendants's actions, and the lack of any basis for Title VII relief. Accordingly, plaintiff's demands should be dismissed in their entirety, with prejudice, at plaintiff's cost.

Respectfully submitted,

GOLD, WEEMS, BRUSER, SUES & RUNDELL

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