ARBITRATION DECISION NO.:
90

UNION:
OCSEA, Local 11, AFSCME, AFL-CIO

EMPLOYER:
Department of Mental Retardation
and Developmental Disabilities,
Columbus Developmental Center

DATE OF ARBITRATION:
December 9, 1987

DATE OF DECISION:
January 22, 1988

GRIEVANT:
Eva Session

OCB GRIEVANCE NO.:
G-87-0941

ARBITRATOR:
Frank A. Keenan

FOR THE UNION:
Linda Fiely

FOR THE EMPLOYER:
Egdilio J. Morales

KEY WORDS:
Just Cause
Neglect Of Duty
Disparate Treatment
Foreseeability Of
Consequences

ARTICLES:
Article 24 - Discipline
§24.01-Standard
§24.04-Pre-Discipline
§24.05-Imposition
Of Discipline

FACTS:

Grievant was a Hospital Aide at the Columbus Developmental Center. At the time of removal she had been employed at CDC for eighteen and one-half years. Grievant's normal shift was third shift (10:15 p.m. to 6:30 am). She normally worked on a ward where the patients were mildly retarded. Many of her students went to classes and worked in a workshop. Grievant was asked to work overtime on first shift on a ward in which all of the residents were significantly retarded. The nurse's aide in charge of the ward explained to Grievant the particular problems in the ward and identified H.J. as a runner, a patient with a bent for escape. The nurse's aide was off the ward for training and lunch from 9:00 am to 11:00 am. Grievant went to lunch at 11:00 am and returned at noon. Sometime before 11:00 am, patient H.J. escaped from the ward and was struck by a car, resulting in extensive injuries. When police and CDC security asked the nurse's aide about the whereabouts of H.J., she stated that he was on the couch. H.J. may have escaped through one of the doors that often failed to close tightly. A sign on the door warned staff to make sure the door closed properly. The ward had five doors and it was physically impossible to see more than two doors at any given time. The ward was situated in such a manner that it was used as a thoroughfare by staff transiting from one ward to another. As a result of the escape and accident, Grievant was discharged and the nurse's aide was given a twenty day suspension, the suspension being reduced to a written reprimand at the third step.

EMPLOYER'S POSITION:

The Agency argues that discharge is called for based on the severity of the patient's injuries. Grievant alone was in charge of the ward at the time patient H.J. escaped. Grievant had been warned that H.J was a runner. There was a note on the door which warned Grievant that it should be checked often. The nurse's aide was disciplined less severely because she was not on the ward at the time the patient escaped. The other cases used by the Union to show disparate treatment can be distinguished on the facts.

UNION'S POSITION:

The grievant's discharge was not in proportion to her offense. Her offense and the nurse's aide's offense are basically the same - both failed to notice H.J.'s absence. It is improper to look only whether harm results since the charge was one of neglect and was not a willful, intentional act. The focus should be upon the potential for harm. There are other records of patient harm resulting from staff neglect or inattention which resulted in less severe penalties. Grievant was treated more harshly than similarly situated employees, including the other employee who received discipline as a result of the incident. Other mitigating factors include: the door probably used for escape was defective, many other people used the door, Grievant was unaccustomed to patients who were this difficult to handle, Grievant was fatigued from working an extra shift, and the nurse's aide left her alone on the ward.

ARBITRATOR'S OPINION:

H.J. clearly escaped while under grievant's care. It was not willful or deliberate. The nurse's aide was also negligent. The vast difference in penalties imposed-discharge and written reprimand - is not justified by the harm resulting. The just cause standard requires a review of the foreseeable consequences of the neglect, here failure to keep an eye on a known runner. The just cause standard dictates like treatment under like circumstances. Grievant's inattention was of longer duration so her penalty could be slightly more severe than the nurse's aide's penalty. Grievant was fatigued, unfamiliar with the ward, and unaccustomed to dealing with such unruly patients. These facts and Grievant's long service and good work record warrant mitigation of the

discipline.

AWARD:

Twenty (20) day suspension and backpay to make whole.

TEXT OF THE OPINION:

ARBITRATION

BETWEEN

OHIO DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES, COLUMBUS DEVELOPMENTAL CENTER

and

OHIO CIVIL SERVICE EMPLOYEES ASSOCIATION, LOCAL 11, A.F.S.C.M.E., AFL-CIO

APPEARANCES FOR THE AGENCY:
EGDILIO J. MORALES,
LABOR RELATIONS SPECIALIST
OFFICE OF COLLECTIVE BARGAINING
OHIO DEPARTMENT OF
ADMINISTRATIVE SERVICES,
COLUMBUS, OHIO

FOR THE UNION:
LINDA FIELY, ATTORNEY
OHIO CIVIL SERVICE
EMPLOYEES ASSOCIATION,
COLUMBUS, OHIO

Opinion and Award of the Arbitrator

Frank A. Keenan
Panel Arbitrator

I. BACKGROUND:

This case was heard in Columbus, Ohio on December 9, 1987. At the conclusion of the hearing, the parties' representatives ably argued their respective positions.

Testifying on behalf of the agency were Vera Wright, police officer, at the Columbus Developmental Center (herein CDC); Joyce Reeves, hospital aide; Teresa Smith, Mental Health Administrator II; Robert Bassinger, Unit D Manager; Michael Fuscardo, Labor Relations Coordinator. Testifying on behalf of the Grievant and the Union were Eva Session, hospital aide, and the Grievant in the case; Sandra K. Glover, former LPN at the CDC; L. Carol Bowshier, Field Representative for OCSEA.

II. STATEMENT OF THE CASE:

CDC is a resident and care facility for the mentally retarded. The Grievant has worked as a hospital aide at the CDC for approximately 18 1/2 years. She was discharged effective February 13, 1987 as a result of an incident which occurred on December 26, 1986. The Grievant normally worked third shift, that is, from 10:15 p.m. to 6:30 a.m. The Grievant normally worked on a ward where the patients functioned rather well. Indeed, the clients on the Grievant's ward had their own set of keys and worked outside of the facility or attended classes at a training center. On December 26, 1986 the Grievant was asked to work overtime on to the first shift at Doren Hall. The ward to which the Grievant was assigned housed 8 clients, all of whom were significantly retarded. This ward in Doren Hall was normally presided over by nurse aide, Joyce Reeves and another nurse aide. Reeves' assistant had called in sick and hence Session was called in to cover for her. The Grievant had never before been assigned to this ward. In this regard it is noted that while only one person need be assigned to oversee 8 clients, it is the CDC's policy to assign 2 persons for every 8 clients. This is especially so on those wards where the clients function at a lower level. When Session arrived on the ward, Reeves outlined what their routine for the day would be. Throughout the Grievant's orientation by Reeves, Reeves identified various clients and their particular problems. Thus, in this manner, she made known to the Grievant that one client known as H.J. was a runner, that is, he would attempt to escape if given the opportunity. Others were identified as being particularly physically aggressive. Reeves left at 9:00 a.m. for training, returned for a brief period shortly before 10:00 and left then for lunch at 10:10 a.m., returning at approximately 11:00 a.m. At that point, the Grievant left for lunch and returned at approximately 12:00 p.m. In the interim and unbeknown to either Reeves or the Grievant, client H.J. had escaped the institution and made his way to the intersection of Broad and Ogden Streets, where at approximately 11:05 a.m. he was struck by an automobile. His injuries were extensive. Several bones were broken as well as serious contusions. The security force at the CDC was notified by the Columbus police. Chief Raney and police officer Wright went to the hospital where H.J. had been taken and they identified him as a client of the CDC. Wright and Chief Raney then returned to the CDC. Reeves was questioned as to the whereabouts of H.J. When she indicated he was lying on the couch, Raney and Wright advised Reeves and Session that, indeed, H.J. had escaped and had been hit by an automobile.

At this juncture, it is appropriate to observe some of the physical characteristics of Reeves' ward. Thus, whereas normally a ward has but 3 doors, Reeves' ward had 5 doors. One of these doors which led to a hallway which in turn led to a door exiting the institution did not always close firmly. A problem evidently the result of some fault with the air pump which was attached to the door. Thus, unless the door was pulled shut it often failed to shut completely. So it was that a sign was placed on the door reading as follows: "Please be sure to close tight to prevent clients from leaving." Still further with respect to the doors, it was the uncontradicted testimony of former LPN Glover that the physical structure of the ward was such that at any one time only 2 doors could be observed. Further with respect to the physical structure of the ward, it is noted that it was located at a place in the institution where people continually walked through to get to other parts of the

institution. Indeed, on the day in question, December 26, 1986, several people affiliated with the institution passed through Reeves' ward while the Grievant was on duty by herself.

Management undertook an investigation as to how it was that client H.J. had escaped. It never was determined just which door it was that he escaped from. Management's investigation resulted in the Grievant's discharge and a 20 day suspension of nurse aide, Reeves. Both actions were grounded on the Grievant's and Reeves' negligence. Both Reeves and the Grievant grieved the discipline meted out to them. At the third step Reeves' suspension was reduced to a written reprimand. Labor Relations Coordinator was the management representative who reduced the penalty on Reeves. Fuscardo did so on the basis of the following rationale gleaned from his third step response: Findings of Fact . . . On December 26, 1986 Ms. Reeves was on duty from 6:15 a.m. to 2:45 p.m. . . . from approximately 9:00 a.m. to 9:55 a.m. Ms. Reeves attended an inservice training program. From approximately 10:00 a.m. to 11:00 a.m. Ms. Reeves was on scheduled lunch break. The client was struck by an automobile at approximately 11:05 a.m. on December 26, 1986. The accident occurred one and a half miles from Columbus Developmental Center at Broad and Ogden Street. At approximately 12:35 p.m., one and one-half hours after client H.J. was struck by the automobile, Ms. Reeves was asked where H.J. was and she responded on the couch, he was there a minute ago. Ms. Reeves was unable to account for the client for at least one and a half hours after she returned from lunch.

CONCLUSION:

After review of all documents and testimony presented, it is felt that evidence does not support the specific charges indicated in the Order of Suspension, therefore, I have no alternative but to grant this Grievance to the extent of Grievant be paid 20 working days pay and record be expunged of suspension. As Fuscardo explained at the hearing, Reeves could not be held accountable for the Grievant's escape and injury because counting back from the time that he was injured, it was clear that he escaped the institution during a time frame when Reeves was, in effect, not on duty. In any event, following Fuscardo's determination a written reprimand was placed in Reeves' personnel file. It recites as follows: "His injury occurred at 11:05 a.m., it is apparent that you did not take a head count when you returned from your lunch break at 11:00 a.m., and that at no time between 11:00 a.m. and 12:35 p.m., for a period of one and a half hours, did you take notice of his absence. This is a serious breach of your responsibility to know the whereabouts of all clients in your care at all times. Please be advised that should an incident such as this occur again, more severe disciplinary measures will be necessary. Current rules and regulations for the conduct of employees as you are aware, require full compliance and it was your responsibility to follow these rules and regulations. A copy of this written reprimand will remain in your personnel file for 12 months. Keeping with the working agreement, if it began in the 12 month period there has been no further infraction, it will be removed from your personnel file."

Fuscardo also heard the Grievant's grievance at the third step. He denied the grievance. His rationale for doing so was set forth in the third step response as follows: "Finding of Fact: Grievant was removed from her position as a hospital aide effective February 13, 1987. On December 26, 1986, Grievant was on duty, she was in an overtime situation, assigned to Doren Hall ll. At the step three grievance hearing, Grievant testified that her co-worker made her aware of who were potential runners prior to leaving for her lunch break. This was at approximately 10:00 a.m. on December 26, 1986. Grievant also testified that she saw the client involved on two occasions after her co-worker left for lunch. The last time she saw him was at approximately 10:30 a.m. According to Columbus Police Department's records, the client involved was struck by an automobile at approximately 11:05 a.m. on December 26, 1986, approximately 35 minutes after

the Grievant saw client on the living area.

CONCLUSION:

A review of the documentation and testimony presented does not support violation of Article 24 . . . however the facts support discipline was for just cause commensurate with the offense. Ms. Session clearly neglected her duty which resulted in a client leaving his living area and being struck by an automobile approximately one and a half miles from CDC. Therefore, based on the aforementioned and the Findings of Fact, this Grievance is denied."

It is noted that agency wide policy at the time called for discipline of 20 days suspension up to discharge for physical abuse or neglect, even for a first offense, if it was "harmful." At the arbitration hearing, Fuscardo indicated that Officer Wright's report reflected that when she arrived back at the CDC from the hospital, after having identified client H.J. as the accident victim, she observed the Grievant in the living area of the ward watching TV. The Grievant, in effect, denied simply watching TV, but rather indicated that she was seated at a desk when Wright arrived on December 26, and that it might have appeared that she was watching TV.

The representative sample of the Grievant's employee performance evaluations reflect that the Grievant is regarded as a good employee who from time to time has problems with her attendance.

Other matters of note concern the fact that hospital aide Susan Riley was issued a letter of reprimand for neglect of her duties during the course of a one-on-one assignment where she took upon herself extra duty and let her attention lapse from care of the patient assigned to her. This inattention on Riley's part resulted in the client engaging in self-abusive behavior and seriously injuring himself. The record also reflects that employee William Miller has been suspended in the recent past for neglect of duty. Point being that he was not discharged for this offense. Further in this regard the record reflects that in the recent past employee Richard Kramer was issued a written reprimand for alleged negligent conduct on his part. Finally it is noted that at the hearing herein, Labor Relations Coordinator Fuscardo indicated that he deemed the discharge of the Grievant appropriate in light of the grave injuries sustained by client H.J. as a consequence of her negligence.

Grievant's Letter of Removal read in pertinent part as follows: "The reason for this action is that you have been guilty of neglect of duty and/or failure of good behavior and/or resident abuse/neglect in the following particulars to wit: Effective 5/1/85, you received a letter of reprimand for late call-off. Effective 3/7/86, you received a letter of reprimand for improper call-off. On 12/26/86, you were assigned to Doren Hall II along with co-worker Joyce Reeves where 8 clients reside. Your failure to properly observe all the clients resulted in one client, H.J., escaping and being struck by an automobile on Broad and Ogden Streets one-half mile away, placing said client in a life threatening position, also causing serious physical harm. This type of laxity on your part cannot and will not be tolerated. Therefore, you are removed from state service for neglect of duty and/or failure of duty and/or failure of good behavior and/or resident abuse/neglect.

Fuscardo's third step grievance response reflects in pertinent part as follows: "Finding of Fact: Grievant was removed from her position as a hospital aide effective February 13, 1987. On December 26, 1986, Grievant was on duty, she was in an overtime situation assigned to Doren Hall II. At the step three grievance hearing, Grievant testified that her co-worker made her aware of who were potential runners prior to leaving for her lunch break, this was at approximately 10:00 a.m. December 26, 1986. Grievant also testified that she saw the client involved on two occasions after her co-worker left for lunch, the last time she saw him was at approximately 10:30 a.m. According to Columbus Police Department records, the client involved was struck by an

automobile at approximately 11:05 a.m. on December 26, 1986, approximately 35 minutes after the Grievant saw client on the living area.

CONCLUSION:

A review of the documentation and testimony presented do not support violation of Article 24, Section 24.04 and 24.05, however, the facts support discipline was for just cause and commensurate with the offense. Ms. Session clearly neglected her duty, which resulted in a client leaving his living area and being struck by an automobile approximately one and a half miles from CDC. Therefore, based on the aforementioned and the Finding of Fact, this Grievance is denied."

It is noted that the parties stipulated that this is not a case of abuse of a patient in the care of the State of Ohio within the intendment of Article 24.01 of the parties' contract.

III. THE AGENCY'S POSITION:

The Agency takes the position that given the very serious nature of the Grievant's offense, discharge was called for. In support of its contention the Agency points to the severity of the injuries sustained by client H.J. and asserts he could have been killed or he could have seriously injured a member of the public while outside the institution. It is the Agency's position that since the Grievant alone was in charge of the ward at the time of H.J.'s escape, she was clearly culpable for his escape. The Agency takes the position that the Grievant had been warned about the fact that H.J. was a runner and hence she should have placed a higher priority on watching him. The Agency further asserts there are no circumstances which serve to mitigate the Grievant's offense. Thus, the Agency asserts that there was nothing unique about the fact that she was assigned to a ward where she was unfamiliar with the clients or that she was serving alone on a ward with 8 clients. The Agency contends that these circumstances arise frequently at CDC. Nor were the clients on Reeves' ward in any way unusual. Rather, they were typical clients. Contrary to the Union's assertion, the Agency contends that the allegedly faulty door was not operating improperly. Moreover, there was a note on the door which warned that it had to be closed tightly.

With respect to the Union's allegations of disparate treatment, the Agency takes the position that Reeves could not be held culpable for H.J.'s escape since she simply was not on duty at the time he escaped. The Agency additionally contends that other cases relied upon by the Union are simply distinguishable and not comparable to the Grievant's situation.

So it is that the Agency contends that the Grievant was properly discharged.

IV. THE UNION'S POSITION:

The union takes the position that the Grievant's discharge was not in proportion to her offense. The Union takes the position that the Grievant's offense and that of Reeves were essentially the same. Namely, that they failed to take note of H.J.'s absence from the ward. The Union contends that under the just cause standard, it is improper to only look at whether or not negligence results in harm or no harm. According to the Union, the focus should be upon whether or not there is a potential for harm. That the potential for harm should be the principal criteria for determining the severity of the penalty. The argument is that since both Reeves' and the Grievant's conduct had the same potential for harm, the penalty meted out should be the same. Thus, when Reeves was merely issued a written warning, it is clear that the Grievant's discharge is disparate and discriminatory.

The Union additionally contends that, in any event, numerous mitigating circumstances exist

here. Thus, the Union points out that this ward contains many rough clients and that, indeed, the Grievant had some difficulty overseeing them. Additionally, the door from which the Grievant most likely escaped, was defective. A circumstance that was significant because a lot of traffic entered and exited Reeves' ward during the time that Grievant was staffing it by herself. Other cases of neglect have resulted in far less penalty than discharge.

So it is that the Union contends that the Grievance be sustained.

V.

As the parties have stipulated, the issue here is: Was the Grievant discharged for just cause.

VI. DISCUSSION AND OPINION:

There can be no question but that the Grievant failed to keep track of the whereabouts of client H.J. while he was under her care on December 26, 1986. And this in the face of aide Reeves specifically pointing out to the Grievant that client H.J. was a runner. It is clear, therefore, that, as the Agency asserts, the Grievant failed to give sufficient priority to the need to keep a watchful eye over client H.J., given her familiarity with his proclivity for escape. These conclusions inexorably flow from the fact that the Grievant escaped from the institution and from the fact that, given the distance (1 1/2 miles) H.J. was from the institution at 11:05 a.m. (Broad and Ogden Streets) and the Grievant's last sight of him at 10:30 a.m., he escaped while solely under the Grievant's surveillance and care. There was nothing deliberate or willful about this failing and hence it is fairly characterized, as the Agency contends, as "negligence." In a similar manner nurse aide Joyce Reeves was also negligent. Thus, it is clear that client H.J. had already made his escape when Reeves assumed full responsibility for H.J.'s ward from 11:00 a.m. to noon, and thereafter until approximately 12:30 p.m. when Reeves and the Grievant shared responsibility for H.J's ward, and hence Reeves' failure to note his absence clearly demonstrated a failure on Reeves' part to give sufficient priority to the need to keep a watchful eye over client H.J., a known runner. However, for these generically same offenses of negligence, Reeves and the Grievant received greatly divergent discipline; a written reprimand was meted out to Reeves (a reduction from the initial determination that a 20 day disciplinary layoff was appropriate), but the Grievant was discharged.

As the Grievant's removal letter and Coordinator Fuscardo's third step determination indicates, the Agency seeks to justify this disparity principally[1] on the ground that the client who escaped while under the sole care of the Grievant, and due to her negligence, was very severely injured while in his escape status. As has been seen, the Union challenges the appropriateness under the just cause standard of the Agency's linking the severity of the discipline to the degree of harm suffered by the client while an escapee. I find the Union's challenge persuasive. In my view the just cause standard requires one to review the foreseeable consequences of the type of negligence in question, here the failure to keep a watchful eye for the whereabouts of a known runner. Doing so here, given the urban setting of the CDC and the severe mental retardation of many of the clients, and certainly of those under Reeves and the Grievant's care on December 26, 1986, it was readily foreseeable that if a client such as H.J. were to escape, he could be seriously injured or even killed by a motor vehicle. Thus, it is this foreseeable consequence itself which dictates the severity of the discipline, and not the fortuitous fruition of the foreseeable consequence. But the foreseeable consequence of potential serious injury to client H.J. was the same in both the Grievant's and Reeves' negligent failure to keep a watchful eye over client H.J. And as is now well established, the just cause standard dictates "like treatment under like circumstances" Alan Woods Steel Co., 21LA843, 849 (Short, 1954). Nonetheless there is some ground for a somewhat greater penalty

for the Grievant, and that is, that the Grievant's inattention was of a longer duration than that of Reeves. In my view, however, given the leniency[2] accorded to Reeves, and indeed to others whose "negligence" led to physical harm to a client, only a 20 day disciplinary layoff would be appropriate. The relative leniency of this sanction for such a concededly serious offense is mandated both by the leniency accorded to Reeves for a like offense, and by the several mitigating factors[3] present here. For one thing, the Grievant was in overtime status and doubtless fatigued. Additionally, while there may have been nothing unique about the feature of unfamiliarity with the clients, and the handling of a ward alone, where the ideal and goal strived for is to cover a ward such as H.J.'s with two staff members, these features of the Grievant's assignment do serve to somewhat mitigate her offense; the lack of uniqueness simply serves to undercut the weight these features might otherwise be given. Also there is the fact that from time to time the Grievant was kept preoccupied by the obstreperousness and shenanigans of the other clients on the ward, which, as the saying goes, gave the Grievant "a handful." Then too there is the Grievant's long and worthy service and good work record. So it is that the Grievant's discharge is set aside and a 20 day disciplinary suspension is imposed in lieu thereof.

In light of this disposition of the grievance and the outcome for the Grievant, I find it unnecessary and unproductive to the parties' relationship, to address the Union raised issue as to the propriety of reciting the incidents of 5/1/85 and 3/7/86 in the Grievant's letter of removal, especially since it appears to be essentially "boiler plate" and to have played virtually no role in the Agency's determination to discharge the Grievant.

AWARD:

For the reasons more fully set forth above, the grievance is sustained in part and denied in part. The Grievant is reinstated to her former position as a nurse aide at CDC without loss of seniority and shall be made whole for all lost earnings except to the extent that she shall be regarded as having been on disciplinary layoff from the date of her discharge and for 20 work days thereafter, and her records shall so reflect, said disciplinary layoff being warranted due to her negligence and/or "neglect of duty."

Dated: January 22, 1988

Frank A. Keenan
Panel Arbitrator

---

[1] It is clear that Coordinator Fuscardo, in determining at step three to not modify the Agency's discharge action, regarded the Grievant as having been caught watching television by the security police on December 26th. In my judgment the record will not support such a conclusion. The Grievant convincingly explained that she was positioned in the living area at the location where she could best observe the most clients and that this position coincidentally allowed her to also be in a position to watch the television. In any event there is no indication in the Grievant's removal letter that this factor weighed heavily, indeed at all, at the time of the Grievant's actual discharge.

[2] No opinion is rendered here as to the propriety of far more severe prospective penalties for similar conduct following due notice to all employees of such.

[3] In the absence of unlimited funds to warrant a flawless physical plant, a factor I am confident is not

present here, I am unwilling to find that the door which required some attention to shut tightly was a "managerial fault" which contributed to H.J.'s escape. The Agency was entitled to rely on the responsibility of staff members entering and exiting to adhere to the directive posted on the door. This door, therefore, is not found to be a mitigating or extenuating circumstance as in essence contended by the Union.