VOLUNTARY LABOR ARBITRATION TRIBUNAL

In the Matter of Arbitration	*	
Between	*	
	*	OPINION AND AWARD
OHIO CIVIL SERVICE	*	
EMPLOYEES ASSOCIATION	*	Anna DuVal Smith, Arbitrator
LOCAL 11, AFSCME, AFL/CIO	*	
	*	Case No. 23-07-20060221-0001-01-04
and	*	
	*	
OHIO DEPARTMENT OF	*	Danita Drake, Grievant
MENTAL HEALTH	*	Removal
	*	

APPEARANCES

For the Ohio Civil Service Employees Association, Local 11 AFSCME, AFL-CIO:

Robert Robinson, Staff Representative
Ohio Civil Service Employees Association, Local 11 AFSCME, AFL-CIO

For the Ohio Department of Mental Health:

W. Pat Mogan, Labor Relations Officer
Ohio Department of Mental Health

Jessie Keyes, Labor Relations Specialist
Ohio Office of Collective Bargaining

I. HEARING

A hearing on this matter was held at 9:15 a.m. on September 25, 2006, at the Northcoast Behavioral Healthcare Cleveland Campus in Cleveland, Ohio, before Anna DuVal Smith, Arbitrator, who was mutually selected by the parties pursuant to the procedures of their collective bargaining agreement. The parties stipulated the matter is properly before the Arbitrator and presented two issues on the merits, which are set forth below. They were given a full opportunity to present written evidence and documentation, to examine and cross-examine witnesses, who were sworn or affirmed and excluded, and to argue their respective positions. Testifying for the Ohio Department of Mental Health ("Management") were Sharon Lawrence, James H. Wuliger and Paul Gugenheim. Testifying for the Ohio Civil Service Employees Association, Local 11 AFSCME, AFL-CIO (the "Union") were Elvida Sewell, Denay Dominic, Jonnie Cooper, Lazarus A. Sanders, MaryAnn Wilson and Danita Drake. A number of documents were entered into evidence: Joint Exhibits 1-15, Management Exhibits 1-3 and Union Exhibits 1-2. The oral hearing was concluded at 3:45 p.m. on September 25. Written closing statements were timely filed and exchanged by the Arbitrator on October 17, 2006, whereupon the record was closed. This Opinion and Award is based solely on the record as described herein.

II. STATEMENT OF THE CASE

This case concerns the removal of a Therapeutic Program Worker ("TPW") who was employed by the Ohio Department of Mental Health in June of 1997, first as an intermittent TPW but eventually (on March 14, 1999) as a full-time permanent TPW. During the course of her employment with the department she performed well, receiving satisfactory and above evaluations. At the time of her removal she had no active discipline on her record.

The incident leading to the Grievant's removal occurred in the early morning hours of December 5, 2005, while the Grievant was working the third shift (11 p.m. - 7:30 a.m.) on 3L of the Northcoast Behavioral Healthcare Cleveland Campus. This unit houses forensic patients in the process of being evaluated for their ability to participate in their criminal trials. During the

night, one of these patients escaped by breaking out a window in his room and then jumping from the balcony to the ground three stories below. The patient was injured as a result but he nevertheless made his way to his brother's residence on the west side of Cleveland. Some time later that morning he left his brother's home and remained at large for some days. The institution was completely unaware of the escape until the patient's parents appeared at the front desk around 7:30 a.m. complaining about the disappearance of their son.

Management subsequently conducted an investigation, interviewing the escapee, his roommate and several other patients, staff on duty that night, the mother, the brother and the person on duty at the front desk to whom the parents had reported the escape. One patient reported he heard a crash around midnight and the patient's brother reported that his daughter told him the patient showed up at their home about 2 a.m. The parties stipulated the escape occurred sometime prior to 3 a.m. At the 11 p.m. check Nurse Jonnie Cooper saw the patient in the day room. She saw him in the bathroom on her midnight check. 1 and 2 a.m. rounds were made by TPW Darryl Walker, who reported in his first investigative interview that he saw "four feet in the beds" of the patient's double room. He later affirmed that he physically went into the room and saw both patients in their beds. The Grievant made the hourly rounds from 3 a.m. through 6 a.m. She, too, reported the presence of the patient. In her investigative interview she said she saw something in the bed each time and believed it was the patient. She could not remember whether she merely looked through the door's window or actually walked into the room.

The Grievant was subsequently charged with violation of the following policies:

> 3.10 Neglect of Duty. Failure to perform the duties of the position or performance at sub-standard levels; Failure to follow the policies, procedures, directives of ODMH, hospitals, CSN; Dishonesty: Falsification, or unauthorized altering or removal of any official document or record; Patient/Client Abuse or Neglect: Any act verbal or physical or failure to act which is inconsistent with the rights of patient/client or is degrading to a patient/client or which may result or did result in psychological or physical injury;
>
> 6.09 Patient Abuse/Neglect, which states in part "Any act or absence of action which results, or could result, in physical injury to a patient." (Joint Ex. 19)

> 5.06 Patient Health and Safety - Twenty Four Hour Safety Checks, which states in part "1. The patient's location must be checked every hour from 7:15 AM. To 11:15 PM.. and a safety check to ensure that the patient is in satisfactory condition every hour from 11:15 PM.. to 7:15 AM. After completing the necessary check, the responsible staff member shall make appropriate entries on the Patient 24 hour Rounds sheet (Form #2-1-24) using the abbreviations listed on the bottom of the form and initial each column...8. The staff member MUST IMMEDIATELY report to the RN any patient not accounted for at rounds. At that time, Patient AWOL from Grounds (HP #06.03) may be implemented." (Joint Ex. 20)

Initial training on policy occurs at orientation. Training Officer Mary Ann Wilson testified she tells those she orients to use a flashlight to make certain a patient is there and in "satisfactory condition" and to follow floor procedures–which would be learned on the floor–in so doing. The Grievant and other Union witnesses testified they learned from other staff. On-the-job training on the cited policies occurred for the Grievant on August 5, 2003 (05.06) and August 1, 2003 (03.10) on a read-and-sign basis. The Nursing Procedures Manual on shift responsibility (02.91, effective November 1, 2004) regarding rounds on the night shift provides that "Night nursing staff will make rounds every one (1) hour and document. Each patient will be checked with a flashlight, lighting their midsection to assure the patient is breathing." (Joint Ex. 18) No record of the Grievant having been trained on or even having read 02.91 was submitted.

A pre-disciplinary conference was held on January 12, 2006. The hearing officer found just cause for discipline on all charges. Chief Executive Officer Guggenheim recommended removal to the director because, he testified, the patient was put at grave risk to his life, the Grievant was dishonest in her reporting and so can never again be trusted, and the institution was put at risk of a lawsuit and was humiliated by the means of its discovery of the escape.

The Grievant was subsequently terminated effective February 15, 2006. This removal was thereafter timely grieved and fully processed to arbitration without procedural defect on the stipulated issues of:

> *Did Management prove that patient abuse occurred?*
> *If not, did Management have just cause to remove the Grievant?*
> *If not, what should the remedy be?*

III. ARGUMENTS OF THE PARTIES

Argument of Management

Management does not argue that the Grievant should have or could have prevented the escape. The escape was not a factor in its decision to terminate her. Its reason was that she falsified an official document four times, leading to physical abuse of a patient. Making rounds to verify the presence and condition of patients is the single most important responsibility of third-shift TPWs and the Grievant failed to meet this responsibility.

Management submits that the Grievant knew what was expected of her. By her signature on the training report she verified that she had read Policy 05.06 which requires a safety check to establish that the patient is in satisfactory condition. If she had any questions, she should have contacted Clinical Nurse Manager Shawn Lawrence. The fact that there was no face-to-face training on the policy is irrelevant because however training occurs, the employee has the responsibility to inquire if she or he is uncertain about the policy's meaning. Moreover, there is no ambiguity in the language of this policy. All she had to do was to observe whether the patient was on the unit and, if so, whether he was in noticeable distress. She even admitted on direct examination that she needed to see the patient's chest moving.

Management argues that the Union's claim of inadequate training is a red herring because the Grievant knew she was required both to see the patient and to observe some sign of life. Seeing a pile of blankets was insufficient. Though she said on cross-examination that she thought she saw the blankets move, it is beyond reason that she could have mistakenly seen movement from an inanimate object four times in succession. Thus, she must have been lying. The fact that she also missed detecting the broken window, shattered glass and abnormally cold temperature of the room suggests that she was not even in the room that night.

Addressing other Union contentions, Management submits that the absence of the cage is another red herring because the real issue is whether the Grievant noticed the escape, not whether there was an escape. As for being afraid of forensic patients, working with this population is in

the nature of the job as noted on the class specification. Apprehension is no justification for not performing required duties. Management suggests that the Grievant could have requested other staff to accompany her if she was afraid or that perhaps she needs another line of work. While it is true that she received good evaluations and that co-workers and supervisors had observed her performing rounds in the past, this only shows that Management had no predetermined agenda. None of this alters the fact that on this night she failed to perform a crucial duty and falsified an official document, thus allowing an injured patient to be exposed to wintry conditions with no possibility of help. The Grievant alone was responsible for the fact that the patient was by himself and in grave danger. This constitutes patient abuse. Under the terms of Article 24.01 of the Collective Bargaining Agreement, the Arbitrator thus has no power to overturn the removal. However, if the Arbitrator should find that there was no abuse, then the grievance should be denied because Management had just cause for removal in light of the severe aggravating circumstance. It was only very good luck that the patient was not severely injured or killed while at large during the period the Grievant certified he was present and in satisfactory condition.

Argument of the Union

The Union submits that it showed beyond a doubt that the Grievant was terminated without just cause and that the allegations constitute a gross stacking of charges.

Taking the patient abuse charge first, the Union avers that the reason Management claims the escape is not the issue is because it, alone, is responsible inasmuch as it did not replace the outer cage that would have prevented it. Although that security lapse and that of the privacy curtains have since been addressed, there has still been no training on safety checks at the Cleveland Campus or anything to correct building temperature other than thermometer readings.

Turning next to the charge of failing to follow policy and violation of 5.06, the Union asks if this was such an important policy, why did it take six years for the Grievant to see it? Management has the responsibility to assure that all employees know what is expected of them. As it was, it was up to each employee to interpret the policy for him or herself. Even the CEO

admitted read-and-sign training is insufficient. Testimony from the various witnesses showed the truth of this in the variety of actual practice.

As for the charge of falsification, the Union says there was none, only an unfortunate incident that was bound to happen because of Management's negligence in failing to train staff properly. The Grievant's character is impeccable and she had nothing to gain by marking the patient present if he was gone. She lacked intent or even motive to deceive and was, herself, deceived. Now that she finally knows from this experience what is expected, she will have no problem complying despite the risks.

Finally, even the charge of neglect of duty (which calls for a reprimand to 2-day suspension for a first offense) should be mitigated by Management's mistakes. For the Grievant to have neglected her duty, she needs to have known from appropriate training what was expected. As it was, although aware of the dangers, she performed her duties as she understood them to be. Managers, nurses and even the police have seen her making rounds and no one had a problem with how she did it, nor has any TPW at the Cleveland Campus ever been in-serviced on Policy 2.91 which specifies checking each patient with a flashlight, lighting their midsection to assure the patient is breathing.

For all these reasons, the Union asks that the removal be overturned and the Grievant made whole for all lost wages, benefits, leave and seniority.

IV. OPINION OF THE ARBITRATOR

Management has a heavy burden in abuse cases. Not only must it have clear and convincing evidence, but in order to meet the Article 24.01 standard, it must establish that the Grievant's actions rise at least to the level of recklessness, which is the standard of Ohio Revised Code Section 2903.33(B)(2) held to be applicable in Article 24.01 cases for both the mental health and mental retardation/developmental disabilities departments (*Ohio Department of Mental Retardation and Developmental Disabilities and Ohio Civil Service Employees Association* (Juliette Dunning, Grievant), Case No. G87-0001. D. Pincus, Arbitrator, October

31, 1987). The Administrative Code definition for the Department of Mental Health has been revised since the *Dunning* decision, but it must still be read with ORC 2903.33(B)(2), which requires intent or, at least, indifference. While it is true that the patient was harmed during his escape and further harm may have befallen him as a result of the delay in the institution learning of his escape by virtue of the Grievant not having reported his absence, these facts are not enough to establish "abuse." Management must also prove that the Grievant was either indifferent to the potential consequences of her failure to see flesh and ascertain respiration or that she intended that there be consequences. That is, Management must prove clearly and convincingly that the Grievant acted (or failed to act) recklessly or knowingly.

Management did not meet this burden. The Grievant was not indifferent to the consequences, let alone intend that there be harmful ones. All the evidence–from her performance and discipline records through her open admissions in the investigation that she only thought she saw him to her testimony in arbitration–is indicative of someone trying to do her job as she understands it to be even though it is sometimes dangerous. There was not one shred of evidence that she actually intended to place this or any other patient or the institution at risk or that she was taking short cuts for her own convenience. What the Grievant was, was negligent. Unlike some other employees who were either better instructed or figured out for themselves that a closer inspection was necessary to ascertain both the presence and condition of a live human being, the Grievant allowed herself to be fooled by a pile of blankets and cold room by not taking greater care during her rounds to see what was under the blankets. This is not abuse warranting removal, but it is neglect of duty and warrants corrective discipline.

Management argues that the Grievant knew what was required or should have known from the written policy, but 5.06 is not that specific and 2.91 not much more so. There is ample room for a range of interpretations. Management also places the burden on the employee to speak up if they do not understand the written policy, overlooking the possibility that a person

may be confident he or she understands what to do and yet, in reality, be wrong about their understanding. This is what check-rides are for.

V. AWARD

1. Management did not prove that patient abuse occurred.

2. Management did not have just cause to remove the Grievant, but did have just cause for discipline.

3. The Grievant is to be reinstated to her former position with full back pay, seniority and benefits less two days pay. Her discipline record will reflect a 2-day suspension for a first offense of Neglect of Duty.

The Arbitrator retains jurisdiction for sixty (60) days to resolve any dispute in the implementation of this award.

Anna DuVal Smith, Ph.D.
Arbitrator

Cuyahoga County, Ohio
January 8, 2007

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