OCB Award No: 25

OCB Grievance No: 686-0476

Union: OCSEA/AFSCME

Department: MRDD

Arbitrator: Duda, Nicholas

Award Date: 87/3/6

IN THE MATTER OF ARBITRATION
UNDER THE 1986 CONTRACT

Between: The State of Ohio Department of Mental Retardation and Developmental Disabilities (Broadview Developmental Center) THE STATE -and- Ohio Civil Service Employees Association, Local 11 A.F.S.C.M.E., AFL-CIO THE UNION	OCB Grievance # G86-0476 ND 476 Grievant: Bruce Collyer

Before: NICHOLAS DUDA, JR., ARBITRATOR

OPINION AND AWARD

March 6, 1987

CASE DATA

SUBJECT

Termination (removal) for alleged "resident neglect".

APPEARANCES

FOR THE STATE

Barbara A. Serve', Assistant Attorney General, Presenting the Case

Mary Foltz, Employee Relations Specialist, Assisting

Robert Dively, Assistant Superintendent-Program Director, Broadview

Frances Marie Hellman, Hospital Aide

Peggy Jones, Supervisor of Hospital Aides

Sandra Clepper, Hospital Aide

John P. Fallon, Security Officer

Donna Johnson, Hospital Aide

FOR THE UNION

Daniel S. Smith, General Counsel, Presenting the Case

Myrl A. Lockett, AFSCME Staff Representative, Assisting

Bruce Collyer, Therapeutic Program worker (TPW), Grievant

BACKGROUND

Grievant was employed as a Therapeutic Program Worker at the Broadview Developmental Center. On August 18, 1986, Broadview's Superintendent gave him a removal order as follows:

> This will notify you that you are removed from the position of Therapeutic Program Worker effective August 20, 1986.

> The reason for this action is that you have been guilty of RESIDENT NEGLECT in the following particulars, to wit: On or about 6/23/86 you were assigned to assist in Cottage 288B. Sometime between 8:00 AM and 9:20 AM you left the clients unattended. You did not advise any staff that you were leaving the clients unattended, thus placing them in a life endangering situation.
>
> On or about 6/24/86 at approximately 11:20 AM one of your assigned clients was found unattended in the Canteen. You did not report that he was missing nor did you know that he was missing when he was returned to your classroom by the Police Department.
>
> This action follows Letter of Reprimand dated 3/31/83, 1 day suspension effective 1/10/84, 3 day suspension effective 6/13/84, 3 day suspension effective 1/8/85, 5 day suspension effective 6/6/85, 5 day suspension 6/11/86.

A written grievance was filed in Step 3 protesting the removal (termination). Specifically the grievance said, "I feel this [removal] is unfair and unjust". At the Step 3 hearing with the Department of Mental Retardation and Developmental Disabilities, the Union alleged violations of Sections 24.01, 24.04 and 24.05 of the Contract. The Department's Step 3 response included the following:

> Finding of Fact: June 23, 1986 incident. Mr Collyer was assigned to Cottage 288B on the morning of June 23, 1986 and he was to perform duties consistent with his classification of Therapeutic Program Worker. He reported to Cottage 288B and that he left Cottage 288B without authorization and he did not tell the Supervisor or anyone else he was leaving. Mr. Collyer was instructed to remain on the Cottage until another Staff member returned from the clinic with a client. There were two (2) staff on 288A for eleven (11) clients and one (1) Supervisor for both 288A and 288B. There was one (1) staff with Mr. Collyer on 288B for eight (8) clients but that staff had left with a client that had to be taken to the clinic. However, none of the staff on 288A nor the Supervisor was aware that Mr. Collyer had left the clients on 288B unattended.
>
> June 24, 1986 incident. A client assigned to Mr. Collyer left the classroom and was found in the canteen. The incident was reported to the Security Office by an employee on the canteen at approximately 11:20 a.m. That when the client was returned to Mr. Collyer's classroom he was not aware that the client was missing. Mr. Collyer did not document that the client left the classroom, nor did he notify the Education Office that the client was missing.

Conclusion: A review of the documentation and testimony presented do not support violation of Article 24, Sections 24.01, 24.04 or 24.05. However, the facts support that the discipline was for just cause. A review of the prior disciplinary record of this employee shows a Letter of Reprimand on 3/31/83, a one (1) day suspension effective 1/10/84, a three (3) day suspension effective 6/13/84, a three (3) day suspension effective 1/8/85, a five (5) day suspension effective 6/6/85 and a five (5) day suspension effective 6/11/86 which indicate a continuing disregard for the rules, regulations and policies of the Broadview Developmental Center. Therefore, the Removal was for just cause and consistent with the Contract.

This grievance is denied.

After that decision was affirmed by the State in Step 4, the Union appealed to arbitration.

POSITIONS OF THE PARTIES

THE STATE'S POSITION

OPENING STATEMENT

Issue:

Was the action of the Department of Mental Retardation & Developmental Disabilities (Broadview Developmental Center) in conformance with the collective bargaining agreement when it removed [Grievant] for just cause when the grievant allowed a client to go unsupervised and on another occasion when the grievant without permission left unattended 7 male patients.

Summary of Evidence:

Evidence that will be presented concerns two separate incidents, one on June 23 and the other on June 24, 1986. According to the testimony of a hospital aide, who was assigned to Ward 288(B), [Grievant] was asked to watch various residents. [Grievant] left the area without informing either the supervisor or other hospital aides assigned to an adjacent area. As a result, a client defecated on himself and smeared feces over parts of the dayroom area.

Evidence will also be presented by a security officer that on June 24, he was called to a canteen area and that an unescorted resident was present. The resident had been under [Grievant's] supervision and [Grievant] either did not know the resident was missing or did not report the resident missing.

Evidence will also be introduced as to the institutional policies that cover each of the above incidents.

THE UNION'S POSITION

The Grievant in this case was disciplined without just cause. The grievant is charged with commitment acts [on June 23 and 24, 1986] Neither act...are acts which should be cause for discipline.

The first act charged is that the Grievant left a cottage unattended....two hospital aides and one supervisor were present...Grievant left after notifying this supervisor, and...Grievant left for good reason - to perform his primary duties as a TPW.

The second act is that the Grievant permitted a resident under his care to go from the classroom...to the canteen. The facts will show that the resident, a chronic masturbator, was permitted to leave the classroom for that practice....was permitted to go from place to place unattended, and...if the resident went to the canteen...it is an act which cannot be faulted to the Grievant.

Consequently, the cause for discipline is not just, is not reasonable.

The discipline is even more unreasonable in light if the Grievant's past record. The [State] attempts to make the Grievant's past record to be lengthy and serious....Prior to July 1, 1986, no discipline less than a ten day suspension could be appealed to a neutral person or board with the authority to reverse the discipline. Secondly, the June 24, 1986 five day suspension reflected in the disciplinary order was modified...to a three day suspension. Lastly, the prior discipline is dissimilar to the basis of the Grievant's removal order.

The Union also contends that the pre-disciplinary hearing was not fair or objective because the Union was not given the opportunity to provide a meaningful defense for the Grievant because it was denied the right to call witnesses or question the evidence brought forth by the Employer.

RELEVANT LABOR AGREEMENT PROVISIONS

ARTICLE 24 - DISCIPLINE

24.01 - Standard

Disciplinary action shall not be imposed upon an employee except for just cause. The Employer has the burden of proof to establish just cause for any disciplinary action. In cases

involving termination, if the arbitrator finds that there has been an abuse of a patient or another in the care or custody of the State of Ohio, the arbitrator does not have authority to modify the termination of an employee committing such abuse.

24.05 - Imposition of Discipline

Disciplinary measures imposed shall be reasonable and commensurate with the offense and shall not be used solely for punishment.

BROADVIEW POLICY ON "ABUSE, NEGLECT AND EXPLOITATION" OF RESIDENTS

IV. DEFINITIONS

B. Neglect

The failure to provide care or services necessary to maintain the mental health, physical health and well-being of the resident. This refers to any situation in which the staff do not fulfill their responsibilities which in turn adversely affects the health, safety and well-being of the resident or the failure of a staff to act in a situation which may adversely affect the health and welfare of a resident. Examples of neglect include, but are not limited to the following:

1. Inadequate supervision of residents such as allowing a resident to wander off unsupervised , or failing to assist a resident who has injured himself/herself.

3. Leaving residents unattended while assigned to them including programmatic and direct care asignments, unless properly delegated.

9. Failure to look for a resident who is unaccounted for or report that a resident is missing.

IX. AUTHORITY: EFFECTIVE DATE

Approved by Executive Committee: July 22, 1986
Effective Date: July 22, 1986

STATEMENT OF THE ISSUE

Did the State have just cause to remove Grievant based on the incidents on June 23 and 24, 1986?

ANALYSIS

FINDINGS OF FACT

GENERAL

The Ohio Department of Mental Retardation and Developmental Disabilities operates a number of units one of which is Broadview Developmental Center, the the location of the events in this case. Broadview has an extensive physical plant including ten cottages in which the clients reside, a large educational building (Thorin) and several other buildings such as dispensary (clinic), etc. A staff of about 400 care for 200 resident clients. Most of the residents are significantly retarded. They require supervision and assistance for basic needs such as personal hygiene, grooming, feeding, and protection from unsafe conditions. Residents are also provided activities for recreation, education and occupational therapy by the educational staff.

Historically the care and educational programs had two primary sites - cottages and the Thorin building. In the morning Hospital Aides helped residents in toileting, grooming and feeding in the cottages. Then at about 9;00 a.m. or shortly thereafter the clients were transported by bus to Thorin where they were turned over to the Thorin building educational staff.

In the Spring of 1986 the Department was dissatisfied with services being rendered at Broadview. A new Assistant Superintendent - Program Director was appointed in March 1986. His specific mission was to improve the effectiveness and efficiency of the program and staff. He was given control of the 290 staff involved in the education and cottage care programs for residents. One of his immediate subordinates supervised the Hospital Aides who worked primarily in the cottages. Another subordinate, the Adult Training Coordinator, was responsible for activities at Thorin and supervised the entire staff in that building.

In May 1986 the Thorin staff consisted of Vocational Rehabilitation Counselors (5), Teachers (2), Teachers Aides (7), Therapeutic Program Workers (6), and Activity Therapists (12) for a total staff of 32 persons. All of the Thorin staff had been functioning essentially as teachers with little distinction among the jobs although the job descriptions were somewhat different. In the morning all residents were taken to Thorin at 9:00 a.m. for classes that began at about 9:15 a.m. After a break for lunch all clients resumed work in the classroom until about 3:30 in the afternoon when they were returned to the cottages presided over by Hospital Aides.

After several months of intensive evaluation of the program structure and staff utilization, the new Assistant Superintendent-Program Director submitted a five page typewritten proposal to the Superintendent for a "Half-Day Workshop Program: Planned Activities and Improved Staff Utilization". The document summarized the Program Director's findings that

> the current utilization of the Thorin building staff...totaling 32 is set up in a poor structure.... Due to the current format little direction is provided to this staff and the activities remain status quo. With full day Thorin classroom activities and mixing of residents of various cottages into large classrooms, there is a great deal of chaos which results from large classes, redundant activities and mass transportation....I would like to implement the following programatic stucture which will be implemented in two stages....
>
> I. The Thorin Building classrooms will be developed (overtime) into workshop production oriented - areas and into specialized programmatic space...residents will be scheduled for workshop production but will be rotated/scheduled into the various activities in these rooms.
>
> II. <u>Mornings</u>
>
> A. One-half of the Center's residents will be scheduled for morning workshop participation...
>
> B. At 8:00 a.m., all T.P.W.'s (6); T.A.'s (7); and Teachers (2) will report to the morning residents' cottages to assist in self-help training and transportation to the Thorin Building....All staff Hospital Aides and Thorin Building staff will report to the Thorin Building.

D. At 8:00 a.m., six, of the 12, Activity therapists will report to the Cottages [including Cottage 288] where residents have remained in the morning.

While Hospital Aide staff provide self-help training Activity Therapist will provide assistance and (more importantly) leisure skill program involvement....

All of these residents will generally eat lunch in the cottages. After lunch, these residents will be transported to the Thorin Building along with all Hospital Aides.

III. Afternoons

A. After lunch, the residents transported to the Thorin Building will participate in workshop programs and station activities. T.P.W.'s, teachers, T.A. and H.A.'s will provide this training.

B. Activity Therapist assigned to morning cottage responsibilities will transfer to Cottage areas where residents are located during the afternoon...

VI. I propose that the morning activity schedule be implemented June 2...and be run for one week...This will allow the residents a brief period of adjustment and give the Vocational Rehabilitation Counselors and me time to plan and adjust schedules....

According to the chart attached to the Program, at 8:00 a.m. twenty of the Thorin staff, including all 6 TPW's, were to go to five identified cottages whose residents would be transported to Thorin at 9:00 a.m. Also at 8:00 a.m. six of the Activity Therapists would be distributed among the five cottages whose clients remained in the cottages, including 288, until the afternoon session.

The Half-Day workshop proposal anticipated a number of major changes. A major long term goal was to have the Thorin staff eventually perform the same work as Aides in the cottages between 8;00 and 9:00 a.m. and between 3:30 and 4:30. Thus, the Thorin staff which had been actively working with residents only six hours per day at Thorin, would eventually work with residents another two hours performing the same duties as Aides in the cottages. However, the Program Director expected in the near term, such as

the first month, that the Thorin staff would only observe without performing duties with residents.

The Superintendent of Broadview approved the written proposal dated May 16, 1986. Thereafter the proposal was explained to the supervisors of Thorin staff and of Hospital Aides. In turn the various supervisors were supposed to explain the new program to the staff in separate meetings. The Hospital Aides, who had been functioning primarily in the cottages, were told by their supervisors that the Thorin Building staff who came to the cottages to work between the hours of 8:00 and 9:00 a.m. would participate with the Aides in all activities that the Aides performed during that hour and would then assist in transporting the residents to Thorin.

As indicated, Grievant was one of the six TPW's. According to the approved plan, all six TPW's were to report at 8:00 to one of five cottages whose clients were to be taken to the Thorin Building at about 9:00 a.m. At arbitration there was no explanation as to who instructed the TPW's in the new system or what specific assignments were made. The Program Director did testify that he had instucted the Thorin supervisors that TPW's as well as the other Thorin staff assigned to the cottages initially would only observe from 8:00 to 9:00 a.m. and then help move the clients to the classroom at 9:00 a.m.; staff was not to replace or perform the work of Aides initially.

Grievant recollects being assigned in early June 1986 "to observe but not to replace" Hospital Aides in cottage 285 or 286 from 8:00 a.m. until 9:00 a.m. when he accompanied clients from the cottage to Thorin. A few days after he began the new program he was suspended for five working days (June 11, 12, 13, 16, and 17, 1986) for alleged misconduct in May, 1986. (On October 23, after his August 18, 1986 removal, the State Personnel Board of Review determined the penalty "too harsh" and reduced the 5 day suspension to a 3 day suspension.)

Grievant returned from the suspension on June 18. Someone instructed him to observe at Cottage 288 every day for the period 8:00-9:00 a.m. beginning June 19, 1986. This assignment was not according to the written program because 288 residents were not to go to Thorin until the afternoon.

Cottage 288 has a central core of dining room, kitchen, laundry and activity room. A number of bedrooms and bathrooms are at both ends of the cottage. Both ends also have a dayroom between the central core rooms and the bedrooms. Immediately adjacent to each of the two dayrooms is a small office. The Aides call one end, "A-side" and the other end, "B-side". Across a narrow hall from the "B-side" dayroom is a larger office used by the Hospital Aide Supervisor who is responsible for aides in 288 and four other cottages.

The Hospital Aides Supervisor assigns each Aide in 288 to one of the sides but they understand that an Aide may be required to work on either side.

On the morning of the June 19th staff brought clients from cottage 285 to Grievant's classroom at 9:05 a.m. He did not appear at Thorin until 9:15 a.m., claiming he had been in cottage 288. He was reproached by a Vocational Rehabilitation Counselor for not having been at his classroom on time. She also submitted a written staff incident report suggesting that Grievant had failed to provide care or services as required thereby constituting neglect.

Grievant recollects that on the morning of the 20th he returned to cottage 288. He next was at 288 on Monday, June 23, 1986.

On June 23, 1986 three Hospital Aides were assigned to cottage 288. Two were assigned to "A-side" where 11 residents slept. The third was asigned to "B-side" which had eight residents. Sometime before 8:00 a.m. the Aide Supervisor gave instructions to the three aides in 288. The B-side Aide was told to take a resident to the Infirmary (clinic). All three Aides knew this should be done between 8:30 and 9:30 a.m., the established time period for

taking residents to the clinic.

Shortly after 8:00 a.m. Grievant entered 288 by using his master key (one of which is assigned to every staff person and is necessary to enter or leave a cottage and rooms within the cottage that are locked). Grievant spent five to ten minutes in the office adjacent to the A-side dayroom. Then an Aide asked him to leave the office so that she could make a private phone call. He went down the hall, past the kitchen and laundry into the B-side dayroom where he sat down.

A few minutes later the Aide assigned to the B-side said she was taking one of the residents, who was sitting in the dayroom, to the clinic. Grievant offered to take the resident for her but she declined his offer explaining that she had to speak with the doctor. She did not give any instruction to Grievant or request any action from him before she left with the resident. At that time, about 8:30 a.m., Grievant was watching television in the dayroom. Some of the other residents were also watching the TV. As she left the cottage the Aide told the other two Aides that she was leaving.

For the next half hour the second Aide was in the office adjacent to A-side dayroom. Briefly the third Aide was in A-side dayroom but most of the time she worked in the laundry and kitchen area in the central hallway which is about midway between the two dayrooms, no more than 20 feet from the B side dayroom.

Most of the time after 8:30 a.m. Grievant was watching television in the dayroom but he says he went briefly into a small locked office to make a phone call. At about 9:00 a.m. the Hospital Aide Supervisor entered 288 and walked down the hall. She made eye contact with Grievant who was sitting in the dayroom. Neither spoke. She entered her own office which was across a narrow hall about five feet from the B side dayroom. He could see her and she could see him.

There is a dispute as to what occurred next. Grievant claims he walked past the Aide in the A-side office saying "I'm going back to education" and proceeded to the exit where he discovered he did not have his key. He returned to B-side. When he looked through a glass window in a locked door he saw his key on the desk in the office he had used to make the phone call. Then he returned to the Aide in the A-side office to borrow her key, after explaining that he had locked his key in the other office. The Aide remembers this conversation and his return of the key a minute or two later but she does not remember his saying, as he claims, "I'm going back to Education" and then "see you tomorrow", when he returned the key.

All three Aides and the Aide Supervisor knew that Grievant was expected to be in his classroom shortly after 9:00 a.m. and no later than 9:15 a.m.

Shortly after 9:15 a.m. the Aide Supervisor came out of her office when she smelled feces. She found human feces on the B-side dayroom floor and furniture.

THE JUNE 24, 1986 INCIDENT

For each resident, the staff prepares and implements a long term written program designed to assist the resident in a major need.

One of the residents in Grievant's class was Thomas. The annual goal for Thomas' program is "To increase attention span to task by reducing time spent out of assigned classroom without permission". His program reflects that Thomas frequently leaves his classroom, sometimes without permission. These departures were primarily to a bathroom where he masturbated. The staff preferred that he not masturbate but if the classroom staff could not divert him when he wanted to masturbate, the Administration approved allowing him to leave for the bathroom. On these occassions Thomas was permitted to go to a bathroom around the corner from the classroom. If more than one staff was present in the classroom a staff would accompany him. If only one staff was

present Thomas was allowed to leave unattended to go to the bathroom. Usually he returned in 5-15 minutes. Sometimes he wandered away rather than return to the classroom. If Thomas did not return after 15 minutes, the TPW would call for someone to look for Thomas.

At other times Thomas was allowed in the hall without a staff attendant. For example, if he had visitors during the day he was allowed to walk alone from the classroom down the stairs and/or elevator to the vistors' section in the lobby.

The Adult Training Coordinator and Program Director believed that Grievant had not exercised enough influence on Thomas to reduce the frequency of the bathroom trips. There had been a controversy between Grievant and the Adult Training Coordinator because Grievant resisted the Coordinator's suggestion to discourage and deny Thomas permission to leave by using limited physical restraint. Grievant maintained that he had exercised as much initiative and ingenuity as possible to discourage Thomas' leaving but he was reluctant to use physical restraint because Thomas, who was quite strong, became upset and unmanageable when physical means were used .

At one point Grievant was told by the Training Coordinator not to allow Thomas to leave without someone accompanying him and to call Security or the Education Office if necessary. Grievant disagreed with that instruction and discussed it with the Program Director. He pointed out that Thomas frequently insisted on going to the bathroom when no other staff was present in the classroom; Grievant said he would comply with the order but he warned the Director that he would be calling several times a day. The Program Director said he did not want that. Their discussion recognized that Grievant could continue to allow Thomas to leave without an attendant if no other staff was in the classroom.

On June 24, 1986 Grievant was in his classroom with eight residents including Thomas. Although other staff may have been present in the room for a time, they had left before 11:00 AM in the morning.

Sometime after 11:00 AM Thomas left the classroom after communicating to Grievant by sign language that he was going to the bathroom to masturbate. Grievant acquiesced to Thomas' departure alone. About ten minutes later Thomas appeared in the canteen which is only three to four minutes walk through inside corridors from the classroom. Thomas did not make any disturbance in the canteen and peacefully accompanied the Supervisor who walked him back to the classroom.

A few minutes later a security officer appeared at the classroom. He asked Grievant if he knew Thomas had been out of the classroom. Grievant said he had let Thomas go to the bathroom. The guard asked Grievant to fill out a written security investigation report about the matter. Grievant explained that he had eight residents to supervise and he did not want to take time away from his classroom duties to make out the report. As stated in the security person's report, "When I asked [Grievant] to make a statement he said he would not at this time, but if I gave him the form he would take it home overnight and fill it out..[Grievant] did not notify the education office at any time that his client was missing....It appears to this officer that [Grievant] was unaware that his client was in the canteen or missing until the client was returned to his room."

EVALUATION

GENERAL

At arbitration the State asserted that Grievant's conduct on June 23 and June 24, 1986 were violations of Section IV-B "Neglect" of Broadview's policy concerning "Abuse, Neglect and Exploitation" of resident clients. The State

submitted that policy as State Exhibit C. To the State, Grievant's conduct on June 23, 1986 violated Subsection IV-B-3 and his conduct on June 24, 1986 violated Subsections B-1 and/or B-9. Application of those subsections to the facts in this case is neither germane nor appropriate for several reasons. First those specific contentions were not stated as the basis for the removal on August 18, 1986. More important, the policy cited was not approved until July 22, 1986 and was not retroactively effective.

Whether Grievant was guilty of "resident neglect" depends on whether events occurred as the "particulars" stated on the removal notice dated August 18, 1986 and if so whether they constituted just cause for removal. The State has the burden of establishing that the facts constituting the violation occurred, and that the standard of conduct to which Grievant was held was reasonable.

The two incidents will be considered sequentially.

THE INCIDENT ON JUNE 23, 1986

According to the State "on or about June 23, 1986, you were assigned to assist in cottage 288B. Sometime between 8 AM and 9:20 AM you left the clients unattended. You did not advise any staff that you were leaving the clients unattended thus placing them in a life endangering situation". The Step 3 answer said Grievant "was assigned to cottage 288B...to perform duties consistent with his classification...he left cottage 288B without authorization and he did not tell the Supervisor or anyone else that he was leaving. [Grievant] was instructed to remain on (sic) the cottage until another staff member returned from the clinic..."

The State's argument is that Grievant was given a duty to provide care to residents until the 288B aide returned or the Grievant gave someone notice that he was leaving. However, the evidence does not show that anyone had made

such an assignment to Grievant. The approved program did not provide for any TPW to be in 288, whose clients were in the afternoon session. Furthermore, the Program Director who developed and implemented the program intended, according to his testimony, for Grievant to be assigned to 288, not specifically to 288B, for the limited purpose of observing and becoming familiar with care rendered by Aides.

One 288 Aide testified she did not know why Grievant was present in the cottage. The other two aides believed Grievant was present to participate in providing client care. Their belief was based on information received from their supervisor. That information concerned a possible future assignment, not the contemporary assignment of Thorin staff.

None of the Aides even attempted to assign Grievant to patient care. Only once was there a conversation between Grievant and an Aide about any aspect of patient care. That occurred when the B-side Aide announced that she planned to take a resident to the clinic. Grievant offered to substitute for her. Because of her misunderstanding about Grievant's assignment, she inferred that he was attempting to change his assignment from resident care in the cottage to the clinic. When she rejected his offer, she assumed he would care for residents in the cottage. That was neither his assignment nor his intention. To Grievant, her refusal of his offer merely meant he would continue to observe care, if any, by the remaining Aides, but he would not provide care himself.

Given the information she had been told, the Aide's incorrect assumption is understandable. It also clarifies why she did not initiate any specific discussion with him about his activities during her absence.

For the foregoing reasons, the Arbitrator finds that the evidence does not show that Grievant was "assigned to assist in cottage 288B" by attending or providing care to residents, or that he had been "instructed to remain on

(sic) the cottage until another staff member returned from the clinic".

In the absence of the claimed duty, there cannot be just cause for removal in connection with the June 23, 1987 incident. However, even if the evidence had established the duty, the State also had the burden of showing a violation of the duty, viz. Grievant "did not advise any staff that [he was] leaving the clients unattended," and "left cottage 288B without authorization."

Grievant says he exchanged verbal communications with one of the A-side Aides four times. She remembers only three. In the first exchange, at about 8:15-8:30 a.m., she asked him to leave the A-side office.

He testified that the second occurred at about 9:05 a.m. when he told her, as she worked in the office, that he was going to "education". She does not remember this communication.

He says he returned after a minute or so to borrow her master key which he returned after another minute or two. She remembers the two contacts about the key. Both Grievant and the Aide seemed to testify honestly and credibly. She does not remember the second communication he claims, but is not certain it did not occur as he contends. There is no reason to refuse to honor his version.

If their versions directly conflicted, so that she absolutely denied that he had said he was leaving, the Arbitrator probably would not be convinced that Grievant had made the announcement. However, Grievant does not have the burden of showing that he did announce that he was leaving. Here the State claimed Grievant "did not advise any staff that [he was] leaving". The State had the burden to show clearly and convincingly that he did not do so; the State did not meet that burden.

The Aide Staff and Supervisor knew that Grievant should leave around 9:00 a.m. to be at Thorin no later than 9:15 a.m. Just two work days earlier he had been severely criticized and made the object of a staff incident report claiming negligence because he had not been at his classroom when clients were brought in at 9:05. He was not only "authorized" to leave before 9:15 a.m., he had been ordered to do so.

All three Aides and the Supervisor knew that the B-side Aide probably would not return from the clinic until after 9:00 AM as had occurred many times before in such situations. Normally the other Aides assumed responsibiity for the entire cottage when the B-side Aide left. The Aides had misleading information about Grievant's assignment in the cottage, partly explaining why they did not believe the A-side Aides were responsible, in accordance with normal practice, to provide care in B-side, after the B-side Aide left. Grievant was not responsible for their misinformation.

Even in the absence of express instructions to care for residents a staff person may have a duty because of apparent dangerous circumstances to care for residents. Did such a duty arise here?

From Grievant's observation, there was no requirement that a staff sit in the dayroom at all times. Quite the contrary. On the very day these events occurred no staff was with the residents in the dayroom on A-side for substantial time periods. Specifically for the period 8:30 AM to 9:15 AM one Aide was in the office and the other Aide was working between the laundry and kitchen.

Grievant was aware that three Aides were assigned to 288 to supervise a group of residents, having bedrooms at one end or the other of the building. There was no showing that Grievant had been made aware that the Aides divided up responsibility in any way between the two sides. One Aide left with one of the residents as often happened. Hospital Aides were still in attendance.

And then their supervisor appeared and remained.

The Aide Supervisor was in an office immediately adjacent to the B-side dayroom. She also knew that Grievant was supposed to be at his classroom within five minutes after she appeared. Relations between those two staff were not good. They did not talk, probably due in part because a few weeks earlier Grievant had submitted an staff incident report about her conduct.

At least one Aide and the Supervisor were within a few feet of the residents in B-side. Under these circumstances, from Grievant's perspective, his departure in compliance with his assignment did not place the B-side residents "in a life endangering situation".

In summary, there is no showing that Grievant was assigned to assist in providing care in cottage 288B. Furthermore the circumstances were not such as to create a duty for Grievant to remain in the cottage after 9:00 a.m. nor was it apparent that his departure created a "life endangering situation". Even if there was a duty, there is no showing of a violation. The State has not shown that Grievant left without announcing his intention to staff. There is no basis for not believing his account, which he told very persuasively despite extensive examination by counsel and the Arbitrator. There is no showing of any act of commission or ommission by Grievant on June 23, 1986 which was just cause for removal.

THE INCIDENT ON JUNE 24, 1986

The removal notice said

> On or about 6/24/86 at approximately 11:20 AM one of your assigned clients was found unattended in the Canteen. You did not report that he was missing nor did you know that he was missing when he was returned to your classroom by the Police Department.

It is true that Thomas was found unattended substantially away from his classroom. Given the nature of the establishment (and of ~~the clients)~~ that fact raises a question as to whether Grievant had exercised ~~adequate~~

supervision. It may even create a presumption that he did not. However, it is not irrefutable proof of malfeasance or ~~nonfeasance by Grievant. At most~~ there is a presumption of inadequacy or impropriety, but the presumption is rebuttable by sufficient evidence to the contrary.

There was no rule that Thomas could not be left unattended. According to his undesputed testimony, Grievant had been recently assured that he continued to have authority to permit Thomas to go unattended to the bathroom if another staff was not present in the classroom.

Grievant's clear credible testimony was that he gave Thomas permission to leave on June 24, 1986. ~~He had such~~ authority under the circumstances in effect that morning.

On June 24 Thomas went to a location ~~beyond his permission. He did~~ not engage in conduct threatening to himself or others. As requested, he quietly accompanied a supervisor back to the classroom.

Whenever a resident is given ~~permission to leave without an attendant~~, there is a risk he may go where he is not authorized. In the past Thomas had sometimes gone to a place other than intended when he was permitted to leave without an attendant. Such occurrences did not result in a prohibition against allowing him to leave without an attendant or a requirement to call for help immediately if he did leave without an attendant.

There is no showing that Thomas was absent longer than he regularly was under the circumstances in effect that morning. Thus Grievant was not remiss in not reporting Thomas "missing". Under these circumstances the incident on June 24, 1986 does not constitute "resident neglect" and therefore is not just cause for removal.

CONCLUSION

In view of the findings above that the State has not established "resident neglect" constituting the just cause required by Section 24.01 of the contract, there is not need to consider the Union's objections based on Subsections 24.04 and 24.05.

AWARD

There is no showing by clear and convincing evidence of just cause for removal. Therefore, the grievance is sustained.

The State and the Department of Mental Retardation and Developmental Disabilities are directed to rescind the August 18, 1986 removal notice and return Grievant forthwith to his position of Therapeutic Program Worker at Broadview Developmental Center without any break in seniority and continuous service. Furthermore the State and Department are ordered to make Grievant whole for any lost wages and benefits he suffered in the period August 18, 1986 until the date he is offered re-employment.

Nicholas Duda, Jr., Arbitrator