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Gene, Tom, et. al
Another post-Dunning modification - in which the arbitrator finds "negligence" but not abuse.
Jack

#188

June 6, 1988

Mr. Jack Burgess
Chief of Arbitration Services
Ohio Department of Administrative Services
Office of Collective Bargaining
65 East State Street, 16th Floor
Columbus, Ohio 43215

Daniel Scott Smith, Esq.
Legal Counsel
OCSEA
995 Goodale Boulevard
Columbus, Ohio 43212

Re: In the Matter of the Arbitration between State of Ohio, Department of Mental Retardation and Developmental Disabilities
Facility: Gallipolis Developmental Center
Grievant: Roger L. Broyles

Dear Mr. Burgess and Mr. Smith:

Enclosed is a copy of the decision and award in the above captioned matter. Also enclosed is a copy of the bill for arbitral services rendered.

Very truly yours,

HYMAN COHEN

HC/cb
Enc.

cc: Mr. Ed Ostrowski
Department of Mental Retardation
Office of Labor Relations
Suite 1020 30 E. Broad Street
Columbus, Ohio 43215

Mr. Robert Goheen
Staff Representative
Ohio Civil Service Employees Association
995 Goodale Boulevad
Columbus, Ohio 43212

VOLUNTARY ARBITRATION

In the Matter of the Arbitration

-between-

STATE OF OHIO, DEPARTMENT OF
MENTAL RETARDATION AND
DEVELOPMENTAL DISABILITIES
FACILITY: GALLIPOLIS
DEVELOPMENTAL CENTER

ARBITRATOR'S OPINION
GRIEVANT: Roger L. Broyles

-and-

OHIO CIVIL SERVICE EMPLOYEES
ASSOCIATION, LOCAL 11, AFSCME, AFL-CIO

FOR THE STATE: ED OSTROWSKI
Department of Mental Retardation
Office of Labor Relations
Suite 1020 - 30 E. Broad Street
Columbus, Ohio 43215

FOR THE UNION: ROBERT GOHEEN
Staff Representative
Ohio Civil Service Employees
Association, 995 Goodale Boulevard
Columbus, Ohio 43212

DATES OF THE HEARING: March 16, 1988; April 1, 1988

PLACE OF THE HEARING: Ohio Department of Administrative Services,
Office of Collective Bargaining
65 East State Street, 16th Floor
Columbus, Ohio

Department of Transportation
37 W. Broad Street, Columbus, Ohio

ARBITRATOR: HYMAN COHEN, Esq.,
Impartial Arbitrator
Office and P. O. Address:
2565 Charney Road
University Heights, Ohio 44118
Telephone: 216-371-2118

* * * * *

The hearing was held on March 16, 1988 and April 21, 1988 at the Office of Collective Bargaining and Department of Transportation, Columbus, Ohio, before **HYMAN COHEN**, Esq., the Impartial Arbitrator selected by the parties.

The hearing began at 10:00 a.m. and was concluded at 4:45 a.m. on March 16, 1988; and began at 9:30 a.m. and was concluded at 1:45 p.m. on April 1, 1988.

* * * * *

Effective June, 1987, **ROGER L. BROYLES** was discharged by the Gallipolis Developmental Center "(GDC") which is a facility operated by the **OHIO DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES,** the **"State"**. In its Order of Removal which was sent to the Grievant on or about June 18, 1987 the State indicated that the reasons for its action were that he had been found guilty of "resident abuse and neglect and/or the neglect of duty and/or failure of good behavior". As a result of his discharge the Grievant filed a grievance with the State on June 22 protesting his discharge. Since the grievance was not resolved at the various levels of the grievance procedure contained in the Agreement between the State and the **OHIO CIVIL SERVICE EMPLOYEES ASSOCIATION, LOCAL 11, AFSCME,** the **"Union"**, the grievance was carried to arbitration.

FACTUAL DISCUSSION

The Grievant had been employed as a Hospital Aide for the GDC for a period of ten (10) years. The Center is licensed to house three hundred (300) individuals who suffer from a profound level of retardation. The overall purpose of the facility is to provide an education to its residents "in the least restrictive environment that is possible based upon individual plans". As Rose Ramos, Program

Director and Assistant Superintendent of the GDC stated, the facility is a "more restrictive environment than the community can afford".

EVENTS OF APRIL 22, 1987

On April 22, 1987 the Grievant worked the third shift [between 11:00 p.m. to 7:00 a.m.] on the second floor of Building 6049, also known as 49-2, of the GDC. Gerry Rothgeb who was also a Hospital Aide worked the same shift on the same floor with the Grievant.There were seventeen (17) mentally retarded residents who resided on the second floor during the day in question. Residential care is provided for sixty-nine (69) residents who are housed in the building. Building 6049 consists of five (5) floors. Male residents are located on the second, fouth and fifth floors. Female residents are on the third floor.

STATE'S VERSION:

On April 22, 1987, Nancy Altizer was the Supervisor in Building 6049. Altizer, the Residential Care Supervisor, was filling in for another Supervisor who was on duty.

During the evening of April 21 or early into April 22 Altizer

received a telephone call from Myron "Neibert", an employee on 49-3, that "there was a male on the third floor who did not belong there". Altizer called the various floors and eventually asked if any of the residents on the floor were missing. Rothgeb told her that there was a resident missing and the Grievant went to get him.

Altizer went to 49-3 and after talking to Neibert she went down the exit stairs and was unable to open the door that led to 49-2. Altizer returned to the third floor and called the telephone operator to tell her that she could not get the exit door open on 49-2. She instructed the telephone operator to get in touch with a police officer so that the door could be opened.

Altizer then reached the second floor by using the elevator. She met Don James, a Police Sergeant, and both of them "walked back through the corridor". She indicated that the Grievant and Rothgeb were sitting in the dayroom; the lights were off and the television set was on. Altizer indicated to them that she was having "problems with your exit door". According to Altizer the Grievant said, "He had wired the door shut". Altizer said "it came as a surprise" to her and "it was not routine". Altizer went on to testify that James said, "it was against Medicaid Policy and the Fire and Safety Codes and if they came to the building, we would be closed down". Altizer talked to

Rothgeb and said "he (the Grievant) should know better than that and she (Rothgeb) said, "I thought so too". Altizer testified that the Grievant told her that he "locked the door to keep Resident "X" in". She indicated that she did not know when resident "X" was asleep; however, the staff "told her that he was asleep at the time that she was on the second floor when she talked to the Grievant and Rothgeb." At the time of the events it was approximately 1:18 a.m. on April 22, 1987.

UNION'S VERSION:

The Grievant said about 11:30 p.m. he received a telephone call from a person, whose name he did not recall "saying that he had one (1) of my residents". The Grievant called the Supervisor that evening and disclosed the name of the resident and she told him that he had a resident on his floor with that name. At this point it should be noted that the Grievant was off for two (2) days before the evening in question. "X", was "a direct admission" on April 21 and it was the first night that he was at the GDC facility. When the Grievant found out that his resident had left his floor, he went upstairs and brought "X" back to his room and watched him get into his bed. Shortly thereafter, "X" tried to leave the second floor three (3) or four (4) times. The Grievant said that he "had to do something" about the

situation so he fastened the door shut with wire that is normally used as a clothes hanger. He first wired the door shut around 12:45 a.m. After wiring the door shut, "X" attempted to leave through the exit door two (2) times. On one (1) occasion the Grievant heard "X" attempt to undo the wire which was looped and wrapped around a railing. The Grievant said that he wanted to slow "X" down before he got into the stairwell. He added that he could not keep an eye on his other residents and he was unable to accomplish his duties because of the number of times that "X" attempted to leave the floor.

Meanwhile, the Grievant said that he showed Rothgeb "the ropes". They mopped the floors, folden linen and washed clothes. When Altizer and James showed up, the Grievant ststed that he was sitting with Rothgeb folding linen .

Rothgeb testified that the evening of April 21 and 22, 1987 was her first evening on the second floor of Building 6049. She knew that the door was wired shut to keep "X" from going out and leaving. She stated that "X" tried to leave the area three (3) or four (4) times and that he had left once but that was before the door was wired. She testified that after the door was wired, "X" tried to leave the floor two (2) or three (3) times. She testified that she could hear the wire rattling on the door which she heard from the laundry room. On one (1)

of the occasions that "X" attempted to leave the unit, he "knocked the wire off" and the Grievant replaced the wire and took Patient "X" back to his room. During this period of time both Rothgeb and the Grievant continued to fold linen and do laundry while standing in the dayroom.

Rothgeb said that she knew the Grievant had wired the door shut inasmuch as she saw him put the wire on the door. She observed the Grievant wiring the door from the dayroom.

EVENTS AFTER APRIL 22, 1987

On May 7, 1987 Charles R. McCormick, Administrative Assistant, notified the Grievant that a Pre-Disciplinary conference would be held on May 12, 1987 because the Suterintendent "is considering suspending or removing" the Grievant. The basis for this action was set forth as follows:

Resident Abuse and Neglect

> It is alleged that on or about April 22, 1987 you wired shut the door that leads into 6049-2 from the rear stairway."

A Pre-Disciplinary Conference was held on May 12, after which McCormick sent a memorandum dated May 12, 1987 to Pamela K. Matura, Superintendent, which in effect stated that since all of the residents were asleep, they had been placed "in grave danger if a fire had broken out on that floor which is the second floor of a five story older building". In light of the Grievant's past disciplinary record which included sleeping on duty on two (2) different occasions, McCormick recommended removal of the Grievant from the postion of Hospital Aide.

On June 2, 1987 Bettilu Goolden, Personnel Director, sent a memorandum to Paul Guthrie, Personnel Director of the Ohio Department of Mental Retardation and Developmental Disabilities in which she attached information on the incident of April 22, 1987 concerning the Grievant, stating that: "We are perceiving this incident of wiring the door shut * * as an extremely serious incident" and that "approximately 100 people could have been seriously injured or killed". Goolden sought the concurrence of Guthrie with regard to the request for the removal of the Grievant.

The instant grievance was filed on June 22, 1987. A third step hearing was held on July 22, 1987 before Mike J. Fuscardo, Labor Relations Coordinator. The grievance was denied and Fuscardo

concluded that he found it "incredible that a 10 year employee thought it was 'O.K.' to wire a fire door shut and thereby [place] the safety of approximately 17 residents in danger not to speak of other residents and staff in the building at the time." Fuscardo concluded that in light of the Grievant's disciplinary history, and considering the facts of April 22, 1987 and seriousness of the offense which in and of itself, warranted removal, the grievance was denied.

DISCUSSION

The parties stipulated that the issue to be resolved by the Arbitrator is whether the Grievant was discharged for just cause; if not, what is the remedy to be awarded.

Based upon the testimony of the witnesses there is no dispute as to events which occurred during the evening and early morning hours of April 21, and 22, 1987. The Grievant used a wire clothes hanger to wire a fire exit door shut at approximately 1:00 a.m. during the morning of April 22, 1987. He did so to keep "X", a new resident, from leaving the floor (49-2). "X" had left the unit earlier that evening and was returned to his room by the Grievant. Thereafter he made several unsuccessful attempts to leave the floor.

I.

a. "ABUSE OF A RESIDENT

The Union claims that the State's charge of "abuse of the resident" by the Grievant, in effect, is not supported by the evidence. At no time during the process leading to the discharge of the Grievant and during the procedure subsequent to discharge did the State refer to Article 24, Section 24.01 of the Agreement, which refers to the offense of "abuse of a patient". Section 24.01 provides as follows:

"ARTICLE 24- DISCIPLINE

Section 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."

Since the parties have addressed the specific offense of "abuse

of a patient" or a "resident" in Section 24.01 of their Agreement, the terms contained in the Section are of great weight in considering the actions of the Grievant during the evening in question. The parties obtained a ruling on the "inherent linkage between the definition of the term 'abuse' and the language contained in Seciton 24.01" in the arbitration decision and award of *Ohio Department of Mental Retardation and Dvelopmental Disabilities v. OCSEA/AFSCME* Grievance No. G 87-0001 (A), (Pincus, March 11, 1988). Since the Grievant was Juliette Dunning, the decision will be referrred to as the "Dunning decision". In his interpretation of Section 24.01, Arbitrator Pincus indicated that the Section "contains an explicit just cause requirement for any disciplinary action." (Emphasis added) . He then stated:

> "* * *The sentence that follows does not modify but supplements the previous sentence. Thus, a determination that an abuse has been committed does not automatically guarantee that termination is the appropriate penalty. In other words, the Employer must establish that it had just cause to undertake the termination before it can allege that an arbitrator does not have the authority to modify a penalty. The purpose of this provision is to prevent an arbitrator from holding that an

> employee was terminated for proper cause on the basis of certain misconduct, but that termination for such misconduct should be reduced [17]". At page 38.

Footnote 17 refers to the decision of *Jones and Laughlin Steel Corp.*, 46 LA 187 (Sherman, 1966). I have carefully read the *Jones and Laughlin Steel* decision and find that it does not support Arbitrator Pincus' statement that "the purpose of this provision" of Section 24.01 (depriving the arbitrator of the authority to modify termination) is to prevent an arbitrator from holding that an employee was terminated for proper cause on the basis of certain misconduct, but that termination for such misconduct should be reduced". In *Jones and Laughlin Steel* the Grievant was suspended for ten (10) days which included three (3) days for participating in a walkout and seven (7) days for "inducing others to walk out". The Arbitrator found that the Grievant participated in the walkout but was "not guilty of the additional offense of inducing employees to walk out". Thus, the Employer had no cause to suspend the Grievant for the latter offense. The contractual clause in *Jones & Laughlin Steel* provided for depriving the Arbitrator of "jurisdiciton to modify the discipline" imposed by the Employer where the Arbitrator has determined that the employee has been suspended or discharged for cause. By concluding that the Employer was justified in imposing the three (3) day suspension, but not the ten (10) day suspension, the Arbitrator

stated in effect, that he was authorized to modify the degree of discipline imposed, inasmuch as the Employer "had no cause to suspend" the Grievant for "inducing others to walk out". At page 491.

In any event, there is no need to consider the "linkage" between the definition of "abuse" and the standard of just cause in the decision and award rendered on October 31, 1987 because the evidence warrants the conclusion that the State failed to prove that the Grievant committed "abuse" of "X" and that the Grievant was discharged for "just cause".

b. DUNNING DECISION

The parties failed to define the term "abuse" in Section 24.01 of the Agreement. In the *Dunning* decision, the parties mutually agreed that the award addressing the definition of the term "abuse" in Section 24.01 "would have statewide application and would not be limited to the Department of Mental Retardation and Developmental Disabilities". In his award, Arbitrator Pincus, in relevant part, stated:

> "For the purposes of the Department of Mental Health and the Department of Mental Retardation and

> Developmental Disabilities, the Parties shall be subject to the definition of [sic] above contained in Ohio Revised Code Section 2903.33 (B) (2) and their respective Ohio Administrative Code Sections, that is, either Section 5123-3-14 (C) (1) or 5122-3-14 (C) (1) * *". At page 39.

In light of the award in the *Dunning* decision, I have concluded that the Grievant did not "abuse" the residents on 49-2 during the early morning of April 22, 1987 within the meaning of O.R.C. Section 2903.33 [the Penal Code], which provides as follows:

> "* *[A]buse" means knowingly causing physical harm or recklessly causing physical harm to a person by physical contact with the person or by inappropriate use of physical or chemical restraint, medication or isolation of the person".

By wiring an exit door shut on 49-2, the Grievant did not "knowlingly [cause] physical harm or recklessly [cause] physical harm" to any of the residents on 49-2 by physical contact with them. Nor did the Grievant use "physical or chemical restraint, medication" or isolate the residents within the meaning of O.R.C. 2903.33.

Contesting the definition of "abuse" contained in O.R.C. 2903.33 in the *Dunning* decision, the State claimed that the definition contained in the Ohio Administrative Code, Section 5123-3-14 (C) (1) should apply to the term "abuse" contained in Section 21.04. The definition of "abuse" in the Ohio Administrative Code Section 5123-3-14 (C) (1) provides as follows:

> "ABUSE" MEANS ANY ACT OR ABSENCE OR ACTION INCONSISTENT WITH HUMAN RIGHTS WHICH RESULTS OR COULD RESULT IN PHYSICAL INJURY TO A CLIENT, EXCEPT IF THE ACT IS DONE IN SELF-DEFENSE OR OCCURS BY ACCIDENT; ANY ACT WHICH CONSTITUTES SEXUAL ACTIVITY, AS DEFINED UNDER CHAPTER 1907. OF THE REVISED CODE, WHERE SUCH ACTIVITY WOULD CONSTITUTES AN OFFENSE AGAINST A CLIENT UNDER THAT CHAPTER; INSULTING OR COARSE LANGUAGE OR GESTURES DIRECTED TOWARD A CLIENT WHICH SUBJECTS THE CLIENT TO HUMILIATION OR DEGRADATION; OR DEPRIVING A CLIENT OR REAL OR PERSONAL PROPERTY BY FRAUDULENT OR ILLEGAL MEANS."

If there are terms in Ohio Administrative Code, Section 5123-3-14 (C) (1) which would arguably be applied to the Grievant's conduct on April 22, the terms are "* * any act * * inconsistent with

human rights which * * could result in physical injury to a client * *." I would agree that the wiring of the exit door by the Grievant could have resulted in physical injuries to the residents located on 49-2, had a fire occurred. However, the evidence does not warrant the conclusion that the Grievant's act of wiring the exit door is "inconsistent with human rights" as provided in Ohio Administrative Code, Seciton 5123-3-14 (C) (1). This leads me to consider the conduct of the Grievant on April 22, 1987.

c. Purpose of Wiring Door Shut

The evidence supports the Grievant's statement that he wired the exit door shut because he wanted to prevent "X" from leaving the floor. He also wanted to slow "X" down "before he got into the stairwell". "X" had done so on one (1) occasion and had made several unsuccessful efforts to leave 49-2. As I shall establish further in my decision, the evidence supports the conclusion that the Grievant had never been told that he could not wire the door shut and that he was never advised that wiring a door shut violated the Medicaid Rules and Regulations and State Fire and Safety Codes.

Because of X's prior attempts to leave the floor, the Grievant indicated that he could not keep an eye on the other residents and he

could not accomplish the duties that he was normally required to perform. Had "X" left the floor and sustained injury the Grievant indicated that he would have been charged with neglect of duty.

I have concluded that the Grievant committed an error of judgment in wiring the exit door shut. In fact, what is most disturbing is the manner in which the Grievant wired the door shut. He used a wire hanger to do so. There is nothing in the record to indicate that the manipulation of a wire hanger to wire an exit door shut to prevent a patient from leaving a floor, is within the reasonable scope of duties of a Hospital Aide. For the Grievant to do so constitutes an unwise act which apparently suited his convenience. It lacked, among other things, good sense. I would agree that he was distracted by X's attempts to leave the floor and the performance of his customary duties were impeded by X's persistence in attempting to leave. Wiring the door shut was one (1) of several choices available to the Grievant. As Altizer indicated, he could have called her to ask her for advice but he failed to do so. Or, he and Rothgeb could have "kept close supervision" of "X". By "close supervision" Altizer said that the Grievant and Rothgeb could have utilized "visual contact" of the Grievant. In any event the Grievant chose to manipulate a wire hanger in order to fasten the exit door shut. In light of the Grievant's purpose in wiring the door shut, and the jeopardy that the residents

on 49-2 could have been placed in, had a fire occurred, at most, there is a tenuous connnection with the term "abuse" as an act contrary to human rights, within the meaning of Ohio Administrative Code Section 5123-3-14 (C) (1). I do not believe it is reasonable to characterize the Grievant's conduct as conduct "inconsistent with human rights". It is inconsistent with the standard of reasonableness, which is an entirely different matter than being "inconsistent with human rights". Had the Grievant been instructed that exit doors were not to be shut because it would imperil residents, if a fire took place, it would arguably provide the necessary element to bring the Grievant's conduct within the meaning of Ohio Administrative Code, Section 5123-3-14 (C). I, therefore, turn to the issue of whether the Grievant was ever instructed or advised never to fasten the exit door shut.

d. Failure to Notify the Grievant on Tying a Door Shut

There was an abundance of testimony on the question of whether the Grievant was instructed on not tying an exit door shut because of the potential peril to the residents. There is no qustion but that as part of his orientation, the Grievant received a "Facility Policy Manual" and "Fire Emergency Procedures". Furthermore, in April, 1987 the Grievant received a GDC "Unit II Procedure Manual". The Manual does not indicate that an exit door is never to be fastened

shut. Gwen Fisher, a registered Nurse, and the Health and Safety Officer provided testimony on a *"Code for Safety to Life from Fire in Buildings and Structures"* adopted by the National Fire Protection Association. One of the provisions states that "no lock * * or other device * * shall be installed or maintained at any time on * * any door on which panic hardware is required by this Code if such device prevents or is intended to prevent the free use of the door for purposes of egress".

There are also provisions of the Code on *"New Health Care Occupancies"* which indicates that doors can be locked provided that occupants are rapidly removed by the use of "remote control of locks or by keying all locks to keys readily available to staff who are in constant attendance". Fisher said that such door locking arrangements are followed on 49-3, 49-4 and 49-5. However, Fisher indicated that the Code was not given to employees "but was available on campus". That the Code was "available on campus" does not translate into knowledge by the Grievant that he was aware of the Code's provisions. Moreover, there is no evidence to indicate that the Grievant was required to read the Code. Fisher said that fire drills are conducted on each shift. The floor, 49-2 has three (3) fire drills each month. Fisher did not disclose that as part of the fire drill, the Grievant or other employees are instructed never to fasten an exit

door shut.

Fisher provided testimony on fire school classes, at which she provides instruction and training. The staff and employees are required to attend one (1) fire school class each year. A written agenda and supporting documentation on the materials that are covered in the fire school classes was submitted by the State as part of the evidentiary record. The documentation does not refer to the tying or fastening of doors shut. Broyles indicated that in the fire school classes, instruction and training covers such areas as "how to put out trash can fires, the application of tourniquets, "CPR", how to use a fire hose and a few other things". He recalled that the subject of "doors" had been mentioned in his fire school classes. He elaborated, by stating that they were instructed not to block a fire door open because air "adds fuel to the fire". Rothgeb also provided testimony on the fire school classes. She said that fire school classes included instruction on the use of various "types of extinguishers", "how to put a fire out in a can", and there were "quizzes given on the things that were gone over in class".

Rothgeb indicated that in fire school classes, she has not "heard anything about wiring a door shut". Fisher said that "some employees have asked to wire the door shut" in the classes and we

have said "no". She went on to state that in twenty (20) classes each year, she "is fairly certain" that they are instructed "not to do that" ("wire the door shut"). On cross-examination, Fisher said that she did not remember if the Grievant was in the class when a question was asked about locking the door. Asked on cross-examination, why the witnesses testifying on behalf of the Union denied that there was any instruction on not wiring fire doors shut, Fisher said that they attend one (1) class each year; and she "might have forgotten" to include it in her instruction, "but in the other 20, 21 classes she may have remembered talking about the locking of doors". Fisher also indicated that "it may have been that [the Grievant] did not get instruction on not fixing doors shut or closed".

Based upon the evidence I cannot conclude that the Grievant was ever instructed in the Fire School Classes not to fasten exit doors shut; moreover, there is nothing in the written documents that the Grievant received, concerning safety, that exit doors were not to be fastened shut.

Ramos indicated that unannounced inspections are performed concerning Medicaid financing. During these inspections, safety is evaluated. She said that the facility can be decertified if there is a violation of a major safety code violation. Ramos said that if an exit

door is wired shut, it could put the facility "in a fast track" "and the facility can be decertified quickly".

There is nothing in the record to indicate that the Grievant was instructed or advised that he committed a major safety code violation when he fastened the door shut. Furthermore, he was not aware, as Ramos indicated, that his actions would lead to the decertification of the facility by Medicaid.

e. Rules Must Be Reasonable, Consistently Applied and Widely Disseminated

In their well recognized treatise, *How Arbitration Works*, Fourth Edition (BNA, 1985), Elkouri and Elkouri stated the following:

> "It has been reported, on the basis of examining over 1,000 discharge cases, that one of the two most commonly recognized principles in arbitration of such cases is that there must be reasonable rules or standards, consistently applied and enforced and widely disseminated". At page 682.

In order for a Rule to be considered reasonable, at a minimum, an employee should know that certain conduct fails to conform to the Rule, and thus constitutes a violation of the Rule. In this connection,

it is unreasonable to conclude that by fastening the exit door shut, the Grievant knew or understood that he had committed the offense of "abuse of a resident"--indeed, abuse of the residents on 49-2 in the sense that it was "inconsistent with human rights", as provided in Ohio Administrative Code Section 5123-3-14 (C) (1). It may very well be that it would be impossible to list the various actions that come within the scope of "abuse" as defined in Ohio Administrative Code Section 5123-3-14 (C)(1). But it is clear, that the Grievant's conduct is not "inconsistent with human rights", in light of the events of April 22 the reason for the Grievant's conduct and the failure of management to instruct the Grievant on fastening a door shut.

f. The "Rambo" Episode

This brings me to another area of inquiry, namely, the "Rambo" incident. The Grievant testified that "back in 1986", when he worked in Building 6242-A or B, a person in Gallipolis who thought he was "Rambo" terrorized the community. Building 42-A had a door leading outside of the building that would not lock, "so it was tied shut with three (3) diapers". He added that the door was tied each evening for a week. The Grievant described the door as a "panic door" which was marked "Exit". He went on to state that when we left the shift each morning, the door was tied shut. To the Grievant's knowledge,

management came through the building within the week, and the fastening of the door was approved by them.

During the Pre-Disciplinary Hearing which took place on May 12, 1987, the Grievant handwrote a note, which, in relevant part, provides:

> "During [Rambo Scare] of last year the door of 6042 A was tied shut by PM and night shift for approx. 1 week.
>
> The Gallipolis Fire Dept. was called and asked if there was a penalty or fine for temporary blocking a stairwell fire door. The answer was NO.* *"

Although the Grievant did not know whether this note was produced at the Pre-Disciplinary Hearing and the Step 3 hearing, Anna M. Hamilton, President and Steward, who was in attendance at the Pre-Disciplinary and Step 3 hearings, indicated that the tying of the door shut during the "Rambo Scare" was "verbally presented" at both hearings. Fuscardo who presided at the Step 3 hearing indicated that, he did not recall the Grievant's note on the fastening of the exit door of 6042-A but he recalled the discussion concerning the episode. Consistent with the Grievant's note, he stated that the discussion over the episode involved "contact with the Fire Department at Gallipolis". Fuscardo went on to state that the Grievant called the

Fire Department and asked about the temporary blocking of the exit door and the response of the Fire Department was "no".

Sharon Brown is the Chief Steward who, on behalf of the Union, served on the Health and Safety Committee. She stated that at a meeting in 1986, the "Rambo" episode was raised and during the discussion it was stated that an exit door of Building 6042-A was tied shut "to promote safety". Fisher was the Chairperson of the Committee. When the instant grievance was filed, Brown called Fisher and discussed the matter with her. Brown said that Fisher recalled the discussion at the meeting about the exit door of 6042-A being shut. Brown testified that he asked Fisher if she "would not mind" looking for a copy of the minutes of the meeting. Brown's copy of the minutes of a Health and Safety Committee meeting that was held on July 23, 1986 was submitted at the hearing. The minutes, in relevant part, provides:

> "* * Supposedly around our campus in the evenings and until after dark, we have a Rambo type person supposedly living in our caves or up in the woods behind our campus. Staff have seen and reported it. (S. Brown reported he was captured last week). It presented a safety hazard for both employee and resident.* * "

Hamilton, who is Brown's mother, indicated that Brown called Fisher from her kitchen on January 14, 1988. She heard "Brown's side of the call". In relating that "side", she remembered that she referred to the "Rambo" episode as "it related to the door being tied shut in Building 6042-A". Hamilton said that there was a "pause" by Brown and then Brown said "if you could find it, I would like to have it (the minutes of the July 26, 1986 Health and Safety Committee). On direct examination, Fisher denied receiving a call from Brown concerning the exit door of Buidling 6042-A being tied shut. On cross-examination, she altered her testimony concerning the telephone call, by stating "I do not deny it--I do not recall it."

The testimony of Brown and Hamilton was uneqivocal on the telephone discussion that Brown had with Fisher on January 14, 1988. By contrast, Fisher's testimony was not credible inasmuch as she altered her testimony on cross-examination on whether she received a telephone call from Brown. Accordingly, I have concluded that Fisher, a supervisory employee, knew of the exit door of Building 6042-A being tied shut during the "Rambo" episode. The inference to be drawn is that the tying of the door was considered proper by supervision, for the purpose of serving the interest of safety from any intrusion by the "Rambo" person. Moreover, Fuscardo's testimony is of some importance. He indicated that at the Step 3 hearing, the

Grievant contacted the Fire Department about temporarily "blocking" the door, and their response was "no". The State had ample opportunity subsequent to the Step 3 hearing to rebut the testimony of the Grievant concerning the response of the Fire Department. The State failed to do so. As a result, the Grievant's testimony concerning the Fire Department's response is of probative weight. Moreover, the State was placed on notice concerning the "Rambo" episode and the tying of the exit door shut of Building 6042-A at the Pre-Disciplinary and Step 3 hearing but failed to rebut the testimony of the Grievant, Brown and Hamilton on the episode.

There are distinctions between the tying of the door shut on April 22, 1987 and the tying of the door shut during the "Rambo" episode. During the "Rambo" episode, the door was tied shut with three (3) diapers each evening for a week to prevent the "Rambo" person from entering the building during the evening. The purpose of tying the door shut was to protect the residents from being imperiled by the "Rambo" person. Thus, as indicated in the minutes of the July 26, 1986 Health and Safety Committee meeting, the "Rambo type person" presented "a safety hazard for both employee and resident".

By contrast, the Grievant tied the door shut to prevent resident "X" from leaving 49-2. I believe that safety was not a factor so much

as it was an act of convenience for the Grievant. He tied the door shut so that he would not be impeded in the performance of his duties by the efforts of "X" to leave the floor. In any event, it is of great weight that the Fire Department stated that there was no penalty or fine for temporarily blocking the stairwell fire door. I have also inferred that the Fire Department was informed as to the reason for the temporary blocking of the stairwell fire door of Building 6042-A.

"NEGLECT OF DUTY"

I am persuaded that the Grievant committed the offense of neglect of duty on April 22, 1987 because he should have known that fastening the door shut was forbidden for the purpose of preventing resident "X" from leaving 49-2. The act of manipulating a clothes hanger to tie an exit or fire door shut to "slow down" or prevent a resident from leaving the floor is an act of convenience and one (1) which suited his personal comfort. He could have called his Supervisor for advise as to how to handle X's repeated attempts to leave the floor. He failed to do so. The Grievant also could have closely supervised the Grievant which he failed to do. Instead, he used what certainly is an unusual method of slowing down or preventing "X" from leaving, namely, a clothes hanger to fasten an exit door. The word "neglect" implies "giving insufficient attention to

something that has a claim to one's attention". It also suggests "disregarding or ignoring through haste and lack of care". *Webster's Ninth New Collegiate Dictionary*, Merriam Webster, Inc., 1986). I believe that the Grievant demonstrated a convenient and hasty attitude, showing lack of care to his duties when he used a clothes hanger to fasten an exit door shut to prevent a resident from leaving the floor. The potential risks and perils to the residents on 49-2 outweighed the benefits from tying the door. It should be noted that between March 1986 and July, 1987, fires have occurred on three (3) separate occasions in Building 6049; in a laundry hamper, a wash basin and in a sick room. As I have indicated, there were at least two (2) other alternatives to the action taken by the Grievant on April 22, 1987. After ten (10) years as a Hospital Aide, taking fire classes and due to the frequency of fire drills, the Grievant should have known that tying a door to prevent a patient from leaving a floor constitutes neglect of duty.

SECTIONS 24.04 AND 24.05

Hamilton testified that she requested copies of Safety and Fire Codes and Medicaid Standards from the State which the State claimed had been violated by the Grievant. She requested such documents at the Pre-Disciplinary Hearing and at Step 3. At no time did she receive

the documents. Section 24.04, which is entitled "Pre-discipline", provides that the State will provide "documents known of at the time used to support the possible disciplinary action". In light of the testimony presented at the hearing, I cannot conclude that there was any prejudice to the Union's preparation or presentation of the case, or to the rights of the Grievant by the State's failure to provide the "documents" referred to in Section 24.04, before the abitration hearing.

The Union claims that the GDC violated its unilaterally established procedure when its "Appointing Authority" submitted a written recommendation to the Director in excess of "fourteen (14) calendar days of the pre-disciplinary hearing". Apparently Section 24.05 of the Agreement confers such discretion upon the "Appointing Authority", to establish such a procedure. I cannot conclude that the seven (7) days in excess of the fourteen (14) days of the Pre-Disciplinary Hearing prejudiced the rights of the Grievant or the Union.

SECTION 24.02

The Union claimed that the principles of progressive discipline, which are required under Section 24.02 of the Agreement, were not

followed by the State. A document entitled "Disciplinary Action" and issued by the GDC was jointly agreed to by the parties at the hearing. Accompanying the text materials, are "Standard Guidelines for Progressive Action". Under these Standard Guidelines are various offenses such as "verbal abuse", "refusal to obey orders" and "creating a disturbance". The GDC sets forth penalties which become more severe as the same offense is repeated. The Union contends, that, at most, the Grievant should have received a three (3) day suspension because the GDC sets forth a penalty of "written reprimand to 3 day suspension" for the first offense of "Physical Abuse or Neglect" which is not harmful. The text materials set forth a major offense of "Abuse or Neglect of a Resident of GDC either Physical or Verbal". At page 4. The evidence in the record does not indicate that the Grievant's offense consisted of physical or verbal neglect or abuse of a resident.

The offense committed by the Grievant was neglect of duty which is set forth in the June 18, 1987 Order of Removal. The major offenses do not contain the offense of Neglect of Duty. As the GDC policy indicates, the major offenses are not limited to the enumerated offenses; but the offenses listed are merely "examples" of major offenses. At page 4. Thus "neglect of duty" constitutes a major offense.

Moreover, the GDC policy sets forth progessive discipline for "minor offenses". At page 3. However, the GDC states that progressive discipline as set forth for minor offenses need not be followed. But, "[T]he employee shall be disciplined immediately based upon the seriousness of the offense". At page 3. In any event, I am guided by the stipulated issue by the parties: Whether the Grievant was discharged for just cause; if not, what is the remedy to be awarded? This issue takes into account the seriousness of the offense, as set forth in GDC's Policy on "Disciplinary Action".

DISCIPLINE

The Grievant has not enjoyed a satisfactory record as an employee of the GDC. He has received a five (5) day suspension and a fifteen (15) day suspension for sleeping on duty in May and November, 1985; and a reprimand dated September 30, 1986 for "misappropriation of resident clothing".

However, the mitigating circumstances present in this case, cannot be overlooked To begin with, the Grievant was never instructed or told by Management that an exit door was never to be fastened shut. Although there are factual distinctions between the tying of the door during the "Rambo" episode and the instant case,

some confusion on the tying of an exit door is understandable on the part of the Grievant. Furthermore, the violation by the Grievant concerns neglect of duty. His offense basically stemmed from poor judgment rather than intent to harm any of the residents on 49-2.

Apart from these mitigating circumstances is a factor which is entitled to great weight. Rothgeb, who as a Hospital Aide, was on duty with the Grievant on April 22, 1987, was not disciplined. The State expended time and energy throughout the hearing indicating that the Grievant was guilty of "abuse of residents" at the GDC; but did not impose any discipline whatsoever against Rothgeb. Indeed, upon discovering what the Grievant had done, Altizer said to Rothgeb "he should know better than that". According to Altizer, Rothgeb said, "I thought so too". Rothgeb's statement to Altizer implies that what the Grievant did was improper. Indeed, Rothgeb said that she "saw" the Grievant tie the door shut. She elaborated by indicating that she saw him "put the wire on the door from the dayroom * *."

It is well established that:

> "enforcement of rules and assessment of discipline must be exercised in a consistent manner; all employees who engage in the same type of misconduct must be treated

> essentially the same unless a reasonable basis exists for variations in the assessment of punishment (such as different degrees of fault or mitigating or aggravating circumstances affecting some but not all of the employees). Elkouri and Elkouri, *How Arbitration Works*, Fourth Edition, (BNA, 1985). At page 684.

There is nothing in the evidentiary record to indicate that Rothgeb's responsibilities during April 22, 1987 were different than the responsibilities of the Grievant. Both the Grievant and Rothgeb were on duty on April 22, 1987. It may very well be that more severe punishment is justified against the Grievant because of his unsatisfactory employment record. However, the State did not carry the burden of proving why Rothgeb was not disciplined and the Grievant was discharged. In fact, there is nothing in the evidentiary record on Rothgeb's past employment. In the State's view, the Grievant's action was a serious violation of the Fire and Safety Codes and the Medicaid standards. Yet, despite the serious nature of the Grievant's offense, there is no explanation for not imposing discipline against Rothgeb who saw the Grievant tie the door shut and apparently did not object or take any action to undo the fastening of the door. It should be underscored that Rothgeb had Fire School classs and went through orientation training. Thus, under the State's version

of the instant case, Rothgeb knew or should have known of the serious violation committed within the scope of her job duties.

An arbitration decision and award in point is *Lone Star Brewing Co.*, 45 LA 817 (Merrill, 1965). An altercation occurred between the Grievant and Bailey, another employee over the scheduling of overtime work. As the Arbitrator found, the Grievant and Baily moved toward each other and a Supervisor who intervened, "may have received a blow on the back, apparently from the Grievant". The intervention by the Supervisor prevented any actual fight. The Arbitrator found that the Grievant interrupted and ignored the Supervisor's request to desist. The Grievant was discharged for his "attempt to exercise violent action" against Bailey. Bailey was not disciplined.

The Arbitrator indicated that:

> "* *the incident did not arise to the magnitude of a full-fledged fight. It was nipped in the bud * *. No one was injured * * *. No one was put in danger. The door leading to the stairway to the engine room was closed. The horrendous consequences of a person being knocked into the machinery were not possible * *. It is clear that the grievant was neither the sole aggressor nor the sole inciter

> of the incident. The honors are pretty even as between Bailey and the grievant, both in uncomplimentary provocation and in physical preparation for fisticuffs. Yet Bailey received no discipline at all." At page 821.

Arbitrator Merrill then stated:

> "* * Some arbitrators would rule that such a discrimination vitiated the right to impose any discipline upon the grievant. I do not feel that properly I should overrule to that extent the decision of management to impose some discipline. If differentiation is necessary, it may be found in the fact that the grievant had required discipline in the past. No evidence has been produced of a similar situation in respect to Bailey. I rule that the grievant properly is subject to discipline for gross misconduct, but that there is not 'sufficient cause' for discharge.* *". At page 821.

The remaining question in *Lone Star Brewing Co.* was the extent of the discipline to be imposed. The Arbitrator addressed this issue by stating that: "[I]n view of the strong policy against violent display, particularly upon Company property and at a time when such conduct is likely to disrupt operation, the Grievant was reinstated

without pay. At page 821.

In this case there are elements present which are comparable to the factors set out in *Lone Star Brewing Co.* Fortunately, the Grievant's conduct did not result in any injury to the residents. No one was put in danger. There was potential jeopardy to their safety but due to the fortuitous action of Altizer, the tying of the door was undone, roughly thirty (30) minutes after the Grievant initially wired the door shut. As in *Lone Star Brewing Co.*, the Grievant was not the only person committing the offense in question. Rothgeb saw the Grievant tie the door and acknowledged Altizer's statement that "he [the Grievant] should have known better". Yet Rothgeb received no discipline at all. I would agree that some arbitrators would declare that "such a discrimination vitiated the right to impose any discipline upon the Grievant. As the Arbitrator stated in *Lone Star Brewing Co.*, "I do not feel that, properly, I should overrule to that extent the decision of management to impose some discipline". The Grievant's unsatisfactory work record cannot be ignored. As a result, although I cannot conclude that the Grievant was discharged for "just cause", he is to be reinstated without back pay.

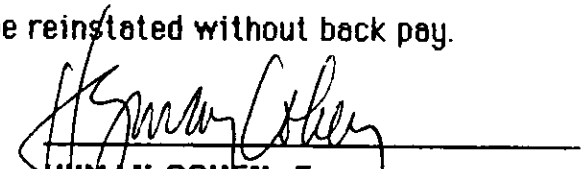
AWARD

In light of the aforementioned considerations:

1. The Grievant was not discharged for just cause;

2. The Grievant is to be reinstated without back pay.

Dated: June 2, 1988
Cuyahoga County
Cleveland, Ohio



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