March 4, 1991

Award #568

In the Matter of Arbitration
between

The Ohio Department of Mental Retardation and Developmental Disabilities

- and -

Ohio Civil Service Employees Association, Local 11, AFSCME

Case No. 24-14-(08-22-90)-333-01-04

APPEARANCES

For the Union:

Lettye Johnson	TPW.
Gerald Burlingame	Staff Rep./AFSCME
Evelyn Morrison	Cook I
Robert Robinson	Staff Rep.
Marlene Johnson	TPW
Ruth Johnson	President
Evette Gaston	TPW

For the Agency:

Paul Kirschner	Advocate
Tim Wagner	Co/Advocate
Pat Matzinger	Unit Manager
Phil Wenner	Police Chief
Charleen Gant	Rehabilitation Manager
Bruce Brown	OCB
O. Douglas Taylor	Director of Operations, WBC

Arbitrator:

Patricia Thomas Bittel

The hearing in this case was held on February 1, 1991 at the Warrensville Developmental Center in Warrensville Township, Ohio before the neutral Arbitrator Patricia Thomas Bittel, mutually selected by the parties in accordance with Article 25, Section 25.04 of the Collective Bargaining Agreement.

The Grievant in this case, Lettye Johnson, was removed from her position at the Center for an incident wherein a client of the institution choked to death during breakfast. The removal was grieved; the grievance denied the charge of client neglect and claimed the death was due to administrative abuse by failure to provide adequate staff for client care. During the course of the grievance procedure the removal was changed to a 30-day suspension, the disciplinary action here challenged at arbitration.

The parties have stipulated to the following facts:

"1. Lettye Johnson is a therapeutic program worker at Warrensville Developmental Center.

2. She has over eleven years of state service.

3. She has no other discipline currently in her file.

4. Lettye Johnson was aware of the client's 'choking' problem and that the client needed special attention during mealtime.

5. Lettye Johnson knew that the client's dietary card required that the client's food be cut into bite-size pieces.

6. Lettye Johnson had good attendance and was punctual.

7. The incident happened on June 1, 1990 at approximately 7:15 a.m.

8. This grievance is properly before the arbitrator for a determination.

The stipulated issue is: "Was the 30-day suspension of the Grievant, Lettye Johnson, for just cause? If not, what shall the remedy be?"

FACTS OF THE CASE

The Collective Bargaining Agreement contains the following applicable provisions quoted in pertinent part:

> "Section 24.01 Standard:
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> 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.
>
> Section 24.02 - Progressive Discipline:
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> The Employer will follow the principles of progressive discipline. Disciplinary action shall be commensurate with the offense. Disciplinary action shall include:
>
> A. One or more verbal reprimand(s) with appropriate notation in employee's file(;)
> B. One or more reprimand(s);
> C. One or more suspension(s);
> D. Termination."

The Police Chief of the Warrensville Developmental Center, Phillip B. Wenner, stated that he supervised the police investigation of the incident. He gave a descriptive overview, explaining that at the time the client ("E.H.") choked, two staff members were away taking residents to

other engagements, the cook was in the kitchen and staff officer Glovie Head was in the office doing reports.

He said when the client began choking the Heimlich maneuver was attempted, then the nurse and paramedics were called. The paramedics transported E.H. to the hospital where he was pronounced dead.

The coroner's verdict noted "Quality care was maintained and on June 1, 1990 at about 7:30 a.m. this man was in the Day Room when he began to choke on food (cereal)." It further noted that when he was admitted to the emergency room he was in full cardio-pulmonary arrest, secondary to aspiration of food. The cause of death was defined as "asphyxia by bolus of food" and was deemed accidental in nature. The coroner identified the food as "soft brown food material".

A dietary card for E.H. was jointly admitted into evidence stating "All foods to be cut into bite size pieces; 1:1 supervision at mealtime". The parties also jointly admitted a menu describing the mechanical soft breakfast (e.g. banana, dry cereal) and the kitchen posting stating for E.H. "Mech soft; All Food chopped into bite size pcs. 1:1 supv. at meals". Wenner stated E.H.'s meal card was erroneous and medical records reflected only a requirement of eyes-on supervision at meal time.

Wenner's investigation included taking a number of witness statements. In his report he concluded "Currently there is not obvious neglect on any staff's part. Many

staff, including direct care and nursing, appear to have done everything possible to assist [E.H.] once he was choking."

Colosimo's statement indicated Grievant was serving breakfast when she returned and began to assist Grievant. The statement reported that E.H. stood up and Grievant started the Heimlich maneuver. Colosimo stated some of the banana on his plate was whole and some was cut in half. She said someone else should have been with Grievant serving breakfast.

Wenner obtained a statement from another nurse, Athelene Fort, who said she assisted Colosimo in giving CPR. She also did a finger sweep to remove food. She identified the food as semi-dry cereal.

Wenner's investigation produced documents from E.H.'s medical history. A May 5, 1990 doctor's order stated E.H. "must be visually supervised during a meal". A prior order dated March 4, 1990 also stated E.H. "must be visually supervised during all meals".

The record shows a choking incident occurred on June 23, 1984 when staff noticed E.H. was not moving, bent him over and gave him a quick thrust in the solar plexus, causing him to throw up an almost whole hot dog. As a result of this incident staff was commended for quick and appropriate procedural reaction.

An Unusual Incident Report dated November 15, 1987 stated E.H. put large amount of spinach into his mouth and

started choking. The Heimlich maneuver was applied and E.H. was described as running away from staff "because of fear because he was turning colors". The ratio at the time of this incident was designated as 3-13. The Incident Report stated that when the nurses arrived on the unit E.H. was lying on the bathroom floor with cyanic color. They were unable to palpate his carotid pulse and two person CPR was initiated with respiration and carotid pulse returning after two minutes. The cause of the incident was described as "too much food, eating too fast".

Another incident report dated December 2, 1989 described E.H. as choking. He was given the Heimlich maneuver but kept choking and began turning blue. When the food was taken out of his mouth he recovered.

Unit Director Pat Metzinger testified that she oversees four houses, including the one which housed E.H.. She stated the clients are severely or profoundly retarded and the staff is responsible for putting together an individual program plan (IPP) for each client on an annual basis. She said the IPP is kept in the unit file where all information about a client can be found. She claimed information is very assessable and it is the responsibility of the Therapeutic Program Worker (TPW) to implement the IPP.

E.H. was admitted to Warrensville Developmental Center on March 28, 1984. The IPP applicable to him at the time of his death had been updated on May 9, 1990. As to mealtime, it noted the following: "Staff needs to constantly monitor

[E.H.] while he is eating. He has a history of choking and will stuff food into his mouth".

It acknowledged a report in the Unusual Incident Log dated January 26, 1990 that E.H. choked on some food. It also noted a report that when unsupervised he eats quickly: "Staff currently do a good job at providing verbal prompts to encourage slower eating pace; this method appears effective in slowing [E.H.] down. The mechanical soft diet cut into bite-size pieces continues to be appropriate." The recommendations for E.H. in the IPP were visual supervision during meals and continued monitoring/ training at mealtime ("He eats too fast and is in danger of choking"); his annual goal was to learn to eat at a moderate pace.

Metzinger stated the TPWs frequently work with no supervision in the house. She said they were responsible for training E.H. in eating skills as defined in his IPP. She explained on the day in question there were four staff assigned to the house. She said at mealtime the first priority is a choker and staff is expected to be in the dining room during mealtime.

In her view, Grievant should have gotten others to help her serve the meal or should have called the charge office where there are supervisors on call. Another option for Grievant, she said, was to delay breakfast or only serve a few clients at a time.

She conceded TPWs should have been told of their options when staffing is short and that this was not

necessarily part of the in-service training they received. She also said that while meals have been served by a single staff alone, it is uncommon.

Metzinger admitted that a staff incident report may have issued had Grievant failed to serve breakfast on time. She claimed such a report would probably not have resulted in discipline, though she acknowledged it could be used as a basis for discipline.

She claimed when food is not properly prepared a TPW can either cut it up herself or send it back to the cook for proper preparation. She stated the TPWs can be disciplined for serving an improper meal though she was not aware of any discipline in the past for such an offense.

She admitted on cross-examination that even if more staff had been available when Grievant served E.H. breakfast, the food stealing incident could have taken the attention of staff away from him. She further admitted that a client such as E.H. is capable of putting food in his mouth and choking even with one-on-one supervision.

Gant stated at the time of the incident she was in her office and had been there all night to complete the paperwork. She stated she was working an irregular shift specifically in order to complete the paperwork. She said Sandy Colosimo knocked on her door and told her E.H. was choking.

At the time she did not know Grievant was serving breakfast, she said, claiming Grievant never came and asked

her for help. She asserted she did not know Grievant was serving meals alone. She contended if Grievant asked her, she would have provided help to serve breakfast. She stated Grievant could have gotten help from other staff, called the charge office for support or waited. She stated everybody helps during mealtime.

Gant said she called the nurse then had the operator call 911. She filed a staff incident report dated June 11, 1990 which stated:

> "On Friday June 1, 1990 E.H. was served an inappropriate diet, as prescribed by dietary. Food was not returned to cook to prepare properly. As a result of this improperly prepared food, E. choked."

She stated the required client-staff ratio is one to eight and said she knew Medicare/Medicaid cited the facility in December, 1990 for improper staffing. The Medicare/Medicaid Plan of Correction submitted to Warrensville Developmental Center stated "Staffing levels will be increased," and "Management will create a schedule for increased supervisory coverage."

Unit Manager Pat Metzinger testified that on January 25, 1990 there was a special team meeting of concerned staff regarding E.H.. The items discussed were described as follows in pertinent part:

> "E. has a history of choking on food because he stuffs his mouth and does not barely chew his food before he swallows. *** It is the feelings [sic] of the above mentioned members that E. should be placed on eating at

a moderate pace program. This will allow the staff to focus more attention on [E.H.'s] need for prompting."

O. Douglas Taylor, Director of Operations at the Center, testified that staff member Glovie Head, who was in the office adjoining the dining room at the time of the incident, received a ten-day disciplinary suspension which was lost in the mail and not found until it was too late to serve it under the 45 day contract limitation. He said the cook, Evelyn Morrison, was also disciplined.

Morrison testified she had been the house cook since 1978. She stated E.H. would stuff his mouth, eat too fast and was a choker. She said his breakfast on that morning was bananas, cereal and toast. She claimed she mashed the bananas with a fork, put cereal on top and cut the toast up.

When referenced to a statement she gave on June 5, 1990 wherein she could not recall how she prepared E.H.'s breakfast that day, she explained that at the time of the questioning she was busy making breakfast and was concentrating on that. She said she always cut up E.H.'s breakfast in the same fashion.

TPW Evette Gaston testified that E.H. was in the house where she worked until February, 1990. She stated E.H. had a brother who had choked to death and a sister who was also a choker. She said she would use the Heimlich maneuver on him when he choked and sometimes he was able to get himself out of it.

She claimed there were times when there was only one staff on the shift with E.H. when he was eating. She contended it was permissible to feed clients alone. She stated she was the union steward and identified a grievance which had been filed protesting the client-staff ratio at the facility.

Chapter President Ruth Johnson, also a TPW, testified to Labor Management meetings regarding staffing levels. She stated there had been too many unusual incidents in certain quadrants. She claimed everyone was supposed to come out on the floor during meal time.

Marlene Johnson, a TPW, testified that E.H.'s family was grateful to the staff for the treatment given E.H. and after his death sent in a card stating: "Our heartfelt thanks to Teresa and all the staff! or whom concerned -- We know you all worked so hard -- gave a good care & a lot of your time. The tree is so nice, (a good idea). Thoughtful of yauns [sic]." She explained after E.H.'s death the staff sent E.H.'s family a tree.

Grievant testified she had worked for the Center for eleven and a half years. She stated on the morning in question she was responsible for twelve residents while two staff went to other buildings to escort clients, leaving only two staff in the unit.

She stated Head was in the office talking with Gant. She said Gant specifically looked up when she asked her for

help but then kept looking through a book. At this point, said Grievant, she went ahead and served the meal.

She stated E.H. was one of the first clients to whom she served breakfast. She said she put his plate down and noticed a client stealing a whole piece of toast from another's tray. She said after attending to this, she turned around and E.H. was pointing to his throat. She said she had served only two tables when E.H. started choking, and claimed she responded immediately by giving him the Heimlich maneuver and calling the nurse. She asserted she monitored the patient when he was eating and claimed all she did was turn around: "All I did was take the toast out of her hand and put it back on the resident's plate."

She claimed E.H. did not require one-on-one supervision, but was supposed to be monitored during meals. She admitted she did not read E.H.'s card that morning but explained she had served him before. She denied that the dietary card admitted into evidence was the one placed on his plate.

She stated she fed clients alone because they had to be out in time to catch their bus, else she would be written up. She admitted serving a meal alone was not the normal procedure but claimed it was sometimes necessary and contended she had served alone on two to three occasions. She claimed she had received no prior instructions regarding what to do when serving a meal alone.

She wrote a statement shortly after the incident which was jointly admitted into evidence. At hearing, she claimed she was not sure whether the food had been cut up. She stated at the time she gave her initial statement she was afraid and unsure.

She said in her prior employment history she was removed for something she did not do then was reinstated. At the time she gave the statement, she explained, she was trying to protect her job.

Grievant's position description states she must have the ability to recognize unusual or threatening conditions, take appropriate actions and carry out instructions. Her performance appraisals are quite good with notations regarding knowledge, cooperativeness, talent, pleasantness, dependability, high-quality, genuine concern, good relationships, conscientiousness, and value as an employee.

ARGUMENTS OF THE PARTIES

The Employer maintains Grievant is guilty of two counts of neglect: one, for serving a breakfast that was not prepared according to specifications to a severely retarded client with a history of choking; and two, failure to supervise the client during the breakfast as required. Each of the charges, it claims, warrants either a twenty-day suspension or removal.

It references the Center's disciplinary rules with guidelines which provide the appropriate discipline for physical abuse or neglect is a twenty-day suspension to removal upon first offense if harm results and a written reprimand to a five-day suspension if no harm results.

As to the allegation of serving an improperly prepared meal it points out that Grievant admitted in her written statement that she served an improperly prepared meal. The directions on the card on E.H.'s plate clearly specified all food was to be cut into bite size pieces, it maintains.

In the Employer's view the contradiction between the Grievant's written statements and her sworn testimony brings all her testimony into doubt.

The Employer points out Morrison's testimony was also contradictory as she did not recall what E.H. had for breakfast at first, yet at hearing she recalled the food was properly prepared. Management points out Morrison was given a 30-day suspension.

The Employer maintains Grievant made the decision to knowingly serve food that was not properly prepared when she could have taken it back to the cook or cut it up herself. In addition, she decided to serve breakfast alone despite the fact that she had a number of other options: waiting until one or both of the TPWs returned, insisting that Head help out, or calling the charge office and reporting her need for assistance.

In the Employer's view Gant had no knowledge of Grievant's request; either Grievant's request was not heard or the request was never made. "By choosing to serve breakfast without assistance, she chose to protect herself, and put the client in danger. Management holds that it was a choice she did not have to make."

The Union maintains there was confusion regarding E.H.'s orders as some staff felt he was on visual observation yet other indications are he required one-on-one. It claims Medicare/Medicaid standards were totally violated by leaving one staff alone with twelve clients, especially during mealtime.

It asserts the allegation of serving improperly prepared food was a smoke screen from the start. Nurse Fort stated in her report that E.H. expectorated cereal and the finger scoop brought out more cereal, it notes, emphasizing there was no mention of banana. Similarly, the autopsy confirmed cereal as the cause of death, it argues. There is no allegation that the cereal was improperly prepared, asserts the Union. Grievant cannot be found guilty of harmful neglect in serving an improperly prepared meal when the harm to E.H. came from properly prepared cereal, it asserts.

Further, it points out that Grievant's initial written statement was made out of fear for her job. It contends she is an excellent employee with a marvelous work record. It further maintains it is significant that the family holds no

one responsible for E.H.'s death. The Union argues the Employer must carry the burden of proof to establish just cause for any disciplinary action, and contends it has failed to do so in this case.

DISCUSSION

1. Did Grievant Neglect the Client by Serving Him Improperly Prepared Food?

Both Cook Morrison and Grievant contradicted themselves about the food preparation for E.H. on the day in question. The only other evidence of improperly prepared food is in Colosimo's written statement.

Notably, both Morrison and Grievant have an interest in their respective disciplinary cases. Each has had the benefit of an opportunity to reflect on the relative advantageousness of their respective positions. The Arbitrator found the testimony of each was an attempted denial of facts correctly reported in their original statements. This conclusion is further substantiated by the statement of Colosimo that E.H.'s banana was not cut into bite sized pieces.

Grievant did in fact serve improperly prepared food to E.H.. It must be noted, however, that E.H. choked on his cereal, not his toast or his banana. Therefore, the fact that the banana and/or toast were not properly cut up did

not directly result in harm to the client. It follows that any neglect by Grievant in serving E.H. the improperly prepared meal was not harmful within the meaning of the disciplinary guidelines.

2. Did Grievant Neglect the Client by Failing to Adequately Monitor His Meal?

The Union testimony that it is necessary on occasion to serve meals alone stands unrebutted. Grievant testified she had done this before and though she admitted it was uncommon, stated it was necessary on occasion. TPW Evette Gaston testified it was permissible to feed clients alone though Chapter President Ruth Johnson stated everyone is supposed to come out on the floor during mealtime.

Even though Gaston testified to the permissibility of serving meals alone she gave no indication of whether this was considered appropriate when one or more of the clients required one-on-one supervision or visual observation during the meals. There was no indication that anyone had ever been disciplined for serving a meal alone, nor was there evidence that staff had been trained not to serve alone. There was no communication to employees that Management considered this neglect.

A critical element of just cause is that the Employer give to the employee some warning or foreknowledge of the disciplinary consequence of his or her conduct. However, this notice requirement is not a barrier to a showing of

just cause when the impermissibility of the conduct is so obvious that employees should have known it was unacceptable. Failure to give notice to employees that they could be disciplined for serving meals alone would defeat just cause in most circumstances. However, in this case, Grievant was serving alone when one of the clients had special instructions for meal time.

Failure to give E.H. visual observation during meals was a clear breach of medical protocol for the client. It was contrary to specific doctor's orders given to the staff and to the explicit instructions in E.H.'s IPP as discussed at staff meetings. Doctor's orders were specific and clear in directing Grievant to watch E.H. eat. Grievant's own testimony confirmed that she knew of his choking problem and special requirements during meals. Hence there was no failure to place Grievant on notice that she must visually observe E.H. during meals. When she decided to serve alone, she placed herself in a position of being unable to insure compliance with doctor's orders and specific instructions.

Grievant's offense is not that she served a meal alone but that she violated specific doctor's orders regarding E.H. when she did. She could not maintain visual observation with E.H. while serving a meal to clients who steal food from each other. To even attempt to serve a meal to twelve severely retarded clients when required to maintain visual contact with one of them is in and of itself a violation of the doctor's orders as well as the IPP. It

follows then that Grievant neglected client E.H. when she served a meal alone despite his need for visual observation.

Grievant has a long history of choking. His records while at Warrensville Developmental Center reflect that he has very nearly died from choking before this incident. There is no indication from the evidence that any discipline resulted from these prior incidents.

The choking incident would not necessarily have been avoided had more staff been present; Matzinger admitted the staff's attention could have been drawn by the stealing incident. The incident would not necessarily have been avoided had Grievant been watching E.H. one-on-one. E.H. had choked before with no staff negligence shown. The Heimlich maneuver was promptly given as it had been in other choking incidences. The fact that staff was unsuccessful in preventing the choking or in resuscitating E.H. this time is not negligence. In the Arbitrator's analysis, E.H. could well have choked to death on June 1 even if staff had complied with all instructions. Given these facts, it cannot be said that Grievant's failure to monitor E.H. was the cause of his choking to death.

It follows that Management has shown Grievant committed two counts of neglect without harm. Because the maximum penalty for each offense was a five-day suspension, her thirty-day suspension was without just cause and must be modified accordingly.

AWARD

The grievance is sustained. Grievant was penalized for harmful neglect when her offenses were not shown to have been the cause of harm to the client. The suspension will be modified from thirty days to ten days and Grievant will be afforded back pay for the difference.

Respectfully Submitted,

Patricia Thomas Bittel

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March 4, 1991