#1285

IN THE MATTER OF THE ARBITRATION BETWEEN: *

Northcoast Behavioral Healthcare Systems	*** Grievant: Paul Claren, RN**
-and-	*** Grievance Number: 23-18-960118-1315-02-11**
Service Employees International Union, District 1199	*

ARBITRATOR: Mollie H. Bowers

APPEARANCES:

For the Employer:
Georgia Brokaw, Advocate, Mental Health
Lou Kitchen, Office of Collective Bargaining
Linda Thernes, Central Office, Ohio Department of Mental Health
Roger Beyer, Labor Relations Officer
Denise Gore, Therapeutic Program Worker
Steven Penwell, Facility Police Officer
John Clepper, Therapeutic Program Worker
Edwina Badjun, Clinical Area Supervisor
Dr. Shin Lee, Staff Psychiatrist

For the Union:
Janice Stephens, Administrative Organizer
Phyllis Perkins, Housekeeper/Custodian
Vera Dean, Therapeutic Program Worker
Keith Dixon, Training Officer

District 1199 of the Service Employees International Union (the Union) brought this matter to arbitration challenging the removal of Paul Claren, RN, Psychiatric MR Nurse Coordinator (the Grievant) from State service after he was accused of violating the patent abuse or neglect policy of the Northcoast Behavioral Healthcare System (the Employer). The Hearing was held on April 14, 1998. Both parties were represented and stipulated that the case is properly before the Arbitrator. The parties had a full and fair opportunity to present evidence and testimony in support of their respective cases and to cross-examine that presented by the opposing party. At the conclusion of the Hearing, the parties agreed to provide written closing arguments on May 8, 1998.

ISSUE

Did just cause exist for the Grievant's removal from State service?
If not, what shall the remedy be?

PERTINENT CONTRACT LANGUAGE AND POLICY

ARTICLE 8 - Discipline
Section 8.01 Standard
Disciplinary action may be imposed upon an employee only for just cause. . . .

Center Policy #6-8
DEFINITION OF PATIENT ABUSE/NEGLECT
"Abuse" is defined as any act or absence of action which results, or could result, in physical injury to the patient. . . .

. . .

Abuse and Neglect include, but are not limited to, the following:

1.0 All acts of physical violence against a patient. It is recognized that an employee shall be entitled to use force in the amount necessary to prevent a patient from injuring himself or to ward off an attack on the employee, a fellow (sic) Any patient may report an incident of abuse/neglect verbally or written to any employee.

An employee suspected of abuse of patients, may be placed on Administrative Leave while the investigation is being conducted. The employee may be reassigned only if he agrees to the reassignment. The responsible Governing Council member of his designee shall make an initial assessment after receiving a report of alleged patient abuse, and based upon the evidence and seriousness of the allegation make a determination as to whether the employee be offered reassignment or placed on Administrative Leave. The CEO or his designee shall have the final authority for placing employees on Administrative Leave.

Center Policy #3-9
Policy
All hospital employees are subject to corrective action for any violation of internal policy or work rule and for behavior or conduct which falls within the areas listed in Section 124.34 of the Ohio Revised Code. . .

The principles of progressive/corrective action will normally be applied for any such violation or inappropriate behavior. The type of corrective action will be based upon the merits of each individual situation and the seriousness of the violation. Emphasis will be placed on prevention

and employee development rather than strict punitive intent and in accordance with existing Collective Bargaining contracts.

STANDARD GUIDE FOR DISCIPLINARY ACTION
PENALTIES

NEGLECT OF DUTY Verbal or physical action or inaction toward public &/or clients where safety & health are endangered.	First Offense 6 Day Suspension or Removal	Second Offense Removal

BACKGROUND

The Grievant was hired as a Psychiatric/MR Nurse Coordinator on October 24, 1997, by the State of Ohio Department of Mental Health. He worked at the Northcoast Behavioral Healthcare Systems facility in Northfield, Ohio. The Employer's mission at this location is to treat forensic clients and adult in-patients, and to provide community services, with the goal of returning clients to the community as soon as possible.

The alleged events which led to the Grievant's termination on January 3, 1996, occurred December 22, 1995. A Code Blue was called on the first shift by Denise Gore, Therapeutic Program Worker (TPW), because she observed patient C running past her and hitting the walls on McKee #4, North Wing. A Code Blue is called when a patient is observed by any staff to be out of control. All available hospital personnel are required to render assistance, the goal being to limit, or to avoid, injury to the patient or to others. There is no dispute patient C. has been diagnosed as both mentally ill and retarded. Additionally, he has a history of acting out and has been restrained by staff in the past.

Police Officer Penwell, Nurse Supervisor Edwina Badjun, TPW John Clepper, and the Grievant responded to the Code Blue. It is undisputed that Penwell and the Grievant were the

first to arrive on the scene. Although agitated, the patient did sit down in a chair, at which time Penwell went to his right side and grasped his right arm/wrist, and the Grievant took the patients' left arm. It is undisputed that they then helped the patient to his feet so he could be escorted to the 'quiet room'; undisputedly normal procedure after an out burst of this type. Once on his feet, the patient began to struggle and kick. TPW Clepper intervened to lift the patient's feet off the floor. Thereafter, the versions of what transpired differed in some significant respects.

Based upon Penwell's testimony and his written police report, he told patient C that he was going to the "quiet room". The patient, who is known to be non-conversational and to utter mostly mono-syllabic responses, said "No". He began to struggle as Penwell said the patient "normally" does under such circumstances. According to Penwell, the Grievant then placed his right arm around the patient's neck in what was described as a "choke hold". A gathering of patients and staff had begun to assemble. According to Penwell, he told the Grievant, at least once, to "Stop Paul. Stop". Simultaneously, Penwell heard Badjun also direct the Grievant to "Stop. We don't use choke holds on patients here. Stop", and to let the patient go; which he did.

TPW Clepper stepped in to assist by lifting the patient's feet off the floor. At this juncture, the patient continued to struggle and, Penwell said, the Grievant reapplied his arm "more firmly up under the patient's neck and leaned him back". Penwell reported that the patient's eyes bulged, he uttered choking sounds, spit was coming from his mouth, and his skin darkened. Clepper released the patient's feet. Both Penwell and Badjun testified they repeatedly told the Grievant to "Stop" and to let the patient go. Their testimony is also in agreement that the Grievant responded by saying, "Fuck you, bitch, you are always telling me what to fucking do. You fucking restrain the patient yourself. You're fucking worthless anyway". The Grievant then

left the area.

Clepper, Penwell, and Badjun then escorted the still struggling patient to the "quiet room", where he was placed in restraints. He was later examined by a physician, who found the patient sustained no injuries.

The Grievant testified that although he had had to restrain the patient several times before, he had no animosity toward him or toward Badjun. He said the incident began when Phyllis Perkins told him there was a problem in the day room. The Grievant said he went into the day room and "Hung around to make an assessment of what we had to do about it". He believed the code blue was called while he was making this assessment. According to the Grievant, TPW's Vera Dean and Denise Gore, and "a plumber" were also present at the time, as well as other patients.

The Grievant's and Penwell's testimony is in agreement about the initial stages of the effort to restrain patient C. The Grievant said he leaned the patient back against his chest "to take him off balance" and put his right arm over the patient's shoulder and across his chest. He acknowledged hearing Badjun "scream", "Let him go", and Penwell telling him Badjun wanted his to let the patient go; so he did. When the Grievant again began kicking, the Grievant stated he "regarbbed him to protect himself and people in the vicinity". He said he subsequently let patient C go and "walked off to the side into the crowd". Badjun testified she told the Grievant to "Stop, because he could kill the patient", and he pushed the patient into Penwell before exiting the area.

Thereafter, the Grievant testified he went to the chart room to document the incident. He said Blanche Dorche, Psychologist, and Vera Dean were also in the chart room. He reported mentioning to Dean "how I was accused in this choking business and how they were interfering in

the care of a patient". The Grievant also said Pam Chasteen, Supervisor, came into the chart room and "she heard me telling Vera Dean how they had interfered and lied about what was going on, so they (Pam and Barb Leugers, RN) turned around and headed back out". On cross-examination, the Grievant explained he knew he was being accused of using a choke hold when he was in the chart room "because Badjun and Penwell went around telling everyone that".

The Grievant denied that Badjun ever came into the chart room while he was there. In her contemporaneous written statement, Badjun wrote:

> After [patient] was secured in 4 [point] leather restraints, I went into the char room [with] Chasteen and B. Leugers, RN, & Officer Penwell to discuss what we had observed & Mr. Claren was sitting at the table stating "I'm sick of the fucking supervisor stupidity & their fucking interference & I'm not holding my fucking tongue anymore.

Patient D came forward voluntarily to report his version of what happened on December 22. He had known patient C for seven years because they had lived on the same ward at one time. He agreed patient C was "out of control" and running around the day room area. Patient D said he saw the Grievant grab patient C around the neck on two different occasions, and heard Penwell say, "Let him go". He said he did not observe any of the physical manifestations Penwell described. On cross-examination, Patient D said he had never seen any other staff use that type of physical restraint (ie., a choke hold) and that he had experienced no change in privileges since he agreed to testify in this case.

Dr. Shin Lee testified that he was familiar with patient D's medical condition at the time of the incident. He opined that patient D was capable of providing the written statement contained in the record and that the medication D was taking at the time would not result in any memory

impairment.

Vera Dean testified that she came into the day room at the time of the incident, but did not assist in the restraint. She said she saw the Grievant's arm around patient C's upper chest. In her contemporaneous written statement, Dean wrote, "I came running in the day area . . . somebody had his arm around the front of [C's] neck. His neck was visible. RN Supervisor made a statement so the RN Mr. Claren wasn't please (sic) with why (sic) she said". Dean testified she heard a supervisor ask the Grievant why he was holding patient C's next and heard the Grievant say, "If you can do better with the patient, help yourself". This witness denied hearing any cursing or seeing the Grievant push the patient.

Staff at the facility must complete and have updated Therapeutic Handling of Aggressive Resident Training (THART). Although there is testimony in the record that such updates are/must be provided annually, the last time the Grievant received such training was in 1993. It is a fact that both before nor after that date, choke holds have been clearly forbidden in handling aggressive patients.

The Grievant was placed on administrative leave on December 11, 1995, so the incident could be investigated. As provided in Article 8, Section 8.03 of the collective bargaining Agreement, a pre-disciplinary conference was held on December 26, 1995. The Grievant was charged with patient abuse for applying a choke hold to patient C twice on December 22. At the conference, the Grievant denied choking the patient, and explained that he had his arm around C's chest. He also stated then, as he did at the Hearing, he was aware choke holds are not a permissible means of handling patients.

The Hearing Officer for the pre-disciplinary conference concluded just cause existed for

the Grievant to be disciplined for patient abuse. It was noted therein that the Grievant had "No Prior Corrective action of record" (during the last two years). Based upon that recommendation, the Chief Executive Officer of the facility ordered the Grievant to be discharged. The Grievant was removed from state service, effective January 3, 1996.

A grievance was timely filed protesting this action. The Employer denied the grievance and the case was advanced to arbitration for decision.

POSITIONS OF THE PARTIES

Employer Position:

The Employer contends the Grievant was discharged for just cause because he violated hospital and state policy forbidding patient abuse or neglect. It maintains a proper investigation of the December 22, incident was conducted, the result of which showed, by credible testimony, that in subduing an agitated patient C, the Grievant used a choke hold, was ordered to "Stop", did so, but applied a choke hold a second time, was ordered to stop, and when he did, he cursed the Clinical Area Supervisor in the presence of both patients and staff.

According to the Employer, patient abuse is an intolerable offense because it is inconsistent with patient rights, potentially injurious to the psychological and physical well-being of patients, and potentially carries with it significant liability for the facility, not only financially, but also in terms of the facility's advantage in a competitive marketplace. Furthermore, given the egregious nature of the Grievant's conduct, the Employer maintains that strict adherence to the tenants of progressive discipline is not appropriate in the instant case. The Employer also rejects the Union's claim that the fact the Grievant has not received THART training since 1993, should

be considered a mitigating circumstance. It argues, instead, that the Grievant's twenty plus years of service at the facility mean that he knew or should have known that choke holds have never been a permissible means of handling any patient; agitated or not.

Based upon these considerations, the Employer asserts that discharge is the appropriate discipline for the offenses proven and asks that this grievance be denied.

Union Position:

The Union maintains the Employer's decision to discharge the Grievant was without just cause. It contends the Employer has over-reacted without rationally and fully considering the circumstances in which the Grievant found himself on December 22. To wit, the Union argues that the Grievant did not administer a choke hold(s) to the Grievant on that date, but rather, as the out of control patient struggled, the Grievant's arm inadvertently could have moved upward from C's chest to his neck area. This is not evidence, the Union contends, that the Grievant administered a choke hold(s) to the Grievant. Furthermore, the Union argues that if the Grievant had a propensity to engage in such behavior, then it is unreasonable to believe that he would have achieved twenty plus years' service at the facility and have no prior discipline on his record at the time of the December 22, incident. The Union asserts this record is all the more remarkable since the Grievant had not received a THART update since 1993; obvious evidence, the Union claims, of the Employer's negligence at this facility.

Based upon these facts, the Union maintains that the Employer has failed to prove that the Grievant committed the offenses for which he is charged and, thus, that just cause existed for any discipline; much less discharge. It asks as remedy that the grievance be granted and that the Grievant be reinstated to his former position, with full back pay, and be made whole in all

respects.

ANALYSIS

The record was carefully and thoroughly reviewed in determining what the outcome of this case shall be. The Arbitrator concluded the credible testimony, written statements, and police report of record prove that an incident occurred on December 22, 1995, in which the Grievant twice applied choke holds to patient C. In so concluding, note was taken that Dean testified she, in essence, saw the Grievant's arm around patient C's upper chest and she could see his neck. This testimony was given no weight vis-a-vis that of Penwell for two reasons. First, Dean's observation point was never established at the Hearing. Second, there is no dispute that Penwell was helping the Grievant restrain the patient and, thus, he was in the best possible position to observe what transpired. Additionally, there is no indication whatsoever that Penwell has anything to gain from the outcome of this case. His testimony was therefore deemed credible. In contrast, the Grievant's testimony was found to be self-serving and not credible with respect to the choke holds and otherwise. On this basis, the Arbitrator concluded the Grievant is guilty of applying a choke hold on two occasions to patient C on December 22.

This conclusion establishes that an offense was committed. The Union made no complaint that the facts and circumstances surrounding this offense were not properly and fully investigated by the Employer, nor does the record contain such evidence. Nevertheless, this finding is not sufficient to affirm that discharge was the appropriate penalty in this case.

Note was made of testimony provided by the Employer at the Hearing that the Grievant cursed Badjun in the day and chart rooms. While the weight of the credible testimony indicates

the Employer's assertion is correct, no weight was given to this information because the cause of action for which the Grievant was discharged was patient abuse/neglect; and did not include insubordination or use of profanity.

There is no dispute that application of a choke hold constitutes patient abuse under both facility and state policy. It is also undisputed that use of such holds has never been condoned at any time during the twenty plus years of the Grievant's employment at the facility. While the Union made a valiant effort to show the Employer's negligence in failing to afford to all employees updated THART training on an annual basis, this was neither persuasive nor dispositive in the instant case. As argued by the Employer, the Grievant's years of service mean that he knew or should have known that application of a choke hold, even on an agitated patient and in the absence of current THART training, was forbidden.

Therefore, the real question before the Arbitrator is whether or not the penalty of discharge is appropriate for the Grievant's proven offenses. The Union claimed it was not, *per se*, or excessive because the principles of progressive, corrective discipline were not followed, no injury occurred to the patient, and there were mitigating circumstances, in addition to the patient's agitated behavior. In determining the outcome of this case, this Arbitrator considered the fact that the physician who examined patient C, after the incident, found no physical injury. She concluded this is not dispositive in terms of whether or not the Grievant was guilty of patient abuse as defined by facility and state policy. Application of a choke hold is not only violative of patient rights, but also of both facility and state policy. The Arbitrator also agrees with the Employer that whether or not the Grievant received updated THART training, he knew, or should have known, because of his years of service and previous THART training, that choke holds

were forbidden. In so ruling, this Arbitrator also makes it clear that she is not condoning the facility's failure to timely and appropriately provide THART.

The Arbitrator also considered whether the discipline for the Grievant's offenses should be progressive. While she supports the principles of progressive discipline, this Arbitrator recognizes that there are certain offenses for which progressive discipline is inappropriate as defined by the circumstances of the case. In the instant case, the Arbitrator agrees with the Employer that the Grievant's proven behavior, on December 22, was so egregious as to warrant the penalty of discharge.

Award

The grievance is denied in its entirety.

Date: May 18, 1998 Mollie H. Bowers

Mollie H. Bowers, Arbitrator