#~~1369~~
#1370

OPINION AND AWARD

IN THE MATTER OF THE ARBITRATION BETWEEN
OHIO STATE PAULINE LEWIS WARFIELD CENTER
-AND-
DISTRICT 1199/SEIU

APPEARANCES

For the State
Bradley A. Nielsen, EEO Regional Program Administrator
Malleri Myricks, Labor Relations Officer
Malcolm King, Director of Nursing
Rhonda Bell, OCB - Labor Relations Specialist
Ladonia Coatney, OCB Observer
Rita Surber, Regional H.R. Administrator
Van Spencer, Campus Police Officer 2
Marianne Russ, Assistant Director of Nursing

For the Union
Janice D. Stephen, Administrative Organizer
Victoria Todd, RN, Grievant
Jackie Hines, RN
Ronald W. Coleman, Former TPW
Doris J. Johnson, Retired
Patricia Wausley, AA

Case-Specific Data
Hearing Held
April 23, 1999

Case Decided
June 16, 1999

Arbitrator: Robert Brookins, J.D., Ph.D.
Subject: Lost Work Keys ---2-day Fine in Lieu of Suspension

Table of Contents

I. Preliminary Statement

A hearing on this matter was held in the Pauline Warfield Lewis Center in Cincinnati, Ohio before this Arbitrator who was mutually selected by the parties from their permanent panel and pursuant to the procedures of their Collective-Bargaining Agreement. The hearing occurred at 10:00 a.m., on May 23, 1999. The parties stipulated that the matter was properly before this Arbitrator and presented one issue on the merits as set forth below.

Both parties had a full and fair opportunity to present evidence and arguments in support of their positions in this matter. Specifically, they were permitted to make opening statements, to introduce admissible documentary evidence, to present witnesses who testified under oath, and to cross-examine the opponent's witnesses. Finally, the parties had a full opportunity either to offer closing arguments or to submit post hearing briefs; they chose the latter.

II. The Facts

The Pauline Warfield Lewis Center (PWLC) hired Ms. Victoria Todd (the Grievant) as a Registered Nurse on January 8, 1996, approximately 3.5 years ago. During her tenure with PWLC, the Grievant maintained a discipline-free work record until October 25, 1997, when PWLC imposed a 2-day disciplinary fine upon the Grievant for neglect of duty in the form of incompetency, after a patient used the Grievant's work keys to escape into the surrounding neighborhood.

PWLC is deeply concerned about security. Therefore, before discussing the specific facts and circumstances of this disciplinary action, one should afford some perspective for these security-based concerns. PWLC is a mental hospital that treats civil and forensic patients. Forensic patients usually come to PWLC from the criminal justice system where they were: (1) "police holds" from police departments; (2) adjudged not guilty by reason of insanity; or (3) adjudged incompetent to stand trial. Because of their psychiatric condition and abnormally threatening behavior, some forensic patients are classified as "high profile."

Obviously, there is an urgent need to monitor and restrain their movements both within and without PWLC. Within PWLC, patients must be denied access to medication carts or medicine rooms, which contain potentially dangerous prescription and controlled substances (pharmaceuticals). Patients who gain unauthorized or unsupervised access to pharmaceuticals present a considerable threat to themselves and to employees. A patient who escapes from PWLC poses a threat to society and to himself. Moreover, this threat may be substantially enhanced if a patient escaped after imbibing certain types of pharmaceuticals. Finally, a patient with the means to escape could help other patients to escape.

PWLC views the control of work keys as critical to the security of both PWLC and society. Because of their duties, some employees have keys to external doors and to medication carts. Barring disciplinary or other prolonged separations from PWLC, employees retain their work keys throughout their tenure with PWLC.[1] In the interest of security, PWLC requires employees to retain control of their work keys. As a Registered Nurse, the Grievant must have a set of work keys to the external doors and to medication carts within PWLC.

The facts leading to the Grievant's disciplinary fine are not in dispute. On August 31, 1997, the Grievant, Ms. Brock (TPW), and Ms. Johnson (TPW) were working the second shift on Forensic Unit 5. As the only Registered Nurse on duty, the Grievant was responsible for a total of three units and three "high profile" patients, not an uncommon assignment at PWLC.[2]

At approximately 8:35 p.m. when the incident occurred, the Grievant was sitting behind a desk in Forensic Unit 5, facing the front of the desk, and updating a kardex file.[3] A counter—approximately four-feet-high—formed an "L" around the front and right side of the desk, and a wall joined the left front side of

---

1 Joint exhibit 12, IV, A3.

2 Note that Johnson said there were three "high profile" patient on the Grievant's ward, but Wausley said there was only one.

3 For added security in retaining patients, Forensic Unit 5 has double doors both of which are locked.

the counter at approximately a forty-five degree angle. Thus, the wall and counter joined to form a "U" around the front and both sides of the desk. From her seated position, the Grievant could see over the counter but not around the wall. To get behind the desk, one must pass through an opening at the end of the counter on the right side of the desk. This opening is situated slightly behind and to the left of where the Grievant was sitting and filing when the incident occurred.

The filing process required the Grievant to select files from the top of the desk, swivel her chair approximately 180 degrees to her right and deposit the files in a portable file cabinet slightly behind her and to her right. During this process, the Grievant's work keys lay well within her reach—on top of the desk, directly in front of her, and slightly to her right.

While filing, the Grievant noticed a "high profile" patient (F.B.) standing approximately three feet beyond the front of the desk and counter.[4] Shortly thereafter, Ms. Johnson announced that she was leaving the area to take a cigarette break. The Grievant last saw F.B. pacing back and forth in front of the counter. Although the Grievant knew that F.B. was in the area, she denied any knowledge that he was a "high profile" patient. Shortly after Ms. Johnson went on break, the Grievant heard her yelling that F.B. had used someone's keys to leave the building. Hearing this, the Grievant immediately reached for her keys; they were gone. A campus police officer (Van Spencer) and Ronald W. Coleman (TPW) chased F.B. but did not apprehend him.[5] Immediately upon returning to Forensic Unit 5, Officer Spencer asked the Grievant about her work keys, and she unhesitatingly admitted that they were missing. Because the entire incident occurred so rapidly, the Grievant had insufficient time to report the lost work keys to the campus police department as required by PWLC procedures.[6] F.B. returned on September 1, 1997, claiming that he left the keys he

---

[4] F.B. was classified as "high profile" because: (1) of his mental condition; (2) he engaged in sexually inappropriate behavior on one unit as well as breaking and entering in the community.

[5] F.B. was subsequently apprehended, but the keys were never found.

[6] *See* Joint exhibit 12, IV, B.

used to escape in a taxi cab.[7] PWLC never recovered the keys and, consequently, had to replace the Grievant's work keys and the medicine-cart lock.

Preponderant evidence in the record as a whole establishes that the Grievant was (or should have been) aware of PWLC's policy that required her to maintain control of her work keys. She "signed off" on Policy D-1,[8] which explicitly addresses the key policy.

On September 26, 1997, PWLC held a pre-disciplinary conference to determine what, if any, action should be taken against the Grievant.[9] On October 28, 1997, PWLC imposed a 2-day, disciplinary fine ($213.76) on the Grievant for violating Hospital Policy HR-101. Specifically, PWLC concluded that the Grievant was guilty of "neglect of duty and incompetency, i.e., failure to complete assigned tasks established by policy and endangering rights, safety or health of a patient."[10] PWLC imposed the fine in lieu of a 2-day suspension because it could ill afford to lose the Grievant's services for two days.

III. Factual Stipulations

1. The grievance is properly before the Arbitrator.
2. The Grievant was classified as Psychiatric/MR Nurse at the Pauline Warfield Lewis Center.
3. The Grievant's date of employment is 1/8/96.

IV. Joint Exhibits

1. Pre-Disciplinary Conference Notice
2. Two-Day Fine Letter
3. Grievance
4. Step-3 Response
5. Letter of Intent to Arbitrate
6. Incident Report #974605
7. Victoria Todd Statement
8. Van Spencer Statement
9. Doris Johnson Statement

---

7 *See* Joint exhibit 1.

8 Joint exhibit # 14.

9 Joint exhibit 1.

10 Joint exhibit 2.

10. Ronald Coleman Statement
11. Disciplinary Policy HR-101
12. Key-Control Policy CP-104
13. Administration of Medication D-1
14. Training Record
15. 1199 Contract

V. Relevant Contractual Provisions

Article 8.01 Standard

Disciplinary action may be imposed upon an employee only for just cause.

6.01 Non Discrimination

Neither the Employer nor the Union shall discriminate in the application or interpretation of the provisions of this Agreement.

VI. Other Relevant Rules

A. Hospital Policy: Hr-101

I. Subject
Disciplinary Action

II. Purpose
To provide guidelines for the administration of disciplinary action.

III. Application
All employees of the Pauline Warfield Lewis Center

IV. Subject Content

A. All employees shall be expected to perform their duties demonstrating good behavior and efficient service.

* * * *

D. Disciplinary action shall include the following:
Verbal Reprimand
Written Reprimand
Suspension
Demotion
Removal

* * * *

F. The attached "Standard Guide for Disciplinary Action" shall be used to determine the appropriate penalty for various infractions.

G. The seriousness of the offense and the disciplinary record of the employee shall be considered in determining the level of disciplinary action to be taken.

B. Excerpt From Standard Guide for Disciplinary Action

Penalties			
Neglect of Duty—Incompetence	FIRST OFFENSE	SECOND OFFENSE	THIRD OFFENSE
Performance at sub-standard levels whereby safety, health, or rights of patients are endangered; failure to complete assignments in an appropriate manner, thereby endangering rights, safety, or health of patients.	2 Day Suspension or 6 Day Suspension or Removal	6 Day Suspension or Removal	Removal

C. Hospital Policy: CP-104

I. Subject
Key Control

* * * *

IV. Subject Content

* * * *

B. Loss of Keys

When an employee loses a key this must be immediately documented on an Unusual Incident Report Form by both the employee and supervisor. The affected employee will be charged $3.00 for replacement of the key. The replacement charge may be higher if any locks need to be changed. Depending upon the circumstances , disciplinary action may also be initiated.

D. Policy D-1

* * * *

Nursing Considerations:

* * * *

B. At no time should the medication cart keys be left hanging in the lock. The keys are to be *kept on your person.*[11]

* * * *

F. The RN/LPN assigned medications *is responsible for the keys* to the medication cart at all times.[12]

---

[11] (emphasis added).

[12] (emphasis added).

VII. The Parties' Arguments

The Union's Arguments

1. The Grievant was a victim of disparate treatment.
2. PWLC acted arbitrarily and capriciously in imposing the 2-day fine. That is, PWLC did not progressively discipline the Grievant for engaging in the alleged misconduct.
3. The Grievant violated no policy or rule by placing her keys on the desk at her work station.
4. PWLC must show that the Grievant acted with intentional or willful negligence to endanger a patient.

PWLC's Arguments

1. The Grievant was not subjected to disparate treatment.
2. The severity of the Grievant's discipline fits her demonstrated misconduct.
3. The Grievant violated policies CP-104 and D-1.
4. The Grievant was negligent in failing to control her work keys, and that negligence violated Policy D-1.

VII. The Stipulated Issue

Was the Grievant disciplined for just cause, if not what shall the remedy be?

VIII. Discussion

Before discussing the parties' arguments, a few preliminary matters warrant some attention. First, although the Key-Control Policy is stated in Policy D-1, during the hearing several of PWLC 's witnesses offered conflicting interpretations of the Key-Control Policy, which raises at least two issues: (1) what does the Key-Control Policy require; and (2) whether the Grievant understood the Key-Control Policy. These issues are discussed below.

A. Nature of Key-Control Policy

Policy D-1 explicitly states: "Keys are to be kept on your person." Despite this rather clear language, two managers expressed a relaxed interpretation of the Key-Control Policy relative to what it explicitly states. First, the Director of Nursing (Mr. Malcum King) testified, under cross-examination, that employees may set work keys in front of them, provided they know where the keys are and can see them. Mr. King also testified that work keys must be secure at all times and the person in possession of work keys should never lose sight of them at work. In contrast, the Assistant Director of Nursing (Ms. Mary Ann Russ) testified that work keys

are to be kept on one's person at all times, either in one's pocket or on a breakaway chain that PWLC provides. Ms. Russ also stated that although the Key-Control Policy applies to patient and non-patient areas, PWLC is not as concerned about key control in the latter areas—home or away from PWLC's campus. Finally, Ms. Russ testified that it was *unacceptable* for an employee to lay work keys on a desk and that work keys must be kept within an employee's control.

Despite their inconsistencies, the testimonies of Mr. King and Ms. Russ reflect a threshold level of care that employee must exercise when handling work keys. In short, employees must retain control of their work keys at all times. Disciplinary consequences may very well follow a failure to exercise this basic level of care.

B. Grievant's Understanding of key-Control Policy

Several reasons suggest that the Grievant knew or should have known about this basic level of care regarding work keys. First, as mentioned earlier, the Grievant "signed off" on Policy D-1[13], which explicitly states: "Keys are to be kept on your person." Also, Policy D-1 states: "The RN/LPN assigned medications is responsible for the keys to the medication cart at all times."[14] During the hearing, the Grievant did not deny that she had "signed off" on Policy D-1. This evidence convinces the Arbitrator that the Grievant had either actual or constructive knowledge of Policy D-1 and of her duty to retain control of her work keys.

C. Violation of Key-Control Policy

Evidence in the record establishes that the Grievant violated the Key-Control Policy. This is perhaps the easiest issue in this dispute because the mere fact that F.B. gained possession of the Grievant's keys at all—let alone in a forensic unit—and used them to escape is indisputable proof that she failed to exercise the baseline level of care with respect to her work keys.

The Union mounts several unpersuasive arguments to support the proposition that, under the

---

[13] Joint exhibit 14.

[14] Joint exhibit 13.

circumstances, the Grievant violated none of PWLC's policies by losing her keys. First, the Union argues that the Grievant violated no policy by simply placing her keys on the desk at her work station. However, the question is whether the Grievant properly controlled her work keys under the prevailing circumstances. She has an undeniable duty to retain control of her work keys and, ultimately, to deny patients possession of those keys. This duty controls the Grievant's right to place her keys on her desk. If she can place the keys on her desk without relinquishing proper control of them—avoid having them fall into a patient's hands—then she would not violate the Key-Control Policy. Given the circumstances at PWLC, the adage "the proof is in the pudding" is a reasonable approach to determining whether the Key-Control Policy has been violated. The Union also argues that no employee should be held responsible or liable for patients' unexpected acts. Again, however, the question is whether the Grievant did all that she reasonably could to retain control of her work keys under the circumstances. She did not. The Grievant knew: (1) she was in a forensic unit; and (2) F.B. was in her area. In addition she should have known that F.B. was a "high profile" patient and that forensic patients can be unpredictable. Therefore, she should have exercised a volume of care that is commensurate with these known risks. In other words, PWLC employees entrusted with work keys must be aware of the prevailing circumstances and exercise the volume of care required to maintain control of their work keys. To expect anything less would essentially confound the Key-Control Policy and the security that it serves. As a result, the Arbitrator is constrained to hold that the Grievant violated the Key-Control Policy by allowing F.B. to obtain her keys under the prevailing circumstances in this case.

Finally, the Union argues for the imposition of a high measure of persuasion when determining whether the Grievant violated the PWLC. Specifically, the Union contends that, to establish a violation of the Key-Control Policy, PWLC must prove that the Grievant acted with intentional or willful negligence to endanger a patient. This high quantum of proof is inapt for several reasons. First, this standard would replace the ordinary negligence standard. Yet, the environment in PWLC is one where patients' psychological conditions might—and probably do—render them irrational and, thus, highly unpredictable. Furthermore, these

psychological conditions significantly increase the risk that a given patient's unpredictable behavior will cause serious injury to the patient and to others. This environment hardly calls for an intentional or willful negligence standard both of which strongly suggests a lower than usual level of vigilance by employees. If anything, the conditions in PWLC show a distinct need for the heightened vigilance normally associated with ordinary negligence.

Traditionally, a negligence standard imposes a duty to increase the volume of care to reflect either an enhanced probability of injury *or* an enhanced magnitude of injury. To permit an employee's volume of care to drop to the level of intentional or wilful negligence is to effectively expose everyone at PWLC (as well as the public) to an unreasonable, unnecessary, and untenable risk of injury. Absent a contractual provision or other type of regulatory requirement to the contrary, ordinary negligence suffices here.

D. Disparate Treatment—2-day Fine

The Union alleges that the Grievant's 2-day fine was arbitrary, capricious, and discriminatory. Virtually all the Union's adversarial energy was focused on the discriminatory element of this allegation, which maintains that the 2-day fine constitutes disparate treatment. In support of this contention, the Union alleges that other employees have lost keys without incurring discipline.

Because this Arbitrator views disparate treatment as an affirmative defense, the Union bears the burden of proof on this issue. That is, the Union must allege and prove disparate treatment by a preponderance of evidence in the arbitral record as a whole by demonstrating that the 2-day fine was not imposed on employees under the same or similar circumstances as the Grievant.[15]

The pith of disparate treatment defense, in the disciplinary phase of a dispute, is whether a substantially higher level of discipline was imposed where relevant circumstances surrounding the misconduct were

---

[15] Observe, however, that instead of requiring unions to establish the irregularity of a particular disciplinary decision relative to others under the same or similar circumstances, a minority of arbitrators require employers to show the regularity of that decision relative to the others. Viewed in this light, employers are not saddled with the impossible task of proving a negative.

essentially the same or similar as those surrounding misconduct that drew milder discipline. "Relevant circumstances" are either aggravating or mitigating in nature and warrant greater or lesser levels of discipline respectively. The degree of difference between aggravating and mitigating circumstances must justify the difference in the measure of discipline imposed. Substantially different measures of discipline, unsupported by substantially different aggravating or mitigating circumstances, are unreasonable, arbitrary, or capricious and, hence, vulnerable to arbitral modification.

In applying this principle, however, arbitrators must recognize that, as a practical matter, some variation in the measure or severity of discipline is unavoidable and, hence, tolerable for at least two reasons. First, a certain, inextricable judgmental element influences every disciplinary decision. Second, no two sets of aggravating and mitigating circumstances are exactly alike. With these principles and caveats in mind, the Arbitrator turns to the case at hand.

As proof of disparate treatment, the Union cites a case in which Ms. Russ (Assistant Director of Nursing) lost her work keys and was required to pay for replacements but was not disciplined. Although some facts in Ms. Russ and the Grievant's case overlap, the differences prevent the Russ case from establishing disparate treatment. The major similarity is that Ms. Russ and the Grievant lost work keys. On the other hand, PWLC alleges three important differences. First, no patient actually used Ms. Russ' keys to escape. This is a solid distinction that, standing alone, warrants the imposition of differential measures of discipline. Allowing a patient to gain control of ones work keys, in the PWLC, is a serious matter as clearly demonstrated in this case. The threat to the public and to PWLC's staff and patients hardly needs elaboration.

Second, Ms. Russ immediately and properly reported the missing keys while the Grievant allegedly did not. This distinction is not as sound as the first because, under the circumstances, the Grievant lacked a fair opportunity to report the incident in timely fashion. Shortly after she missed her keys, Officer Spencer returned from chasing F.B. and asked about the keys that F.B. had used to escape. The Grievant immediately admitted that her work keys were missing. Clearly, this verbal admission falls short of a written report on an

Unusual Incident Report Form. Nevertheless, under the circumstances, the Grievant's admission substantially reduces her culpability for failing to timely report the lost work keys on an Unusual Incident Report Form. Therefore, this distinction is too slight to justify subjecting the Grievant to an enhanced measure of discipline.

Third PWLC alleges that, unlike the Grievant, Ms. Russ lost her work keys outside PWLC. A more detailed assessment is required for this alleged distinction. During the arbitral hearing, Ms. Russ categorically testified that she was sure she lost her keys outside PWLC because she used them to exit the building but could not reenter the building because she did not have her keys.

The difficulty is that Ms. Russ was not so certain that she lost her keys outside the building when she drafted the following statement on Monday, June 12, 1995: "Hospital keys not in purse or on office desk Thursday a.m. Over weekend searched home, car, & retraced steps to stores visited Wed. evening. Keys not found. I do not think I lost these keys in a patient area."[16]

Relative to her testimony, the above passage is a prior inconsistent statement regarding Ms. Russ' conviction that she lost her keys outside the building. First, the statement reveals that Ms. Russ looked on her desk for the keys which means that she entertained at least the possibility that she could have lost them there inside the building. Then she searched for her keys in multiple areas outside PWLC. This behavior hardly supports (or even suggests that), on June 12, 1995, Ms. Russ was certain that she had lost her keys outside the building. Yet, when testifying before this Arbitrator, she was absolutely sure that she lost the keys outside the building. Normally, one would expect Ms. Russ' recall to have been markedly clearer on June 12, 1995, than on May 23, 1999, when she testified before this Arbitrator. If Ms. Russ were sure that she did not lose her keys inside the building or in a patient area, why did she not assert that conclusion with the same conviction on June 12, 1995 as she did approximately four years later? Ultimately, a preponderance of the evidence in the record does not support PWLC's purported distinction that Ms. Russ lost her keys outside PWLC. That conclusion is entirely inferential, and the credibility of the facts that support it are weakened by the inconsistencies

---

[16] Union exhibit 1.

between Ms. Russ' testimony in the arbitral hearing and her prior written statement. An inference can be no stronger than the facts that support it. PWLC alleged and, thus, has the burden of proving this distinction. It has not. Therefore, the record remains unclear as to exactly where Ms. Russ actually lost her keys.

Apparently, concerning the allegation that Ms. Russ lost her keys outside the building, PWLC also maintains that, in Ms. Russ' case, there was no danger that patients would escape. Assuming, agruendo, that Ms. Russ lost her keys outside PWLC (an unproven allegation), it does not necessarily follow that there is *no* risk of patients escaping. An outsider (non-patient) may very well find lost work keys outside the building and use them to enter and either intentionally or negligently allow patients to escape. Moreover, once inside, an intruder might steal pharmaceuticals and controlled substances. Although these risks are relatively slight, they are hardly nonexistent. Still, all matters considered, risks associated with losing keys outside PWLC are considerably less than risks associated with losing keys inside a forensic unit where a "high profile" patient uses them to escape.

Also, the risk to which Ms. Russ and the Grievant exposed PWLC influences the severity of discipline. At the outset, it is clear that the Grievant exposed PWLC and the public to a greater risk not only because she clearly lost her keys inside PWLC but also because she lost them in a forensic unit where a "high profile" patient got them during an inattentive moment and actually used them to escape. Except for consequences such as personal injury or imbibing harmful pharmaceuticals, this probably is the most dreaded consequence of losing work keys inside PWLC.

In a further effort to equate the cases, the Union points out another risk in Ms. Russ' case: the keys were never found and, therefore, could have been floating around PWLC and could have fallen into the wrong hands. Then, the Union points out that no such risk existed in the Grievant' case. Observe, however, that the Grievant's keys were never found either. Therefore, they also could be floating around somewhere near or far from PWLC. Furthermore, the risk associated with not finding lost working keys is substantially reduced in both Ms. Russ and the Grievant's case if PWLC changes the appropriate locks and keys.

E. Progressive Discipline

Finally, the Union argues that imposing the 2-day fine violated the standards of progressive discipline. The Arbitrator cannot agree. The penalty table provides that the lowest level of discipline for a first offense of neglect of duty in the form of incompetence is a 2-day suspension.[17] As pointed out earlier, because PWLC could not afford to lose the Grievant's services for two days, it opted to impose a 2-day fine instead. Section 8.02 of the Collective-Bargaining Agreement provides for penalties ranging from verbal reprimands to removal, including fines, which are the third level of discipline in this progressive disciplinary list. Note, however, that nothing in the parties' contract suggests that disciplinary action for all misconduct must follow the strict order of Section 8.02. Instead, Policy HR:101 relies on a penalty table to determine the proper level of discipline for various types of misconduct based on the seriousness and/or frequency of the misconduct. Thus, Policy HR:101 provides in relevant part: "The attached 'Standard Guide for Disciplinary Action' shall be used to determine the appropriate penalty for various infractions. . . . The seriousness of the offense and the disciplinary record of the employee shall be considered in determining the level of disciplinary action to be taken."[18] This establishes that PWLC will (as it should) look to the seriousness of misconduct to determine the level of discipline imposed.

Ultimately, three reasons rebut the Union's argument that PWLC failed to impose progressive discipline: (1) two-day suspensions are clearly a part of the range of penalties for the form of infraction that the Grievant committed—neglect of duty in the form of incompetence; (2) Policy HR-101 explicitly recognizes that the seriousness of a given form of misconduct dictates the severity of discipline to be impose, even for the first occurrence; and (3) Section 8.02 of the parties' Collective-Bargaining Agreement explicitly permits PWLC to impose fines. Taken together, these provisions clearly permitted PWLC to discipline the Grievant with a 2-day fine in lieu of a like suspension for her particular infraction.

For all of the reasons set forth in this opinion, the Arbitrator holds that: (1) the Grievant violated the

---

17 Joint exhibit 11.

18 Joint exhibit 11.

intent or spirit of Policy D-1 by allowing a "high profile" patient to gain control of her work keys in a forensic ward; and (2) a preponderance of evidence in the record as a whole does not support the Union's disparate-treatment defense.

X. The Award

For all of the foregoing reasons, the 2-day fine was for just cause. As a result, the grievance is hereby **DENIED**.

Notary Certificate

State of Indiana)

)SS:

County of Marion

Before me the undersigned, Notary Public for Marion County, State of Indiana, personally appeared Robert Brookins, and acknowledged the execution of this instrument this 17th day of June, 1999

Signature of Notary Public: Deborah Kay Washington

Printed Name of Notary Public: Deboran Kay Washington

My commission expires: 30 March 2007

County of Residency: Marion

Robert Brookins

Robert Brookins, Labor Arbitrator