#1603

ARBITRATION DECISION

September 23, 2002

In the Matter of:

State of Ohio, Department of Mental Health, Northcoast Behavioral Healthcare System, Northfield Campus	)	
and	)	Case No. 23-18-(02-03-12)-0035-01-04 Darin Locy, Grievant
Ohio Civil Service Employees Association, AFSCME Local 11	)	

APPEARANCES

For the State:

Brian Walton, Labor Relations Officer, Department of Mental Health
Richard Corbin, Office of Collective Bargaining
Linda Thernes, Labor Relations Officer, Department of Mental Health
Roger Beyer, Human Resources, Northcoast Behavioral Healthcare
Thomas Cheek, Chief Executive Officer, Northcoast Behavioral Healthcare
Lieutenant James Wuliger, Northcoast Behavioral Healthcare

For the Union:

Robert Robinson, OCSEA Advocate
Darin Locy, Licensed Practical Nurse, Grievant
Alex Martin, Custodial Worker
Edmonia Antoine, Therapeutic Program Worker
John Mastnick, Therapeutic Program Worker
Deborah Grier, Therapeutic Program Worker

Arbitrator:

Nels E. Nelson

BACKGROUND

The grievant is Darin Locy. He was hired as a Licensed Practical Nurse by the Department of Mental Health in 1993 and worked at the Northfield Campus of the Northcoast Behavioral Healthcare System for five years. The Northfield Campus houses patients with severe mental illnesses, many of whom are aggressive and violent. The only discipline in the grievant's file is a two-day suspension for neglect of duty for allowing his license to expire.

The events leading to the grievant's discharge occurred on January 5, 2002. On that day, patients in McKee 3 were watching a movie in the TV room when AP, an aggressive and sometimes violent patient, hit Edmonia Antoine, a Therapeutic Program Worker, on the back of her head. AP was restrained and escorted to the door of the TV room by Donald Chambers, a TPW, and Alex Martin, a Custodial Worker.

At the time AP struck Antoine, the grievant was at the nurses' station. When he heard the commotion, he went to the TV room. The grievant looked through the window of the closed door and saw Chambers and Martin restraining AP. He opened the door and took AP by the left arm and moved him out of the room. As he ushered AP across the hallway he put AP's left arm up behind his back placing him in a hammerlock.

The grievant pushed AP against the wall opposite the door keeping him in the hammerlock. As the grievant told AP that he had to go to the seclusion room, AP grabbed the handrail on the wall with his right hand. The grievant pulled on AP's right arm to free his hand from the handrail so he could take him to the seclusion room.

When AP lost his grip on the handrail, he and the grievant fell to the floor. Since

the grievant had both of AP's arms, AP had no way to break his fall and hit his head on the floor. He suffered a cut over his left eye and was momentarily dazed. A Registered Nurse from another unit arrived and examined AP. He was then taken to the seclusion room.

The campus police conducted an investigation of the incident. They took statements from many of patients and staff members. Because some of the patients' statements claimed that Antoine hit AP, the investigation initially focused on her. She was placed on administrative leave for nearly two months until the charges against her were dropped. The grievant was questioned and released to go back to work.

At some point, the grievant was charged with patient abuse. Presumably, a pre-disciplinary meeting was held. In any event, on March 6, 2002, the grievant was removed by Michael Hogan, the Director of the Department of Mental Health. Thomas Cheek, the Chief Executive Officer of Northcoast Behavioral Healthcare, made the removal effective the next day.

The grievant filed a grievance on March 7, 2002. He charged that his termination violated Article 24 of the collective bargaining agreement. The grievant asked to be reinstated with back pay and to be made whole and to have the discipline removed from his file.

A step three grievance hearing was held on March 20, 2002. On April 15, 2002, Linda Thernes, the hearing officer, issued her report. She stated:

> The Grievant's actions caused the injury that resulted. This particular hold is not taught as a therapeutic move. The Grievant was also charged with a violation of that policy. The abuse policy also states that any action or inaction that results in a patient being harmed is a violation. The patient in this case was harmed as a direct result of the Grievant's use of a

non-therapeutic hold.

Thernes concluded that the grievant violated the abuse policy and found that there was just cause for the discipline.

On April 24, 2002, the case was appealed to arbitration. The hearing was held on August 7, 2002. The parties submitted written closing statements on September 3, 2002.

ISSUE

The issue as agreed to by the parties is:

Was the grievant, Darin Locy, removed for just cause? If not, what shall the remedy be?

RELEVANT CONTRACT PROVISIONS

Article 24 - Discipline

24.01 - Standard

Disciplinary action shall not be imposed upon an employee except for just cause. The Employer has the burden of proof to establish just cause for any disciplinary action. In cases involving termination, if the arbitrator finds 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 the authority to modify the termination of an employee committing such offense.

* * *

24.02 - Progressive Discipline

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 oral reprimand(state) (with appropriate notation in employee's file);
B. one or more written reprimand(state);
C. a fine in an amount not to exceed two (2) days pay for discipline related to attendance only; to be implemented only after approval from OCB;
D. one or more day(state) suspension(state);
E. termination.

* * *

24.05 - Imposition of Discipline

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

STATE POSITION

The state argues that the grievant's actions meet the definition of patient abuse. It points out that NBH Policy #6.09 defines abuse as "any act or absence of action which results, or could result, in physical injury to a patient." The state notes that Cheek testified that because the grievant's actions led to AP's injury, he had no choice but to remove him.

The state maintains that Lieutenant James Wuliger carefully investigated the incident. It reports that he interviewed the grievant on several occasions. The state indicates that he also videotaped the grievant's demonstration of what occurred on January 5, 2002.

The state reports that Lt. Wuliger explained how and why the grievant's intervention was inappropriate. It summarizes his testimony as follows:

> Lt. Wuliger went through the Grievant's explanation one step at a time explaining how or why the Grievant's attempt at intervention was inappropriate. Lt. Wuliger stated that the Grievant's demonstration raised several concerns over the handling of the situation. First, Lt. Wuliger explained that the Grievant should have attempted to determine what was happening and what needed to be done prior to taking A.P. out of the TV room. The Grievant should have asked the two employees who were holding A.P., Donald Chambers and Alex Martin, what they wanted to do. Instead he acted independently. A basic principle of the THART and Crisis Intervention Training is to analyze a situation before acting and to work in teams. The Grievant's actions were inconsistent with that training.

> Lt. Wuliger was also concerned with the hammer-lock hold used by the Grievant. Lt. Wuliger explained that THART teaches employees to use the least restrictive means to restrain a patient. This type of hold could lead to injury (as it did), and it is not an approved hold.
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> He went on to explain that once the Grievant had A.P. against the wall, albeit using an inappropriate hold, A.P. was no longer a threat to strike or attack the Grievant. At this point the Grievant could have utilized an approved hold such as a basket hold, and he should have requested assistance from one of the two employees who were in close proximity, Mr. Chambers and Laverne Claxton. Lt. Wuliger stated that if A.P. were fighting with the Grievant, these two employees would have assisted without being asked. Based upon their actions, it appears they did not believe A.P. was a threat to the Grievant.
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> Lt. Wuliger was also concerned with the lack of verbal prompts given to A.P. Prior to using physical intervention, employees are expected to attempt verbal intervention. In this instance, the Grievant claims to have asked or told A.P. once or twice to go to seclusion. Then in a matter of only seconds, he attempted to escort A.P. to the seclusion room. Lt. Wuliger could not understand why the Grievant acted so hastily. At this point A.P. was not a threat, he was merely uncooperative.
>
> If the Grievant was concerned with A.P.'s unpredictability and potential to lash out, that was all the more reason to seek assistance or wait for assistance. The Grievant should have held A.P. against the wall until one of the employees came to assist him. There was no logical reason to act alone. Finally, Lt. Wuliger pointed out that a two-person escort should have been used. If two people attempted to escort A.P., he probably would not have fallen and therefore would not have been injured. (State Written Closing, pages 3-5.)

The state rejects the union's claim that the grievant did not have time to think. It contends that this argument is flawed because once the grievant had control of AP, he could control the pace of the situation. The state claims that the grievant did not need to pull AP's hand from the handrail after only 10 to 15 seconds and after only a few verbal comments to go to the seclusion room. It asserts that the staff present did not feel any sense of urgency or they would have intervened.

The state argues that the mere fact that AP has a history of being physically

aggressive and violent did not justify the use of unnecessary physical intervention. It points out that he is not the only patient who fits this description and the grievant has worked with other patients who were aggressive or violent.

The state contends that the grievant ignored the rules in the Crisis Intervention Training Manual. It claims that he violated rule #3 that states, "don't act alone, stay away from the patient until enough help arrives." The state charges that the grievant also ignored the rule to "use the physical techniques only as a last resort." It asserts that "the grievant thought that this was his chance to be a hero." (State Written Closing, page 7.)

The state rejects the union's argument that THART and Crisis Intervention techniques are not effective. It states that these techniques were developed by experts in the field and are nationally recognized. The state indicates that they are taught at all nine of the Department of Mental Health's in-patient hospitals and the developmental centers of the Department of Mental Retardation and Developmental Disabilities.

The state challenges the claim that the amount of THART and Crisis Intervention training is inadequate. It observes that the grievant and other union witnesses acknowledged that they received training when they were hired and then got annual updates. The state adds that testimony indicates that it is not the case that employees receive training and then forget it because they never have to use it.

The state rejects the allegation that the grievant was a "scape-goat." It acknowledges that Antoine was investigated as a result of the January 5, 2002, incident but claims that it is irrelevant. The state notes that the grievant's conduct was the subject of an administrative investigation and that he received due process. It adds that it was his

own statements that shed light on his offense.

The state discounts the argument that the grievant's use of a hammerlock was not enough to warrant an abuse charge. It points out that Lt. Wuliger testified that the hold was inappropriate and that employees were never trained to use it. The state indicates that once AP was under control and up against the wall, it would have been easy and appropriate to use a basket hold in accordance with THART training.

The state cites the decision of Arbitrator David Pincus in State of Ohio, Department of Mental Retardation and Developmental Disabilities, Gallipolis Developmental Center and OCSEA, Local 11, AFSCME; Case No. 24-07-(91-02-14)-0396-01-04. It observes that in the case before Arbitrator Pincus, the grievant, who was accused of using a chokehold on a client, insisted that he only used a bear hug. The state reports that Arbitrator Pincus stated:

> The use of a "bear hug" would have rendered her action as abusive even if she never choked Robert E. Feneerbosch stated that a "bear hug" was not a facility-approved technique; it is not taught to employees. Also, the "bear hug" appears to be highly intrusive technique in light of the circumstances discussed by the Grievant. (State Written Closing Statement, page 11.)

The state also relies on the decision of Arbitrator Mollie Bowers in Northcoast Behavioral Healthcare Systems and Service Employees International, District Union 1199; Case No. 23-18-(96-01-18)-1315-02-11. It points out that in the case before Arbitrator Bowers the grievant, who was accused of using a chokehold on a patient, argued that he had not received sufficient THART training. The state observes that the Arbitrator held:

> There is no dispute that application of a chokehold constitutes patient abuse under both facility and state policy. It is also undisputed that the use of such hold 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 this 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. (State Written Closing, page 13.)

The state concludes that the grievant's use of inappropriate intervention techniques and the resulting injuries to AP constitute abuse. It states that since Article 24, Section 24.01, prohibits the Arbitrator from reducing the penalty where abuse is proven, he must deny the grievance in its entirety.

UNION POSITION

The union argues that the grievant did not abuse a patient. It claims that the grievant was disciplined as a result of management wanting to make someone responsible for AP's injuries. The union asserts that when the charges against Antoine did not stick, management turned to the grievant as the scapegoat. It states that "how else can management explain that after thousands of patient incidents requiring staff intervention, the grievant is the only person to use a non-therapeutic THART hold?" (Union Written Closing Statement, page 1.)

The union contends that management knows about the ineffectiveness of THART. It indicates that all staff, including the police, doctors, and others, understand that restraining aggressive, unpredictable, and hostile residents is dangerous. It asserts that "as long as there is no negligence or intent to hurt the resident, the methods of restraint were always overlooked." (Ibid.)

The union maintains that THART is impractical. It points out that it takes time

and repetition to learn the techniques but staff are given neither. The union complains that even though staff receive training only once each year, they are expected to become Bruce Lee.

The union acknowledges that the part of the Crisis Intervention program that talks about assessing a situation is good. It states, however, that most incidents require immediate action since someone is already under attack. The union notes that in the instant case, AP, an aggressive, dangerous, and unpredictable patient, had just knocked Antoine out of her chair. It states that the grievant got the only grip possible on AP in an attempt to get him to another area. The union stresses that the whole incident lasted only ten seconds or so.

The union observes that the grievant never attempted to hide his actions. It reports that from the start he showed what he did and explained that he was only trying to get AP to a quiet area. The union insists that his actions were only a duplication of how everyone has handled potentially dangerous situations. It stresses that staff have the right to protect themselves from injury.

The union maintains that the testimony of its witnesses attests to the inefficiency of THART training. It points out that they characterized it as a "farce" since some have received only a few minutes of training and others have gotten no updates. The union notes that its witnesses indicate that no one has seen anyone use THART but has seen a doctor and the assistant director of nursing use inappropriate methods to restrain patients.

The union challenges Lt. Wuliger's testimony. It claims that he gave prepared and calculated answers to questions about the grievant's actions and THART. The union

accuses Lt. Wuliger of pretending that no police office ever used anything but THART holds. It claims that it was no accident that management did not bring the THART trainer to the hearing.

The union contends that the grievant demonstrated his instinct to care for AP. It points out that after he and AP accidentally fell to the floor, he turned AP over to assess his well-being. The union indicates that AP was never unconscious but that management made up that claim to "spruce up" its case.

The union maintains that the grievant's actions are not abuse under the Ohio Revised Code or the Administrative Code. It observes that Section 2903.33(B)(2) of the ORC indicates that abuse means "knowingly or recklessly causing physical harm" and that under Section 5122-3-14(C)(1) of the OAC abuse is "any act or absence of action inconsistent with rights, which results or could result in physical injury to a resident, except if the act is done in self defense or occurs by accident." (Union Written Closing, pages 4-5.)

The union complains that the grievant's termination has left the staff on edge. It states that management's actions have created animosity and chaos. The union worries that in the future, fewer and fewer staff will be willing to respond to codes.

The union concludes that there was not just cause to discharge the grievant. It asks the Arbitrator to reinstate the grievant with full back pay; health, dental, and other benefits; and no loss of seniority.

ANALYSIS

The basic facts are not in dispute. On January 5, 2002, the grievant heard a

commotion in the TV room and went to offer assistance. When he arrived, he found that Chambers and Martin were escorting AP toward the door. The grievant took AP from them, placed him in a hammerlock, and pushed him against the wall opposite the door. AP grabbed the handrail on the wall and struggled with the grievant as he tried to take him to the seclusion room. When AP lost his grip on the handrail, he and the grievant fell to the floor. AP hit his head on the floor and suffered a bruise and cut by his left eye. He was checked by an RN and taken to the seclusion room.

The campus police conducted an investigation. Initially, Antoine, who was in the TV room and was struck by AP, was suspected of striking AP and causing the bruise and cut by his eye. She was placed on administrative leave for nearly two months but was eventually returned to work without being given any discipline.

The grievant then became the focus of attention. He was charged with patient abuse. The grievant was removed on March 6, 2002, and immediately filed a grievance. When his termination was upheld at step three of the grievance procedure, his case was appealed to arbitration.

The grievant was charged with violating Section 06.09 of the Northcoast Behavioral Healthcare System's Policies and Procedures. It defines abuse as:

> Any act or absence of action which results, or could result, in physical injury to a patient. Any act which constitutes sexual activity as defined under Chapter 2907 O.R.C., where such activity would constitute an offense against a patient under that chapter; insulting or coarse language or gestures directed toward a patient which subjects the patient to humiliation or degradation; or depriving a patient of real or personal property by fraudulent or illegal means.

The state's case against the grievant was presented in the testimony of Lt. Wuliger. His testimony was based very heavily on the grievant's account of what took

place and especially on a videotape he made demonstrating exactly what he did on the date in question. Lt. Wuliger stated that the grievant's conduct was inconsistent with the department's Crisis Intervention manual in a number of ways. He charged that the grievant did not determine what was happening before taking action, did not ask Chambers and Martin what they wanted to do with AP, did not analyze the situation, and did not use verbal prompts more than once or twice.

The Arbitrator must discount these charges. First, the grievant did not have time to proceed as Lt. Wuliger suggested. The grievant properly felt that it was important to get AP out of the TV room where an audience may have encouraged bad behavior. Events occurred very rapidly giving him no time to analyze the situation as is possible when watching a videotape of an incident. In fact, the grievant testified the entire incident took only five or ten seconds. Second, even if in the grievant could have handled the situation in a different fashion, the conduct that Lt. Wuliger complained about does not constitute abuse under Section 06.09 of the Northcoast Behavioral Healthcare System's Policies and Procedures.

The major charge against the grievant relates to the use of a hammerlock in restraining AP. Lt. Wuliger felt that the grievant should have used a less restrictive hold and that its use could have, or did, result in an injury to AP. He also complained that the hammerlock was not an approved hold and was not included in THART training.

The Arbitrator cannot conclude that the grievant's use of a hammerlock, under the circumstances, was improper. As indicated above, events moved very rapidly. Chambers and Martin brought AP to the door of the TV room and the grievant had to immediately

take control of him. He did so in whatever way he could because AP was an aggressive and violent patient who was resisting.

The Arbitrator acknowledges that the hammerlock is not one of the holds included in the THART manual. However, it does not seem more harsh or hazardous than many of the holds that are included in the THART manual. In fact, grammar school children sometimes use the hammerlock in wrestling with their classmates.

The Arbitrator is aware that AP was injured. However, the bruise and cut he suffered were not the result of the hammerlock but his fall to the floor. It would not have mattered what hold was used, the result was likely to have been the same.

The situation in the instant case is vastly different from the two cases submitted by the state. In Northcoast Behavioral Healthcare Systems and Service Employees International, District Union 1199; Case No. 23-18-(96-01-18)-1315-02-11, the grievant put a patient in a chokehold and Arbitrator Bowers credited the testimony of a witness that "the patient's eyes bulged, he uttered choking sounds, spit was coming from his mouth, and his skin darkened." (Page 4.) The Arbitrator properly concluded that the use of the chokehold by the grievant constituted patient abuse.

In State of Ohio, Department of Mental Retardation and Developmental Disabilities, Gallipolis Developmental Center and OCSEA, Local 11, AFSCME; Case No. 24-07-(91-02-14)-0396-01-04, the grievant was charged with using a chokehold on a patient. Although she testified that she only used a bear hug, it is clear that Arbitrator Pincus did not believe her. On that basis, he appropriately upheld the grievant's discharge.

The Arbitrator, however, rejects any suggestion in that decision that the use of any hold that is not "facility-approved" and is not "taught to employees" is necessarily "abusive." In some situations employees have to react very quickly to control a patient or protect themselves. Not every alternative hold can be taught to employees and sometimes a hold that is not taught to employees may be the best or only option under the circumstances.[1]

Based on the above analysis, the Arbitrator must conclude that there was not just cause to discipline the grievant. His failure to analyze the situation as suggested by Lt. Wuliger was impossible given the fast pace of the events and, in any case, did not constitute patient abuse. Furthermore, the grievant's use of a hammerlock was not inappropriate under the circumstances.

AWARD

The grievant is to be reinstated to his former position with full back pay and benefits less interim earnings. The Arbitrator will retain jurisdiction for 60 days from the date of his award to resolve any disputes regarding the calculation of the back pay and

benefits due the grievant.

Nels E. Nelson

Nels E. Nelson
Arbitrator

September 23, 2002
Russell Township
Geauga County, Ohio

[1] Although Arbitrator Pincus found the bear hug to be "abusive" and "highly intrusive," page 104 of the Department of Mental Health's Crisis Intervention Manual instructs employees how to apply a bear hug and describes it as "an excellent maneuver" and a "great way to begin the basket hold."