OPINION AND AWARD
IN THE MATTER OF THE ARBITRATION BETWEEN

OHIO DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
-AND-
Ohio Civil Service Employees Association AFSCME Local 11

Appearing for the Ohio Department of MRDD
Robin Bledsoe, Acting Human Resources Director
Laura Janel Frazier, Labor Relations Coordinator
Kim Hensley, TPW, Full-time
Chip Kirby, Mental Health Administrator
Melvin Massie, TPW/Full-time
Jamshed Nuggud, Physician/Psychiatrist
Sarah Richards, Registered Nurse
Sharon Saunders, TPW/Full-time
Donald L. Walker, Superintendent
Michael Ward, Labor Relations Specialists

Appearing for OCSEA
Tammy Lane, TPW/OCSEA
Emily Miller, TPW
Michael Pope, Grievant
Donald Sargent, Advocate/OCSEA

CASE-SPECIFIC DATA
Grievance No.
Grievance No. 24-07- (01-22-04)- 1001-01- 04)
Hearing Held
September 28, 2004

Post-Hearing Briefs Submitted
10/14/04

Case Decided
11/17/04

Subject
Removal–Client Neglect & Failure to Follow Policy (Client Related)

The Award
Grievance Denied

Arbitrator: Robert Brookins, Professor of Law, J.D., Ph.D.

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I. Facts

The parties to this dispute are the Ohio Department of Mental Retardation and Developmental Disabilities ("the Agency") and the Ohio Civil Service Employees Association ("the Union"),[1] which represents Mrs. Michael Pope ("the Grievant"). This dispute involves the removal of the Grievant. There were no procedural objections in this dispute, and the Parties agreed that it was properly before the Arbitrator.

The essential facts in this case are largely undisputed. On August 19, 1991, the Agency hired the Grievant as a Therapeutic Program Worker ("TPW") at the Gallipolis Developmental Center ("GDC") On January 21, 2004, the Agency terminated the Grievant, for Client Neglect ("Neglect") and Failure to Follow Policy (Client Related). (Joint Exhibit 2A) When he was fired, the Grievant had approximately 12½ years of service with the Agency, satisfactory job performance, and no active discipline.

The Agency is responsible for many clients, among them Mr. Aaron H ("Client"). The Client's personality profile includes the following "Target Behaviors:"

- Suffers Injurious Behaviors: placing things in his mouth or ears, picking at his lips, scratching self, tying string around them as cutting off circulation, etc.
- Aggression to others: scratching, lighting, pushing, pulling, pinching, slapping, breaking glasses, etc.
- Disruption: inappropriate verbalizations such or [sic] suggesting that he will hurt himself, noncompliance, any statements intended to shock others, lewd suggestions, teasing our mimicking his peers, etc.
- Feces Smearing: digging feces, any attempt to smear feces on others, himself or objects.[2]

Obviously, the Client was not only dangerous to himself but also irritated others, which made him a target for retaliation. Given this profile and other considerations, the Agency required arms-length, one-on-one supervision of the Client for his safety and that of others. Arms-length, one-one-one supervision requires that the Client remain within arms length of his observer for the entire shift that they are assigned.

The Grievant was properly trained on arms-length, one-on-one supervision as well as the Agency's

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[1] Hereinafter referred to as ("Parties").
[2] Joint Exhibit 4, at F1.

regulations. During his tenure with the Agency, he had supervised the Client many times and was familiar with the Client's "target Behaviors." A summary of the Grievant's training follows:

1. January 31, 2003, Specific Training regarding the Client.[3]
2. April 16, 2003 Specific Training regarding the Client.[4]
3. May 10, 2001, Abuse and Neglect of Individuals and Residence.[5]
4. July 7, 2003, Disciplinary Action and Work Rules.[6]
3. July 8, 2003, Supervision of Individuals.[7]
4. July 18, 2003, Specific Training regarding the Client.[8]
5. September 2, 2003, Unusual Incidents.[9]

On or about November 20, 2003, the Client was transferred from his third-shift supervisors to the Grievant for arms-length, one-one-one supervision.[10] The Client was actual transferred while staff was giving him a shower after he had defecated in his pants toward the end of the third shift.[11]

At approximately 2:00 P.M. on November 20, 2003, the Client told the Grievant he had to urinate. The Grievant took the Client to the restroom, but, instead of escorting the Client into the restroom pursuant to the arms-length, one-on-one supervision, the Grievant stopped at the restroom's entryway and yelled "Is anybody else in here?" No one responded. Then, to afford the Client a modicum of privacy and dignity, the Grievant allowed him to enter the restroom alone.

Between thirty and forty-five seconds after the Client entered the restroom, the Grievant heard a grunt and immediately saw another client hurriedly leaving the restroom. The Grievant quickly entered the restroom and found the Client lying face-up on the restroom floor with one leg draped over the commode.[12] The Client said he was ok, and the Grievant helped him off the floor and escorted him to his assigned area for activities. Contrary to applicable rules, the Grievant neither took the Client for a medical examination

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[3] Joint Exhibit 6, at G2
[4] Joint Exhibit 6, at G1.
[5] Joint Exhibit 6, at B1.
[6] Joint Exhibit 6, at F1.
[7] Joint Exhibit 6, at E1.
[8] Joint Exhibit 6, at 1.
[9] Joint Exhibit 5, at C1.
[10] Joint Exhibit 7B.
[11] Joint Exhibit 4F.
[12] Joint Exhibit 5, at H1.

nor wrote an Unusual Incident Report on the restroom incident.

At the end of the Grievant's shift, on November 20, a second shift TPW, Mr. Melvin Massey, assumed arms-length, one-one-one supervision of the Client. Toward the beginning of that shift, the Client asked Mr. Massey for permission to go to the restroom, and Mr. Massey escorted him there. In the restroom, the Client showed Mr. Massey his scrotum and penis both of which were bruised and complained that his "balls hurt."[13] Mr. Massey immediately took the Client for medical examination and treatment. Sarah (Sally) Richards, Registered Nurse, ("Nurse Richards") was the nurse on duty. After thoroughly examining the Client, Nurse Richards contacted Dr, Jamshed R. Nuggud (Physician/Psychiatrist) and requested that he also examine the Client and he did.

Because the Grievant failed to maintain arms-length, one-one-one supervision of the Client and to submit an Unusual Incident Report on the restroom event, the Agency placed him on administrative leave on November 21, 2003.[14] Then Mr. Chip Kirby, the Agency's Major Incident Investigator and Matthew Richards (Police Officer) investigated the incident.

Officer Richards interviewed the Grievant on November 25, 2003.[15] During that interview, the Grievant took full responsibility for failing to maintain arms-length, one-one-one supervision with the Client on November 20, 2003. Also, the Grievant admitted that he knew he should have written an Unusual Incident Report about the Client's mishap, that he should not have sent the Client to the restroom alone,[16] and that he took full responsibility for the matter. Furthermore, the Grievant stated that one of the reasons he did not issue an Unusual Incident Report was that he had not maintained arms-length, one-one-one supervision of the Client.[17]

On December 23, 2003, after completion of the investigation, the Parties scheduled the Grievant's

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[13] Joint Exhibit 5, at 12.
[14] Joint Exhibit 7A.
[15] Joint Exhibit 5, at H1.
[16] Joint Exhibit 4, at H6-H7.
[17] Joint Exhibit 5, at H7.

pre-disciplinary meeting for January 3, 2004 at 3:00 P.M.,[18] though the meeting was actually held on January 6, 2003 at 3:00 P.M.[19] At the end of that meeting, the pre-disciplinary hearing officer found just cause for the charges of Neglect and Failure to File a Report (Client Related). On January 21, 2003, the Agency terminated the Grievant for Neglect and Failure to Follow Policy (Client Related).[20] On January 22, 2004, the Union filed Grievance No. 24-07- (01-22-04)- 1001-01- 04) ("Grievance"), challenging the Grievant's removal.[21] The Agency denied the Grievance at the Step-Three grievance meeting on February 23, 2004,[22] after which the Parties elected to arbitrate the dispute before the Undersigned.

2. Relevant Contractual Provisions and Regulatory Regulations

A. Relevant Contractual Provisions

Article 24.01 - Standard
Disciplinary action shall not be imposed upon an employee except for just cause. The Employer has the burden of proof to establish just cause for any disciplinary action. In cases involving termination, if the arbitrator finds that there has been an abuse of a patient or another in the care or custody of the State of Ohio, the arbitrator does not have authority to modify the termination of an employee committing such abuse. . . .

Article 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(s) (with appropriate notation in employee's file); B. one or more written reprimand(s); C. working suspension; one or more fines in an amount of one (1) to five (5) days, the first fine for an employee shall not exceed three (3) days pay for any form of discipline; to be implemented only after approval from OCB. one or more day(s) suspension(s); F. termination

B. Relevant Regulatory Provisions

DISCIPLINARY ACTION—ADMINISTRATIVE POLICY NO. 2

Section I. Policy

I-D Where extenuating circumstances exist and dependent on the nature of the infraction, progressive discipline is acceptable. However, in situations of a major are severe violation such as abuse, neglect or mistreatment, the employee will be terminated.[23]

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[18] Joint Exhibit 2B.
[19] Joint Exhibit 2, at C1.
[20] Joint Exhibit 2A.
[21] Joint Exhibit 1, C1.
[22] Joint Exhibit 1, at B2.
[23] Joint Exhibit 3, at 1.

Section III. Definitions

A "Major Offense" "An offense which, in and of itself, may constitute grounds for the imposition of a suspension or removal from employment; an incident where disciplinary action need not follow the progressive corrective action sequence."[24]

P Failure to Act/Client Neglect– Includes, but is not limited to, "*failure to act* in any manner which *results in* any *potential or actual* harm to a resident, *failing to report or covering up* resident abuse/*neglect*/mistreatment."[25]

Section IV. Employee Responsibility

A Employees who witnessed by have knowledge of alleged, suspected, or actual client abuse, neglect or mistreat men shall be obligated to act immediately to insure the safety of clients involved and report such incidents to his/her a media supervisor will be immediately inform the G.D.C. Police and the Superintendent, or his/her designee. Failure to do so shall be considered Client Abuse/Neglect.[26]

Section V. Disciplinary/Corrective Action

B For major breaches in behavior, the principal of progressive corrective action do not necessarily apply. The employee shall be disciplined in a timely manner in accordance with the guidelines for the alleged cited offenses listed in Attachment 1.[27]

ABUSE AN NEGLECT OF INDIVIDUAL IN RESIDENCE—ADMINISTRATIVE POLICY NO. 4-77

Section III. Definitions

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Failure to Act/Client Neglect– Includes, but is not limited to, "*failure to act* in any manner which *results in* any *potential or actual* harm to a resident, *failing to report or covering up* resident abuse/*neglect*/mistreatment."[28]

Section IV. Procedure

B Corrective

1, a. Employee Responsibility

Each employee who witnesses or has knowledge of alleged, suspected, or actual abuse, neglect, or mistreatment of a client shall be obligated to act immediately to ensure the safety of client(s) involved and immediately report such incidents to his/her immediate supervisor (or other available

[24] Joint Exhibit 3, at 2.
[25] Joint Exhibit 3, at 4.
[26] Joint Exhibit 3, at 4-5.
[27] Joint Exhibit 3, at 5.
[28] Joint Exhibit 6, at B3.

supervisor) and immediately inform the G.D.C. Police who will inform the Superintendent, or his/her designee. Failure to do so shall be considered Client Abuse/Failure to Act/Client Neglect per Administrative code 5123-3-14, and disciplinary action may be taken.[29]

UNUSUAL INCIDENTS–ADMINISTRATIVE POLICY NO. 68
(People in Residence)

Section III Definitions

A. Unusual Incident – Any incident, act, event, or circumstance that has a real potential negative impact on a client, the living area, or the center. Examples include, but are not limited to:

* * * *

3. All Falls[30]

B. Major Unusual Incident means the alleged, suspected, or actual occurrence of an incident that adversely affects the health and safety of an individual, including acts committed all allegedly committed about what individual against another. Major Unusual Incidents include, but are not limited to, the following:

1. Abuse means any of the following:

* * * *

e. Neglect means, when there is a duty to do so, failing to provide the individual with any treatment, Care, goods, supervision, or services necessary to maintain the health and safety of the individual.[31]

Section IV. Procedures

A. Unusual Incidents
Unusual incidents are to be reported immediately by the observer to the living area visor or scheduling office R.C.S, and an R,N. or L.P.N. . . . It is the responsibility of the person observing an incident to complete and Unusual Incident Report.[32]

The principles of progressive corrective action will be followed as a means to prevent the employee from committing future violations. Discipline will be prompt, reasonable, consistent with the offense, and commensurate with the individual employee's disciplinary record.[33]

Where extenuating circumstances exist and dependent on the nature of the infraction, progressive discipline is acceptable. However, in situations of a major or severe violation such as abuse, neglect or mistreatment, the employee will be terminated.[34]

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[29] Joint Exhibit 6, at B4.
[30] Joint Exhibit 6, at C2.
[31] Joint Exhibit 6, at C4.
[32] Joint Exhibit 6, at C7.
[33] Joint Exhibit 6, at D2.
[34] *Id.*

C. Standard Guidelines for Progressive Corrective Action[35]

Misconduct	Discipline For First offense
Neglect	Removal
Failure to follow Policy (Client Related)	Written Reprimand to Removal
Poor Judgement (Non-Client Related)	Oral Reprimand[36]

III. The Issue

The Parties stipulated to the following issue: "Was the Grievant, Michael Pope, Removed from his Position as a Therapeutic Program Worker for Just Cause? If not, what shall the Remedy be?"

IV. Summaries of the Parties' Arguments

A. Summary of the Agency's Arguments

1. The Grievant was properly charged with Neglect.
   a. By failing to escort the Client into the restroom, the Grievant violated the arms-length requirement, and exposed the Client to actual or potential harm.
2. The Grievant was properly charged with Failure to Follow Policy (Client Related). The Client's fall in the restroom constituted an "Unusual Incident."[37] This required the Grievant to issue an Unusual Incident Report, which he failed to submit.
3. The Grievant understood the Agency's rules. He had received training on: (1) arms-length, one-one-one supervision; (2) work rules such as Neglect and Failure to Follow Policy (Client Related); (3) writing Unusual Incident Reports; (4) and other training covering his responsibilities to clients.[38]
4. Neglect and Failure to Follow Policy (Client Related) are "Major offenses," and, as such, undermine the Agency's mission.
   a. The penalty for Neglect–removal for the first offense–reflects its seriousness.[39] Also, the numerous training sessions on Neglect indicate that it is an area that deeply concerns the Agency.
   b. Similarly, Failure to Follow Policy (Client Related) is a "Major offense," the seriousness of which is also reflected in the penalty of a written reprimand to removal for a first offense.[40]
5. The penalty of removal was proper in this case.
   a. Under the Disciplinary Action Policy, removal was an appropriate measure of discipline for a first occurrence of these "Major offenses," especially in light of the Grievant's length of service, training history, and intentional misconduct.[41]
   b. Policies for Neglect and Failure to Follow Policy (Client Related) follow Federal Medicaid Regulations, which require removal for a first offense.
   c. Federal Medicaid Regulations forbid progressive discipline for Neglect or major breeches in policies and procedures.[42] The Disciplinary Action Policy,[43] clearly defines a Major Offense, Neglect, and the penalty for a first offense. Federal Medicaid Regulations dictate the rules and penalties to both

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[35] Joint Exhibit 6, at D11.
[36] Joint Exhibit 6, at D16.
[37] Joint Exhibit ^C.
[38] *See* Joint Exhibits 6B, at 2; 6B, at 1; 6C, at 1; 6D, at 1, and 6F, at 1.
[39] Joint Exhibit 3, at 10.
[40] Joint Exhibit 3, at 2, defining "major" and "Minor" offenses.
[41] Joint Exhibit 3, at 3.
[42] Joint Exhibit 6, at A-F.
[43] Joint Exhibit 6D.

the Center and the employee and hold each accountable.

d. Either of the charges standing alone supports removal for a first offense.

6. The need for safety trumps the Client's privacy rights.
7. The Grievant willfully placed the Agency at odds of Federal Medicaid Regulations.[44]

B. Summary of the Union's Arguments

1. Management failed to establish just cause to terminate the Grievant.
2. Management impermissibly tied the Client's groin injury to the Grievant's not having written an Unusual Incident Report" and to allow the Client to enter the restroom alone.
3. The Grievant's decision not to escort the Client into the restroom reflected poor judgement (Non-client Related) and an attempt to afford the Client some semblance of privacy.
4. The Grievant did not submit an Unusual Incident Reports because the Client indicated that he was ok after the fall and immediately resumed his activities for the day.
5. The Client was not injured in the Rehabilitation Center.
   a. None of the ten or more employees and sixty clients in the common area saw the Client's injuries, which suggests that the injuries did not occur at the Rehabilitation Center.
   b. Logic suggests that a blow to the Client's groin while he was in the restroom could not have caused his injuries. Surely a blow that could have caused such extensive bruising and discoloration would have prevented the Client from returning to his activities immediately after leaving the restroom.
   c. Falling down in the restroom could not have caused the Client's injuries. Nor could another resident have inflicted such injuries in the approximately thirty seconds that the Client was out of the Grievant's sight.
6. The Grievant was a good employee and did not deserve removal for a first offense.
   a. During his almost thirteen years of tenure with the Agency, he maintained good evaluations and a discipline-free record. This incident in the instant case was the first time during his tenure with the Agency that his job performance slipped.
   b. Given the Grievant's proven worth as an employee, removing him for any first offense, save client abuse (which the Agency neither charged nor established), is a manifest abuse of managerial discretion.
   c. The Grievant neither intentionally nor negligently injured the Client. Nor did the Grievant intentionally fail to file an Unusual Incident Report on the restroom incident.
   d. Management failed to consider the seven tests of just cause.
   e. Management conducted a faulty and haphazard investigation.
   f. Management failed to consider the Grievants thirteen years of service, his exceptional record, his relationship with his client's including the Client, and the favorable view from his colleagues.
   g. The Grievant's conduct is at worst client-related poor judgement, warranting no more than a written reprimand.
7. The Grievant did not injure the Client.
   a. The Client exhibits SIBS and could have injured himself by tying a string around his genitals or even by striking himself in the groin. Indeed, photographs of the Client's pubic hair reveal a line through it, which could have been caused by strangulation from a rubber band or another type of obstruction. The Client likely injured himself either before or after the Grievant left for the day.
   b. No one pinpointed when the Client's injuries occurred. After falsely claiming that the Grievant

[44] Joint Exhibits 6B, "Abuse and Neglect of Individuals in Residence"; 6E, "Supervision of Individuals," 6C, "Unusual Incidents," 4G"Aaron's Profile Card," and 4F, the Client's "Behavior Program."

kicked him in the groin, the Client explicitly retracted that statement during a video played during the arbitral hearing.

c. Since the Client did not testify, the Grievant's testimony must be credited. The Grievant was cooperative, and there were no first-hand witnesses except the Grievant and the Client, who did not testify and who gave conflicting statements.

8. Privacy is a client right, and employees should keep that in mind when working with the Clients at Gallipolis.
9. The Grievant's removal violated the Collective-Bargaining Agreement.
   a. The Agency's rules provide for automatic termination upon a first offense of Neglect, that measure of discipline violates just cause under Article 24.01 of Collective-Bargaining Agreement.
   b. Article 24.02 requires Progressive Discipline, which the Agency ignored. Automatic removal is not progressive, especially with respect to a long term employee with exceptional performance and disciplinary records.
   c. Article 24.01 ignores progressive discipline and principles of just cause by prohibiting arbitrators from modifying discipline if abuse is proven.
   d. Article 24.05 requires reasonable discipline that is not punitive and reflects the seriousness of the offense. Management's work rules are unreasonable, nonprogressive and uninformative, failing to notify employees of the magnitude of discipline.
   e. The Grievant's removal also violated Article 44.03, which requires work rules and directives, after the effective date of the Contract, to comply with it.
10. Arbitral Precedent supports the Union's Position.
   a. Page four of Arbitrator John Murphy's opinion define Neglect as "a purposeful or negligent disregard of duty imposed on an employee by statute, rule, or professional standard and owed to a client by that employee." The Grievant did not purposefully injure or neglect the Client.
   b. Also carefully review the first page of standards and arbitration 717 and the other arbitral opinions the Union presented in this case.

V. Analysis and Discussion

A. Whether the Grievant's Conduct Constitutes Neglect

1. First Provision Defining Neglect

For the reasons discussed below, the Arbitrator holds that the Grievant engaged in Neglect and Failure to Follow Policy (Client Related) and was removed for just cause. To determine whether the Grievant's acts on November 20, 2003 constituted Neglect, the Arbitrator must begin with the Agency's definition of that term. Client Neglect is defined as "*failure to act* in any manner which *results in* any *potential or actual* harm to a resident, *failing to report or covering up* resident abuse/*neglect*/mistreatment.[45] This passage contains two definitions of "Neglect." The initial definition has two components. First, there must be a "failure to act."[46] Second, that failure must "result in" or cause "potential or actual" harm. In other words, there must

[45] Joint Exhibit 3, at 4.

[46] Of course a failure to act implies a duty to act in the first instance.

be causation. The second definition in the quoted passage prohibits, "failing to report or covering up . . . neglect." Under this definition, Neglect occurs where one either fails to report or otherwise conceals neglectful behavior. If, as the Agency alleges, the Grievant failed to report or sought to cover up his own neglect of the Client, then that act also qualifies as "Neglect" under the quoted passage.

Here the task is to apply the first definition of Neglect to the Grievant's conduct during the restroom incident on November 20, 2003. The Union claims that the conduct does not constitute Neglect and offers two arguments to support its position. First, it contends that even if the Grievant had accompanied the Client into the restroom, he probably could not have prevented the Client from falling. This argument essentially limits Neglect to the occurrence of *preventable* accidents. The difficulty, however, is that the quoted definition does not premise Neglect solely on whether actual harm was preventable. Instead, that passage extends the definition of Neglect to include *potential* harm. In other words, Neglect occurs where a client is exposed to a potentially harmful situation, irrespective of whether the harm was preventable.

Second, the Union argues that the actual harm in question–injury to the Client's genitals–was unlikely to have occurred in the restroom. The Arbitrator agrees that a preponderance of the evidence in the record does not establish that the Client was injured in the restroom.[47] Again, however, the foregoing definition of Neglect focuses on both actual and *potential* harm.

In contrast, the Agency argues that because there was an arms-length, one-one-one relationship between the Grievant and the Client, the Grievant exposed the Client to actual or potential harm by failing to escort him into the restroom and remain there with him. Thus, the Agency's argument recognizes the prohibition against exposing a client to *potential* harm.

The Agency's argument is more persuasive. As previously mentioned, the first definition of Neglect in the quoted passage has two components: (1) failure to act, which implies a duty to act, (2) and causation, i.e.,

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[47] Since the Agency never formally accused the Grievant or anyone else of injuring the Client in the restroom, the physical location of the Client's injuries and who inflicted them are not issues in this dispute and, therefore, warrant no further discussion.

the failure to act *caused* the Client to be exposed either to actual or potential harm. As a TPW, the Grievant's duty to act involved keeping the Client (and his peers) safe by *constantly* keeping the Client within arms length. The Grievant failed to perform that duty (failed to act) when he allowed the Client to enter the restroom alone, thereby permitting the Client to be greater than arms length away from the Grievant. The second component, the element of causation, requires that the Grievant's "failure to act" caused either the Client or his peers to be exposed to "potential or actual harm." Since evidence does not establish that the Client's injuries either occurred in the restroom or resulted from the Grievant's failure to escort the Client into the restroom, there is no causal link between the Grievant's failure to act and the actual injuries to the Client's genitals.

Thus, the issue becomes whether the Grievant's failure to enter the restroom with the Client exposed the Client to "potential harm." It did. A major reason for requiring the Grievant to maintain an arms-length, one-one-one relationship with the Client was to shield the Client and his peers from actual or potential harm. Thus, the mere need for arms-length, one-one-one supervision establishes the existence of potential harm to the Client or his peers if the Client is left alone. And the fact that the Client was found lying face up on the restroom floor with one leg draped over the toilet dramatically demonstrates that he was at least exposed to *potential* harm, even though he was left alone for no more than forty-five seconds.

Under these circumstances, the inescapable fact is that the Grievant's failure to escort the Client into the restroom on November 20, 2003 constitutes Neglect as that term is defined in the quoted passage. And the Arbitrator so holds.

2. Second Provision Defining Neglect

A completely separate passage says Neglect exists, "when there is a duty to do so, *failing to provide* an individual with any treatment, care, goods, *supervision*, or services necessary *to maintain the health and safety* of the individual.[48] On its face, this definition explicitly requires a duty to supervise in order to

[48] Joint Exhibit 6, at C4

preserve the health and safety of another person. Neither of the Union's arguments (discussed above) shields the Grievant from a charge of Neglect under this definition. The Grievant was explicitly required to afford the Client arms-length, one-one-one supervision for the specific purpose of preserving the health and safety of the Client and/or his peers during the first shift. Therefore, the Grievant's failure to maintain an arms-length, one-one-one relationship with the Client undoubtedly constitutes Neglect under this definition. Again, the Arbitrator so holds.

B. Whether the Grievant's Conduct Constitutes Failure to Follow Policy (Client Related)

The basis for this charge is that the Grievant failed to submit an Unusual Incident Report, describing the facts and circumstances surrounding the Grievant's fall in the restroom on November 20, 2003. The Arbitrator begins his analysis of this issue by turning first to the definition of an "Unusual Incident." An Unusual Incident is defined as "[A]ny incident, act, event, or circumstance that has a *real or potential* negative impact on a *client*, the living area, or the center. Examples include, but not limited to: . . . all falls.[49]

The Grievant's failure to escort the Client into the restroom was an "act" or "circumstance" with at least "a potential negative impact" on the Client. In fact, there was an actual negative impact because the Client fell to the floor alone in the restroom. And "falls" are explicitly listed in the definition of Unusual Incidents.[50] As a result, the Arbitrator holds that an "Unusual Incident" did occur in the restroom on November 20, 2003, when the Client fell.

C. Whether the Grievant Had a Duty to File an Unusual Incident Report

Now the task is to determine whether the Grievant had a duty to report the Client's November 20 fall in the restroom. Section IV-A of the Agency's Administrative Policy No. 68 provides in relevant part: "Unusual Incidents are to be reported *immediately* by the observer to the Living Area Supervisor or Scheduling Office R.C.S. and an R.N. or L.P.N. . . . It is the *responsibility* of the person observing an incident

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[49] Joint Exhibit 6, C2 (emphasis added).
[50] Joint Exhibit 6, at C2.

to complete an Unusual Incident Report. . . ." [51]

Based on this language, there is little doubt that the Grievant had a duty to report the Client's November 20 fall in the restroom. Nor does either the Grievant or the Union offer a contrary argument. Instead, the Grievant sought to explain *why* he did not complete an Unusual Incident Report by offering two conflicting explanations. First, during his investigatory interview, the Grievant suggested that he did not report the incident because he knew he should not have allowed the Client to enter the restroom alone.[52] Nevertheless, during the arbitral hearing, the Grievant testified that he did not report the incident because the Client was not injured when the Grievant found him lying on the restroom floor. The basis for this position is that when the Grievant assisted the Client to his feet and asked if he was alright, the Client said he was unharmed and quickly returned to his activities.

Aside from the credibility problems associated with the Grievant's conflicting statements, neither of his reasons either excuses or justifies his failure to submit an Unusual Incident Report. Two reasons support this conclusion. First, protecting its clients from actual and potential harm and ultimately rehabilitating them are the cornerstones of the Agency's mission. Second, timely, informative Unusual Incident Reports are a vital avenue to achieving that mission. Therefore, it stands to reason that only dire circumstances could either justify or excuse the Grievant's deliberate failure to submit an Unusual Incident Report. But his reasons fail in that respect. The logical conclusion of this analysis is that the Grievant violated Section IV-A of Policy No. 68 and, therefore, Failed to Follow Policy (Client Related).

D. Whether the Grievant's Misconduct Constituted a Major Offense

Section III defines "Major offense" as "[A]n offense which, in and of itself, *may* constitute grounds for the imposition of a suspension or removal from employment; an incident where disciplinary action *need not* follow the progressive corrective action sequence."[53] The Agency offers several arguments to support its

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[51] Joint Exhibit 6, at C7.
[52] Joint Exhibit 5, at H7
[53] Joint Exhibit 3, at 2 (emphasis added).

position that the Grievant committed a Major Offense that warranted termination upon a first occurrence. First, the Agency contends that its Disciplinary Policy together with the Grievant's tenure, training, and willful conduct toward the Client constitutes a Major Offense that violates the Agency's "major policies and procedures."[54] Second, the Agency argues that the Grievant committed a Major Offense because he committed a "major breech of policy and procedure" by failing to report the incident, thereby depriving the Client of medical care for potential injuries. Third, the Agency maintains that, standing alone, either of the charges against the Grievant (Neglect and Failure to Follow Policy (Client Related)) warrant removal for a first offense.

In contrast, the Union never directly challenges the definition of Neglect or whether it is a Major Offense. Instead, the Union characterizes the Grievant's conduct–not accompanying the Client into the restroom–as simply poor judgement. Furthermore, the Union seems to argue that the Grievant's failure to file an Unusual Incident Report was mitigated, if not excused, by the Client's suggestion or statement that he was uninjured when the Grievant assisted him to his feet in the restroom.

The Arbitrator has already held that the Grievant's conduct satisfies the definitions for Neglect and Failure to Follow Policy (Client Related). Therefore, at this point, the issue is whether either or both of those acts constitute a Major Offense. The manner in which Section III defines Major Offenses controls the analysis here. First, Section III defines a Major Offense in terms of its disciplinary consequences. Second, even if removal is a disciplinary consequence for a certain type of misconduct, Section III does not *mandate* removal for *any and all* major offenses. Instead, it provides that removal for a Major Offense is *permissible* and that progressive discipline *may be inapplicable*. Implicit in Section III is the intent that removal *may be* warranted, depending on the circumstances surrounding a Major Offense. If the Agency had intended to mandate removal for *all* Major Offenses, it could have explicitly stated that intent.

Therefore, the Agency's third argument correctly states that either episode of the Grievant's misconduct

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[54] Agency's Post-Hearing Brief

constitutes a Major Offense because, under the Agency's unilaterally promulgated Penalty Table,[55] either episode may draw removal without resort to progressive discipline.[56] Specifically, a first offense of Neglect mandates removal. And a first offense of Failure to Follow Policy (Client Related) can draw discipline ranging from a written reprimand to removal.[57] Since the Arbitrator has already held that the Grievant's misconduct constitutes Neglect and Failure to Follow Policy (Client Related), the Grievant's misconduct is also a Major Offense under Section III.

E. Impact of the Collective-Bargaining Agreement on the Propriety of Automatic Removal

The Agency insists that Neglect and Failure to Follow Policy (Client Related) warrant removal on the first occasion, without consideration of progressive discipline because they violate "Major policies and procedures. Then the Agency argues that the seriousness of these offenses is reflected in the Agency's Penalty Table, which provides for removal on the first occasion of Neglect and a written reprimand to removal for a first offense of Failure to Follow Policy (Client Related). Third, the Agency insists that the Grievant's tenure with the Agency, his training history, and the intentional nature of his misconduct further establish that removal is warranted in this case. Finally, the Agency vigorously maintains that federal Medicaid regulations require removal (and forbid progressive discipline) for first offenses of Neglect and Failure to Follow Policy (Client Related).

The Union argues, in contrast, that automatic removal, without consideration of just cause for a first offense of either Neglect or Failure to Follow Policy (Client Related) violates just cause under Article 24.01 of Collective-Bargaining Agreement. According to the Union, Article 24.01 contains but one exception for summary discharge and that exception is applicable for demonstrated patient abuse. The Union also maintains that Article 24.05 requires the measure of discipline to be commensurate with the seriousness of the offense. Furthermore, the Union claims that the Agency's work rules are unreasonable, nonprogressive

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[55] Joint Exhibit 3, at 10.

[56] Of course, as discussed below, the Parties' Collective-Bargaining Agreement is a factor in determining the applicability of progressive discipline.

[57] Joint Exhibit 3, at 10.

uninformative, in that they fail to notify employees of the magnitude of discipline. Also, the Union claims that the Grievant's removal violated Article 44.03 which requires work rules and directives, after the effective date of the Contract, to comply with it. Finally, the Union contends that arbitral precedent supports its Position, specifically citing Arbitrator John Murphy's definition of "Neglect" as "a purposeful or negligent disregard of duty imposed on an employee by statute, rule, or professional standard and owed to a client by that employee." In the Union's view, the Grievant did not purposefully injure or neglect the Client. Also, the Union invites the Arbitrator to review the first page of standards and arbitration 717 and the other arbitral opinions the Union presented in this case.

F. Medicaid Regulations and Discipline for Neglect and Failure to Follow Policy (Client Related)

Two difficulties undermine the Agency's argument that Federal Medicaid Regulations demand removal for Neglect and Failure to Follow Policy (Client Related). First, throughout its Post-hearing Brief, the Agency makes only general references to Federal Medicaid Regulations that purportedly mandate removal for first offenses of Neglect and Failure to Follow Policy (Client Related). Preponderant evidence in the arbitral record does not establish this position. In other words, the Agency failed to establish federal regulations that mandate specific measures of discipline for specific types of conduct. As a last resort, the Arbitrator researched the "Medicaid standards" cited in Joint Exhibit 6, a D2 for evidence of specific disciplinary mandates. However, none of the citations recommended specific disciplinary measures for specific types of misconduct.[58] Had the Agency produced clearer proof of the alleged federal mandates, the

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[58] Section 483.420 a(5), d(1), d(1)(i), d(1)(ii), d(1)(iii), 2, 3, and 4. Were cited and are set forth below.

d) Standard Staff Treatment of clients

a(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

d) Standard: Staff treatment of clients.

(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

d(i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.

d(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

d(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

Arbitrator surely would have considered them. However, in this case, the Arbitrator is left with Article 24.01, which recognizes but one explicit exception to the application of progressive discipline and that is for demonstrated patient abuse.[59] Furthermore, Section 24.02 explicitly requires employers without exception to follow the principles of progressive discipline. Understand that Section 24.02 does not ban removals for first offenses other than patient abuse, but to justify first-offense removal for misconduct other than patient abuse, the employer must consider progressive discipline. In this case, provisions of contrary federal law are not considered because they are not in the record, and the Arbitrator can only find general references like those cited above. As a result, the Arbitrator holds that principles of progressive discipline apply to the Parties' relationship unless the Collective-Bargaining Agreement limits their application or federal law in the arbitral record requires summary removal. For specified forms of misconduct. The upshot is that the Arbitrator finds the Union's position more persuasive on this issue, and, therefore holds that the Agency must consider progressive discipline, absent the two circumstances set forth above.

VI. The Penalty Decision

Preponderant evidence in the arbitral record establishes that the Grievant's conduct on November 20, 2003 constituted Neglect and Failure to Follow Policy (Client Related). Some measure of discipline is, therefore, indicated. However, for reasons discussed above, the Arbitrator is not persuaded that, under the Parties' Collective-Bargaining Agreement, these infractions warrant automatic removal *without consideration* of progressive discipline, which entails the balancing of mitigative and aggravative factors. Consequently, to determine the proper quantum of discipline in this case, the Arbitrator will assess both

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(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

(3) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken.

[59] Joint Exhibit 1, at 72.

mitigating and aggravating factors. However, the Agency's penalty will remain undisturbed, unless the balance of aggravative and mitigative factors reveals the penalty decision to be unreasonable, arbitrary, capricious, discriminatory, or otherwise abuses its discretion.

A. Aggravative Factors

The major aggravative factor is the nature of the Grievant's misconduct and the inherent need for trustworthiness in his position as a TPW in charge of clients who may be vulnerable and virtually helpless. TPWs must be held to high standards of integrity and honesty, since, during their day-to-day activities, they will likely encounter numerous opportunities to exploit clients who are incapable of adequately protecting themselves. Trustworthiness is, therefore, a non-negotiable trait for TPWs. The Grievant failed to display those qualities when he allowed the Client to enter the restroom alone and then deliberately concealed the Client's fall from the Agency.

The latter act greatly exacerbated the Grievant's misconduct because it denied the Client medical attention for possible internal or other unobvious injuries. The Grievant had neither a right nor a good reason to elevate the Client's abstract right to privacy over his concrete and practical need to be shielded from actual or potential harm. Still, in the Arbitrator's view, the act that ultimately justifies resolving doubts against the possible rehabilitative effects of a lesser penalty is not the Grievant's decision to permit the Client to enter the restroom alone; it is his decision not to report the fall, a decision for which there is absolutely no discernible justification, including the desire to avoid disciplinary retribution. Any reasonable person would view that decision, without more, as substantially eroding the Grievant's trustworthiness. More importantly, the decision to conceal the fall together with the decision not to accompany the Client into the restroom irreparably damages the Grievant's trustworthiness. One may debate whether this type of deliberate misconduct is the "tip of the iceberg" or an isolated incident which is unlikely to recur. Nevertheless, what is clear beyond cavil is that the Grievant's conduct signifies a troubling disregard for the Agency's central mission and its rules–Neglect and Failure to Follow Policy

(Client Related)–rules which no doubt emanate from experience and commonsense.

Nor can the Grievant claim ignorance of the applicable rules for supervising clients in general or this Client in particular. The Grievant knew how to properly supervise the Client, was fully aware of the Client's "target behavior," was well-versed in arms-length, one-one-one supervision, and understood that leaving the Client alone could endanger him and/or his peers.

B. Mitigative Factors

By way of mitigation, the Grievant is a 12.5 year employee with no active discipline and a satisfactory record of performance. In short, for 12.5 years, he was a good employee. This is not an insubstantial consideration.

Also, having reviewed all arbitral precedents that the Union submitted in this case, the Arbitrator finds them to be factually distinguishable from the instant case. None of the precedent involves a situation where, as here, the Grievant deliberately violated a vital, clear, and well-known regulation and then sought to conceal the consequences of that violation essentially for self-gain. Although precedent found that the grievants misconduct amounted to "poor judgement" rather than Neglect or Patient Abuse, the Undersigned concludes that all Neglect involves some degree of "poor judgement," though the reverse is not necessarily true. The important point is that reasonable minds can differ about the degree of overlap between "poor judgement and Neglect or Failure to Follow Policy (Client Related)–where one begins and the other ends. However, the Grievant's misconduct involves a deliberate, wholly unjustified violation of a vital supervisory rule followed by a deliberate, wholly unjustified attempt to coverup the consequences of that violation. For reasons discussed above, this type of misconduct is much more than mere poor judgement.

VII. The Award

Yet, under the circumstances of this particular case, the balance of aggravating and mitigating factors do not justify reinstating the Grievant as a TPW. On balance, the Grievant's demonstrated

deliberate misconduct is inconsistent with continued employment as a TPW responsible for fragile and vulnerable clients. For all of the foregoing reasons, the grievance is hereby **denied** in its entirety.

Robert Brookins

Robert Brookins, Professor of Law, Labor Arbitrator, J.D. Ph.D.