#1207
Rec'd 3/23/2022

In the Matter of Arbitration Between the	:	Grievance Number: DMR-2021–00818-04
	:	
STATE OF OHIO, DEPARTMENT OF DEVELOPMENTAL DISABILITIES, COLUMBUS DEVELOPMENTAL CENTER, Employer	:	Grievant: Margaret Njenga
	:	
and the	:	
	:	Arbitration Hearing Date:
OHIO CIVIL SERVICE EMPLOYEES ASSOCIATION, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, LOCAL 11, AFL-CIO, Union	:	January 20, 2022
	:	
	:	Howard D. Silver, Esquire
	:	Arbitrator

DECISION AND AWARD OF THE ARBITRATOR

APPEARANCES

For: State of Ohio, Department of Developmental Disabilities,
Columbus Developmental Center, Employer

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PROCEDURAL BACKGROUND

This matter came on for a remote arbitration hearing on January 20, 2022 at 9:00 a. m. via the teleconferencing platform Zoom. At the hearing both parties were afforded a full and fair opportunity to present evidence and arguments in support of their positions. The arbitration hearing concluded on January 20, 2022 at 12:40 p. m. and the evidentiary portion of the hearing record was closed at that time.

The arbitrator received post-hearing briefs from both parties by February 25, 2022, and the arbitrator exchanged these post-hearing briefs between the parties on February 25, 2022.

This matter proceeds under a collective bargaining agreement in effect between the parties from May 12, 2018 through February 28, 2021, Joint Exhibit 1.

No challenge to the arbitrability of the grievance has been raised.

Based on the language of the parties' collective bargaining agreement, the arbitrator finds the grievance at issue herein to be arbitrable and properly before the arbitrator for review and resolution.

JOINT ISSUE

Was the Grievant, Margaret Njenga, removed for just cause?

If not, what shall the remedy be?

JOINT STIPULATIONS

1. The Grievance is properly before the Arbitrator.
2. The Grievant was hired by the Employer on October 17th, 2016, as a Therapeutic Program Worker (TPW).
3. The Grievant was removed from her position as a TPW on March 4th, 2021.

4. The Grievant was removed for a violation of the Ohio Department of Developmental Disabilities Standards of Conduct Policy, specifically rules:

- Abuse of a Client, A-1 - Abuse of any type or nature to an individual under the supervision or care of the Department or State, including, but not limited to, physical, sexual, or verbal as defined by Ohio Administrative Code 5123-17-02 addressing major unusual incidents and unusual incidents to ensure health, welfare, and continuous quality improvement.

- Neglect of a Client, E-1 – When there is a duty to do so, failing to provide an individual with medical care, personal care, or other support that consequently results in serious injury or places an individual or another person at risk of serious injury. Serious Injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner.

5. At the time of her removal, the Grievant had active performance track discipline on her record consisting of :

- May 15th, 2020 – Written Reprimand for F2 (Failure to Report)

JOINT EXHIBITS

1. 2018-2021 OCSEA Contract

2. Grievance Trail

3. Discipline Trail

4. DODD Standards of Conduct, Rule Violations and Penalties

5. Ohio Administrative Code 5123-17-02

6. Medicaid Regulations

STATEMENT OF THE CASE

The parties to this arbitration proceeding, the State of Ohio, Department of Developmental Disabilities, Columbus Developmental Center, the Employer, and the Ohio Civil Service Employees Association, American Federation of State, County and Municipal Employees, Local 11, AFL-CIO, the

Union, are parties to a collective bargaining agreement that was in effect from May 12, 2018 through February 28, 2021, Joint Exhibit 1. Within this collective bargaining agreement is an Article that addresses discipline, Article 24, which begins with the following language in section 24.01:

> 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.

The grievant in this proceeding, Margaret Njenga, was employed at the Columbus Developmental Center as a Therapeutic Program Worker (TPW) from October 17, 2016, when Ms. Njenga was hired to serve as a TPW, until March 4, 2021, when Ms. Njenga's employment at the Columbus Developmental Center was terminated at the direction of the Employer. The removal of Ms. Njenga was grounded in the allegation that Ms. Njenga had violated two policies within the Ohio Department of Developmental Disabilities Standards of Conduct Policy, specifically rule A-1, Abuse of a Client, and rule E-1, Neglect of a Client.

The events at issue in this proceeding occurred on October 31, 2020, beginning at 2:46 p. m. in living unit 1720B at the Columbus Developmental Center. These events occurred in the living unit's kitchen, dining room, and exterior patio, at a time when the grievant, Margaret Njenga, was on scheduled, active duty as a TPW assigned to residence unit 1720B. Much of what is described below was recorded on video as these events were happening, with the two video recordings shown at the arbitration hearing.

At the beginning of the chronology of events that bear on the issues raised by this case, Ms. Njenga was located in the residence unit's kitchen and had had an opened bottle of Sprite soda sitting on a kitchen counter from which Ms. Njenga intermittently sipped while carrying out her

responsibilities as a TPW. While Ms. Njenga's attention was directed away from the bottle of soda, a resident on the unit (hereinafter referred to as Resident 1) entered the kitchen and surreptitiously absconded with Ms. Njenga's bottle of soda. Resident 1 carried the bottle of soda to an exterior patio located adjacent to sliding glass doors that separate an exterior patio seating area with picnic table and benches from the unit's interior dining room. Resident 1, with Ms. Njenga's bottle of soda in hand, seated himself on a bench at the picnic table on the exterior patio.

Resident 1 had been seated outside on the patio for about fifteen (15) seconds when Ms. Njenga approached Resident 1, regained possession of her bottle of soda, communicated her disapproval of Resident 1 taking property that did not belong to Resident 1, and threw away the soda remaining in the bottle.

Within five (5) minutes of the bottle of soda being reclaimed by Ms. Njenga, Resident 1, while seated in the dining room of living unit 1720B, began composing a written apology intended for Ms. Njenga, for taking Ms. Njenga's bottle of soda.

Ms. Njenga left the premises of the Columbus Developmental Center at 2:49 p. m. on October 31, 2020 and remained away from the living unit and the Center during the ensuing ninety-six (96) minutes. There is no indication in the hearing record that Ms. Njenga notified a supervisor about her leave-taking; there is no indication in the hearing record that Ms. Njenga had secured prior approval to absent herself from her assigned, scheduled, active duty on the residence unit as a TPW for those ninety-six (96) minutes on October 31, 2020.

Ms. Njenga returned to residence unit 1720B on October 31, 2020 at 4:25 p. m.

At 4:27 p. m. Resident 1, with his written apology in hand, approached Ms. Njenga while both were located in the unit's kitchen. Resident 1 proffered the written apology to Ms. Njenga for his actions but was rebuffed in this attempt by Ms. Njenga who explained to the resident that this was not

the time to discuss his apology. Resident 1 was directed to leave the kitchen area by Ms. Njenga. Resident 1 left the kitchen and seated himself in the living unit's dining room.

Ms. Njenga entered the living unit's dining area wherein food for dinner was displayed on the dining room table. In addressing Resident 1, Ms. Njenga pointed to the outside. Resident 1 gathered a plate of food for his dinner but did not wish to exit the dining area for the exterior patio and re-seated himself in a chair at the dining room table. Ms. Njenga then moved Resident 1's plate of food away from Resident 1, whereupon Ms. Njenga was pushed away by Resident 1, using one arm to do so. Ms. Njenga then grabbed Resident 1's torso for about ten (10) seconds until another staff member came over to assist. At this point Ms. Njenga picked up Resident 1's plate of food and carried it to the picnic table on the exterior patio. Resident 1 followed TPW Njenga and seated himself on a bench on the patio. Ms. Njenga reentered the dining area and then left the dining area to retrieve another resident.

When Ms. Njenga returned to the dining area she found Resident 1 in the dining room getting more food and packets of ranch dressing. Resident 1 again left the interior dining area and seated himself outside on the patio. The glass doors separating the exterior patio from the interior dining area were then locked by Ms. Njenga. The glass doors were locked at 4:33 p. m. with Resident 1 seated outside by himself.

Ms. Njenga ate her dinner in the dining area from a vantage point from which she could see Resident 1 seated outside. When two staff members questioned the appropriateness of the treatment of Resident 1 by Ms. Njenga, and when Ms. Njenga was questioned by an investigator about what had occurred, Ms. Njenga had explained that Resident 1 had been offered a choice and had chosen to eat outside. When asked about locking the glass doors, Ms. Njenga had explained that this was done because Resident 1 had been throwing himself against the glass doors.

At 4:37 p. m. the glass doors are unlocked. At 4:42 p. m. a staff member goes outside and talks

to Resident 1. The staff member reenters the living unit at 4:43 p. m., and at 4:49 p. m. Resident 1 reenters the living unit.

On February 23, 2021 a predisciplinary meeting occurred that addressed allegations of abuse and neglect made against Ms. Njenga.

On March 4, 2021 Ms. Njenga was removed from employment by the Employer under allegations of abuse and neglect.

On March 6, 2021 a formal grievance was submitted to the Employer by the Union challenging the removal of Ms. Njenga that occurred on March 4, 2021.

The grievance was considered under the parties' grievance procedure, Article 25 of the parties' collective bargaining agreement but remained unresolved. The unresolved grievance was directed on to final and binding arbitration by the Union.

The arbitration hearing in this case occurred on January 20, 2022. Post-hearing briefs were received from the parties on February 25, 2022 and exchanged between the parties by the arbitrator on February 25, 2022.

The grievance is determined arbitrable and properly before the arbitrator for review and resolution.

SUMMARY OF TESTIMONY

Bethany Sullivan

Bethany Sullivan is an Investigator employed by the Ohio Department of Developmental Disabilities at the Columbus Developmental Center.

Investigator Sullivan recalled in her testimony at the hearing that she had received a report of an incident of resident abuse through a telephone call from the grandmother of a resident at the Columbus

Developmental Center, Resident 1. The grandmother of Resident 1 told Ms. Sullivan that she had spoken to her grandson, Resident 1, and the grandmother was reporting an abuse of Resident 1. Ms. Sullivan explained that the allegation of abuse made by the grandmother triggered an investigation of the events surrounding the allegation of abuse that included two videos, the first commencing with the taking of TPW Njenga's bottle of Sprite by Resident 1, and the second video commencing with the grievant's return to the living unit at 4:25 p. m. Ms. Sullivan noted that the investigation conducted into the allegation of abuse reported by the grandmother of Resident 1 included written statements from staff, a statement from Ms. Njenga, a major unusual incident report, and other records maintained by the Center that pertain to resident care on the living unit.

Ms. Sullivan talked to Ms. Njenga during the investigation of the report of an abuse of Resident 1, and recalled being told by Ms. Njenga at that time that Ms. Njenga had arrived for her scheduled shift and had been advised that Resident 1 had had problems during the prior shift. Ms. Njenga's bottle of soda had been taken by Resident 1 without permission; Ms. Njenga had reacquired the bottle of soda and discarded the soda remaining in the bottle; Resident 1 had tried to apologize to Ms. Njenga but had been told to wait; Resident 1 began to act out and was directed to eat his evening meal outside. Ms. Njenga had told Ms. Sullivan that Resident 1 had agreed to eat his meal outside and took his food to an outside patio area. Ms. Njenga had said no force was used to get Resident 1 to follow Ms. Njenga's direction and it had not been cold outside.

Ms. Sullivan referred to written statements from staff members about the events in question. These written statements are in different forms (question and answer, written narrative) and found in Joint Exhibit 3, Discipline Trail, pages 104 through 120. Pages 118 through 120 in Joint Exhibit 3 are Ms. Njenga's written statement provided on October 31, 2020 at 9:15 p. m. to Investigator Sullivan. Ms. Sullivan stated that the witness statements from staff members indicated that attempts had been

made to verbally redirect Resident 1 but Resident 1 refused to be dissuaded from attempting to agitate his peers in the dining area of the living unit. When Resident 1 continued his behavior he was directed to take his meal outside.

Ms. Sullivan testified that Ms. Njenga's written statement provided on October 31, 2020 noted that initially Resident 1 had not wanted to eat his dinner outside, complaining that it was too cold outside to eat outside. Resident 1 was told that he had been causing issues with others living on the unit and was directed to eat outside. Ms. Njenga stated in her statement that Resident 1 had agreed to eat outside. No mention was made of locking the glass doors separating the interior of the unit from the unit's exterior.

Ms. Sullivan testified that subsequently it was discovered that two videos of the events in question were available and an examination of the videos indicated that Resident 1 did not wish to go outside to eat his dinner.

Under questioning by the Union's representative, Ms. Sullivan confirmed that the Center's investigation found no sign of a physical injury on Resident 1. Ms. Sullivan stated that the video recordings show that Resident 1 ate his dinner on October 31, 2020 while located outside of the living unit. Ms. Sullivan stated that the videos indicate that there had initially been a physical struggle between Resident 1 and TPW Njenga in the dining area of the living unit, with Resident 1 pushing Ms. Njenga away from him while he was seated in a chair at the dining room table. It was at this point in their interaction that the grievant grabbed Resident 1's torso for about ten seconds in an attempt to physically restrain Resident 1. When this physicality failed to move Resident 1, Resident 1's plate of food was carried outside by TPW Njenga, followed by Resident 1 who seated himself on the patio and remained outside with his meal while TPW Njenga returned to the interior of the living unit.

Matt Hoffman

Matt Hoffman began his employment at the Columbus Developmental Center in 2010 as a staff member providing direct care to residents. In 2012 Mr. Hoffman was promoted to Grounds Supervisor, serving as a House Manager. In 2018 Mr. Hoffman accepted the position of Investigator and in that role assisted in the investigation of the events in question, resulting from a telephone call from Investigator Bethany Sullivan.

Mr. Hoffman explained that he conducted most of the investigation, reviewed the videos, conducted interviews, considered Resident 1's history at the Center, and prepared the investigation report. Mr. Hoffman's investigation report found verbal abuse and neglect to have been substantiated by what had been discovered during the investigation.

Mr. Hoffman played the two video recordings of the events in question. The first video begins on October 31, 2020 at 2:46 p. m. and the second video concludes on October 31, 2020 at 4:49 p. m. with Resident 1 entering the living unit from the patio.

Mr. Hoffman commented in his testimony that there is nothing in either video that indicates Resident 1 threw himself against the glass doors separating the patio from the living unit's interior. Mr. Hoffman also expressed the opinion that the physical altercation between Resident 1 and TPW Njenga had been unnecessary, avoidable, and unreported.

Under questioning by the Union's representative, Mr. Hoffman was asked whether Ms. Njenga had been AWOL (away without leave) on October 31, 2020. Mr. Hoffman stated that he was not certain about that.

Mr. Hoffman confirmed that another entrance to the living unit had been located near the patio but Mr. Hoffman did not know whether that entrance was accessible from the outside.

Robert Capaldi

Robert Capaldi, Ph.D., served as Superintendent of the Columbus Developmental Center from 2013 through 2021.

Dr. Capaldi recalled that a pre-disciplinary report issued on February 25, 2021 had recommended that just cause existed for the removal of Ms. Njenga from her employment by the Center.

Dr. Capaldi testified that after reviewing all of the investigative materials available and after viewing the video recordings of the events in question, CDC Superintendent Capaldi determined that just cause existed for the discharge of Ms. Njenga for abuse and neglect. An order of removal was authorized by Superintendent Capaldi, and effective March 4, 2021 Ms. Njenga's employment at the Columbus Developmental Center was terminated. Superintendent Capaldi stated that he found intimidation, lack of supervision, and neglect in the actions of TPW Njenga, and concluded that the discharge of Ms. Njenga was warranted and needed.

Margaret Njenga

Margaret Njenga, the grievant, explained in her testimony at the arbitration hearing that by October 2020 Ms. Njenga had served as a TPW at the Columbus Developmental Center for four (4) years. Ms. Njenga testified that she had been aware of Resident 1's treatment plan and had been aware of Resident 1's past behavior. As stated at Joint Exhibit 3, Discipline Trail, page 46, Resident 1 had good days that included talking over the telephone with his grandmother, engaging in social activities and community outings, and sitting in the yard during nice weather, and bad days that included interrupting others and making demands, reacting negatively to being told “No,” and repeatedly asking the same question despite knowing the answer. Ms. Njenga recalled that October 31, 2020 had mostly

been a bad day for Resident 1.

Ms. Njenga recalled that snacks were passed out to residents and each resident was free to decide where the snack would be consumed. Ms. Njenga recalled that Resident 1 had chosen to eat his snack outside.

Ms. Njenga recalled in her testimony that on October 31, 2020 she had started her assigned shift at 2:00 p. m. Ms. Njenga recalled that shortly after arriving on the living unit Ms. Njenga began preparing food for the next meal. While engaged in these preparations Ms. Njenga had been periodically sipping from an opened bottle of Sprite. The bottle was siting on a kitchen counter when it was taken by Resident 1 without notice or permission. Ms. Njenga noticed the bottle of soda was missing from the kitchen and shortly thereafter noticed an opened bottle of Spite on a picnic table on the patio where Resident 1 was seated. Ms. Njenga confronted Resident 1 on the patio about stealing the bottle of soda, to which Resident 1 responded with a verbal apology. Ms. Njenga took back the bottle of soda, poured out its contents, and returned to the living unit's kitchen.

Ms. Njenga explained that on her shift she had been entitled to a one-half (½) hour lunch break, and two (2) fifteen-minute breaks. When asked why she had been away from the Columbus Developmental Center on October 31, 2020 for ninety-six (96) minutes during her assigned shift, Ms. Njenga had at first said that the reason for her absence had been personal. Later, Ms. Njenga stated that her daughter suffers from asthma and Ms. Njenga had been checking on her daughter, and securing medicine for her daughter. Ms. Njenga recalled that she had told a co-worker, Wilson, that she was leaving on her lunch break.

Ms. Njenga recalled in her testimony that when she returned to the living unit on October 31, 2020 she entered the unit's kitchen and was approached by Resident 1 who said he had written a letter of apology for Ms. Njenga. Ms. Njenga recalled saying to Resident 1: “We are going to talk later, after

dinner."

Ms. Njenga testified that she knew the letter was a written apology about taking the bottle of soda and Ms. Njenga testified that she had acknowledged the apology from Resident 1.

Ms. Njenga testified that when Resident 1 was in the dining room he was told he had the option of sitting in a chair near the microwave oven or eating his meal outside. Resident 1 refused both options and was directed by Ms. Njenga to go eat outside. Ms. Njenga recalled Resident 1 continuing to refuse this direction. Ms. Njenga recalled Resident 1 asking why he had to wait to talk about his apology and was instructed by Ms. Njenga to sit outside and calm himself.

Ms. Njenga testified that she was then kicked by Resident 1 and Resident 1 appeared to become more agitated. Ms. Njenga stated that Resident 1 had a history of throwing food at others.

Ms. Njenga stated that Resident 1 finally did travel to the exterior patio; Ms. Njenga locked the glass doors separating Resident 1 on the exterior patio from the interior of the living unit; Ms. Njenga noted that an entry door was located two (2) to three (3) feet from the patio, an entry door that was often used and well-known to all residents of the living unit.

Ms. Njenga recalled that later that day she and Resident 1 discussed his apology and Resident 1 calmed down. Ms. Njenga emphasized that no punishment was imposed on Resident 1.

Under questioning by the Employer's representative, Ms. Njenga stated that on October 31, 2020 she had passed out snacks to residents between 2:25 p. m. and 2:30 p. m.

Ms. Njenga recalled that prior to going outside from the dining area to the patio, Resident 1 had been seated in the dining room at the dining room table with two (2) other residents. When Resident 1 began asking why they had to wait to talk about Resident 1's apology, he was told by TPW Njenga that the discussion would occur later. Ms. Njenga picked up Resident 1's plate of food and carried it outside to the picnic table on the patio to assist Resident 1's relocation to the patio.

Ms. Njenga was asked why she had locked the glass doors with Resident 1 seated outside. Ms. Njenga stated that she had locked the glass doors so Resident 1 would not bang into them. Ms. Njenga noted that to reach the other entrance to the living unit required four (4) steps away from the patio.

Ms. Njenga was asked whether she had offered to get a coat for Resident 1 when he was seated outside eating his dinner. Ms. Njenga stated that she had not.

Ms. Njenga stated that when she left the Center on October 31, 2020 during her shift she had left staff member Wilson in charge. Ms. Njenga did not provide notice to a supervisor that she was leaving the Center's grounds.

Ms. Njenga agreed that physical contact with a resident is to produce a report of the contact. In this case Ms. Njenga filed no report of any kind.

Ms. Njenga identified Joint Exhibit 3, Discipline Trail, page 118 as Ms. Njenga's first statement about the events in question, a statement provided to Investigator Sullivan on October 31, 2020 at 9:15 p. m. Ms. Njenga identified Joint Exhibit 3, Discipline Trail, page 122 as her second statement about the events in question, a statement provided by Ms. Njenga to Investigator Hoffman on November 1, 2020.

POSITIONS OF THE PARTIES

Position of the Employer

The Employer understands the issue raised by this case to be whether the grievant was removed for just cause. The removal occurred on March 4, 2021 and was grounded in alleged violations of two Department of Developmental Disabilities Standard of Conduct Policy rules: A-1, Abuse of a Client, and E-1, Neglect of a Client.

The Employer understands that on October 31, 2020, while dinner was being served among the

residents of living unit 1720B, the living unit to which the grievant was assigned to serve as a TPW, and the living unit in which Resident 1 resided, the grievant got into a physical altercation with Resident 1, followed by the grievant taking the plate containing Resident 1's food to an outside table and directing Resident 1 to eat his dinner outside. The grievant then re-entered the interior of the living unit, closed and locked the glass doors separating the interior of the living unit from the exterior of the living unit, leaving Resident 1 seated alone at the picnic table on the exterior patio.

This event was reported by Resident 1 to his grandmother who contacted the Columbus Developmental Center and caused to be filed an unusual incident report, whereupon an investigation of the incident was conducted by the Investigative Services Unit. The two investigators who conducted the investigation, Bethany Sullivan and Matt Hoffman, testified at the arbitration hearing. The investigative materials gathered during the inquiry include written statements, written interviews, and video recordings. The Employer recalls Investigator Hoffman playing the video recordings of the events in question at the arbitration hearing, walking us through who we were seeing, where the events observed were occurring, and when these events were occurring, events recorded in real time as they occurred.

Also testifying at the arbitration hearing was former Columbus Developmental Center Superintendent Robert Capaldi. Dr. Capaldi recalled in his testimony reviewing the investigation report and watching the video recordings and determining that the grievant had violated rules A-1 and E-1, Abuse of a Client and Neglect of a Client, respectively. Dr Capaldi found both violations substantiated and ordered the removal of the grievant on that basis. Dr. Capaldi found no reason to require Resident 1 to eat outside and found the grievant had not accurately reported what had happened.

Dr. Capaldi recalled that CDC staff were permitted one thirty-minute lunch break during which an employee could choose to leave the grounds of the Center, and two fifteen-minute breaks during

which staff were not authorized to leave the Center's grounds. The Employer notes that on October 31, 2020 the grievant had left the grounds of the Center during her assigned shift for ninety-six (96) minutes. The Employer notes that the grievant failed to file any report of her physical altercation with Resident 1 on October 31, 2020.

The Employer points out that Ohio Administrative Code section 5123:2-17-02 does not require physical harm to constitute abuse, requiring only that the use of force may result in physical or serious physical harm, with such force as hitting, slapping, or pushing. The Employer claims that the physical restraint applied by the grievant around Resident 1's neck could reasonably have resulted in physical harm.

The Employer recognizes the difficult challenges that client behaviors on the living unit can pose for staff members, but the Employer emphasizes the importance of staff modeling healthy behavior and following the rules of the Center and the Department.

The Employer reminds the arbitrator that pursuant to expressed language in the parties' collective bargaining agreement, if abuse is found to have been perpetrated upon a client by an employee, the arbitrator is without authority to modify the discharge of that employee. The Employer asserts that the grievant abused Resident 1 when she restrained him around his neck, and neglected Resident 1 when the grievant ordered Resident 1 to eat his meal outside, by himself, on the other side of locked glass doors.

At page 11 of the Employer's post-hearing brief the following is presented:

> … The grievant states that she was trying to keep [Resident 1] from aggravating the other residents while they were having dinner. As you watch the video you clearly see she continues to approach him, trying to take his plate and then the salad bowl. The other residents sat quietly eating their dinner as this interaction took place. You will then see Michael, get up after [Resident 1] pushes back on the grievant as she approached him. She then puts her arm around his neck performing a physical restraint around his neck

area/upper chest.

The Employer claims the grievant has shown through her actions a blatant disregard of the Center's work rules and the Department's policies. The Employer argues that a preponderance of the evidence admitted to the hearing record proves that on October 31, 2020 the grievant abused and neglected a client residing at the Columbus Developmental Center. The proven misconduct by the grievant provides the just cause necessary to ordering the termination of the employment of the grievant. Such proof, argues the Employer, should result in a denial of the grievance in its entirety.

Position of the Union

The Union understands the issue raised by this case to be whether the Ohio Department of Developmental Disabilities removed the grievant from her Therapeutic Program Worker (TPW) position for just cause. If not, the question becomes the remedy needed to heal this breach of the parties' Agreement.

The Union reminds the arbitrator that the grievant, Ms. Njenga, was a four-year employee of the Ohio Department of Developmental Disabilities at the Columbus Developmental Center, serving from a Therapeutic Program Worker position.

The discharge of the the grievant balances on the charge that the grievant abused a client, a violation of Standards of Conduct Policy Rule A-1, and neglected a client, a violation of Standards of Conduct Policy Rule E-1.

The Union notes that on October 31, 2020 the grievant was on duty and working an assigned shift in living unit 1720B. TPW Njenga was engaged in preparing the residents' next meal while located in the living unit's kitchen when a bottle of soda sitting on the counter belonging to Ms. Njenga was taken by Resident 1 and transported to the living unit's exterior patio, where Resident 1 seated

himself at a picnic table located there, with Ms. Njenga's bottle of soda. When Ms. Njenga discovered what had happened to her bottle of soda she approached Resident 1 who was seated on the patio with the bottle of soda. Later, Resident 1 approached TPW Njenga with a written apology in hand about taking her bottle of soda. Ms. Njenga at that moment had been occupied with meal preparation and told Resident 1 they would have their discussion after dinner. The grievant denies having been angry with Resident 1 but had wanted at that moment to complete preparing and serving the dinner meal to residents. The Union notes that when this was explained to Resident 1, Resident 1 became progressively more agitated and eventually was directed to eat his meal outside on the patio so as to not incite bad behavior among other residents.

The grievant does not deny locking the glass doors separating Resident 1 on the exterior patio from the interior of the living unit. The Union emphasizes that at no time during Resident 1's dinner taken on the patio of the living unit was Resident 1 outside the view of staff who were located in the living unit's dining room. The Union asserts that Resident 1 suffered no physical injury as a result of eating his meal outside and suffered no physical injury "... as a result his aggressive behavior towards the Grievant." See Union's post-hearing brief, page 2, first full paragraph.

As to Ms. Njenga's absence from her assigned living unit on October 31, 2020 for what the Employer finds to have been an extended period of time, the Union claims that Ms. Njenga explained this in her testimony, taking her lunch break to pick up medicine for her daughter and to obtain party favors and candy for the residents for Halloween.

The Union points out that discipline is to be imposed for the purpose of correcting an employee's behavior. The Union argues that discipline is not to be used in a punitive way. The Union concedes that while some of the grievant's actions may have been misguided, they were not sufficiently serious to warrant removal. The Union claims that the grievant has been denied an opportunity to learn

from her mistakes and improve in those areas the Employer claims require improvement. The Union argues that the grievant can still prove to be a valued asset to the Employer and asks that the grievant be given the opportunity to demonstrate that.

The Union urges the arbitrator to grant the grievance, order the removal of the grievant vacated, and direct that the grievant be made whole through placing the grievant in the position she would have been in had no discipline been imposed, including full back pay, reinstatement retroactive to March 4, 2021, expungement of all references to the removal of the grievant from the grievant's work history maintained by the Employer, and all other compensation, benefits, and opportunities to which the grievant would have been entitled had the discharge of the grievant not occurred.

DISCUSSION

The removal of the grievant from her employment effective March 4, 2021 balances on whether the Employer possessed just cause to order this discharge. That question is grounded in charged violations of work rules A-1, Abuse of a Client, and E-1, Neglect of a Client, rules within the Ohio Department of Developmental Disabilities Standards of Conduct Policy.

Standards of Conduct Policy rule E-1, the rule that prohibits neglecting a client, defines such negligence as:

> ... failing to provide an individual with medical care, personal care, or other support that consequently results in serious injury or places an individual or another person at risk of serious injury. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner.

Joint Stipulation 5 states that the grievant, at the time of her removal, had active discipline on her employment record, a written reprimand for a failure to report issued May 15, 2020. The arbitrator

understands this written reprimand to have complained of a neglect of duty, and five and one-half months later, on October 31, 2020, the grievant is accused of neglecting her duty owed to clients residing under the care and support of the grievant in her role as a TPW. Rule E-1 refers to personal care or other support owed to a client.

It is difficult for the arbitrator to understand how the grievant could have provided any form of client care while spending ninety-six (96) minutes away from the grounds of the Columbus Developmental Center, an absence without notice to a supervisor, without prior approval, and unreported. The grievant's lunch break on October 31, 2020, during which she was authorized to leave the grounds of the Center, lasted thirty (30) minutes. The two fifteen-minute breaks did not include the option of leaving the Center's grounds.

What is particularly striking about the grievant's ninety-six (96) minute absence was how casually it was implemented. The grievant's leave-taking appeared to be solely known by the grievant until the moment of departure, at which time the grievant notified a co-worker that Ms. Njenga was leaving on her lunch break and the co-worker was to be in charge of the living unit. The grievant departed the living unit and the Center's grounds for the next hour and a half. Considering the lunch policy in effect, even an abrupt departure for lunch would presume an absence of no more than thirty (30) minutes. There is nothing in the Employer's work rules that could explain how being away for the sixty-six (66) minutes after the grievant's thirty-minute lunch break had concluded squares with the Employer's policy on work shift breaks, a policy well-known to all. The extra sixty-six (66) minutes of paid duty time while the grievant was away from the Center does not appear to have been the subject of any report from the grievant.

It is also the case that on October 31, 2020 Ms. Njenga began her assigned work shift at 2:00 p. m. and left on her ninety-six (96) minute off grounds sojourn shortly before 3:00 p. m., within the

first hour of her assigned work shift.

As to the reason for the grievant's extended absence from her assigned work shift on October 31, 2020, the hearing record offers a number reasons from which to choose. At first the reason for the grievant's absence was believed by Ms. Njenga to be too personal to share. The grievant subsequently explained that she was checking on her daughter who suffers from asthma. Then the grievant explained that Ms. Njenga was securing medicine for her daughter that the daughter needed due to her asthma. Ms. Njenga also explained that she had purchased a spatula and an air freshener for use on the living unit because she was out. See Joint Exhibit 3, page 137, interview of Margaret Njenga on November 1, 2020. Ms. Njenga explained in her testimony that because that day was Halloween she intended to buy decorations appropriate to the day.

Any one of the reasons given for the extended absence of the grievant from her assigned duties on October 31, 2020 can be accepted as a reason for this absence. The arbitrator cannot find however that the absence of the grievant on October 31, 2020 was anything other than a neglect of duty and a dereliction of the grievant's duty to provide personal care and support to clients, the focus and core of the grievant's responsibilities in her employment as a TPW. While serving under an active written reprimand for failing to report as scheduled for an assigned work shift, the grievant on October 31, 2020 decided to extend to herself the authority to be away from the persons to be directly cared for for three times the authorized lunch break at the Center. The absence was effected without notice to or approval from supervisory authority, and appears to have been the unilateral action of the grievant, an action that was not voluntarily disclosed. The way this unauthorized extended absence was effected by the grievant, so confidently, so casually, raises an implication that this was not an unprecedented event.

The arbitrator finds the actions of the grievant on October 31, 2020 to have been neglectful of a duty owed to clients on the living unit by being away without authorization and by being unavailable

during the extended separation from the clients that were to be served through the provision of TPW responsibilities assigned to Ms. Njenga's position.

Rule E-1 of the Standards of Conduct Policy, however, does not refer just to a neglect of duty, but to neglect that "... results in serious injury or places an individual or another person at risk of serious injury." The hearing record reflects no injury to Resident 1, to say nothing of a serious injury. To the extent that the Employer scheduled a certain number of staff for the shift to which the grievant was assigned on October 31, 2020, and the grievant, without authority to do so, absented herself from her assigned TPW duties in violation of the Employer's policies, and to the extent that the unanticipated shortage of staff on the living unit caused by the grievant's extended absence made for less supervision, less care, less support for clients, the risk of harm to clients increases. Whether the absence of the grievant affected risks associated with serious injury can be the subject of speculation but the hearing record does not indicate a measurable or quantifiable risk of serious injury resulting from the grievants' extended absence on October 31, 2020.

The grievant was no doubt neglectful of her duty on October 31, 2020 under the policies of the Employer but there is not a preponderance of evidence in the hearing record substantiating a violation of rule E-1 of the Standards of Conduct Policy. The Employer bears the burden of proof on all issues bearing on just cause, including whether the unauthorized absence of the grievant on October 31, 2020 placed a client or another at risk of serious injury. The arbitrator does not find a violation of rule E-1 to have been proven by a preponderance of the evidence in the hearing record.

What remains to be resolved is whether the grievant violated rule A-1 of the Standards of Conduct Policy as charged by the Employer in terminating the employment of the grievant effective March 4, 2021.

The hearing record provides a substantial amount of documentary and video evidence as to

what occurred on October 31, 2020 in living unit 1720B, during the work shift assigned to the grievant in her role as a TPW, a shift that began at 2:00 p. m. The hearing record contains written witness statements and written interviews of witnesses, including the written statement provided by the grievant on October 31, 2020 to Investigator Sullivan, Joint Exhibit 3, pages 118-120, and a written question and answer interview conducted by Investigator Hoffman on November 1, 2020, Joint Exhibit 3, pages 122-139. Also available in the hearing record is the investigatory work product resulting from the investigation of the events in question, and video recordings of the events in question recorded in real time.

The work shift on October 31, 2020 that began at 2:00 p. m. on that date starts with a staff communication to the grievant of misbehavior by Resident 1 during the work shift just concluding. This change of shift report preceded by forty-five (45) minutes the unauthorized taking of the bottle of soda by Resident 1 and its retrieval by the grievant while TPW Njenga and Resident 1 were on the living unit's exterior patio. During this interaction TPW Njenga expressed her displeasure with Resident 1 taking things that belonged to others. Ms. Njenga retrieved her bottle of soda from Resident 1, emptied what had remained in the bottle, and returned to the interior of the living unit.

It is difficult to find fault with the actions of TPW Njenga in her initial interaction with Resident 1. TPW Njenga stressed to Resident 1 the importance of respecting other peoples' property by not stealing other peoples' property. There is no indication in the hearing record that any abuse of Resident 1 occurred during this portion of the events in question. Resident 1 had voluntarily exited the living unit to sit on a picnic table on the unit's exterior patio, doing so to hide the fact that he had absconded with the grievant's bottle of Sprite. What was said between TPW Njenga and Resident 1 appears to have been communicated in a controlled, respectful manner, with no form of physical contact or verbal abuse indicated in the hearing record.

What follows TPW Njenga's return to the living unit's interior from the patio is TPW Njenga leaving the living unit and the Center's grounds at 2:49 p. m., announcing to a co-worker as she was leaving that TPW Njenga was taking her lunch break and the co-worker was being left in charge of the living unit. TPW Njenga then departed the living unit and the grounds of the Center. Ms. Njenga was away from the living unit and the Center for the next ninety-six (96) minutes.

The arbitrator has addressed the ninety-six (96) minute absence by the grievant on October 31, 2020 as it relates to whether rule E-1 had been violated. Beyond that issue, however, the extended absence remains a neglect of duty, a failure to carry out responsibilities and obligations owed to clients as a direct care service provider employed for their care and support, and a duty also owed to the Employer as an employee employed under rules and policies established by the Employer. The grievant's assigned shift on October 31, 2020 anticipated seven (7) hours of TPW duties provided on the living unit at the Center in direct support of clients. To the extent that the grievant failed to provide that amount of work, the shortcoming represents a neglect of clients, a form of abuse inflicted through omission. The fact that the grievant had active discipline in effect from a neglect of duty from May, 2020 at the time the extended absence on October 31, 2020 occurred is viewed by the arbitrator as an aggravating circumstance, not a mitigating one.

There are two video recordings of the events in question admitted to the hearing record, with one video recording presenting the events prior to the grievant's ninety-six (96) minute absence on October 31, 2020, and the other video recording showing events that occurred after the grievant's return to the living unit at 4:25 p. m.

The latter video recording presents what occurred following the grievant's return to the Columbus Developmental Center and the living unit at the conclusion of her ninety-six (96) minute absence. The interaction between TPW Njenga and Resident 1 presented in the latter video transpired

amid an escalating level and frustration on the part of both participants. Resident 1's frustration was caused by TPW Njenga's refusal to discuss Resident 1's written apology until later, triggering a known trait in Resident 1, repeating a question over and over when not receiving the answer desired. TPW Njenga was being subjected to this annoying behavior and her actions and demands upon Resident 1 were affected by this relentless, irritating behavior.

In the midst of TPW Njenga's frustration with Resident 1 and his grating behavior, the grievant began asserting her authority, ordering that Resident 1 to make a choice about where to be seated when partaking of the dinner being served. The choice was a chair near the microwave oven or a bench at a picnic table on the exterior patio. Resident 1 did not care for either option and continued to be seated at the living unit's dining room table. While Resident 1 was refusing to choose between what Resident 1 perceived to be equally unacceptable alternatives, Resident 1 remained seated at the dining room table with no physical demonstration of anger or violence or threat of harm. What ensued was a competition of wills, with TPW Njenga at first directing that Resident 1 choose his seating arrangement between the two options offered, and when this did not resolve the impasse, the grievant ordered Resident 1 to eat his meal outside at the picnic table on the exterior patio.

When Resident 1 continued to refuse to relocate to the patio to eat his dinner as ordered by TPW Njenga but remained seated in a chair at the dining room table, the grievant closed the distance between herself and the seated Resident 1 by walking up to Resident 1, and by reaching around the shoulders of Resident 1, applied physical force in an attempt to move Resident 1 out of his chair. Resident 1 pushed back against this physical force but was not the initiator of this physical alercation, had not been attempting to harm TPW Njenga, but had been attempting to maintain his position on the dining room chair.

TPW Njenga, finding herself unable to move Resident 1 physically from the dining room,

picked up the plate containing Resident 1's dinner and carried this food to the picnic table on the outside patio. Resident 1 reluctantly traveled to the patio where he seated himself at the picnic table and began eating his meal, while the grievant re-entered the interior of the living unit, closed the glass doors between herself and Resident 1, and locked these glass doors at 4:33 p. m. Resident 1, while seated on the patio, could be seen from the dining room in the living unit. Resident 1 finished his meal while seated on the patio and re-entered the living unit at 4:49 p. m.

Resident 1 on October 31, 2020 was required to sit outside when eating his dinner for a total of sixteen (16) minutes and there is no indication in the hearing record that Resident 1 suffered or was threatened with suffering any physical or sexual abuse. The hearing record does not reflect any physical injury being inflicted upon Resident 1.

There is in the hearing record, however, a preponderance of evidence that is clear and convincing showing that the grievant did at one point in the events in question attempt to physically force Resident 1 to move to a different location. This physical force proved unsuccessful from TPW Njenga's perspective, but it was nonetheless done with purpose, was not accomplished for any reason related to self-defense or any threat of harm, and was not action allowed by the rules and policies of the Employer as they relate to client care and support. The physicality initiated by the grievant against Resident 1 in the dining room on October 31, 2020 at 4:30 p. m. was unnecessary, avoidable, and contrary to the rules and policies of the Department, including rule A-1 prohibiting abuse of a client.

The grievant has maintained throughout these proceedings that Resident 1 had chosen to sit outside to consume his meal. A preponderance of evidence in the hearing record reveals that Resident 1 eventually concedes to TPW Njenga's demand by eating on the patio by himself, during the late afternoon on October 31, 2020, without a coat, and with all other residents and staff eating while located inside the living unit. Resident 1 may have followed his meal to the patio after TPW Njenga

placed the food there, but at no time did Resident 1 give any indication that he wished to eat outside, by himself, on the other side of locked doors. This circumstance was based solely on the demand by TPW Njenga that it be so. TPW Njenga had prevailed in this contest of wills, but there was nothing voluntary about Resident 1's eating arrangements that day during the dinner meal.

The demand that Resident 1 isolate himself from other staff and residents by eating his dinner outside, alone, was an act of exclusion, a demonstration of ostracism that categorized Resident 1 as "the other," a resident who had not merited the right to be treated as others are treated on the living unit. The separation ordered by TPW Njenga may have been intended to modify behavior but it was inappropriate, misguided, and destructive when viewed from the perspective of the resident. The arbitrator believes that the grievant's actions were influenced more by frustration with Resident 1's behavior than any real animus toward Resident 1, but the effect of such actions upon Resident 1 remain harmful, unauthorized, and abusive. The combination of physical bullying, shunning, intimidation, lack of supervision, and neglect substantiates the abuse of Resident 1 as charged by the Employer. A preponderance of evidence presented to the hearing record is clear and convincing in proving a violation of rule A-1 of the Employer's Standards of Conduct Policy based on the abuse of Resident 1.

Accordingly, the arbitrator finds the Employer possessed just cause for the discharge of the grievant and declines to sustain the grievance.

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AWARD

1. Under the language of the parties' collective bargaining agreement, the arbitrator finds the grievance at issue in this case to be arbitrable and properly before the arbitrator for review and resolution.

2. The hearing record substantiates, by a preponderance of clear and convincing evidence, that the grievant violated Rule A-1 of the Ohio Department of Developmental Disabilities Standards of Conduct Policy.

3. The grievant was removed for just cause.

4. The grievance is denied.

Howard D. Silver

Howard D. Silver, Esquire
Arbitrator
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Columbus, Ohio
March 23, 2022

CERTIFICATE OF SERVICE

I hereby certify that duplicate originals of the foregoing Decision and Award of the Arbitrator in the Matter of the Arbitration Between the State of Ohio, Department of Developmental Disabilities, Columbus Developmental Center, and the Ohio Civil Service Employees Association, American Federation of State, County and Municipal Employees, Local 11, AFL-CIO, Grievant: Margaret Njenga, grievance number: DMR-2021-00818, were directed electronically to the following this 23rd of March, 2022:

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March 23, 2022