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In The Matter of the Arbitration

-between-

State of Ohio, Ohio Department of Mental Retardation and Developmental Disabilities

-and-

OCSEA, AFSCME, Local 11

OPINION AND AWARD
Case No. 24-07-(98-10-29)-0792-01-04
The Hazel Fields Matter

ARBITRATOR: John J. Murphy
Cincinnati, Ohio

APPEARANCES:

FOR THE STATE:
Tondra Brokaw
Labor Relations Coordinator
Ohio Department of Mental Retardation
and Developmental Disabilities
30 E. Broad Street, 12th Floor
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Rhonda Bell
2nd Chair
Office of Collective Bargaining
State of Ohio

Also present:
Eric Young
Program Director
Gallipolis Developmental Center

Laura Sexton
Qualified Mental Retardation Professional

Susie Klinger
Therapeutic Program Worker

Shirley Vanco
Therapeutic Program Worker

FOR THE UNION:
Barbara Follmann
Staff Representative
OCSEA/AFSCME, Local 11
1680 Watermark
Columbus, Ohio 43215

Also present:
Steve Little
Social Program Specialist

Sandra McCreedy
Chapter President

Hazel Fields
Therapeutic Program Worker
Grievant

FACTUAL BACKGROUND

A) Parties

This case involves the decision by the Gallipolis Developmental Center to remove one of its employees represented by the Union. The Center provides programs, services and other supports to approximately 241 residents who are unable to live in the general community. The residents with mild to severe and profound disabilities live in twelve residential buildings located at the Center. Also located at the Center are other buildings, called vocational sites, where the residents learn various skills during the course of the day. One of these vocational sites, called Unique Experiences, or "the green house," exposes the residents to gardening and planting skills.

The day-to-day supervision of the residents at the residential buildings and at the vocational sites is a responsibility of Therapeutic Program Workers, represented by the Union. The Center's policy is set forth in writing, and the Therapeutic Program Workers are provided training in the requirements of this policy. The policy states that "the individuals of this facility shall be supervised in accordance with their demonstrated level of need." Staff is expected to be "responsible to supervise their assigned individuals according to each individual's supervision level as defined . . .". Finally, the policy defined five different levels of supervision including one called "close supervision." If an individual resident is determined to require

this level of supervision, staff is required "to have visual contact with the individual at all times as determined by need."

B) The Incident on August 24, 1998

This case involves the decision by the Gallipolis Developmental Center to remove the Grievant, a Therapeutic Program Worker, for an incident that occurred on August 24, 1998. The Grievant served in this capacity for the past eighteen years prior to her removal, and never had any disciplinary incident on her record. On this date, the Grievant signed a document called a Daily Living Report at approximately 6:45 a.m. signifying her responsibility for five named residents at the residential building 6047. She performed her early-morning supervisory duties at the residential building until approximately 9:00 a.m. At this point the residents are transported to vocational sites throughout the Center, and the assignment for supervision of residents changes. Two documents prepared by management called "Family Schedule" and "Scenario Instructions" set forth the shift or change in residents assigned to Therapeutic Program Workers.

It was at this point--approximately 9:00 a.m. on August 24, 1998--that Raymond K. was first assigned to the Grievant. Raymond K., a tall, 206-pound male resident, was known as a "runner" in that he attempted AWOL. He was also known to exhibit physical aggression and to be obsessive in repeatedly requesting tea and coffee. It was undisputed in the record in this case that Raymond K. required a level of supervision called "Close Supervision," i.e., visual contact should be maintained by assigned staff.

At approximately 9:00 a.m., the Grievant with supervisory responsibility for four residents, including Raymond K., rode in a van to the green house, otherwise known as Unique Experiences. At the green house the Grievant met with two other Therapeutic Program Workers from another residential building, 6041, who also had residents under their supervision. At that point, the three Therapeutic Program Workers, including the Grievant, met with Steve Little, a Social Program Specialist, who operated the green house.

At about 2:00 p.m. on August 24, 1998, one of the Therapeutic Program Workers (not the Grievant) noticed that Raymond K. was missing. The Grievant, at the suggestion of Steve Little, immediately called Laurie Sexton, the supervisor who was responsible for residential building 6047--Raymond K.'s abode. Ms. Sexton, the Grievant, and others searched for Raymond K. Ms. Sexton discovered Raymond K. a short time later at a Super America store where he had ingested some coffee or tea.

After an investigation, the director of the Center decided to charge the Grievant with a "major offense." Under the disciplinary policy of the Center, the particular offense was that of "Failure to Act/Client Neglect." This disciplinary charge is in furtherance of a separate policy of the Center entitled "ABUSE AND NEGLECT OF CLIENTS IN RESIDENCE." This policy requires management and employees of all classifications to be alert and diligent in reporting abuse/neglect of clients and residents and "to seek corrective action at once." Central to this case is the definition of neglect as found in the policy:

> "Neglect" means 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."

After a predisciplinary hearing, the Grievant was removed by notice that stated:

> The reason for this action is that you have been guilty of FAILURE TO ACT/CLIENT NEGLECT. In the following particulars, to wit: On August 24, 1998, at approximately 2:00 p.m., you were assigned close supervision of client Raymond K. However, you failed to assure proper visual contact with Raymond and he went AWOL from the work site.

A timely grievance was filed challenging the decision to remove the Grievant, and the grievance was agreed to be properly presented for arbitration under the terms of the contract between the parties.

STIPULATED ISSUE

Did management violate Article 24 of the contract when they removed Hazel Fields for Failure to Act/Client Neglect? If not, what shall the remedy be?

POSITIONS OF THE PARTIES

A) State Position

The State concentrated on the testimony of the two Therapeutic Program Workers who were at the green house with the Grievant on August 24, 1998. Both testified about the practice of transferring responsibility for residents. It was the Grievant's responsibility to pass the supervision of Raymond K. to another staff member should the Grievant depart from visual contact with Raymond K. At no time were either of the two other Therapeutic Program Workers asked by the Grievant to supervise Raymond K., and the Grievant

agreed in her testimony that she did not so ask her coworkers. It was the Grievant's duty to pass the supervision of Raymond K. to another staff member. Due to her negligent disregard of this duty that the Grievant owed to Raymond K., Raymond K. walked away from the green house to a Super America and consumed either tea or coffee.

The State acknowledged that certain documents signifying responsibility for residents at the green house were changed as a result of this incident on August 24, 1998 and the Grievant's removal. However, "the changes were de minimis, and were merely for clarification purposes."

The State rejected the affirmative defense raised by the Union of disparate treatment of the Grievant by the Center in choosing to charge the Grievant with failure to act/neglect of client. The State argued that the Union had failed to meet its burden of proof on this affirmative defense, and that the Director of the Center explained that other cases were not similarly situated to that involving the Grievant.

Lastly, there is no mitigation present in this case. The Grievant could have shifted the responsibility of Raymond K. to another employee as is the practice, or she could have taken Raymond K. with her when she left the visual line with Raymond K.

B) Union Position

The Union claimed that supervision of the residents at the green house is commonly shared by the Therapeutic Program Workers. There is a mingling of the residents from different residential

buildings. In addition, Steve Little, the Program Specialist at the work house assigns tasks to residents by ability and behavior and not by their residential living area. The bottom line, according to the Union, was that supervision is very fluid at the green house, and it was not necessary for the Grievant to verbally transfer supervision of Raymond K. to other Therapeutic Program Workers at the green house. All that is necessary is that the circumstances would be such as to reasonably expect the coworkers to note Raymond K. when the Grievant was out of the visual line of Raymond.

Changes in the documentary assignment of supervision in the green house occurred as a result of this incident. Those changes are substantial in directing attention to lines of supervision for individual residents.

The Grievant left the line of vision of Raymond K. in responding to two requests from Steve Little. Little viewed himself as having authority over the Therapeutic Program Workers, and is similarly viewed by the Workers. This is true even though he is a member of the bargaining unit.

Lastly, the Center treated the Grievant unfairly by choosing to bring the charge of neglect of client in this AWOL case. Since 1995, there have been approximately eight cases of discipline of Therapeutic Program Workers for an incident involving an AWOL resident. In all of these cases, the result was discipline in the form of a minor offense, if any, instead of the major offense charged against the Grievant.

OPINION:

A) The Merits

The State's charge of failure to act/neglect of client against the Grievant has a particular factual foundation in this record. There is no dispute that under two documents signifying supervisory assignments at the green house--the Family's Schedule and the Scenario Instructions--Raymond K. was a resident assigned to the Grievant for supervision in a group totaling four residents. There is also no doubt that Raymond K. required "Close Supervision"--visual contact by the Grievant with Raymond. It is also undisputed that the other three residents to which the Grievant was assigned also required the same level of supervision.

The particular factual foundation of the charge against the Grievant is the failure by the Grievant to verbally communicate to either one of the other two Therapeutic Program Workers at the green house the transfer of supervisory responsibility of Raymond K. The cornerstone of the State's case was the testimony by the other two Therapeutic Program Workers at the green house that the Grievant had never asked either one of them to supervise Raymond K.

The striking part of the record is the Grievant's agreement with this factual core of the State's case against the Grievant. The Grievant testified that she was asked by Steve Little to telephone her supervisor, Laura Sexton, on whether Sexton wanted a water lily from the green house. In addition, on hearing news of an affirmative response from Sexton, Little asked the Grievant to assist him in removing the water lily from the pond.

The Grievant testified that on both occasions she removed herself from the line of vision with Raymond K., and she did not ask anyone to take over the supervision of Raymond K. The Grievant assumed that the other Therapeutic Program Workers were taking over her clients when she made the phone call to her supervisor, and when she assisted Little in retrieving the water lily.

The case, therefore, on the merits comes down to the question of whether the Grievant had a duty to verbally communicate to the other Therapeutic Program Workers at the green house a transfer of responsibility for Raymond K. before she acceded to the two requests from Little. There is no written record of the practice of transferring responsibility for residents at a work site. There is, of course, the testimony of the two other Therapeutic Program Workers. There is also the following factors concerning the operation of the green house: the mixing of residents from different residential buildings; the integration of supervision among the Therapeutic Program Workers and Steve Little; the assignment of duties to the residents by Little; and the role of Steve Little. These factors do not support the claim that verbal communication for the transfer of responsibility of Raymond K. at the green house was required by the Grievant on August 24, 1998. This finding is further supported by changes since the removal of the Grievant in the documents signifying supervisory responsibility for residents at the green house.

Mixing of Residents. The clear division of residents supervised by Therapeutic Program Workers at the residential

buildings was not present at the green house. On August 24, one resident came from Building 6038 while the other eight residents came from either 6041 or 6047. In addition, while at the green house residents were assigned gardening tasks by Steve Little not according to their residential building assignment, but according to their ability and functioning.

The Grievant was assigned four residents from 6047 at the green house. On the other hand, these residents could be split and assigned with residents from other buildings to do tasks at different locations at the green house. Indeed, the record indicates that Steve Little had supervision of Raymond K. and a resident from a different building for a portion of the day on August 24.

Integration of Supervision. The most credible testimony that characterized the style of supervision at the green house came from the person viewed by the Therapeutic Program Workers as the overseer of the green house. Little testified that supervision "floated" at the green house because he merged people from different residential buildings. He stated that it was "common for Therapeutic Program Workers to share responsibility for residents, back and forth." He concluded that "a lot of sharing of responsibility is assumed--sometimes not discussed, but implied."

Given the mixing of residents in task assignments at the green house, and the role of Steve Little discussed below, the testimony of Little about the integration of supervision is credible. It is further supported by the Grievant who noted that all Therapeutic

Program Workers worked as a group at the work house. "We never said--will you watch my client--; it was implied if a Worker left."

The testimony of one of the other Therapeutic Program Workers at the green house supports the fluid status of supervision and the finding that verbal communication was not a sine qua non to the transfer of responsibility. Shirley Vanco testified that she engaged in loading the residents from 6047 as well as her residents from 6041 while Little and the Grievant were retrieving the water lily at the green house. She testified that the Grievant did not ask her to put residents charged to the Grievant from 6047 on the van. Vanco testified that "I did it automatically." This clearly demonstrates the fluidity and integration of supervision of the residents at the green house on August 24.

Role of Steve Little. While Little was a member of the bargaining unit, he perceived himself as having authority over the Therapeutic Program Workers at the green house. He testified that he gave directions and suggestions to the Workers about the tasks to be performed by the residents under their supervision. He noted that the Workers did not refuse his directions and suggestions because the Workers realized that "I have authority through their (Workers') supervisors" if a worker said no to a direction or suggestion from Little "I would go to the Workers' supervisor."

Not only did Little perceive himself as "in charge" at the green house, the Therapeutic Program Workers shared this view. All three Therapeutic Program Workers, including the Grievant, noted that Little was the "overseer" at the green house, or that Little

made assignments to residents. The Grievant testified that she saw Steve Little "as having supervision at the work house."

Changes in Documents at the Green House. Prior to this incident, Therapeutic Program Workers signed a daily living report at 6:45 a.m. signifying their responsibility for the supervision of certain named residents at a residential building. While supervision responsibility could change at 9:00 a.m. (as it did in this case) when the residents were taken to one of three work sites, there was no ceremonial signing to signify personal responsibility for the change in supervisory responsibility. Since this incident, there is a separate daily living area report for the three work sites that staff must sign at 9:00 a.m. or on arrival at the work site. This form is now specific and has more detailed instructions. An example was made part of the record and the following instruction illustrates the duties of a Therapeutic Program Worker signified by "Staff A."

> Staff A is responsible to ensure these five individuals are on the van when it leaves (the residential building). Staff A is responsible for the five individuals just mentioned until they return to the living area at 3:00 p.m.

The record shows that these changes in the documentary signification of responsibility for residents were put in place due to the incident that occurred on August 24, 1998.

The above analysis supports the conclusion that the Grievant did not have a duty to verbally communicate a transfer of responsibility for Raymond K. on the two instances on August 24 when she followed the direction of Steve Little to call her

supervisor, Laura Sexton, and to assist Little in retrieving the water lily for Sexton. The existence of this particular duty to verbally communicate the transfer is necessary to support the charge of failure to act/neglect of client. Consequently, the State did not have just cause to remove the Grievant based upon this charge.

In light of this analysis and decision on the merits, it is unnecessary to consider the Union's affirmative defense. This defense asserted that the Grievant had been treated unfairly as compared to other Therapeutic Program Workers who had been disciplined since 1995 in instances involving resident AWOL. It is unnecessary to consider and determine this affirmative defense.

B) Remedy

While the Grievant did not have the duty to constantly verbalize a transfer of responsibility for Raymond K. in the integrated supervisory situation at the green house on August 24, the Grievant did exercise poor judgment in breaking her visual contact with Raymond K. on two occasions within a short span of time. First, the Grievant acceded to Little's request that she telephone Sexton, her supervisor, to determine whether Sexton would wish to have a water lily from the green house. Shortly thereafter, she acceded to a second Little request to help him retrieve the water lily for transport to Sexton. It is true that the Grievant as well as others viewed Little as a supervisor at the green house; it is also reasonable to assume that the Grievant had altruistic motives in trying to enhance residential building 6047

with the water lily. On the other hand, the Grievant dropped visual contact with Raymond K.--a known runner--twice in a short period of time. This displays an act of poor judgment. This constitutes a minor offense under the Center's disciplinary policy, also characterized in the policy as a Category B offense. The policy requires progressive corrective action for Category B offenses. Since the Grievant does not have any prior disciplinary record, this would constitute a first offense with the required sanction of "an oral or verbal reprimand--with appropriate notation in the employee's file for the first offense."

While the State did not have just cause to remove the Grievant for the commission of the major offense of Neglect of Client, the Grievant's behavior on August 24 did exhibit poor judgment concerning resident Raymond K. This constitutes a minor offense of poor judgment, and warrants as a first offense a verbal reprimand with notation in the Grievant's employee file.

The Union requested that the make whole remedy awarded to the Grievant in the event of reinstatement should include a loss of overtime. The record does include a statement of overtime earnings by the Grievant from 1979 through 1998 for varying amounts from $8.00 in 1994 to $825.00 in 1998. This record is insufficient to base an award upon the loss of overtime compensation from the date of the Grievant's discharge to the date of her reinstatement. There is no testimony indicating that overtime would have been offered and accepted or that overtime is optional or mandatory. This makes any such award of overtime too speculative.

C) Award

For the reasons stated above, the Grievant is to be reinstated to a position similar to that she occupied prior to her removal on October 28, 1998. The reinstatement shall take effect within two days from the date of this decision.

The Grievant's removal shall be converted to an oral or verbal reprimand with appropriate notation in the Grievant's employee file for the first offense of the commission of "Poor Judgment"--a "Minor Offense" (Category B).

The Grievant is to be made whole by the restoration of all contract benefits to her including lost wages from the date of her removal to the date of her reinstatement. Interim earnings, e.g., unemployment compensation, shall be deducted from the payment for lost wages, and lost wages shall not include overtime.

Date: May 1, 2000

John J. Murphy
Arbitrator