IN THE MATTER OF ARBITRATION

#965

BETWEEN

STATE OF OHIO – DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

AND

OHIO CIVIL SERVICE EMPLOYEES ASSOCIATION
AFSCME LOCAL 11, AFL-CIO

Grievant: Tom Halas

Case No. 24-06-(20061122)-0894-01-14

Date of Hearing: April 10, 2007

Place of Hearing: Columbus Developmental Center
Columbus, Ohio

APPEARANCES:

For the Union:
Advocate: William Anthony, Jr., OCSEA Staff Representative

Witnesses:
Grievant: Tom Halas
Lois French

For the Employer:
Advocate: Laura Frazier, Labor Relations Officer
2nd Chair: Donna Haynes

Witnesses:
David Ott – Human Resources Director
Keith Davis – Chief of Police
Charles R. Flowers – Superintendent

OPINION AND AWARD

Arbitrator: Dwight A. Washington, Esq.

Date of Award: May 8, 2007

INTRODUCTION

The matter before the Arbitrator is a Grievance pursuant to the Collective Bargaining Agreement ("CBA") in effect March 1, 2006 through February 28, 2009, between the State of Ohio Department of Mental Retardation and Developmental Disabilities ("MRDD") and the Ohio Civil Service Employees Association AFSCME Local 11, AFL-CIO ("Union").

The issue before the Arbitrator is whether just cause exists to support the removal of the Grievant, Tom Halas ("Halas") for violating MRDD policies regarding failure to report or act on alleged abuse of residents that Halas observed or was told had occurred by a co-worker.

The removal of the Grievant occurred on or about November 20, 2006 and was appealed in accordance with Article 24 of the CBA. This matter was heard on April 10, 2007 and both parties had the opportunity to present evidence through witnesses and exhibits. Post-hearing briefs were waived and both parties presented closing arguments to the Arbitrator on April 10, 2007. This matter is properly before the Arbitrator for resolution.

BACKGROUND

The Grievant was employed as a Therapeutic Program Worker ("TPW") for the Department of MRDD. The Grievant was hired November 29, 2004 and worked at the Columbus Developmental Center ("CDC") location for MRDD. CDC is one of ten (10) developmental centers in the State of Ohio where clients and/or residents are housed whose disabilities preclude their living in a community environment.

TPWs provide active treatment and assistance to the clients whose unique circumstances require a healthy and safe environment. TPWs are required to report any incident of known or suspected abuse they observe or become aware of to ensure that a proper and timely response occurs considering the unique circumstances of each client. TPWs as part of the direct care staff

to the residents, receive extensive training in numerous areas including but not limited to: completing various reports; TPW basic responsibilities to clients; teamwork; and Policy and Procedural manuals governing TPW care obligations for the clients. (JX 34, pp. 1-2).

Due to the unique disabilities of the clients, all employees of CDC are responsible for client safety to ensure protection against neglect or abuse, whether self-inflicted or caused by others. TPWs are trained to report any suspected incident of neglect or abuse by completing a report on a form entitled Unusual Incident Report ("UIR"). (JX 39, pp. 1-4).

At issue herein are three incidents that led to the Grievant's removal. The Grievant in June 2005 worked the second shift in the residential unit called Carlson 2 Unit ("Carlson"). The residents housed in Carlson had a range of disabilities from mild to more severe mental retardation. Additionally, some of the residents had a criminal background and were considered "savvy' in dealing with the staff. The first incident involved David Baker ("Baker"), a TPW who was bitten by a resident in June 2005, and retaliated by pinning the resident on the couch and punching the resident four or five times in the face according to the Grievant. The Grievant admits to being present when this incident occurred, along with two or three other witnesses including his supervisor. The Grievant completed a UIR form and failed to report the assault by TPW Baker on the resident.

The second incident involved TPW Robert Hampton ("Hampton") who smacked a resident on the back of his head. The Grievant was the only witness to this incident, and was not certain if Hampton hit the resident with ill will or in a playful manner. The Grievant could not remember when this incident occurred.

The final incident involved an unknown TPW who informed the Grievant that a resident was injured while being awakened by TPW Euleetha Pringle ("Pringle") who grabbed and

twisted the resident's fingers which created a fracture. The Grievant could not remember which TPW told him about this incident and could not recall when this incident occurred as well.

None of the incidents were reported timely on a UIR, but were disclosed by the Grievant in August 2006 during an official investigation by CDC's Police Department into alleged abuse occurring in the Carlson housing units. The Grievant also provided additional examples of alleged abuse in Carlson that were either already known by CDC or were verified by CDC after a thorough investigation in August 2006. Although other alleged incidents of abuse were known by the Grievant, CDC removed the Grievant for failing to report the three incidents cited above and this decision will concentrate on those incidents only. (JX 3, p.1)

The Grievant's overall position on the above incidents is that he was a relatively new employee, and acts of unreported abuse were an acceptable practice by co-workers and supervisors. He alleges that a code of silence existed between co-workers to cover up abuse, and that if reported, then the reportee or snitch would be fired. The Union admits that the Grievant did not timely report the incidents but the discipline was too severe, others were treated less severely for similar acts and mitigation exists to lessen the discipline.

MRDD removed the Grievant for failure to follow CDC Policies 1.09 and 5.11.[1] MRDD indicates the Grievant's conduct warranted removal and cited three (3) reasons: (1) failure to

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[1] CDC Incident Reporting and Review Section 1.09 (in part): "The first person that becomes aware of or observes the incident shall notify the Grounds Office and obtain a UIR number. The observer shall make the appropriate notation in the individual record and begin filling out the incident report form while awaiting nursing personnel." (JX 18, p. 1).

CDC Abuse and/or Neglect (Section 5.11 (in part):

"III(B) Failure to act/resident neglect – including but not limited to failure to act in any manner which results in any potential or actual harm to an individual; failing to report or covering up individual abuse/neglect/mistreatment. (JX 39, p. 2).

IV Preventative Measures
Each employee shall be responsible for safeguarding individuals from abuse or neglect which could be self-inflicted or caused by other individuals and for reporting immediately any suspected incidents. (JX 39, p. 2). (Cont'd on pg. 5).

report or act and failure to follow policy regarding TPW Baker's incident; (2) delayed report of an incident and failure to follow policy regarding two individuals with MRDD regarding TPW Hampton's incident; and (3) delayed report of an incident and failure to follow policy pertaining to individuals with MRDD regarding TPW Pringle's incident. (JX 3, p. 1)

The Union seeks reemployment, back pay and restoration of all rights, whereby MRDD contends that removal was appropriate and the only remedy.

ISSUE

Was the discipline imposed for just cause? If not, what shall the remedy be?

RELEVANT PROVISIONS OF THE CBA AND MRDD POLICIES

ARTICLE 24 – DISCIPLINE

24.01 – STANDARD

> Disciplinary action shall not be imposed upon an employee except for just cause. The Employer has the burden of proof to establish just cause for any disciplinary action. In cases involving termination, if the arbitrator finds 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. Abuse cases which are processed through the Arbitration step of Article 25 shall be heard by an arbitrator selected from the separate panel of abuse case arbitrators established pursuant to Section 25.04. Employees of the Lottery Commission shall be governed by O.R.C. Section 3770.02(i).

MRDD/CDC POLICY AND PROCEDURE (IN PART)

Policy Section 5.22 – Human Rights of Individuals

V Preliminary Reporting Procedures
Any individual who has reason to believe that individual abuse and/or neglect has occurred must report such incident immediately by verbally contacting his/her immediate supervisor, department head, police officer or administrator on call, who will immediately inform the Superintendent/Designee, and Chief of Police . . . .

Any individual who fails to report such incident and/or complete the Report of Unusual Incident shall be considered to have neglected the individual and be subject to corrective action and/or criminal prosecution." (JX 3, p. 2).

I. POLICY

It shall be the policy of Columbus Developmental Center (C.D.C.) to provide participative opportunities for the promotion of human dignity and the elimination of dehumanizing conditions, attitudes, practices and environment within this Center.

IV. DEFINITIONS

Human Rights of Individuals refers to those constitutional rights which are guaranteed under the U.S. Constitution to all citizens, and through federal statutory legislation. The following rights apply to all persons regardless of disability:

The right to be treated at all times with courtesy and respect and with full recognition of their dignity and individuality;

The right to an appropriate, safe, and sanitary living environment that complies with local, state, and federal standards, and recognizes the person's need for privacy and independence.

Policy Section 1.09 – Incident Reporting and Review (contained in Footnote 1)
Policy Section 5.11 – Individual Abuse and/or Neglect (contained in Footnote 1)

POSITION OF THE PARTIES

THE EMPLOYER'S POSITION

CDC is one of the developmental centers within the Department of MRDD, devoted to providing a safe and healthy environment to residents whose disabilities require the unique services offered by CDC. A key component is that residents are treated at all times in an ethical and humane manner. All TPWs attend annual in-service training to reaffirm the behavioral care and respectful treatment that the residents must be afforded.

Charlie Flowers ("Flowers"), Superintendent, testified that each of the one hundred fifty three (153) residents of CDC have unique circumstances requiring that common core values such as kindness, self respect, etc. are expected of staff when interacting with the residents. Flowers

also added that any allegation of abuse/neglect of a resident is viewed very seriously and all staff are trained regarding the process to follow in reporting any incident. Flowers also indicated that the families of each resident plays an important role in their care and treatment. To that extent, if a resident experiences any unusual event at CDC the family is notified and provided information known by CDC regarding the incident.

During an investigation by CDC's Police Department in August 2006 of alleged abuse, the Grievant indicated that he was aware of abuse of residents by co-workers. In a written statement on August 8, 2006 at 4:50 p.m. (JX 27), the Grievant stated that he had knowledge of numerous examples of resident abuse, including the three incidents which were the basis for his removal. Later the same day at 6:41 p.m., Grievant met with CDC's Police Department and reaffirmed the following: (1) he had witnessed TPW Baker strike a resident four to five times in the face on the couch in Carlson; (2) he had witnessed TPW Hampton hit a resident in the back of the head with an open hand; and (3) he was told by an unknown TPW that TPW Pringle grabbed a resident by her fingers causing a fracture, while attempting to pull her out of the bed. (JX 28, pp. 2-11).

CDC upon learning of the alleged abuse requested the Police Department to investigate each incident. Keith Davis ("Davis"), Chief of Police – CDC, testified that in researching past UIRs, they discovered that the bite incident involving TPW Baker happened on June 29, 2005. Davis' unrefuted testimony indicated that the Grievant completed a UIR on June 29, 2005 but failed to include any reference to the hitting incident. Moreover, no other UIRs on file regarding TPW Baker's incident contained witness statements documenting any alleged injury. Chief Davis indicated that the thirteen-month delay in reporting the Baker incident made the investigation difficult, to say the least. Chief Davis was unable to substantiate the alleged slap

by TPW Hampton due to lack of any credible evidence. The final incident involving TPW Pringle had been previously investigated, due to the need for medical intervention at the time of the incident.

CDC indicates that the Grievant has been less than candid throughout the disciplinary process. During the third step meeting on December 21, 2006, the Grievant indicated that the reason the UIR on June 29, 2005 was false, was because he was fearful of losing his job and health insurance benefits. However, at the predisciplinary hearing held earlier on October 6, 2006, the Grievant stated that he was "coached" by others to falsify his June 29, 2005 UIR. When asked who coached him to falsify the UIR, the Grievant refused to answer.

CDC further points out that during the predisciplinary hearing, the Grievant indicated because he did not want to be labeled a "snitch", was another reason he did not report the TPW Baker incident. Additionally, during the predisciplinary hearing, the Grievant indicated that he was not sure if TPW Hampton was playing with the resident when Hampton smacked him in the head. This position is contrary to his original written statement of August 8, 2006 when he stated that the slap to the head was not done in a playful manner. However, according to Grievant's testimony at the Arbitration hearing, since he did not see any harm to the resident, he did not report it.

The Grievant's credibility is also questioned surrounding the incident with TPW Pringle. Throughout all of the disciplinary proceedings, the Grievant insists that he cannot recall which co-worker told him about the fracture but does recall telling his supervisor, Karey Peters ("Peters") on the night he was informed. However, Peters' written statement contradicts the Grievant and indicates that he never reported any allegations of abuse to her. (JX 23, pp. 1-5).

CDC offered undisputed evidence that the Grievant on April 10, 2006 attended staff training which included, but was not limited to, areas regarding resident treatment, reporting procedures, personnel policies and procedures, etc. The Grievant was also provided a copy of CDC's Rules which cover areas such as contact with residents, hours and supervision, use and control of property, weapons; and philosophical operative principles for the performance of staff duties ("staff duties"). (JX 36, pp. 4-7). The Grievant was aware of what he was supposed to do but failed to act to timely report if and when his co-workers' conduct harmed a resident.

Since it is undisputed that the Grievant violated CDC's policies, the issue for resolve was whether the discipline was appropriate. The Grievant was removed not for reporting the incidents in August 2006, but failure to report/act when he became aware of the incidents. If the Grievant had reported each of the incidents when they occurred no discipline would have occurred. The Grievant's uncredible versions of the events and by his own admissions of failure to report or act warrants upholding his removal.

The Union wrongfully believes that mitigation principles apply, due to a code of silence among TPWs, that only penalizes the employees who report the abuse/neglect. Unfortunately, Grievant's argument fails to point out any other TPW who either witnessed or was told abuse had occurred that was treated differently. The Union presented two examples of employees who were comparable to the Grievant but were treated differently.

One of the alleged comparables was an employee who failed to report an incident for twenty minutes or so who received a written warning and the other example was an employee who failed to complete a UIR properly who received a five day suspension. Neither of the alleged comparables situation is remotely similar to the Grievant's, thereby abrogating the

despair treatment analysis. The Union has presented no examples of employees who failed to report/act or delayed reporting for up to thirteen months.

THE UNION'S POSITION

The Grievant admits that he should have reported co-workers' abuse in a timely manner, but asserts that he was actually fired because he broke the code of silence. The Grievant indicated at the hearing that once reported, all other co-workers and supervisors would deny any knowledge or involvement. To support this position, Lois E. French ("French"), a TPW for over three years, testified that while no other TPW told her about a code of silence, it was her belief that there was "an unwritten policy not to tell" about abuse. French stated that after she provided a written statement that indicated "derogatory" comments were being made toward the residents by co-workers and her supervisor, she was regularly called into the supervisor's office on minor issues. The implication being, retaliation will occur when you report abuse incidents that causes a negative light to shine on the employees and/or supervisors which may lead to an internal investigation.

The Grievant testified that when first employed at CDC he was intimidated by co-workers and just wanted to get along. He further added that his personality is basically non-confrontational, but the Grievant indicated that he is ready to return to work understanding his past shortcomings. The Grievant stated that TPW Hampton and others didn't like him and as a new employee he was attempting to fit in.

The Grievant further claims that he reached a point one day that he could no longer accept how the clients were being treated. In August 2006 upon being informed of an incident with a resident, the Grievant "became fed up with what was going on" – which led to his written statement of August 8, 2006. He also believes that he accurately provided data to the Police

Department on August 8, 2006 regarding the incidents involving TPWs Baker, Hampton and Pringle. Any alleged inconsistencies regarding the incidents are due to his inability to remember the event details – not because of being dishonest.

The code of silence is real, and even during the predisciplinary hearing and at the arbitration hearing the Grievant was unwilling to add any more names from CDC's staff who may have knowledge of past abuse/neglect situations.

The Union contends that despite the delay in reporting, no actual abuse was discovered that CDC was not already aware of. Therefore, how can the Grievant be removed? If this removal stands, TPWs will forever go further underground and never report abuse. The message conveyed is that if you follow CDC's policies, you will be disciplined, not the perpetrators.

Finally, the Union contends that two examples of similarly situated employees who were treated more favorably for violating the same rules as the Grievant. One employee failed to report a case of abuse and received a five day suspension and another employee failed to correctly complete a UIR and received a verbal reprimand. Therefore, the Grievant was treated in a disparate manner, warranting a lesser discipline.

DISCUSSIONS AND CONCLUSIONS

Based upon the sworn testimony at the hearing, extensive exhibits presented by both sides and the post hearing arguments, the grievance is denied. My reasons are as follows:

Performing services as a TPW for clients of MRDD who are mentally or developmentally challenged by all accounts is a difficult task. Supt. Flowers and the Grievant acknowledged that all clients are entitled to an environment that is safe and healthy. To that extent, TPWs are the "eyes and ears" of the Developmental Center due to their constant contact with the clients. The facts also indicated that some clients residing in the Carlson Unit had a

criminal background, which would require the Grievant and his co-workers to exercise greater restraint when dealing with such clients. It is also undisputed that clients on occasion will push, hit, kick and spit on TPWs while performing their duties. Regardless of the provocation of the aggression by a client, all TPWs are trained in passive restraint and no client should ever be hurt or abused while under the custody of a developmental center.

Given the foregoing, on August 8, 2006, the Grievant reports TPW Baker's incident that he witnessed a client being struck four to five times in the face with a closed fist by TPW Baker. TPW Baker was bitten by the client, which prompted the reaction. The bite incident occurred on June 29, 2005, as noted in the UIR completed by the Grievant, which documented the conduct of the client, but was silent regarding TPW Baker's conduct. As a result, the Grievant was charged with failure to report an act in violation of CDC Policy 1.09 (5.11).

The Grievant admits that he witnessed the Baker incident on August 8, 2006 (JX 27, pp. 1-3), but failed to report or act until over thirteen (13) months later. The Union argues that other witnesses, including his supervisor, were present who also failed to comply with CDC's reporting requirement. Unfortunately for the Grievant, the record indicates the opposite.

John Flemon ("Flemon"), supervisor, and other alleged witnesses were interviewed and all denied witnessing TPW Baker striking the client who bit him (JX 11, pp. 32-33). No evidence aside from the Grievant's testimony exists in the record to infer that the hitting was observed by any other employee of CDC. The Grievant admitted during the hearing that his UIR of June 29, 2005 was incomplete, but attempts to justify his actions by alleging in part that he had been employed only seven months and did not want to be viewed as a "snitch" among his peers, or that he was "coached" to falsify the UIR. The Grievant further added that his conduct was based in part upon his passive personality and he was concerned that other TPWs may

retaliate against him. Finally, according to the Grievant, an unwritten "code of silence" was utilized by his co-workers which encouraged him and other TPWs not to report unusual conduct.

All of the reasons submitted by the Grievant to rationalize why an accurate UIR was not completed on June 29, 2005 greatly puzzles this arbitrator. Singularly or combined, none of the reasons justified the Grievant's conduct in not accurately reporting this incident. The Grievant's failure to report TPW Baker's conduct is exacerbated because a potential injury to the resident is not treated; family members not informed that an injury occurred; a timely internal investigation didn't occur; and TPW Baker's behavior is not properly addressed. I agree with the employer that the Grievant had a duty to report and he failed to comply.

As a threshold inquiry, if CDC was not conducting an investigation in August 2006, would the Baker incident ever been discovered? The Grievant is not vested with the discretion to decide which incidents to report or not to report. CDC, Section 1.09 makes it mandatory that if the Grievant either observed or became aware of any unusual incident, he had a duty to report it. Otherwise, the Grievant becomes the arbiter of defining what incidents are reportable or not. The conduct of the Grievant clearly violates this policy by not preparing a UIR accurately containing the hitting in the face acts of TPW Baker.

Moreover, by omitting TPW Baker's conduct on the UIR prepared by the Grievant on June 29, 2005, he covered up what occurred, also a violation of CDC, Section 5.11. CDC, Section 5.11 addresses abuse/neglect and provides in part: ". . . failure to act in any manner which results in any potential or actual harm . . ." (CDC 5.11; IIB) are subject to corrective action or criminal prosecution. The absolute protection of MR and/or MRDD clients resonates in all of CDC's policies and procedures. The evidence is undisputed that when acts of abuse/neglect are reported by any staff, an investigation results. No evidence exists in the record

to infer otherwise. The Grievant failed to act and covered up the Baker incident for over thirteen (13) months, and as a result, violated CDC Policy, Section 5.11.

Regarding the "code of silence" mitigation defense, if the Grievant had reported TPW Baker's incident on June 29, 2005 and was subsequently disciplined, then maybe the code of silence argument would be meritorious. However, the facts before this arbitrator are undisputed that the Grievant failed to comply with CDC's policies regarding TPW Baker's alleged conduct that he witnessed. The decision thirteen months later to break the code of silence is inconsistent with the Grievant's stance of not identifying other TPWs who told him they had witnessed abuse/neglect of residents and his refusal to indicate which co-worker told him to falsify the June 29, 2005 UIR. If the code of silence exists, the Grievant perpetuated that unwritten policy by his own conduct!

The Union presented TPW French as a witness who testified that it was an unwritten policy not to tell, but on cross examination indicated that "no one ever told me about the code of silence . . ." French believed that TPWs would not set up other TPWs and would look the other way. French's testimony, if indicative of other TPWs at CDC, is probably why rumors of abuse/neglect necessitated the August 2006 investigation by the institution. Simply, one of CDC's missions is to assist and protect disabled individuals in its care. Any and all incidents observed or reported to a TWP by another TPW must be documented and reported – with no exception.

The second incident involved TPW Hampton's slap on the back of the head of a client. The Grievant was the only witness to this incident and originally indicated the slap was not in a playful manner. The Grievant could not recall the date this incident occurred. At the hearing, the Grievant testified that he could not ascertain if the slap was horseplay or not, so no UIR was

prepared. As indicated above, the determination if the slap was horseplay or not, was up to others to decide, not the Grievant. Once again, the Grievant as a firsthand witness, was required but failed to report the incident in accordance with CDC, Section 5.11. The Grievant's written statements (JXs 27, 28 and 29) and hearing testimony are admissions by the Grievant of his failure to comply with the policy. Therefore, credible evidence exists to find that the Grievant violated CDC, Section 5.11.

The third incident occurred when the Grievant was told by another TPW of an injury that resulted from conduct by TPW Pringle. The Grievant indicated that TPW Pringle fractured a client's finger while awakening the client. The Grievant was unable to remember which TPW told him or recall when the Pringle incident occurred. Chet Davis testified that from a review of UIRs prepared by others, he was able to verify that the fracture did occur. Although, the TPW Pringle incident was documented by others properly, the Grievant was also required to prepare a UIR which he did not.

The Grievant indicated that he informed Supervisor Peters of this incident. However, Peters was interviewed by the Police Department and refuted that the Grievant reported this incident to her. (JX 23).

The credibility of the Grievant throughout this matter was an issue. When pressed about which TPW told him of Pringle's conduct, the Grievant's only response was he believed it was a female and she was African American. The arbitrator found the Grievant to be articulate and alert but not very believable as a witness. Portions of the Grievant's testimony including the Pringle incident, were laced with memory loss, selective recall and outright refusal to implicate any other TPWs by name who were not already known to CDC who potentially violated the same policies as the Grievant. The arbitrator had to sort through the oftentimes rambling

testimony of the Grievant to determine if believable testimony existed upon which logical inferences could be drawn to support Grievant's position. The Grievant's overall testimony was not credible and believable, buttress by my determination that he provided no specific facts or verifiable supportive evidence to support any claims that alleged abuse unknown to CDC, occurred during his employment. Particularly, not one witness verified the TPW Baker incident when four co-workers were also present, and his inconsistent versions of the TPW Hampton incident.

The record contains reliable, credible and trustworthy evidence consisting of over three hundred pages of exhibits which included over forty-five written witness statements/interviews, which support the thoroughness of the investigation conducted by CDC regarding this matter. Given all of the foregoing, I concur with CDC that the level of discipline was appropriate and not arbitrary.

The Union raised the affirmative defense of disparate treatment. The burden of proof shifts to the Union. The Union presented two examples of other employees who were treated differently but were similarly situated to the Grievant. One employee failed to report an incident and received a five day suspension and another employee was charged with not correctly completing the UIR and was only given a verbal reprimand.

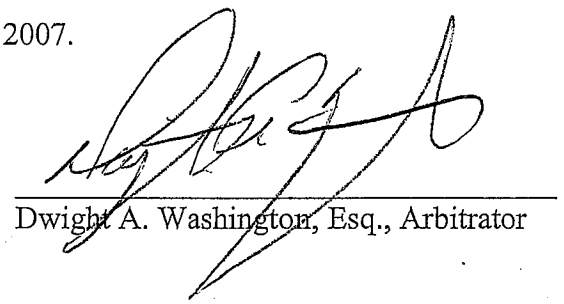
The employee who failed to report was not a TPW and no evidence exists to indicate that the employee was trained comparable to the Grievant. The evidence offered is insufficient for a finding that the employee and the Grievant's behavior were closely aligned in all major respects. Furthermore, the employee who failed to correctly complete the UIR for about twenty minutes is not similarly situated with the Grievant as well. The Union facts do not meet the burden of proof required to support the affirmative defense of disparate treatment.

Based on the above analysis the discipline was for just cause and was not excessive.

AWARD

Therefore, for all the reasons cited above, the grievance is denied.

Respectfully submitted this 8th day of May, 2007.



Dwight A. Washington, Esq., Arbitrator