

In the Matter of Arbitration )  
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 between )  
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 STATE OF CONNECTICUT )  
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 and )  
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 NEW ENGLAND HEALTH CARE )  
 EMPLOYEES UNION, DISTRICT 1199 )

Grievant: David Morales

OLR Case No: 10-8449

Before: EILEEN A. CENCI

Appearances:

For the State: Frederick W. Heisler

For the Union: Shirley Watson, William Meyerson

Dates of Hearing: December 1, 2010 and January 10, 2011

AWARD:

The dismissal of David Morales was not for just cause. The penalty imposed upon the grievant was disproportionately severe in comparison to the penalties imposed on the other employees who were involved in the same incident. The penalty is therefore reduced to an unpaid thirty-day suspension.

The grievant is to be reinstated and made whole for all losses he sustained as a result of his dismissal, with the exception of lost pay and benefits for the period of a thirty-day suspension.

*Eileen A Cenci*  
Eileen A. Cenci

Date of Award: April 8, 2011

11-28

## **OPINION**

### **STATEMENT OF PROCEEDINGS:**

The Union appealed the above-captioned matter to arbitration and a hearing was held before me on December 1, 2010 and January 10, 2011 in Hartford, Connecticut. The parties appeared and were given a full and fair opportunity to be heard, to present evidence and argument and to examine and cross-examine witnesses. Witnesses were sequestered and testified under oath. At the conclusion of the hearing the parties agreed to file post-hearing briefs, to be postmarked no later than March 7, 2011. The briefs were received by the arbitrator on March 9, 2011 and the record was closed at that time. The briefs were subsequently exchanged to the parties by the arbitrator.

### **ISSUE:**

The parties filed a written stipulation to the following issue:

Was the dismissal of David Morales for just cause?

If not, what shall be the appropriate remedy, consistent with the collective bargaining agreement?

### **FACTS:**

This case concerns the dismissal of the grievant, who was employed as a Forensic Treatment Specialist at the Whiting Forensic Institute, a division of the Connecticut Valley Hospital (CVH) beginning in December 2007. CVH is part of the Department of Mental Health and Addiction Services (DMHAS). Clients at the Whiting Forensic Institute suffer from severe mental illness and frequently exhibit challenging behavioral problems. They have been placed at the Institute through a Psychiatric Security Review Board commitment, a civil commitment, or transfer from the Department of Correction (J. #6). The staff of the Whiting Institute are trained to respond appropriately to the challenging and difficult behavior exhibited by the clients.

The incident that led to the grievant's dismissal occurred on October 12, 2009 during the second shift. Although the grievant's regular work assignment is in Unit #3, he was working in

Unit #6 at the time of the incident. The grievant was at the nursing station when he heard a commotion in the bathroom across from the station. He went into the bathroom to investigate and found two other employees, Julie Davis and Robert Martineau already there. Client W, whose behaviors include obsessively drinking water to the point of water intoxication, was in the bathroom and was refusing to leave. W was yelling and cursing, had dropped to the floor, and was attempting to move around the other two workers to get the water. He was spitting and kicking as he did so. The grievant and the other workers who were present in the bathroom decided to do a guided escort to return W to his room. The manner in which the client was moved from the bathroom to his bedroom, a short distance away, led to the grievant's dismissal.

The incident came to light the following morning after Renata Kozak, the Director of Nursing and Chief of Patient Care Services arrived at work and was informed that Julie Davis had reported a sexual assault by W the previous night.<sup>1</sup> In the course of investigating that allegation Ms. Kozak reviewed tape from a video monitor that operates continuously in the hallway outside the bathroom on Unit #3 where W had been the previous night. Review of the video, which was also shown at arbitration, showed Mr. Morales, with his back to the camera, holding onto W's sweatshirt and dragging him from the bathroom to his room. Employees Robert Martineau and Julie Davis followed closely behind the grievant and W, in clear view of the video camera, while this occurred.

A second camera showed W being brought into his room. In the video Mr. Morales had his hands on W and was still dragging him, though now by the legs. The camera showed Julie Davis reaching toward W apparently in an effort to help. It is at this point that she alleged W sexually assaulted her by grabbing her groin area and pulling her to the ground. Inside the room W was briefly exposed as his pants came down from being dragged by the legs. The mattress on the floor of W's room appeared to move, and the State alleged that W was thrown against the mattress at that point, causing the movement.

Lance Mack was the Nurse in Charge at the time of the incident. He reported to W's room after hearing staff call for assistance. He can be seen on the video arriving at the room just after W had been taken into the room, with W on the floor and the three workers standing near

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<sup>1</sup> Ms. Davis filed a workers' compensation claim over the injury and Mr. Morales wrote a statement on March 13, 2009 in support of her claim.

him.

No report was filed on the evening of October 12, 2009 concerning the manner in which W was moved from the bathroom to his bedroom. The only incident that had been reported as of the morning management meeting on October 13, 2009 was the allegation by Julie Davis that she had been injured when W grabbed her groin area.

Ms. Kozak was shocked by the video as she believed it demonstrated a completely inappropriate way to move a client. In addition, W has brittle bone disease and could have been injured by being dragged in such a manner. Ms. Kozak, who is a mandated reporter, wrote a Work Rule Violation Report naming David Morales as the alleged violator (J. #7). Her description of the incident stated that it was an inappropriate use of techniques with a patient and that the employee had dragged the patient by himself down the hall from the bathroom to the patient's room. The patient was checked for signs of physical injury on October 13, 2009 and was found to be ambulatory without any difficulty. No signs of injury were noted (J. #8). The grievant was placed on Administrative Leave effective October 14, 2009, pending an investigation.

Human Resources Associate Alphonso Mims conducted an investigation into the matter. He spoke to Renata Kozak to get preliminary information, then reviewed the video and identified those who were present at the time of the incident. Mr. Mims conducted interviews with the grievant, Julie Davis and Robert Martineau. Mr. Mims also spoke to Lance Mack. The employees who were interviewed had the right to have Union representation during the interviews. Ms. Kozak was also present at all interviews. Each of the three employees who were present at the time of the incident in the bathroom was interviewed both before and after they were shown the video. Mr. Mims took notes during the interviews and asked the employees to sign those notes. If they did not wish to sign they were given an opportunity to write their own statement.

Mr. Morales was initially interviewed on October 29, 2009. He wrote a statement in which he said that when he entered the bathroom, Robert Martineau and Julie Davis were telling W that he had to return to his room but W would not do so. Mr. Morales stated that the three workers decided W needed to go back to his room and that when he heard this, he dropped to the bathroom door intentionally. He said they then decided to use a guided escort and that he took

hold of W's arm. He wasn't sure whether it was his left or right arm and could not recall who took his other arm. When told that there was a video that showed him dragging W down the hall, Mr. Morales stated that he did not recall such an event. He recalled that in the bedroom, as he tried to back away from W, W grabbed his leg and tried to pull him down (J. #8).

After viewing the video the grievant wrote an addendum to his written statement on November 5, 2009. He stated that he was extremely upset after viewing the video and that it painted an incomplete picture of the event. He also stated that he had no intention of causing harm to W and that the situation had gotten out of hand in a matter of seconds. In the addendum the grievant stated that he and the other workers made an earnest attempt to persuade W to leave the bathroom and return to his room, and that they tried "for what seemed like an eternity." The three workers then made the decision to do a guided escort and he acted, but the others did not join him. He said that he grabbed the back of W's sweatshirt and thought the others would carry his legs, but he was the only one who carried out what he believed had been a joint decision. Once he realized that, he decided to continue because W's bedroom was only a few feet away. At the bedroom door W grabbed the grievant's right leg, so the grievant swung around and brought both his legs into the bedroom (J. #8).

In her initial statement on October 17, 2009, Julie Davis wrote that W had been extremely agitated because he could not drink water from the faucet. She stated that she and David Morales walked out of the bathroom with W and there was no contact with W by either of them. She stated that she did not witness the grievant drag W to his room. After viewing the videotape she wrote another statement on November 16, 2009 stating that her memory and the videotape were at odds, that dragging a patient on the floor was not a correct procedure and she would consider it patient abuse (J. #8).

Robert Martineau, in his initial statement on October 26, 2009, recalled asking W to get up off the bathroom floor but said that he could not recall what happened after that. He could not recall seeing the grievant drag W down the hall (J. #8). After viewing the video Mr. Martineau wrote an addendum on November 3, 2009 to his previous statement. In it he said that he clearly remembered that he, Julie and David discussed a guided escort of W to his room. He further stated that the video showed W being taken to his room in an extremely unprofessional manner, but that he had worked with the grievant and knew him to be a kind, honest, gentle individual

who had never been abusive to a patient. Mr. Martineau also said that although he was not offering excuses for the behavior, it had “long been the culture on this particular unit.” He said he would have to characterize what he viewed on the video as patient abuse, but that the incident should be seen in its entire context, in which a screaming, verbally abusive patient had dropped dead weight to the floor and continued to scream, spit and behave in an abusive manner even though the employees were practically begging him to leave the bathroom (J. 8).

Mr. Mack gave a statement saying that when he arrived at the room the patient was sitting on the floor and had a hold on Mr. Morales’ leg. When he arrived at the door of the room he saw the patient grab Ms. Davis’ groin and pull her down to a sitting position. The patient was asked to sit on his bed and he complied and let go of the staff. Mr. Mack denied seeing Mr. Morales drag W into the room and said that no one reported an incident of patient abuse or mistreatment to him (J. #8).

Following his interviews with staff Mr. Mims conducted a Loudermill hearing with the grievant on November 13, 2009. The grievant had Union representation at that meeting and had an opportunity to present mitigating information. Mr. Mims consulted further with leadership at the Whiting Institute and at DMHAS after the Loudermill hearing, then recommended that the grievant be dismissed. He based that recommendation in part on his concern over the grievant’s initial misrepresentation of the incident when questioned about it and on the grievant’s denial of responsibility. Mr. Mims was also concerned about the level of intervention, since there was no evidence that W was at risk of harming himself while he was in the bathroom. Lance Mack was not disciplined for failing to report a critical incident. Ms. Davis and Mr. Martineau received five-day suspensions for their role in the incident, and those suspensions were later reduced to three days.

The grievant was notified by letter dated November 16, 2009 that he was being dismissed from State service because he had physically abused a patient on October 12, 2009 in violation of DMHAS Work Rule #19 and Commissioner’s Policy Statement No. 29 regarding “Client Abuse” (J. #3). The Union filed a grievance, which was denied and appealed to arbitration.

There was a great deal of evidence introduced at arbitration about the training employees receive and the techniques they are trained to use with uncooperative patients. All staff members

receive a three-day training in Collaborative Safety Strategies (CSS) when they are hired.<sup>2</sup> There is also an annual one-day CSS refresher course. Participants in CSS training receive a workbook, which includes illustrations and written guidelines that govern physical skills, such as guided escorts and take-down procedures (S. #1). Although the workbook does not include a technique for moving someone who is on the floor and refusing to get up, Sharon Ciarlo, who directs the safety education and training unit, testified that there is a video which is played during the training in which the lift technique is demonstrated. During the classes instructors also demonstrate the various techniques and then participants are required to demonstrate that they can perform a skill in order to successfully complete the class.

When asked what the correct course of action would have been for the employees in the bathroom with W on October 12, 2009 Ms. Ciarlo responded that a number of clinical factors would have to have been considered. The amount of water the patient had already taken in would have been a consideration. The employees would then be expected to use the least restrictive and safest intervention, given the patient's history and current mental status. With a patient who was on the floor and refused to return to his room, it would have been necessary to assess the risk of danger to himself and others if he were allowed to remain on the floor. It might have been possible to allow him to remain sitting or it might have been necessary to move him. If physical intervention were required, the patient should always be lifted by at least two people. If the client is expected to be uncooperative a nurse should also be present. If a patient refuses to walk and must be carried, at least five people would be required to assist. One person has to support the head and one person has to carry each limb. One employee dragging a patient would never be an appropriate technique.

The treatment plan that was in place for Client W as of October 12, 2009 stated that W would be educated by a nurse regarding the harmful effects of excessive fluid intake and would be encouraged to adhere to recommended daily fluid allowances. The "Patient Actions" section of the plan stated, "Adhere to recommended daily fluid intake..." (S. #3). The treatment plan was changed after the October 12, 2009 incident to be more focused on behavior. The new plan, for example, included in the Nursing Services section, "1) Lock bathroom door when patient

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<sup>2</sup> The predecessor training to CSS was called Behavioral Management Strategies or BMS. The grievant had received training in BMS and CSS techniques (J. #13).

focused on drinking 2) Staff will verbally engage patient to avoid use of physical contact whenever possible and 3) When patient or other unit member safety becomes and (sic) issue (drinking from faucet, sitting on floor in front of bathroom, attempting to assault staff/other patients), charge nurse will collect minimum of four staff members and use CSS technique to remove patient” (S. #4).

**CONTRACT:**

**Article 33 Dismissal, Suspension, Demotion or Other Discipline**

SECTION ONE. No permanent Employee or Employee as provided in Article One Section Four, who has completed the Working Test Period, shall be disciplined except for just cause. Discipline shall be defined as dismissal, demotion, suspension, reprimand or warning...

**Department of Mental Health and Addiction Services**

**General Work Rules**

19. Physical violence, verbal abuse, inappropriate or indecent conduct and behavior that endangers the safety and welfare of persons or property is prohibited.

(J. #10).

**Commissioner’s Policy Statement No. 29**

**Client Abuse**

It is the policy of the Department of Mental Health and Addiction Services that client abuse is prohibited. This policy applies to verbal abuse, physical abuse, or any other abusive conduct towards clients. As Commissioner of the Department of Mental Health and Addiction Services, it is my expectation that all clients shall be treated with dignity and respect; these are basic client rights which are guaranteed to all clients. All reported incidents of client abuse must receive a thorough investigation, regardless of the nature of the complaint. All complaints of abuse made by clients must be reported. All employees must report incidents of client abuse whether they have knowledge of such an act or whether they are a participant or witness. Without exception, this must be adhered to and applies to all employees of the Department of Mental Health and Addiction Services...

## **POSITIONS OF THE PARTIES:**

### **State**

The State argues that each of the seven tests of just cause has been met, and that just cause for the grievant's dismissal has therefore been established. The grievant was on notice that the employer had reasonable work rules prohibiting client abuse. He had signed copies of Work Rules and the Commissioner's Policy #29 that explicitly prohibit such conduct. The grievant had also received training in correct patient escort techniques and knew that dragging a patient was not an acceptable technique.

The State conducted a full and fair investigation into this matter that included interviews with the grievant and other witnesses. The grievant had an opportunity to provide a written statement and to supplement that statement after he viewed the video. He had Union representation at both interviews and at a Loudermill meeting, where he had the opportunity to present mitigating information.

The State clearly proved that the grievant violated work rules by dragging a patient down the hall to his room. His conduct did not comply with procedures he had been taught. Even the grievant admitted, when he viewed the video, that his conduct was extremely unprofessional.

The penalty was warranted under all the circumstances of this case. The department has a zero tolerance policy for patient abuse, which must be enforced in order to ensure that clients are protected. The grievant was not initially truthful when questioned about the incident. He is also a short-term employee whose conduct must be evaluated in light of that fact under the just cause standard.

The grievant was not treated unequally in comparison to the other employees who were involved in the incident. The Union has the burden of proving discrimination and has not met that burden. The grievant's conduct was not similar to that of Ms. Davis and Mr. Martineau, who were suspended but not dismissed. The grievant was the only person who physically dragged the patient and thereby engaged in physical abuse. The other employees committed acts of omission by not reporting the abuse they witnessed. The penalty imposed in this case was consistent with penalties imposed in similarly egregious cases. The State asks that the grievance be denied.

## Union

The Union argues that just cause for the dismissal was lacking. The State gave insufficient weight to the significant mitigating factors in this case. The grievant was unfamiliar with Unit #6 at the time of the incident since he normally works on Unit #3. The colleagues with whom he worked on October 12, 2009 were more familiar with Unit #6. Client W was engaged in behavior that posed a medical risk to him and verbal interventions, which are not shown on the video, had not been successful. Moving the client away from the bathroom was in the interest of his own health and safety. The grievant and two more experienced employees agreed to physically move the client but the other two did not assist as they had agreed to do. Although the manner in which the grievant moved the client did not comply with procedures employees are trained to use, the grievant had no malicious intent and did not cause injury to the client.

Neither the treatment plan that was in place at the time of the incident nor the training manual provided to employees described what staff should do in a situation such as the one that arose, where the patient dropped to the ground and was spitting, kicking, cursing and refusing to move away from a water source. The employees were forced to make a quick decision and had no real guidance as to how to proceed.

The investigation into this matter was not fair and objective. The lead investigator admitted that he would not have recommended the grievant's dismissal if the grievant had acknowledged wrongdoing when first questioned about the incident. However, the other employees who were involved in the incident also failed to acknowledge their role when initially questioned, and they were not terminated.

The penalty of dismissal was too severe under all the circumstances and was not consistent with the principle of just cause. The grievant had good service ratings and no prior discipline. Nothing in his record indicates a pattern of abusive conduct. The Union does not suggest that the grievant's conduct was totally appropriate but believes that the penalty was unreasonable and should be modified.

The Union asks that the grievant be reinstated and that the arbitrator impose a penalty that would be consistent with the principle of just cause.

## **DISCUSSION:**

There is no doubt in this case that the grievant violated reasonable work rules that were known to him when he moved a patient from the bathroom by dragging him along the floor. The grievant himself acknowledged that his conduct was extremely unprofessional. His conduct violated work rules he had signed and was inconsistent with training he had received.<sup>3</sup> It is fortunate that the patient did not sustain injuries, but that fact does not constitute a defense for the grievant, who was charged with violating work rules and physically abusing a client. These behaviors are prohibited whether or not they result in injury to a client. Similarly, the fact that the grievant did not act with malice or intent to harm the patient does not constitute a defense, though evidence of malicious intent on the grievant's part would certainly make the violation even more serious. The investigation that was conducted in this case was fair and thorough. Nothing about it violated the just cause standard. It is indisputable that the grievant did not initially acknowledge his misconduct when questioned in the course of that investigation.

The only element of just cause that is in any doubt in this case is whether the penalty of dismissal was consistent with the nature of the offense and the grievant's past employment record. Part of that analysis must include consideration of whether the penalty imposed on the grievant was unduly harsh in comparison to penalties imposed on other employees. Here, I find cause for real concern.

It must be acknowledged, in reviewing the penalty imposed in this case, that the State has adopted a zero tolerance policy governing patient abuse. It is not uncommon that the penalty imposed for a first instance of abuse by even an employee with no prior disciplinary record would be dismissal or, at a minimum, a lengthy suspension. In this case, however, there were mitigating factors. More significantly, the penalty imposed on the grievant differed so markedly from the penalties imposed on the other employees who were involved in the incident, that the discrepancy raises real doubt as to whether the treatment of all parties was fair and equitable.

The argument that just cause for a penalty is lacking because the grievant was treated in an unequal or discriminatory manner usually rests on a comparison between the penalties

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<sup>3</sup> I am persuaded that the grievant and other employees had received training in the correct procedures for escorting, lifting and moving patients. Despite having received such training the grievant clearly used a technique for moving the patient that is neither approved nor taught.

imposed on employees who have engaged in substantially similar conduct. In this case there was a clear distinction between the grievant's conduct and that of the other employees who were involved in the incident. The grievant was the only person who physically intervened and moved the patient in a manner that did not comply with approved techniques. I agree with the State that the grievant's conduct was therefore more serious than that of the other employees, and that it warranted a more severe penalty. Nonetheless, the grievant and the other employees who were present in the bathroom with W all shared responsibility for what occurred.

All three employees who were in the bathroom with W apparently agreed that he should be moved, whether for his own safety or so that others could use the bathroom. The grievant testified that it was a joint decision. His testimony was not refuted and was corroborated in part by Robert Martineau's statement that the three of them discussed moving W. Some doubt was cast at arbitration on the wisdom of the decision to move the patient. It was suggested that W could have safely remained on the bathroom floor and that if he had to be moved, a code should have been called so that enough employees would have been present to accomplish the move safely. Even assuming the decision to move W was a poor one, it was made jointly by the three employees who were present. The grievant was a relatively inexperienced employee who did not work regularly in Unit #3 and was presumably less familiar than the others with W and his behaviors. His responsibility for the decision to physically intervene in order to move W is no greater than that of the other employees.

The grievant does bear greater responsibility than the other employees as the only one of the three to physically touch W and move him from the bathroom. The grievant testified that he thought the other two would take W's legs to assist in moving the patient, but they did not do so. It is clear from the video, however, that the other two employees were very close to the grievant and the patient while the grievant dragged W from the bathroom to his room. It appears from the video that the others made no attempt to intervene. They did not try to assist the grievant with the move they had all decided to make by carrying W's legs, which would have offered the patient additional protection. Nor does it appear that they made an effort to stop the grievant from moving the patient.

The grievant, Julie Davis and Robert Martineau were equally culpable for violating rules that required them to report the incident. In addition Lance Mack, who arrived while W was on

the floor in his room and who saw W pulling Julie Davis down and holding onto the grievant's leg, failed to report the incident. He also seems to have made few, if any, inquiries about what had occurred before he arrived in W's room.

Julie Davis, Robert Martineau and the grievant all gave misleading or untrue initial statements to investigators who questioned them about the incident. Alphonso Mims cited this as one of the reasons he recommended the grievant's dismissal, even stating that his recommendation might have been different if Mr. Morales had acknowledged his responsibility from the outset. However, Julie Davis and Robert Martineau, who provided equally misleading or untrue written accounts of the incident when they were initially questioned about it, received only short suspensions for their misconduct.

As stated previously, I do not disagree with the conclusion reached by DMHAS management that the grievant was more culpable than employees Davis and Martineau because he was the only employee who physically intervened and moved the patient in an inappropriate manner. Equal treatment of the employees who were involved in this incident did not require that the penalty imposed upon the grievant be the same as the penalty imposed on the other employees. Nonetheless, just cause requires that there be a degree of proportionality in the penalties, in relationship to the degree of culpability of the individuals. This was not the case. The grievant received the most severe penalty that can be imposed for a workplace violation while the other two employees, who were involved in every aspect of the incident except the physical intervention, received very short suspensions. Moreover, the lack of involvement by Julie Davis and Robert Martineau in the actual physical intervention with the patient may not be entirely to their credit, since they had decided that moving the client was necessary but then failed to assist in the process. The difference in the penalties imposed upon the three employees who were primarily involved in this incident was so extreme as to violate the concept of just cause.

For the reasons set forth above I find that the dismissal of David Morales was not for just cause and that the discipline must be reduced to a thirty-day suspension.