OLR File: 10-9973

In the Matter of the Arbitration Between

State of Connecticut
Department of Mental Health & Addiction Services

and

District 1199 NEHCEU

Arbitrator Michael R. Ricci
Decision & Award
April 23, 2020

Re: Manases Santiago Termination

APPEARANCES

For the State:
Megan Krom
Labor Relation Specialist
Office of Labor Relations
State of Connecticut

For the Union:
Henry F. Murray, Esq.
Livingston, Adler, Pulda, Meiklejohn & Kelly, P.C.

Procedural History

Pursuant to the Collective Bargaining Agreement (CBA) between District 1199 NEHCEU (the Union) and the State of Connecticut, Department of Mental Health and Addiction Services (the State), the parties have designated Arbitrator Michael R. Ricci to determine certain issues arising from the CBA. The parties presented evidence and arguments on December 10, 2019 and January 3, 2020. The Union was represented by Henry F. Murray, Esq. of the law firm Livingston, Adler, Pulda, Meiklejohn & Kelly, P.C. and the State was represented by Labor Relations Specialist, Megan Krom. The Hearing was held on the Department of Mental Health and Addiction Services (DHMAS), Connecticut Valley Hospital campus in Middletown. There was a stenographic record of the proceedings that was available to the parties. The record was closed April 6, 2020, after the parties electronically filed written briefs with the Arbitrator.

Issue

The issues, as stipulated by the parties, are as follows:

Did the Department of Mental Health and Addiction Services have just cause to terminate the Grievant, Manases Santiago?

If not, what shall be the remedy consistent the NP-6 contract?

Applicable CBA Language

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. All reprimands or warnings shall be in writing and placed in the Employee's personnel file in accordance with Article 38 (Personnel Records). Unless an Employee has been given a written reprimand or warning, which is placed in the Employee's personnel file, the Employee shall not be considered to have been reprimanded or warned.

Background

The Grievant has been a DMHAS employee for over seventeen years, serving as a Forensic Treatment Specialist (FTS) at the Whiting Forensic Hospital (Whiting) in Middletown.

Whiting is a forensic hospital that serves as a maximum security facility. It houses some of the most serious and violent offenders in the State. Patients are hospitalized at Whiting for various reasons, with many of them remanded by the courts due to psychological issues.

The hospital is staffed by various professional staff, with the FTS providing the day-to-day care of the patients. The Job Description (Joint12) states that the FTS is to "develop a therapeutic relationship with the patients". In essence, the FTS provide direct patient care and, they also provide physical and verbal intervention to defuse any unsafe situation. In short, the FTS are the staff that ensure a safe environment for the patients and the staff, while they provide the direct patient care.

The Grievant had been assigned with other FTS colleagues to perform [redacted] for Patient 1; this patient has been committed to Whiting since [redacted] suffers from [redacted] and [redacted] is considered [redacted] because [redacted] can [redacted] Up to about [redacted] years ago, the care for Patient 1 was clinically assessed to require care of a [redacted]: which is [redacted] of the patient. For some reason (that is not fully explained in the record), DMHAS developed this new level of observation or care. According to the record, [redacted] was developed specifically for Patient 1 and there is "not a defined policy" (TrII:52Flannery); thus, there is no definitive documentation on what exactly [redacted] is and what are its requirements. (the parties argued in the hearing over the requirements of [redacted] specifically the [redacted] As was the practice, [redacted] for Patient 1 (in shop vernacular these are called the "Sit").

On February 27, 2017, March 5, 2017 and March 13, 2017, the Grievant was assigned to provide care to Patient as a [redacted]

On February 27th, the Grievant and FTS Martineau were serving as the [redacted] for Patient 1. Around 5:40pm, FTS Willie Bethea stops by to visit Patient 1. FTS Bethea was not assigned to Patient 1 or even that particular Unit. Immediately as he enters the room, FTS Bethea sits on the bed along side Patient 1, and the two start to engage in touching or tapping each other's arms. The taps grow in frequency and in volume until Patient 1 gets off the bed and FTS Bethea follows [redacted] after a second or two both sit back down on the bed. They return to tapping and touching each other until FTS gets up to leave; at this point Patient 1 pushes the FTS off the bed with [redacted] foot and Bethea opens his hand to push Patient 1's head away. FTS Bethea leaves the room at approximately 5:47pm.

On March 5th, the Grievant and FTS Demarco were serving as the [redacted] for Patient 1. At approximately 2:38pm, Forensic Nurse (FN) Presnick enters the room to [redacted] on Patient 1's head. FN Presnick has blue medical gloves on and he attempts to [redacted] Patient 1 resists by trying to push FN Presnick away with [redacted] arms and feet. After about 30 seconds of trying to [redacted] FN Presnick moves to the doorway, where he removes the gloves and then starts to shadow spar with the patient who is sitting up in bed; this goes on for at least 15 seconds. The Grievant is standing about three feet directly behind RN Presnick in the doorway while this takes place.

On March 13th, around noon, the Grievant relieves FTS Olawale to serve as the [redacted] with FTS Quider for Patient 1. The Grievant sits in the hallway and by the doorway with a partial view of the room. Quider sits close to Patient 1 who is sitting up on the front half of the bed while [redacted] rinks a cup of some beverage. At 12:00:00:7 (according to the time stamp on State 11), FTS Quider extends his right leg to nudge Patient 1's left arm (the one holding the cup). The Patient moves [redacted] arm away from the FTS's foot and then pulls the arm back spilling the beverage towards FTS Quider, who pulls back away from Patient 1. Within the next six seconds, the Patient spills the beverage on the floor and throws the cup on the floor (in the opposite direction of FTS Quider).

Also on March 13th, around 12:50pm, the Grievant is sitting in the hallway, with partial view of the room, while FTS Quider is sitting close to the Patient's bed. FTS

Olawale is also in the hallway. FTS Quider rips the sheet off the Patient who was masturbating. Olawale moves into the doorway, while he laughs at the incident.

(The above is a based on State11, which is the frame by frame still photos from the pertinent video recording and it is also based on the video shown at the hearing)

In March of 2017, a whistleblower came forward to DMHAS to report potential abuse of Patient 1. The DMHAS administration started to investigate by acquiring video footage from Patient 1's room and the hallway outside the room. The video collection system has finite space and therefore, the Agency was only able to review archival video from February 27, 2017 to March 22, 2017; which totaled over 1,000 hours of video. During the process of reviewing the video, the administration identified potential abuse and placed the alleged perpetrators of the abuse on Administrative Leave. Around late spring or early summer of 2017 the State Police started a criminal investigation concerning the alleged abuse, and they took possession of the video recording; this in effect paused the DMHAS investigation until the video was returned in September.

In August, 2017, the State Police served Arrest Warrant Applications on ten employees from their investigation of alleged abuse. FTS Bethea was arrested on various charges and with some being tied to the February 27th incident cited above. Also, FTS Quider was arrested on various charges with at least some linked to the March 13th incidents.

The Grievant was placed on Administrative Leave on April 24, 2018 (Joint2) and there was a Loudermill hearing on January 12, 2018. The Grievant was terminated January 17, 2018 (effective) for the following:

-DMHAS Work Rule #19: Physical violence, verbal abuse, inappropriate or indecent conduct and behavior that endangers the safety and welfare of persons or property is prohibited.

-DMHAS Work Rule #14: Sleeping or inattentiveness on duty is prohibited.

- DMHAS General Work Rule #21 'Employees shall immediately report alleged violations of existing work rules, policies, procedures or regulation to a supervisor.

-Commissioner's Policy Statement #29: Client abuse.

--Commissioners Policy Statement #24A: Sleeping or Inattentiveness on Duty.

-Commissioner's Policy Statement #29: Client Abuse, CVH Agency Compliance Code of Conduct Policy and State of Connecticut Acceptable Use of State Systems Policy.

(Joint2)

The Union grieved the Termination within the contractual time limits and it was filed to Step II on January 18, 2018. The Step II was heard on March 22, 2018 and the State denied the grievance on April 20, 2018. The Union filed for arbitration and the final arbitration hearing was held on January 3, 2020.

As stated above, the Grievant has been with DMHAS since 2002 as a Forensic Treatment Specialist. His service ratings for 2015 and 2016 were overall "Excellent" (Union5&6) for both years and there was no record of any discipline entered into evidence. It was stipulated by the parties that the Grievant was familiar with all DHMAS General Work Rules and statutes, the Commissioner's Policies and the DMHAS Acceptable Use of State Systems Policy. (Joint24-28)

State's Position

DMHAS terminated the Grievant for just cause by not reporting abuse and failing to perform his duties as a Constant Observer on three different dates (February 27th, March 5th and March 13th). The Grievant violated various Work Rules and Commissioner's Policies by his actions and inactions on the three Sits. Furthermore, the Grievant has a duty to ensure every patient's health and welfare, and, he violated his duty as a mandatory reporter by not reporting the abuse. Finally, the fact that the Grievant still considers the actions of the FTS to be allowable, even though they were charged and convicted for those actions, shows that he is incapable to adhering to the Code of Conduct and thus, incapable of performing the duties of an FTS.

The State contends that since *just cause* is not defined in the CBA, they look to the *common law* standard defined by Arbitrator Carol Daugherty in Enterprise Wire, 46 LA 359 (Daugherty 1966). In Daugherty's seminal arbitration award, a set criteria is to be satisfied to meet the burden of *just cause.* The following is the State's argument to meet the burden developed by Daugherty.

The record shows that the Grievant was aware of the work rules (Joint24-29) and that the violations may lead up to termination (Joint18). Also, that the work rules: prohibits inattentiveness on duty, forbids inappropriate conduct towards patients and requires violations of the work rules to be reported (Joint14).

The Agency is required to run a healthy, safe and efficient facility for the criminally insane. The Work Rules and Commissioner's policies exist to ensure that DHMAS is able to fulfill their requirements. The Grievant broke and violated rules and policies that counter DMHAS' ability to run an orderly, efficient and safe operation.

DHMAS investigated the incidents before they disciplined the Grievant. In fact, the investigation was triggered by a *whistleblower* complaint in general and initially was not focused on any individual. After reviewing the video evidence, it was determined that an investigation was warranted and a thorough investigation was conducted before disciplinary action was taken.

The investigation was thorough and objective. The investigation summaries show evidence that there was abuse and that the Grievant failed to report the abuse.

The investigation provided substantial evidence that the Grievant witnessed abuse and did not report the abuse. Furthermore, the investigation showed that that the Grievance did not perform the duties of a Constant Observer on three separate Sits.

The Grievant admits to witnessing the February 27th incident with FST Bethea. He denies that the prodding, pushing and the teasing of Patient 1 was not abuse, even though the State Police charged FTS Bethea with two felony counts and six misdemeanors. The Grievant never documented the incident on Patient 1's Constant Observation form.

The Grievant witnessed FN Presnick trying to apply lotion to Patient 1 who was resisting on March 5th. He admits in testimony that he did not document the interaction on Patient 1's Constant Observation form.

On March 13th, there were two incidents with FTS Quider, one where he prods Patient 1 into throwing [redacted] coffee and the other, where the FTS ripped off Patient

1's sheet to humiliate [redacted] In both cases, the Grievant claims he did not see the incidents even though he was on Constant Observation. Furthermore, he did not document either incident, even though the video shows he clearly witnessed the aftermath. These events were so egregious that FTS Quider was arrested and convicted for his actions with Patient 1.

DHMAS was consistent with the investigations and the discipline handed out. There were 39 employees who were investigated and who were terminated or left voluntarily in lieu of termination. The Grievant's actions were inexcusable and, therefore, negated possible progressive discipline.

Termination is proportionate to the Grievant's transgressions. Moreover, the egregious nature of his actions nullify the Grievant's work record. They note that their termination of the Grievant was not arbitrary, capricious or unreasonable. The State cites various Arbitration awards, that argue arbitrators should give deference to management's determination of the penalty (if the discipline was made in good faith). They also cite Arbitrator Cenci, in the Keller Award (with similar fact patterns as the instant case), where she opines that the failure to report abuse is counter to the essence of the DMHAS' mission: patient care and safety.

Union Position

The Union argues that the termination is not for "just cause" because the Grievant has credibly and consistently maintained throughout the entire process: that he did not witness abuse, he did not report what he reasonably believes was not abuse and also, he correctly performed his duties as a CO+1. They also argue, that even if the Grievant failed to report abuse, that termination is historically inconsistent with the Agency's actions in similar circumstances. Moreover, that the Grievant's excellent work record should mitigate any inadvertent mistakes he may have made. Finally, that the allegation of patient abuse carries a social stigmatization so great that the quantum of proof should be commensurate with the severity of the penalty sought by the DMHAS.

The Union notes that as much as the termination letter cites various work rules and policies, it is clear from the evidence presented that the principle charge against the Grievant is failure to report abuse of Patient 1 on the February 27th and March 5th Sits.

Concerning the February 27th Sit, the Grievant reasonable believed that the FTS Bethea's interaction was "playful" and not abusive. That the rhythmic nature of the touches combined with the mutuality of the responses served as a method to control Patient 1's behavior. That the last touch by FTS Bethea, as he runs out of the room belie the game-like nature of the interaction. The fact, that the Patient 1 never showed signs of distress corroborated the Grievant's belief that it was benign.

Concerning the March 5th Sit, the Grievant reasonably believed that FN Presnick's actions of [redacted] was consistent with Patient 1's normal medical care. A FTS would not have access to a patient's medical records or would he specifically know if medical procedures were being properly followed; medical procedures are the exclusive bailiwick of the Forensic Nurses and the medical staff. At one point, FN Presnick takes up defensive stance as a response to Patient 1's swipes at him; the Grievant believed this was just a standard response by FN Presnick.

The Grievant did not witness either incident on the March 13th Sit. The video is clear that the Grievant is sitting in the hallway and was looking away when FTS Quider prompted Patient 1 to spill [redacted] coffee and then prodded the Patient to throw the cup. He became aware of the cup dropping, but since it was not an unusual occurrence, the Grievant did not document the cup on the ground. The Union admits that Quider engaged in abuse by ripping the sheet off to humiliate Patient 1, however the Grievant's line of sight was obstructed by FTS Olawale who was standing in the doorway. Therefore, the Grievant could not report what he did not see.

The Union argues that DMHAS has not historically terminated employees for failing to report abuse. They note that through a FOIA request, the Union has obtained evidence (Union4) that the Agency in the past five years, has disciplined four instances of failure to report abuse and the most severe discipline was suspension.

Finally, that the Grievant is an exemplary employee with Excellent Service Ratings. So, the Grievant's long dedication as an excellent staff member, should enhance his credibility and mitigate any unintended mistake he may have made.

Discussion

DMHAS terminated the Grievant for violations of various Work Rules and Commissioner's Policies, however the defining issue is the failure to report patient abuse (Commissioner's Policy Statement No. 29, Work Rules 19 & 21). All FTS are mandatory reporters, so the Grievant as an FTS, has a contractual and moreover, a legal obligation to report patient abuse.

Since the State is the moving party, they have the burden to prove that the Grievant was aware of the abuse and that he failed to report it, also, that the penalty is commensurate with the transgression.

The State argues that the physical evidence is convincing that the Grievant witnessed abuse or should have witnessed abuse as a Constant Observer, and therefore, the Grievant violated both his contractual and legal obligation to report abuse.

The Union counters that the evidence shows that the Grievant did not witness any abuse because either: 1. He reasonably did not believe the interactions he witnessed were abuse or, 2. If abuse did take place, that he physically did not see the abuse happen. They argue that under any quantum of proof, that the State did not meet their burden to sustain a termination.

The video record from Patient 1's room and the hallway right outside the room are the most pertinent evidence presented in the hearing. Since, the videos were not allowed outside the hearing room due to the Patient's right to privacy, the Arbitrator viewed the videos various times in the hearing and paid particular attention to the details to best understand what actually took place during the three Sits. The still photos from the video in evidence (State 11) corroborate the videos that are restricted to the hearing only.

The following is a discussion on each Sit and the impact each has on the final ruling.

On February 27th, the Grievant acknowledges that he witnessed the interaction between Patient 1 and FTS Bethea. However, the Grievant has been consistent that the interaction that he saw that day, was nothing more than benign "horseplay"(TrII:26) and not abuse. The Union points out that the FTS had a rapport with Patient 1 as exemplified by the fact that he was "visiting" Patient 1 (since Bethea worked on another unit) and more importantly, that the Patient allowed FST Bethea to share [redacted] personal space on [redacted] bed. Furthermore, the touching between the two had a rhythmic cadence to it, instead of an act of aggression and the final touches between the two, had the feel of a game of tag. The Arbitrator's first impression was that the interaction was playful and benign. The Patient is protective of [redacted] personal space and when [redacted] allowed FST Bethea to sit on [redacted] bed, it speaks to the rapport that the two have. FTS Bethea's last touch, which was really a slight push, appeared to straddle the line beyond playful, but no where during the seven minute incident did FST Bethea show any mal intent towards Patient 1. The State argues that since FST Bethea was charged and convicted, that his actions on February 27th must constitute abuse, the Arbitrator respectfully disagrees with the State and agrees with the Union counter (TrII:49UnionObjection), that we do not know what incident lead to the conviction of FST Bethea.

On March 5th, the Grievant was on the Sit with Patient 1 when FN Presnick was [redacted] to the Patient's head. FN Presnick, was standing on the window side of the bed, he has blue surgical gloves on and he was [redacted] Patient 1 was resisting and FN Presnick was steadfast on getting the [redacted] on to the Patients's head. FN Presnick finishes, walks around to the opposite side of bed, into the doorway and takes off the surgical gloves. Then FN Presnick moves towards Patient 1, gets into a "defensive stance" (UnionBrief11) and shadow spars with the Patient. The FN never touches Patient 1, but he takes numerous air jabs at the Patient which come close to touching [redacted] When FN Presnick takes the surgical gloves off, it signifies that the medical procedure is over and the FN's actions towards Patient 1, who has not moved off [redacted] bed, are to tease and antagonize [redacted] Unlike, the incident with FTS Bethea where there is a rapport between the two, at no time was there any sign of a rapport between the care giver and the patient. In fact, when the [redacted] it appears to more of a fight than caregiving. The Grievant

acknowledges that he saw the activity, however he believes it was just part of the medical procedure. The Union argues that any FTS would not be privy to Patient 1's prescribed medical procedures and thus, the Grievant could not distinguish if any of FN Presnicks' actions would be outside of a valid medical procedure. The State's video evidence clearly shows that FN Presnick finishes [redacted] and then goes back into the room to tease Patient 1. When questioned by the Arbitrator (TrII:45), the Grievant identifies himself in the video as standing within three feet of FN Presnick as he jabs at Patient 1.

On March 13th, the Grievant and FTS Quider were on the Sit with Patient 1. As stated in the Background section, there were two distinct incidents that took place on this Sit. During a majority, if not all of the Sit, the Grievant was sitting in a chair in the hallway, outside the doorway of Patient 1's room. He was relieving FTS Olawale on the CO+1. FTS Quider was sitting in the room with Patient 1.

Around noon, FTS Quider prods and nudges Patient 1 with his foot in attempts to disrupt Patient 1 from drinking a beverage. After being prodded enough, Patient 1 spills some liquid from [redacted] cup onto the bed, then [redacted] throws the contents of the cup on the floor, and Patient 1 throws the cup onto the floor. The Grievant has been consistent that he did not see FTS Quider's actions, but only the cup on the floor (which was not an unusual occurrence on a Sit). The hallway video shows that the Grievant was facing down the hallway and not directly into the Patient 1's doorway. After watching the hallway video various times, while matching the time code with the actions taking place in the room, the Arbitrator can not ascertain that the Grievant witnessed FTS Quider's actions. The Grievant did look in to see the cup on the floor but, he did not look in to see the actual incident.

Around 45 minutes into the Sit, the physical scenario was the same as above, however, FTS Olawale was also in the area. FTS rips off Patient 1's sheet to expose and humiliate the patient. Patient 1 stands naked on the lower half of [redacted] body with the sheet thrown on the floor. FTS Quider's action causes an obvious commotion because FTS Olawale quickly moves into the doorway to laugh at Patient 1's humiliation. After thoroughly watching the hallway video, the Arbitrator can not ascertain that the Grievant witnessed FTS Quider rip the sheet off (he was looking down the hallway and FTS Olawle stepped into the doorway) However, there is no doubt that the Grievant saw the aftermath of the sheet on

the floor and Patient 1 standing semi naked in the room. Even if he did not witness FTS Quider's action, the confluence of being the Observer in that close of proximity and the commotion it created (Olawale ran in to laugh), it is implausible to believe that the Grievant did not know what took place.

The Grievant did not document any issues on the Patient Observation forms for the three Sits.

The Union raises the issue of disparate treatment in imposing termination on the Grievant. The Arbitrator agrees that uniform discipline is a keystone of industrial justice, however, with 39 staff members being arrested, terminated or who have resigned in-lieu of termination, it is hard to understand how termination in this case is disparate.

Finally, Commissioner's Policy Statement No. 29 (CPS 29) illustrates the root of this case. First, the "…expectation that all clients shall be treated with dignity and respect; these are basic client rights which are guaranteed to all clients." And second: "All Employees must report incidents of client abuse whether they have knowledge of such an act or whether they are a participant or witness." (State17) These patient rights and the necessity to report abuse that are witnessed or even just possessing the knowledge of, are contractually mandated by Work Rules 19 and 21. The incidents on March 13th were egregious violations of Patient 1's right to be treated with dignity and respect. At the very least, the Grievant knew what had happened and did not report it, as CPS 29 requires him to. On March 5th, FN Presnick's actions of teasing and antagonizing Patient 1 fail to treat the patient with dignity and respect. Again, the Grievant did not report the incident or even inquire about the medical aspect of the FN's actions. Lastly, concerning the February 27th incident, the Grievant has limited culpability because Bethea's actions were taken with a benign intent; the FTS may have gone over the line that warrants some discipline but termination for a failure to report that particular incident would be severe.

Taking into account the full weight of the three incidents, the Grievant violated CPS 29 and Work Rule 21 for failing to report abuse. The Arbitrator acknowledges that the Grievant did not commit abuse however, he failed to report abuse he knew about or witnessed.

In conclusion, the State met the burden of terminating the Grievant for just cause. The Arbitrator took into consideration the Grievant's work history however, the transgression goes to very essence of DMHAS' mission to provide care and the Grievant failed to provide that care.

Conclusion

The Arbitrator has considered all the evidence and arguments made by the parties. The Arbitrator, however, may not have repeated every item of documentary evidence or testimony: nor re-stated each argument of the parties.

Award

Having heard the evidence and the arguments of the parties, the Arbitrator awards as follows:

The Grievance is denied.

Michael Ricci

April 23, 2020 Arbitrator Michael R. Ricci

I, Michael R. Ricci, do hereby affirm upon my oath as Arbitrator that I am the individual described in and who executed the foregoing instrument, which is my Award.

Type text

Michael Ricci

April 23, 2020 Arbitrator Michael R. Ricci

Certification

This is to certify that April 23, 2020 a copy of the above Award was sent electronically:

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