VERMONT LABOR RELATIONS BOARD

GRIEVANCE OF:)
) DOCKET NO. 91-2
WILLIAM BUCKBEE)

Statement of Case

On January 16, 1991, the Vermont State Employees' Association ("VSEA") filed a grievance on behalf of William Buckbee ("Grievant") alleging that the State of Vermont, Department of Mental Health ("Employer") violated Article 14 of the collective bargaining agreement between the State and VSEA for the Non-management Unit, effective from July 1, 1990, to June 30, 1992 ("Contract"). Specifically, the grievance alleges that Grievant's dismissal from the Vermont State Hospital ("VSH"), effective December 19, 1990, violated Article 14 in that: 1) there was no just cause, 2) progressive discipline was improperly bypassed, 3) discipline was not imposed within a reasonable time of the alleged offenses, 4) the letter of dismissal was too vague, and 5) the penalty of dismissal was unreasonable.

On September 5, and 12, 1991, hearings were held before Vermont Labor Relations Board Members Charles McHugh, Chairman; Catherine Frank, and Carroll Comstock. Michael Seibert, Assistant Attorney General, represented the Employer. Jonathan Sokolow, VSEA Staff Attorney, represented Grievant. The parties filed Proposed Findings of Fact and Memoranda of Law on September 27, 1991.

FINDINGS OF FACT

1. Article 14 of the Contract provides in pertinent part:

> 1. No permanent or limited status employee covered by this Agreement shall be disciplined without just cause. The

parties jointly recognize the deterrent value of disciplinary action. Accordingly, the State will:

a. act promptly to impose discipline or corrective action within a reasonable time of the offense;
b. apply discipline or corrective action with a view towards uniformity and consistency;
c. impose a procedure of progressive discipline or progressive action;
d. in misconduct cases, the order of progressive discipline will be:
    i. oral reprimand;
    ii. written reprimand;
    iii. suspension without pay;
    iv. dismissal.

...

f. The parties agree that there are appropriate cases that may warrant the State:
    i. bypassing progressive discipline or corrective action;

...

2. The appointing authority . . . may dismiss an employee for just cause with two weeks' notice or two weeks' pay in lieu of notice. Written notice of dismissal must be given to the employee within twenty-four (24) hours of verbal notification. In the written dismissal notice, the appointing authority shall state the reason(s) for dismissal . . .

8. The appointing authority . . . may suspend an employee without pay for reasons for a period not to exceed thirty (30) workdays . . .

. . .

10. In any misconduct case involving a suspension or dismissal, should the Vermont Labor Relations Board find just cause for discipline, but determine that the penalty was unreasonable, the Vermont Labor Relations Board shall have the authority to impose a lesser form of discipline (Grievant's Exhibit 1).

2. VSH has a written Policy on Client-Employee Relationships. It was issued in 1985 and revised in 1987. The Employer distributes a copy of this policy to all newly hired employees. Revisions are posted hospital-wide and the Employer provides in-service training concerning revisions. The Policy states in pertinent part:

. . .

II. DEFINITIONS

. . .

PHYSICAL ABUSE shall mean any act, including incitement of others to act, which results or could result in physical harm to a client. A charge of physical abuse may be substantiated without observable injury. Spanking, hitting, or rough treatment shall be considered physical abuse. Planned physical interaction for therapeutic purposes shall not be considered abuse. Questionable activities shall be referred to the responsible administrator for resolution.

...

III. POLICY AND PROCEDURE

A. Any person who has seen or has any knowledge of any form of mistreatment, neglect or abuse shall immediately report such incident to the Psychiatric Nursing Administrator or any person designated by him/her to receive such reports.

B. Any person who has seen and fails to report an instance of mistreatment, neglect or abuse may be held accountable in the same manner as the person committing the act.

...

D. A preliminary investigation will be conducted to establish the circumstances and facts of the situation...

E. All persons who saw or have direct knowledge of the incident shall prepare a complete written report, signed and dated...The Nursing Services Supervisor shall complete the attached checklist. The written statement(s) shall be submitted to the Psychiatric Administrator within twenty-four hours of the alleged incident...

...

F. If(sic) the case of an allegation of physical or sexual abuse, employees shall be granted temporary relief from duty with pay pending completion of an investigation . . .

...

I. Where the Chief Executive Officer has reasonable cause to believe that an employee has mistreated, neglected, or physically...abused a client, that employee shall be disciplined as appropriate under the circumstances. Employees guilty of any form of abuse will ordinarily be dismissed, but the Chief Executive Officer may impose a

lesser form of discipline if there are compelling mitigating or extenuating circumstances.

...

(State's Exhibit 8).

3. The checklist to be completed by the Nursing Service Supervisor, required by Section E of the Client-Employee Relationship Policy, delineates a list of responsibilities to be performed by the Supervisor (and to check off on the checklist) when conducting an investigation of an incident. In practice, the checklist is not used, except for guidance.

4. Grievant started his employment with VSH on December 18, 1978 as a Ward Aide. He successfully completed the Psychiatric Technician training program. He was promoted to Psychiatric Technician A in 1982. He continued in that capacity until his dismissal effective December 19, 1990 (Grievant's Exhibits 2, 14 - 20).

5. As a Psychiatric Technician A, Grievant provided direct care to mentally ill patients who reside at VSH. Grievant took care of patients' needs, including such services as bathing, shaving, changing clothes and bedding, and generally providing patients with a safe environment. During Grievant's tenure with the Employer, Wards Dale One and Dale Two became the nursing home component of the hospital. Grievant primarily worked on Dale One and Dale Two.

6. During Grievant's 12 year tenure with the Employer, he received seven overall annual performance evaluations of "3" ("consistently meets job requirements/standards"), two overall performance evaluations of "4" ("frequently exceeds job

requirements/standards") and three overall performance evaluations of "5" ("consistently and substantially exceeds job requirements/standards"). Grievant received the "4" and "5" overall ratings during his last five years of employment at VSH. The supervisors who rated Grievant noted on his 1988, 1989 and 1990 performance evaluations that he needed to be aware of his own strength and/or monitor his own strength in working with patients. None of these evaluations suggested Grievant had mistreated patients. He received an overall "5," "5" and "4" on these evaluations (Grievant's Exhibits 2 - 13).

7. Grievant received letters of commendation during his tenure with the Employer. Nursing Administrator Marsha Kincheloe commended Grievant in 1986 for giving a patient who liked trains his deceased father's railroad magazines. Kincheloe wrote in part: "It is a perfect example of expert professional nursing care - to know what is important to a patient and personally do something about it." In 1988, VSH Executive Director Claudia Stone wrote Grievant a letter of thanks on the occasion of Grievant's 10th anniversary as a hospital employee. She wrote in part: "It is staff such as yourself who add so much to make the lives of patients as comfortable as possible." On October 10, 1989, Stone awarded Grievant a $250 merit bonus for outstanding performance, informing Grievant: "You are certainly deserving of this recognition, and we are very fortunate to have you on staff." (Grievant's Exhibits 21, 22, 24, 25).

8. Grievant was known to wax floors, paint rooms, and generally show concern about the patients' environment. Grievant also worked many overtime shifts. He worked 42.5 overtime shifts between January 1 and September 28, 1990 (Grievant's Exhibit 30).

9. Clinton Russell retired as night Nursing Supervisor in July, 1990. Russell worked regularly with Grievant for approximately 9 - 10 years. Russell never knew Grievant to abuse patients.

10. Stone has served as Executive Director of VSH since 1985. After Stone became Executive Director, all staff received training and refresher courses in a program called Nonaggressive Psychological and Physical Intervention ("NAPPI"). Prior to this, only targeted staff received the training. Under NAPPI, staff are instructed to assess a patient's misbehavior and first attempt to use psychological methods to control them. If that is not possible and physical restraint is needed, NAPPI teaches the employee to physically intervene with the patient in an acceptable way that is not harmful to the patient or the employee. NAPPI does not provide an answer for all situations and employees have to "think on their feet" and quickly assess a situation. Inflicting pain on a patient is not considered an appropriate form of restraint. Grievant received 30 hours of training in April, 1986, an eight hour recertification in December, 1987, a one hour recertification in January, 1990, and an eight hour refresher course in February, 1990 (State's Exhibit 5).

11. Patients on Dale One and Two sometimes are violent and need to be restrained. Grievant has had his glasses broken, two teeth knocked out, his watch ripped from his wrist, and has received back injuries and cracked ribs. Grievant was out of work on workers' compensation claims two times due to patients' assaults (Grievant's Exhibits 23, 24, 27, 28; State's Exhibit 6).

12. Martha Kincheloe has been the Nursing Administrator at VSH since 1985, except during a maternity leave from June, 1990 to May, 1991. Sometime in 1989 or prior to May 1990, an employee who worked with Grievant, Kathleen Shambo, reported to Kincheloe that she did not like the way Grievant worked with patients. Shambo did not offer specifics, but told Kincheloe that Grievant was loud and complained of the way he handled patients. Kincheloe counseled Grievant to speak to patients in a "softer and gentler way." Kincheloe only spoke with Grievant in a general way and did not discipline him. Kincheloe told Stone about Shambo's complaint at a supervisory meeting.

13. Linda Peatman was a temporary Psychiatric Aide at VSH for the nine months preceding March, 1989. She worked again at VSH from October, 1989 - October, 1990. Peatman received NAPPI training in 1988. Peatman worked the third shift, from 10:45 p.m. to 7:00 a.m., generally on Dale Two. She worked infrequently with Grievant (Grievant's Exhibit 7).

14. Peatman worked the third shift on Dale Two the night of September 4 and 5, 1990, with Grievant and Charge Nurse, Mary Dimick. One of the responsibilities of the staff on third shift is to make rounds and "changes" at approximately 2:00 AM and 5:30 AM. "Changes" involve checking patients for wet or soiled beds and clothing, and then changing the patient and/or the bed if necessary. Peatman and Grievant were doing the second change on September 5, at approximately 5:30 a.m., when they came to patient Bobby B's room.

15. Bobby B is in his late 50's and weighs approximately 150 - 160 pounds. Bobby B can make noises but cannot carry on a

conversation. Bobby B frequently urinated and/or defecated in his bed and clothing. That morning, Bobby B had urinated and there was a puddle on the floor. Peatman heard Grievant yell at Bobby B that he was "sick and tired of cleaning up after him" or words to that effect. Grievant shoved a mop at Bobby B, telling him he could clean it up himself. Bobby B apparently did not know what to do with the mop and it fell on the floor. Grievant grabbed Bobby B from the front and held him down on the bed with Bobby B's arms crossed at his chest and his wrists twisted. Grievant also restrained Bobby B with his knee on Bobby B's abdomen. Bobby B made groaning noises.

16. The method of restraint used by Grievant is not a NAPPI approved method of restraint. There is a NAPPI armhold that is similar, but the wrists are not twisted, and ideally the staff person is behind the patient.

17. Peatman called Stone when she got home from work that morning and Stone returned her call later in the morning. Peatman told Stone about several incidents, including the incident between Grievant and Bobby B. Peatman also told Stone that Dimick had grabbed a patient by the throat and choked the patient. Stone did not ask Peatman to put anything in writing, but she did say she would investigate.

18. Stone began an investigation of the complaint against Dimick by immediately interviewing employees. Stone did not speak directly with Dimick, nor did she suspend her pending the outcome of the investigation. Dimick continued to work until September 12, 1990, when she left on a pre-scheduled vacation. At

that time, no investigation was conducted with respect to the incident between Grievant and Bobby B.

19. Peatman worked on Dale Two on September 18, 1990, with Charge Nurse Mary Archer. They were the only two employees on Dale Two that night. John G was a patient on the ward at that time. John G is approximately 60 years old, weighs approximately 150 pounds and is over 6' tall. At times, John G is verbal, but this night he was not verbal. John G is sometimes very restless and will pace for hours. John G's behavior is also unpredictable. He can strike out and kick without warning. He broke Grievant's tooth on a previous occasion with a "sucker punch".

20. The night of September 18, John G could not sleep and kept getting out of bed and wandering. Peatman guided him down the hall and put him in bed, and by the time she was back at the nurses' station, he was back up. He continued walking, or standing by the window of the nurses' station where Peatman was sitting. Peatman did not feel threatened by John G. Archer expressed concern to Peatman several times that there was not a male employee working on the ward that evening. Archer called Grievant, who was working on Dale One, and asked him to come to Dale Two and put John G back in bed. Grievant came to the ward and guided John G back to his room and put him in bed. Grievant returned to his ward.

21. John G subsequently got out of bed again. He was given some medication and Peatman put him back to bed, but shortly thereafter John G got out of bed again. Archer again called Grievant. John G made gestures which led Grievant to believe that

John G might become agitated. Grievant guided John G back to his room, and placed him on his bed. Grievant told John G he was to stay in his room and kept him in his bed, holding him from the front and folding John G's arms against his chest and twisting his wrists. John G put his feet on Grievant's chest, and Grievant used his knee to keep John G's feet down and protect himself. Grievant held John G down on the bed for a few minutes, and released his hold when John G was no longer resisting. At some point, a nurse came in with John G's medication and Grievant sat on the bed next to John G while he received it.

22. Peatman reported this incident by writing a letter to Stone, dated September 20, 1990. The letter also recounted earlier incidents she had observed between staff and patients, including the incident of September 5 involving Grievant and Bobby B, and the choking incident involving Dimick. Peatman stated that she was appalled by the lack of action by the VSH Administration since her September 5 conversation with Stone. At some point around September 20, Peatman delivered a copy of her letter to Stone to Adult Protective Services ("APS"), a division of the Vermont Agency of Human Services that investigates allegations of abuse to elderly and disabled persons (State's Exhibit 10).

23. Stone received a call from APS on September 27, 1990, about Peatman's letter. Although Peatman had mailed the letter to Stone about September 20, Stone had not received the letter prior to the call from APS. After speaking with APS, Stone called Peatman and asked her to meet after her shift. Stone and Acting Nursing Administrator Jan Perkins met with Peatman on

September 28. They discussed Peatman's letter and the reported incidents in detail.

24. Stone temporarily suspended Grievant from his duties with pay pending the outcome of an investigation. Stone and Perkins began investigating the allegations against Grievant immediately. Stone reviewed Grievant's recent performance evaluations. She and Perkins interviewed Grievant's co-workers and supervisors, including Ramona Sulham, Ruth Friot, Rebecca Hill and Kathleen Shambo.

25. Perkins interviewed Ramona Sulham on September 28, 1990. Sulham worked as a Temporary Ward Aide for approximately three years and is currently a permanent Psychiatric Aid Trainee. Sulham has received NAPPI training. Sulham reported that, on approximately December 18, 1989, she had witnessed Grievant grab patient John G by the hair on his head and pull John G off his bed. Sulham reported that John G had urinated in his clothes and then sat on the bed causing it to become wet. Sulham did not report this alleged incident until Perkins interviewed her on September 28, 1990. Prior to December 18, 1989, Sulham had reported another alleged incident of patient abuse to her supervisor, and the supervisor had told Sulham that reporting the incident would do no good. Sulham testified at the hearing in this matter to the alleged incident involving John G. The majority of the Board panel finds the testimony of Sulham was not sufficiently credible. Thus, the majority concludes that the Employer has not demonstrated by a preponderance of the evidence that Grievant did grab John G by the hair on his head and pull him off his bed. (State's Exhibit 12).

26. Perkins interviewed Ruth Friot on September 28, 1990. Friot is Psychiatric Aide and has worked at VSH approximately 12 years. Friot reported that she had witnessed Grievant throw patient Philip G against a wall because he had urinated in his bed. At the hearing in this matter, Friot could not place an approximate time on when this alleged incident occurred. She indicated only that it occurred at some point during the "quite a few years" Philip G was a patient at VSH. Friot did not report this alleged incident until Perkins interviewed her on September 28, 1990. The majority of the Board panel concludes that the testimony of Friot was not sufficiently credible. Thus, the majority concludes that the Employer has not demonstrated by a preponderance of the evidence that Grievant did throw patient Philip G against a wall because he had urinated in his bed. (State's Exhibit 11).

27. Perkins interviewed another full time employee, Rebecca Hill, Registered Nurse, on November 7, 1990, by telephone. Hill recalled no instances of Grievant mistreating patients. Perkins summarized her conversation in a memorandum to Stone, reporting that Hill said "she was always present when patients needed physical containing - she would ask Bill to help her change someone and he was always willing to help and never out of line in the way he handled patients." Hill did not testify at the Board hearing in this matter (Grievant's Exhibit 31).

28. Stone spoke with Kathleen Shambo by telephone on November 7, 1990. Shambo had worked at VSH for approximately three years before leaving employment on September 15, 1990. Shambo had received NAPPI training. Shambo reported that, in the

past six months, she had seen Grievant bend the arms of patients Norman M and John M behind their backs, and twisting them and applying pressure (State's Exhibit 13).

29. Norman M is in his early 70's, shorter than 5'6" and of average build. During changes, Norman always had his fists moving and was difficult to handle. As many employees as were available would assist during his changes. Norman yelled when Grievant changed him and he yelled when others changed him as well. Close to the time of her departure from VSH, Shambo observed Grievant restraining Norman M by twisting his arm behind his back. Shambo observed this more than one time. This is not a NAPPI approved method of restraint.

30. John M is in his mid 60's, over 5'6" and of average build. He paces constantly. At "changes", it is at times necessary to have a second person assist in the change to keep him from pacing. It was not necessary to use much force with John M to keep him from pacing. Shambo observed Grievant restrain John M by twisting his arm behind his back. She observed this more than once within months of her departure from VSH.

31. Shambo did not report these incidents to her supervisors during the time of her employment at VSH. She had reported a previous incident involving an employee other than Grievant, where Shambo believed patient abuse had occurred, and no action was taken against the employee.

32. Grievant had observed an employee hold a patient in a hold called a "chicken wing", which involved putting a patient's arm behind his back up to the shoulder. This was not a NAPPI

approved method of restraint. He had reported this to his supervisor, Joan McKenny, and no action was taken against the employee.

33. In approximately August, 1990, Grievant reported to Perkins that he had witnessed Peatman, Sulham, Friot and McKenny sleep while they were on duty during their shifts. Perkins laughed when Grievant told him this. Perkins did counsel McKenny.

34. As a result of Stone's investigation into the allegations against Grievant, Stone met with Grievant and his attorney on November 14, 1990. Stone discussed the allegations that had been made against him by Peatman, Sulham, Friot and Shambo. Grievant did not specifically respond to the allegations. He did indicate that he did not engage in abusive treatment of patients.

35. On November 20, 1990, Stone sent Grievant a letter. Stone told Grievant that she was contemplating dismissing him, indicating that "I believe there is reasonable cause to conclude that you physically and verbally abused patients under your care." Stone cited the following incidents reported in the investigation by Peatman, Sulham, Friot, and Shambo:

> Specifically, on September 5, 1990, you twisted the arms of patient R.B, and yelled at him to clean up his own urine; on September 18, 1990, you twisted the arms of patient J.G., and said to him, "get your feet off my chest or I'll break every bone in your foot"; on another recent date, you threw patient P.G., against the wall because he was incontinent; you were observed grabbing patient J.G., by the hair and pulling him off the bed; staff state that you employed an arm twisting hold on patients, N.M. and J.M, in which you pinned the patient's arms behind their backs and applied pressure; and witnesses report that you yell at patients and refer to patients as "assholes" (State's Exhibit 1).

36. Stone gave Grievant the opportunity to respond to these allegations in a meeting held on November 30, 1990, with Grievant and his attorney. Grievant again did not respond specifically to the allegations. He reiterated that he did not engage in a pattern of abuse of patients.

37. Stone sent Grievant a letter on December 17, 1990, terminating him effective December 19, 1990, and providing him with two weeks pay in lieu of notice. Although Stone had earlier charged Grievant with physical and verbal abuse, her explanation for dismissing him was physical abuse of patients. Stone stated in part:

> My decision to terminate your employment is based on my belief that you physically abused patients. The specific incidents are outlined in my letter to you of November 20, 1990 and are incorporated herein by reference. (State's Exhibit 2).

38. Grievant began work with International Business Machines on September 9, 1991. At the September 12, 1991, hearing in this matter, Grievant indicated that he is no longer interested in returning to work at VSH.

MAJORITY OPINION

Grievant contends that his dismissal violated Article 14 of the Contract in that: 1) there was no just cause, 2) progressive discipline was improperly bypassed, 3) discipline was not imposed within a reasonable time of the alleged offenses, 4) the letter of dismissal was too vague, and 5) the penalty of dismissal was unreasonable.

The ultimate criterion of just cause is whether an employer acted unreasonably in discharging an employee for misconduct. In re Grievance of Brooks, 135 Vt. 563, 568 (1977). There are two requisite elements which establish just cause for dismissal: 1) that it is reasonable to discharge an employee because of certain conduct, Id, and 2) the employee had fair notice, express or fairly implied, that such conduct would be grounds for discharge. Id. In re Grievance of Yashko, 138 Vt. 364 (1980).

In reviewing dismissals, our review does not go beyond the reasons given by the employer in the dismissal letter for the action taken. In re Grievance of Warren (Unpublished Decision, Vt. Supreme Court Docket No. 83-640, August 22, 1986). Grievance of King, 13 VLRB 253, 282 (1990). Here, while the Employer initially informed Grievant that it was contemplating dismissing him for verbally and physically abusing patients, the Employer's dismissal letter of December 17, 1990, charges Grievant only with physical abuse. Thus, we will only consider the allegations of physical abuse against Grievant.

The Employer made the following charges of physical abuse against Grievant in the dismissal letter: 1) twisting the arms of

patient Bobby B on September 5, 1990; 2) twisting the arms of patient John G on September 18, 1990, 3) throwing patient Phil G against the wall because he was incontinent, 4) grabbing patient John G by the hair and pulling him off the bed, and 5) employing an arm twisting hold on patients, Norman M and John M, in the course of which he pinned their arms behind their backs and applied pressure.

As detailed in the Findings of Fact, we have concluded that the Employer has proven some of these charges by a preponderance of the evidence, and has not proven other charges. We have concluded that the charge of throwing Phil G against the wall was not established, primarily due to the fact that the only witness to the alleged incident, Ruth Friot, could not place the incident in even a general time period. Such vague testimony inhibits Grievant's ability to defend against the charges and is insufficient to establish a serious charge of physical abuse. We have concluded that the charge of grabbing John G by the hair and pulling him off the bed was not established primarily due to the fact that the only witness to that alleged incident, Ramona Sulham, gave varying accounts of the incident over time. This was particularly so with respect to the location of the window in which she allegedly saw a reflection of the incident and with respect to whether she actually observed the alleged incident directly, or only by the reflection. These inconsistencies are sufficient to lead us to conclude that the charge was not proven by a preponderance of the evidence.

However, we have concluded that the Employer has established that Grievant did twist the arms of Bobby B and John G, and did

twist the arms of Norman M and John M behind their backs. In so concluding, we found the testimony of the witnesses to these actions, Linda Peatman and Kathleeen Shambo, substantially credible. These actions by Grievant violated VSH policy against physically abusing patients. The VSH Policy on Client-Employee Relationships defines "physical abuse" in pertinent part as "any act . . . which . . . could result in physical harm to a client," and indicates that "rough treatment" shall be considered physical abuse. Grievant's actions of twisting the wrists of two patients, and twisting the arms behind the backs of two other patients, were all contrary to the approved NAPPI methods of restraining employees followed by VSH. Such actions could have harmed the patients, although no evidence was presented that physical injury actually resulted. Also, it is clear these actions constituted rough treatment which evidently was not provoked by the patients in any of the situations. Thus, Grievant did physically abuse four patients.

The fact that some of the charges against Grievant have not been proven does not necessarily mean that his dismissal lacked just cause. Failure of an employer to prove by a preponderance of the evidence all the particulars of a dismissal letter does not require reversal of a dismissal action. King, 13 VLRB at 283. Grievance of Regan, 8 VLRB 340, 366 (1985). In such cases, the Board must determine whether the remaining proven charges justify the penalty. King, 13 VLRB at 283. Grievance of Colleran and Britt, 6 VLRB 235 (1983).

We look to the factors articulated in Colleran and Britt, 6 VLRB at 268-269, in determining whether the proven charges

justify dismissal. The pertinent factors here are the nature and seriousness of the offenses in relation to the employee's duties, the employee's past work record, the clarity with which the employee was on notice of the prohibited conduct, the potential for the employee's rehabilitation, and the adequacy and effectiveness of alternative sanctions to deter such conduct in the future by the employee or others.

The proven charges against Grievant were serious. Grievant's position was one of custodial responsibility and trust; this imposed on him a special duty of care. He acted contrary to this duty of care by his rough treatment of patients. The VSH Policy on Client-Employee Relationships certainly contemplates that abuse of patients is a serious offense, by providing that "(e)mployees guilty of any form of abuse will ordinarily be dismissed."

However, the evidence before us indicates that the practice of the VSH Administration in enforcing its own written abuse policy and handling allegations of patient abuse generally was neither vigorous nor consistent. Section III(F) of the policy provides that, in cases of allegations of physical abuse, employees shall be granted temporary relief from duty with pay pending completion of an investigation. However, the evidence indicates that, on at least several occasions, employees made allegations of physical abuse against other employees, and they were told by their immediate supervisors that it would do no good to report the abuse or their allegations resulted in no action being taken against the involved employee, to the employees'

knowledge. On one occasion occurring shortly before Grievant was temporarily relieved from duty with pay, an employee was allowed to work a full week, and then go on a previously scheduled vacation, after an allegation was made that she choked a patient. Section III(E) of the policy provides that persons who witness physical abuse shall prepare a written report, and that the Nursing Services Supervisor shall complete a checklist. Nonetheless, the evidence before us indicates instances where the VSH Administration in practice did not require employees to prepare written reports. Also, the completion of the checklist was not required, but was used only for guidance.

Also, we are struck by the fact that Stone took no actions to investigate Linda Peatman's allegations, reported by Peatman to Stone on September 5, that Grievant abused patient Bobby B until Adult Protective Services inquired of the incident on September 27. This incident bolsters our conclusion that the practice of the VSH Administration in seriously addressing allegations of patient abuse was lacking.

This failure of the VSH administration and supervisors to consistently follow through with respect to reported incidents of patient abuse, in direct contravention of its written policy, indicates that a climate existed at VSH of not treating patient abuse as seriously as its written policy would lead one to believe. This diminishes to some extent the seriousness of Grievant's actions when the environment within which he was operating is fully considered. Also, while abuse of patients in any form can never be condoned, the abuse engaged in by Grievant

was not as serious as deliberately and repeatedly striking a patient, which the Board has held to constitute just cause for dismissal. Grievance of Sherman, 7 VLRB 380 (1984).

We recognize that Grievant reasonably should have been aware that he should not have employed the methods of restraint he used against the four patients. This results in the conclusion, under applicable case law, that Grievant had fair notice that he could be discharged for such conduct. The governing standard is whether the conduct was or should have been known to the employee to be prohibited by the employer. In re Grievance of Carlson, 140 Vt. 555, 560, 442 A.2d 57 (1982). In re Grievance of Brooks, 135 Vt. 563, 568, 382 A.2d 204, 207-208 (1977).

Nonetheless, it was unreasonable to take the ultimate action of dismissing an employee for the degree of physical abuse engaged in by Grievant when management's own actions indicate that it was not vigorously and consistently enforcing its policy prohibiting physical abuse.

Also, Grievant's past work record weighs heavily in favor of his retaining his job. In his twelve years of employment, he had never been disciplined. His performance was always rated at least satisfactory, and in his last five years of employment his performance was exemplary, as indicated by overall ratings of either "frequently exceeds job requirements/standards" or "consistently and substantially exceeds job requirements/standards". In short, until the incidents at issue here came to light, Grievant was considered by his superiors to be a model employee.

In sum, we conclude that just cause existed for discipline but that the penalty of dismissal was unreasonable. The Employer acted unreasonably in bypassing progressive discipline. The disciplinary article of the Contract provides that the State shall impose a procedure of progressive discipline in increasing order of severity, while recognizing that there are appropriate cases that may warrant the State bypassing progressive discipline. This was not an appropriate case to bypass progressive discipline. A suspension would have been an adequate and effective alternative to impose on Grievant to deter such conduct by him or others. Clearly, given his past work record, Grievant exhibited much potential for rehabilitation.

We impose a ten day suspension. This is a penalty consistent with the seriousness of Grievant's misconduct, while recognizing that not all charges against Grievant were proven and that he had an otherwise exemplary work record.

Since Grievant indicated at the September 12 hearing in this matter that he was not interested in returning to employment at VSH, the appropriate remedy to make Grievant whole is limited to awarding him back pay and benefits up to the date of the September 12 hearing.

/s/ Charles H. McHugh
Charles H. McHugh, Chairman

Carroll P. Comstock

DISSENTING OPINION

I dissent from the majority opinion, although I do conclude that just cause does not exist for Grievant's dismissal.

I disagree in some respects with the majority concerning the charges against Grievant which were proven by the Employer. I concur with the majority that the Employer has established that Grievant did twist the wrists of Bobby B and John G, and did twist the arms of Norman M and John M behind their backs.

I also concur with the majority view that the charge of throwing Philip G against the wall cannot be used as a basis to support disciplinary action against Grievant, but for a different reason. The majority concludes that the Employer has not established that the incident was proven by a preponderance of the evidence because the testimony of Ruth Friot on this matter was not sufficiently credible. On the contrary, I believe that Friot did actually observe Grievant throw Philip G against the wall. However, I believe that Friot's inability to place the incident in even a general time period results in the Employer not being able to use this incident against Grievant. The disciplinary article of the Contract requires the Employer to "act promptly to impose discipline . . . within a reasonable time of the offense." I conclude that a necessary inference to be drawn from this provision is that the Employer must at least be able to establish a general time period in which an incident occurred before it can be used as a basis for disciplinary action.

However, I disagree with the majority that the Employer has not demonstrated by a preponderance of the evidence that Grievant grabbed John G by the hair on his head and pulled him off his bed. I found the testimony of Ramona Sulham sufficiently credible to conclude that this incident occurred. It is apparent that the accounts of the incident given by Ramona Sulham were not identical over time. However, her accounts were sufficiently similar for me to conclude that she did see in a reflection of a window the incident she reported (i.e., Grievant grabbing John G by the hair and pulling him off the bed).

Absent mitigating circumstances, I would conclude that the proven charges against Grievant justified his dismissal. The proven charges against Grievant were serious. He acted completely contrary to his duty of care by his physical abuse of patients, and he knew or should have known that such conduct was prohibited. Such abuse can never be condoned. Absent mitigating circumstances, Grievant's abuse of patients demonstrated sufficient misconduct in my mind to warrant the bypassing of progressive discipline because he demonstrated a pattern of abuse of patients over time.

However, I believe that mitigating circumstances did exist here. The failure of the VSH Administration and supervisors to consistently follow through on reported incidents of patient abuse presents mitigating circumstances affecting the discipline which should be imposed on Grievant. This climate at VSH leads to the conclusion that it was unreasonable to take the ultimate action of dismissing Grievant for his actions when management's own actions indicate that it was not vigorously and consistently enforcing its policy prohibiting physical abuse.

The maximum penalty short of dismissal permitted by the Contract - i.e., a 30 day suspension - would have been an appropriate penalty under the circumstances of this case.

Catherine L. Frank

Catherine L. Frank

ORDER

Now therefore, based on the foregoing findings of fact and for the foregoing reasons, it is hereby ORDERED that the Grievance of William Buckbee is SUSTAINED; and

1. Grievant shall be awarded back pay and benefits from the date commencing 10 working days from the date of his discharge until September 12, 1991, for all hours of his regularly assigned shift, minus any income (including unemployment compensation received and not paid back) received by Grievant in the interim;

2. The interest due Grievant on back pay shall be computed on gross pay and shall be at the rate of 12 percent per annum and shall run from the date each paycheck was due during the applicable period indicated in Paragraph 1 above, and ending on the date he actually receives such monies; such interest for each paycheck date shall be computed from the amount of each paycheck minus unemployment compensation received by Grievant during the payroll period; and

3. The parties shall submit to the Board a proposed order indicating the specific amount of backpay and other benefits due Grievant.

Dated this 9th of March, 1992, at Montpelier, Vermont.

VERMONT LABOR RELATIONS BOARD

/s/ Charles H. McHugh
Charles H. McHugh, Chairman

Carroll P. Comstock
Carroll P. Comstock