AMERICAN ARBITRATION ASSOCIATION
BEFORE ARBITRATOR AUDREY B. EIDE, ESQUIRE

SERVICE EMPLOYEES INTERNATIONAL UNION HEALTHCARE 1199NW, Union, vs. WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES, Employer.	ARBITRATOR'S DISCUSSION AND AWARD AAA #01-23-0001-2275 Grievance of Allen Cabanos

Registered Nurse Allen Cabanos was dismissed from Western State Hospital on May 2, 2022. Service Employees International Union Healthcare 1199NW filed a Grievance. This matter came on for hearing before the Arbitrator at 6403 Lakewood Drive West, University Place, Washington on Tuesday November 7, 2023, and Wednesday February 28, 2024. Washington State Department of Social and Health Services (DSHS), the Employer was represented by Janelle Peterson, Assistant Attorney General of the Labor & Personnel Division, Washington State Attorney General's Office. Service Employees International Union Healthcare 1199NW (SEIU 1199NW), the Union was represented by Carson Flora, General Counsel of SEIU Healthcare 1199NW. The proceedings were reported by Tai B. Reidt on November 7, 2023, and Anita W. Self on February 28, 2024, of Buell Realtime Reporting, LLC.

This is a discipline case. The parties agreed that the burden of proof is on the Employer DSHS. The parties did not agree on the measure of persuasion the Arbitrator should apply in this case. There are no issues of substantive or procedural arbitrability. Each party had the opportunity to present evidence, to call and cross-examine witnesses and to argue their case. On April 26, 2024, both parties timely filed post-hearing briefs and supporting authorities. The evidence presented at the hearing and the arguments of the parties filed in post-hearing briefs have been carefully considered.

ISSUE

The parties stipulated the issue before the Arbitrator is: Did the Employer Washington State Department of Social and Health Services have just cause, according to Article 25 of the Collective Bargaining Agreement, to dismiss the Grievant Allen Cabanos? If not, what is the remedy?

FACTS

The Union and DSHS are parties to a Collective Bargaining Agreement (CBA) effective July 1, 2022, through June 30, 2023. The Union is the exclusive bargaining representative for registered nurses covered by the CBA. Allen Cabanos, the Grievant is a Registered Nuse 2 and is a member of the bargaining unit.

DSHS operates Western State Hospital (WSH) in Lakewood, Washington. WSH is a psychiatric hospital that houses and cares for vulnerable patients who are suffering from mental illness. The patients at WSH can have behavioral, psychiatric, social, medical, and correctional problems. They may exhibit bizarre behavior which can also be aggressive and destructive behavior towards themselves or others. Specific skills are required of the staff who care for the patients at the hospital so they can address bizarre or aggressive behavior appropriately. Training is provided to staff in these special skills and techniques. The Grievant attended the following such trainings: "Crises Prevention", 'Seclusion Restraint Competency", "Patient Safety Rounds and Environmental Safety", "Safety and Claims", "Patient Handling", "Best Practices for Interacting with Patients", "Understanding Aggression", and "De-escalation".

The Grievant was employed as a Registered Nurse for fifteen years at DSHS. He began his career with DSHS at WSH from 2000 until 2006. From 2007 to 2011 he was employed at Rainier School which is also a DSHS facility. In 2016 he returned to WSH. The Grievant received positive performance evaluations. The Grievant is a Registered Nurse 2 on Ward C-3. His responsibilities included direct patient care and collaboration with the care team of doctors, pharmacists, social workers, and physical therapists to assess, plan, implement and evaluate nursing care provided to psychiatric patients. The Grievant was also the Lead to staff on Ward C-3 which consisted of two Registered Nurses (RN), one Licensed Practical Nurse (LPN) and four Medical Health Technicians (MHT). There were about 28 female and male patients on the Ward.

When the Grievant arrived for his day shift at 7:00 AM the morning of July 8, 2021, he received a nursing status report to transition from night shift to day shift. The Grievant was informed that the night before Patient GF who was in his early thirties and had resided at WSH for more than ten years had refused to take his medication. When Patient GF was not medicated, he insisted on being naked and could exhibit bizarre behavior including sexual activity, hitting something, and spontaneously acting out which could be assaultive. He was allowed to be naked in his room.

WSH Social Worker Wright arrived at Ward C-3 about 9:00 AM. She checked in at the Nurse's Station and learned that one of her patients (Patient GF) had refused to take his medications that morning. Ms. Wright talked to Patient GF for about five minutes but was unsuccessful in persuading him to take his medications. Ms. Wright reported back to the Nurse's Station and told RN Ong that she was not successful in convincing Patient GF to take his medications. Ms. Wright stated she was returning to her office and to call her if they needed her.

Around this time LPN Kariuki informed the Grievant that when he distributed morning medications Patient GF refused to take them and was roaming Ward C-3 with a blanket around his naked body. The Grievant was on his way out of the Nurse's Station to help MHT Bell clean a room. The Grievant grabbed gloves and told LPN Kariuki that the Grievant had to let Patient GF know that he could not be in the day area naked. The Grievant proceeded out of the Nurse's Station where he encountered Patient GF with a blanket wrapped around his naked body. Patient GF walked towards the Grievant and said: "I am naked". The Grievant replied "Naked?'. Then the Grievant told Patient GF to go to his room and put on his clothes. Patient GF responded by kicking the Grievant in the left thigh.

As WSH Social Worker Wright was approaching the end of the hall and the exit to Ward C-3, she heard a voice and turned back towards the Nurse's Station. Ms. Wright saw Patient GF wrapped in a blanket walking toward the Grievant who was standing in front of the Nurse's Station door. Ms. Wright heard the Grievant say to Patient GF "you gonna kick me, go ahead, I will take you down".

Patient GF kicked the Grievant again in his left thigh. The Grievant charged Patient GF and pushed him across the hall against laundry bins and onto the floor. The Grievant went down to the floor with Patient GF who landed onto the floor face down. Patient GF yelled, "I have been

assaulted". LPN Kariuki entered the hall from the Nurse's Station and saw the Grievant and Patient GF on the floor. Patient GF was kicking and combative. LPN Kariuki assisted the Grievant with Patient GF on the floor. At about that time, MHT Bell stepped into the hall to see if the Grievant was coming to help him clean and saw that the Grievant and LPN Kariuki had Patient GF down on the floor. MHT Descanzo came into the hall from the Nurse's Station. MHT Bell and MHT Descanzo assisted in putting Patient GF in five points restraint.

Central Security was dispatched for a patient to staff assault. Patient GF was being secured in restraints when they arrived. Security interviewed the Grievant who stated he had no visible injuries at that time. The (No Injury) Assault Patient to Staff Report states the Grievant told Security that he was kicked from behind by Patient GF twice, contacting the Grievant's inner and outer left thigh area and that the Grievant escorted Patient GF to the ground and waited for ward staff to assist as the code was initiated. Later, the Grievant found he was injured during this incident and was out of work on sick leave from July 8, 2021, until February 16, 2022.

The Grievant filled out an Administrative Report Of Incident (AROI) on July 8, 2021, within about forty minutes of the incident. He described the incident:

> Pt. approached this writer by the hallway "I am naked" (but covered with blanket) Staff replied "You can put [on] your clothes" Pt suddenly kicked the staff to his left outer leg, Staff responded "Do that one more then I will put you on the floor" then pt. without hesitation kick the staff again
>
> Action/Treatment: Staff assisted to floor then to 5 pt restraint.

In March 2022 DSHS interviewed the Grievant. He stated he told Patient GF "Don't do that again or you will be in restraints". When presented with his AROI the Grievant said his intent was to say he would put Patient GF in restraints but admitted he told Patient GF "Do that one more time then I will put you on the floor". The Grievant denied charging Patient GF and denied having any physical contact with the Patient until he was on the floor. The Grievant could not recall how Patient GF got on the floor.

The Grievant was notified on May 2, 2022, that he was being dismissed because his interaction on July 8, 2021, with Patient GF was non-therapeutic, unprofessional and reckless behavior constituting patient abuse, and violated WSH and DSHS agency policies and procedures. The Union filed a Grievance.

MEASURE OF PERSUASION

The parties agreed that DSHS has the burden to prove there was just cause to dismiss the Grievant. The parties did not agree to the measure of persuasion the Arbitrator should apply in deciding this case. There are three measures of persuasion that can be required of DSHS in meeting their burden of proof. They are beyond a reasonable doubt, clear and convincing evidence, or by a preponderance of the evidence. They require varying degrees of certainty on the part of the Arbitrator in deciding if DSHS proved the Grievant's interaction on July 8, 2021, with Patient GF was non-therapeutic, unprofessional and reckless behavior constituting patient abuse, and violated WSH and DSHS agency policies and procedures.

The Union argues that DSHS should be held to a clear and convincing evidence measure of persuasion in this case which would require a higher level of certainty than preponderance of the evidence on the part of the Arbitrator in deciding this case. The Union contends that the allegations against the Grievant could prevent him from working with patients again because of their serious nature and that coupled with his long history of service a higher measure of persuasion than preponderance of the evidence should be applied in this case. (Union Brief, p. 12-13)

DSHS argues that this "case does not demand a heightened standard of proof because it does not involve behavior of an instantly recognizable criminal nature, a crime of moral turpitude or stigmatizing behavior." DSHS claims that this dismissal or any level of discipline for this offense does not automatically preclude the Grievant from working with patients other than possibly psychiatric patients in the future. Further, DSHS argues that it is not the job class of an employee that has convinced Arbitrators to apply a higher standard of proof than by preponderance of the evidence, it is the stigmatizing nature of behavior which supports the higher measure of proof. (DSHS Brief, p. 4-7)

Arbitrators consider three factors to determine the measure of proof should be a higher standard of proof than by a preponderance of the evidence: did the conduct constitute criminal behavior, did the conduct involve moral turpitude or social stigma and was the discipline imposed a discharge or a lesser discipline. (Elkouri & Elkouri, How Arbitration Works, 8th Edition Pages 15-27 and 15-30 (Bloomberg BNA, 2016)) In this case the allegations of staff to patient abuse and policy violations do not constitute criminal behavior, moral turpitude, or social stigma, although they did result in a discharge. Arbitrators have applied the "clear and convincing" measure of persuasion in

discharge cases especially when the Grievant has a long and positive employment record and allegations of improper personal conduct, hostility, negligence, or violation of a crime, that could detrimentally affect future employability. However, most Arbitrators do not hold the employer in a discharge case to a heightened measure of persuasion beyond preponderance of the evidence unless the alleged misconduct involves dishonesty, breaches of moral turpitude, fraud, undue influence, a special danger of deception, misconduct that could be subject to criminal prosecution, or misconduct that has a stigmatizing effect (such as sexual harassment).

In this case Patient GF did not file a complaint, and the record does not reflect that the Grievant is subject to criminal prosecution. The allegations that Grievant's interaction on July 8, 2021, with Patient GF was non-therapeutic, unprofessional and reckless behavior constituting patient abuse, and violated WSH and DSHS agency policies and procedures do not rise to the level of violations where most Arbitrators would hold the employer to a heightened measure of persuasion. The Grievant was employed by DSHS for about fifteen years, which falls short of the twenty plus years required to be considered a long-term employee. The Arbitrator will apply the measure of persuasion by a preponderance of the evidence. Preponderance of the evidence is defined as more likely than not.

DSHS must prove by a preponderance of the evidence that it is more likely than not the Grievant's interaction on July 8, 2021, with Patient GF was non-therapeutic, unprofessional and reckless behavior constituting patient abuse, and violated WSH and DSHS agency policies and procedures.

POSITION OF THE PARTIES

Both parties argue the seven steps of just cause. Article 25 of the CBA provides: "The Employer will not discipline any permanent nurse without just cause." The criteria for just cause are commonly summed up by Arbitrators as: knowledge of the standards of performance required of the employee and of the consequences if performance standards are not met, investigation of the alleged violation of those standards, notice of the alleged offense, a chance to be heard, proof of the alleged offense, and discipline rendered commensurate to the offense.

The Union argues that there was not just cause to dismiss the Grievant. The Union claims DSHS's investigation was not timely, was incomplete, was conducted with a narrow scope and did not prove the Grievant assaulted a patient. The Union further argues that dismissal is too harsh

because there is no proof the Grievant assaulted a patient, the facts of the incident show mitigating factors such as the assault by the patient on the Grievant when the patient kicked the Grievant, the Grievant has a good record and long employment history. The Union also points out that DSHS should not have considered a "Communication Record" which is a non-disciplinary record of the Grievant reporting a safety concern. The Union claims a lesser and progressive discipline is appropriate as there was no assault, leaving the remaining allegations of policy violations including the use of non-therapeutic language with a patient which do not rise to the level of a dismissal and are infractions that can be corrected. For these reasons the Union asks the Arbitrator to reinstate the Grievant with a warning and a make-whole remedy.

DSHS argues there was just cause to dismiss the Grievant. DSHS claims the Grievant violated policy and abused a patient when he did not use verbal or any de-escalation techniques, did not call for staff to assist him, did not find an exit for himself from the situation and ran into the patient slamming him into the wall taking him down to the floor. DSHS points out that in violation of policy the Grievant gave Patient GF a threatening ultimatum which escalated the situation and then the Grievant physically charged Patient GF which was an improper technique and took both to the floor. Patient GF was then so agitated that he had to be put in restraints which were circumstances the Grievant created and therefore violated the patient's rights. DSHS further argues that despite training the Grievant did not understand the objectives of his position in that the Grievant testified he preferred to spend his shift inside the Plexiglas-enclosed Nurse's Station, and that during the incident he followed his training "Hundred percent". Regarding the level of discipline DSHS argues the dismissal was appropriate because the Grievant was not trainable, did not take responsibility for his actions, changed his story as the disciplinary process unfolded, and caused the incident and injury. DSHS asks the Arbitrator to deny the Grievance.

DISCUSSION

The alleged violations against the Grievant can be divided into two categories: (1) policy violations (2) patient abuse:

Policy Violations. The incident in question began when the Grievant was informed that Patient GF had refused to take his morning medications and was roaming the ward with a blanket around his naked body. The Grievant knew Patient GF had also refused to take his medications the previous evening and that Patient GF could be assaultive when he was not taking his medications.

The Grievant was on his way to help MHT Bell clean a room, but he said as he left the Nurse's Station that he had to let Patient GF know that he could not be in the day area of the ward naked. It is important to have more than one staff encounter a difficult patient so that they can assist each other in de-escalation. It also provides staff assistance in exiting the situation or calling for help. The Grievant did not follow his training when he went to encounter Patient GF without first reviewing his file and without staff assistance.

The point of intervention and de-escalation training and WSH policy is to avoid combative or assaultive situations and to ensure the safety of the staff and the patients. The goal is to have a conversation with the patient that is therapeutic and can result in a positive outcome. MHT Bell testified he had been successful in verbal de-escalation to avoid combative, aggressive or assaultive behavior with Patient GF. When the Grievant entered the ward, he encountered Patient GF naked with a blanket around him. Patient GF said, "I am naked". The Grievant testified he responded with a validating statement, "Naked?" and suggested to Patient GF an alternative or maybe a redirection, "Why don't you go to your room and put your clothes on". Patient GF kicked the Grievant. The Grievant testified that when Patient GF kicked the Grievant, he decided the Validate, Defer, Suggest Alternative, Positive Prompt (VDSP) Training did not work and there was no time for more verbal intervention or de-escalation. The Grievant did not follow his de-escalation and therapeutic encounter training.

Staff are required to call for help and/or find an exit to remove themselves from a potentially volatile situation. The record shows it was not an emergency to interact with Patient GF. The Grievant could have chosen to walk away from Patient GF when he first encountered him and interact with him at another time with assistance and when he was in an ideal physical location to remove himself (if he needed to) from the situation. The record also shows that in this interaction there was an opportunity for the Grievant to call for help, push the panic button or find an exit. The Grievant did not call for help. The Grievant had his back to the locked Nurse's Station door. If he had side stepped a few steps he could have knocked on the Plexiglas window in the Nurse's Station and had the attention of staff who could assist. LPN Kariuki testified that he opened the door to the Nurse's Station at about this time. This gave the Grievant an exit he did not take. The Grievant put himself in a vulnerable position and did not call for help or remove himself from the situation.

The Grievant stated in his initial report of the incident (AROI) and during the DSHS Investigation that once Patient GF kicked the Grievant, he told Patient GF "Do that one more time

then I will put you on the floor". The Grievant confirmed at the arbitration that his AROI was an honest and coherent account of the incident. He testified he also said, "Stop kicking me". The Grievant is on blood thinners and was fearful of being injured. The Grievant went on to explain: "I did not threaten the patient. I have no intention of threatening my patient. I am just trying and begging the patient to stop kicking me". English is the Grievant's third language. He grew up in the Philippines and speaks the Ilocano dialect and the national language Tagalog. Even if you give the Grievant deference that in the heat of the moment speaking in his third language, he may not have realized he was threatening Patient GF with an ultimatum, there is no doubt that throughout the investigation and three years later he still does not consider his statement to be a threat with an ultimatum. The Grievant further justifies his statement with his intention to say that he would put Patient GF in restraints which according to policy would also have been an unacceptable threat and ultimatum to Patient GF. Grievant admitted he abandoned the VDSP Training because in his opinion there was no time to continue de-escalation efforts after Patient GF kicked the Grievant.

The record shows that the Grievant did not follow his VDSP training and violated WSH Policy when he did not review Patient GF's file, encountered Patient GF alone, did not use verbal de-escalation, did not call for help or remove himself from the situation and threatened Patient GF with an ultimatum.

Patient Abuse. Restraint of patients at WSH is a last resort. WSH Procedure 10.34 (A)(1): Seclusion or Restraint provides when a patient can be put in seclusion or restraint:

> Patient must be in immediate danger of harming self or others, and mitigating least restrictive interventions were ineffective to prevent that potential harm.

The Grievant abandoned "least restrictive interventions" when he discontinued verbal de-escalation, and told Patient GF to "Stop kicking him" and gave Patient GF a threatening ultimatum.

The Grievant denied in his Investigation Interview he touched or had any physical contact with Patient GF until after he was on the floor. The Grievant testified that after Patient GF was on the floor MHT Kabucho grabbed Patient GF's legs to keep him from kicking and then the Grievant assisted. However, MHT Kabucho signed a statement during the investigation that states when he went to the scene of the incident the patient had already been "put down" on the floor.

Patient GF was being secured in restraints when Central Security responded to the incident. The (No Injury) Assault Patient to Staff Report states the Grievant told Security that he was kicked from behind by Patient GF twice, contacting the Grievant's inner and outer left thigh area and that the Grievant escorted Patient GF to the ground and waited for ward staff to assist as the code was initiated. About a half hour later the Grievant filled out an AROI report which states: "Staff assisted to floor then to 5 pt restraint." SW Wright testified she saw Patient GF kick the Grievant and the Grievant then immediately lower his head and run into Patient GF hitting him in the stomach which pushed him into the laundry bins and then the Grievant took Patient GF to the floor face down. Wright's statement is consistent with the Grievant's AROI that he "assisted to the floor" and statement to Security that he "escorted Patient GF to the ground and waited for ward staff to assist". Staff who came to the scene testified they assisted the Grievant in restraining Patient GF once the Grievant and Patient GF were on the ground.

During the grievance process and at Arbitration the Grievant continued to deny he touched, head butted or took Patient GF down to the floor. The Grievant testified he did not know how the Grievant ended up on the floor. He has offered a couple of possibilities: first that Patient GF lost balance after he kicked the Grievant and fell to the floor or that Patient GF slipped on his blanket and fell to the floor. These possibilities conflict with the Grievant's report of the incident and the statements of witnesses and Patient GF who said the Grievant attacked him by punching him in the chest and throwing him to the ground.

At the time of the incident Patient GF was progressing in his treatment towards release to a less secure facility. Once Patient GF was on the floor, he became so agitated he had to be put in 5 points restraint and forcibly medicated. While in the restraint chair he continued to be so agitated he bit off a fingernail, and bruised and abraded his heels and hands against the restraints and the chair. He was moved to a restraint bed in seclusion. Patient GF was evaluated by WSH Dr. Xie who found Patient GF was severely agitated during this incident which might have impacted him on that day however he has not shown long-term negative impacts from the incident.

The record shows the Grievant did charge Patient GF and push him into the laundry bins and then to the floor face down which was an inappropriate tactic and placed Patient GF in restraints without first using less restrictive interventions which was patient abuse.

Investigation: DSHS Behavioral Health Administration Investigator Janet Wade investigated the July 8, 2021, incident. She has 29 years of experience, which includes more than 50 investigations with the state. She has completed the annual training that they have which includes verbal and hands on de-escalation. She completed a Preliminary Review of the incident which is a fact finding that includes security and administrative reports and statements. Investigator Wade determined from the preliminary review what documents should be obtained and who needed to be interviewed. The scope of the investigation was identified: (1) Did Staff Cabanos threaten the patient stating "Go ahead, I will take you down."? (2) Did Staff Cabanos physically assault the patient by charging him and hitting him in the chest or stomach area and taking him down to the floor? The Investigation concluded that the Grievant confirmed he said, "Do that one more time then I will put you on the floor", and although the Grievant denies he charged Patient GF or touched him until after he was on the floor SW Wright and Patient GF confirmed that the Grievant charged Patient GF hitting him in the stomach/chest area and took him to the floor. The Investigation did not determine credibility. The evidence and facts were presented to management for a final determination and conclusion.

The DSHS Investigation considered the Grievant's term of service with WSH from 2016-2021. In fact, the Grievant had been employed for fifteen years at DSHS. There was not a good explanation for the oversight of the Grievant's correct term of service with DSHS. The Grievant's fifteen-years of service as an employee with DSHS does not make him a long-term employee. Because the Grievant was not a long-term employee his term of service for either five or fifteen years would not weigh heavily in determining the level of discipline issued to the Grievant.

A "Communication Record" was included in the Investigation. It is a non-disciplinary record of the Grievant reporting a safety concern. The safety concern occurred when the Grievant objected to WSH taking a staff from his already understaffed Ward to fill in on another Ward. The Grievant eventually did let his staff report to the other Ward. Daniel Davis, WSH Interim Deputy Chief Executive Officer reviewed the Investigation and made the decision to dismiss the Grievant. Mr. Davis testified this communication record is not discipline and was not considered in his decision to dismiss the Grievant.

The July 8, 2021 "Safety Incident/Close Call Report" regarding this incident was approved by a Supervisory Nurse and Safety Officer who found that appropriate standards and policies were followed. The Grievant described the incident as Patient GF kicking the Grievant twice from behind

contacting his left inner and outer thigh. This report reads like a patient kicking staff without provocation. The Safety Incident Report does not contain a complete statement of the facts and cannot be relied on as determinative of the issue: did the Grievant follow appropriate standards and policies in this case.

The Investigation was conducted as a preliminary review within the first few days and weeks after the incident. The Grievant was interviewed in March 2022 after he returned to work and the Investigations Department had proceeded with a Formal Investigation. However, his statements and reports of the incident were made as early as a few minutes after the incident. Statements were obtained from employees who were considered witnesses, most of which were interviewed. The Investigation did not include interviews of everyone on staff in Ward C-3 on July 8, 2021. The record does not show that employees who were safety staff, supervisors of witnesses, or employees who gave statements and were not interviewed had information which should have been considered by DSHS in the investigation or discipline of the Grievant. The scope of the Investigation was the alleged staff to patient assault. DSHS did not conduct a separate investigation of the alleged patient to staff assault in this incident. The Investigation does include the facts of Patient GF kicking the Grievant. There is no dispute that Patient GF kicked the Grievant two times. The Investigation included the Security Patient to Staff Assault Report and the Safety Incident/Close Call Report regarding the Patient GF's assault on the Grievant. The Grievant did not file a police report. The record does not show that the Investigation was incomplete, narrow in scope or untimely.

DSHS conducted a fair and thorough investigation.

Discipline: Daniel Davis, WSH Interim Chief Executive Officer made the determination to dismiss the Grievant. Mr. Davis testified his decision to discipline the Grievant was made after he reviewed and considered the Investigation and the pre-disciplinary process. Mr. Davis found evidence to support that the Grievant violated WSH and DSHS policies when he did not review Patient GF's file before the encounter to see how best to approach him, Grievant did not take another staff with him to encounter Patient GF, Grievant did not find an exit when Patient GF first kicked the Grievant, Grievant did not call for staff assistance, Grievant did not follow de-escalation tactics throughout the encounter, Grievant did threaten Patient GF with an ultimatum of violence of either restraints or to be taken down both of which were inappropriate responses to Patient GF as the situation was not an emergency, and ultimately in an act of violence Grievant took Patient GF down to the floor which constituted patient abuse.

Mr. Davis testified he determined the appropriate level of discipline for the Grievant was dismissal. Mr. Davis came to that conclusion based on the facts, the Grievant's self-report of patient abuse and that the Grievant made conflicting statements, did not take responsibility for his actions or admit he did not follow policy. Mr. Davis determined the Grievant was not a candidate for corrective action and that there was no option but to dismiss the Grievant.

The Union argues for leniency from the Arbitrator. The Union claims that DSHS did not prove that the Grievant committed the alleged assault on Patient GF and this leaves only policy violations which do not support the summary dismissal of the Grievant. The Union points out that under the circumstances in this case it is unrealistic to expect that the Grievant should have encountered Patient GF with another staff or found a way to retreat from the situation and the Grievant's deviation from the therapeutic language usually employed by the Grievant with patients was impossible to avoid while under physical attack. Further the Union argues the Grievant is a candidate for training and corrective discipline. For these reasons the Union argues summary dismissal of the Grievant is too harsh.

Arbitrators have pointed out in numerous discharge cases that leniency is the prerogative of the Employer rather than that of the Arbitrator: and the latter is not supposed to substitute their judgment in this area for that of the Employer unless there is compelling evidence that the Employer abused this discretion. (Enterprise Wire Company, 46 LA 359 (Carroll R. Daugherty, 1966)) In this case, the record does not show that DSHS abused their discretion in the Grievant's dismissal. DSHS proved by a preponderance of the evidence that it is more likely than not the Grievant's interaction on July 8, 2021, with Patient GF was non-therapeutic, unprofessional and reckless behavior constituting patient abuse, and violated WSH and DSHS agency policies and procedures. The Grievance must be denied.

AWARD

The Employer Washington State Department of Social and Health Services did have just cause, according to Article 25 of the Collective Bargaining Agreement, to dismiss the Grievant Allen Cabanos.

The Grievance is hereby DENIED.

Respectfully Submitted, this 7th day of June 2024.

Audrey B. Eide, Esquire
Arbitrator & Mediator