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BURR ROAD OPERATING COMPANY II, LLC *v.* NEW
ENGLAND HEALTH CARE EMPLOYEES
UNION, DISTRICT 1199
(AC 33954)

DiPentima, C. J., and Bear and Borden, Js.

Argued October 18, 2012—officially released April 30, 2013

(Appeal from Superior Court, judicial district of
Hartford, Hon. Robert F. Stengel, judge trial referee.)

Andrea C. Kramer, for the appellant (plaintiff).

Michael E. Passero, for the appellee (defendant).

Opinion

BORDEN, J. The dispositive issue of this appeal is whether the award of the arbitrator reinstating the grievant, Leoni Spence, who is an employee of the plaintiff, Burr Road Operating Company II, LLC, operating as Westport Health Care Center, and a member of the defendant, New England Health Care Employees Union, District 1199, violates public policy and, therefore, must be vacated. We conclude that the award does violate public policy and, accordingly, we reverse the determination of the trial court to the contrary.

The plaintiff terminated the employment of the grievant. The defendant took the termination to arbitration. The arbitrator found that there was just cause only to suspend the grievant for one month, not to discharge her. Accordingly, the arbitrator ordered that she be reinstated with back pay and lost benefits, less the one month period during which she was suspended from work, and that she be issued a final warning. The plaintiff filed with the trial court an application to vacate the award, and the defendant filed a cross application to confirm the award. The court denied the application to vacate the award, granted the cross application to confirm the award and rendered judgment accordingly. This appeal by the plaintiff followed.

The plaintiff claims that the court improperly denied the application to vacate and granted the cross application to confirm for two reasons: (1) the award violates public policy, and (2) the arbitrator exceeded his authority. We agree with the plaintiff's first claim. Therefore, it is not necessary to reach its second claim.

The arbitrator was asked to answer two questions on the basis of the collective bargaining agreement between the plaintiff and the defendant: "Was [the grievant's employment] terminated for just cause? If not, what shall the remedy be?" After a hearing, the arbitrator found the following facts.

The plaintiff is a 120 bed, skilled nursing facility located in Westport. The grievant was employed there as a certified nursing assistant from 2002 until the termination of her employment in 2010, and is represented by the defendant.

The events leading to the termination of the grievant's employment occurred between March 20 and 24, 2010. Prior to that time, the grievant had received a number of disciplinary actions that remained as part of her personnel file. In 2005, her employment was terminated after she improperly restrained a resident by using a bedsheet to tie him into his wheelchair. That termination was reduced to a suspension and final warning by agreement between the plaintiff and the defendant. Because that disciplinary action resulted from an incident of patient abuse, that suspension and final warning properly was retained in the grievant's personnel file

indefinitely.¹ In April, 2009, the grievant received a written warning for speaking in an inappropriately rude, loud and scolding manner to a resident, and for being insubordinate and disrespectful to her shift supervisor. That written warning was challenged by the grievant and the matter proceeded to arbitration, where it was upheld as having been imposed for just cause. In August, 2009, the grievant received a “2nd and Final Written Warning” for having been disrespectful in addressing a resident and touching the resident without explaining the procedure that the grievant would be applying to the resident. The grievant did not file a union grievance with respect to that warning.

The incident that led to the termination of the grievant’s employment occurred between March 20 and 24, 2010. The grievant worked the night shift from 11 p.m. on Saturday, March 20, until 7 a.m. on Sunday, March 21. She was assigned to work on the “Riverside Unit,” along with charge nurse Dezra Leonard. The shift supervisor, registered nurse Gay Muizulles, and another certified nursing assistant, Laurel Johnson, were working on the “Woodside Unit.” At some point during the night shift, Johnson came over from Woodside to Riverside and had a conversation with Leonard. Although the grievant was not a participant in this conversation, from where she was working in a resident’s room she overheard part of the conversation, namely, Johnson talking about a resident on Woodside who had been crying. The grievant further overheard Johnson state to Leonard something to the effect of, “[i]f the supervisor wasn’t so rude, I would have picked up more residents,” or, “[t]hat’s what Gay (Muizulles, the shift supervisor) gets, for not calling Kim.” The grievant came out into the hall and asked who had been crying. Leonard did not respond. The grievant asked Johnson, who replied that she would talk with the grievant later. Both the grievant and Johnson, however, were busy and did not have the opportunity to talk further before their shifts ended.

From what the grievant had overheard, her sense was that “[i]t could have been abuse, but I was not sure.” She knew that Muizulles was involved and that a patient had been crying. Before her shift ended, the grievant went over to Woodside “to snoop” around to see who was crying. The residents were all asleep, however, and no one was crying.

The grievant next worked from 11 p.m. on Sunday to 7 a.m. on Monday, again with Muizulles as the shift supervisor. She then worked again on the Monday night to Tuesday morning shift, this time on Woodside. During that shift, she spoke to a resident, CJ, who told her that, on the previous Saturday night, Muizulles had been somewhat rough as she helped CJ in getting her legs up onto her bed, had spoken gruffly to CJ and had turned down the television without asking CJ’s permission. CJ’s roommate confirmed that this had upset CJ,

who had cried for some time after the incident. The grievant realized that this likely was the incident of a crying resident about which she had overheard on the Saturday night shift. The grievant comforted CJ, explained to her that she should not have been subjected to such treatment and that she should feel comfortable about reporting it. The grievant suggested that she could arrange for someone to come and speak to CJ about what had happened to her, and CJ agreed.

The grievant went home, and then telephoned in to speak with the social worker at the facility to report what CJ had told her. The social worker was not in, but the grievant left a message in the social worker's voice mail box, and during the course of the day she left three separate, lengthy recorded messages for the social worker, reporting what CJ had told her and urging the social worker to talk to CJ in order to hear CJ's concerns directly from CJ.

The arbitrator also found that the plaintiff carried out a very thorough investigation of the possibility of patient abuse by Muizulles in her treatment of CJ. The ultimate conclusion was that Muizulles had acted insensitively toward CJ, but that the insensitivity had not risen to the level of abuse or neglect. Given Muizulles' twenty years of employment with the plaintiff with no prior discipline on her record, the plaintiff gave her a five day suspension and final warning. It was during that investigation regarding Muizulles' conduct that the plaintiff obtained the information that led it to conclude that three other staff members—Johnson, the assistant director of nursing, and the grievant—had failed to fulfill their obligation promptly to report possible abuse by Muizulles. Johnson was issued a final warning and a two day suspension for failing to report a complaint made by a resident regarding possible abuse by another staff member. The assistant director of nursing was suspended because, once she was informed by the social worker of the possible abuse of CJ, she failed immediately to notify the director of nursing or the administrator of the plaintiff's facility. Although the assistant nursing director initiated an investigation, she failed to inform her superiors immediately as required by policy.

Regarding the grievant, the plaintiff reached the following conclusions: “[The grievant] had a final warning in her employee file and termination was appropriate. [She] stated that she was concerned about overhearing another employee discuss a resident who was crying after receiving assistance from another employee. Although [the grievant] stated she overheard this information, she did not report it until Tuesday, March 23, in which [she] left a voice message for the social worker. According to [the grievant], what she heard on Saturday, March 20, bothered her to the point where she felt she needed to go to the other side [Woodside] to investigate

however, towards the end of the shift and the resident was found sleeping at that time. [The grievant] worked the 11-7 shift on Monday, March 22 and was assigned to the unit of the resident in question. [The grievant] states that the resident told her what happened on [Saturday] and [the grievant] stated that she told the resident that it was not right. . . . Given this course of events, it would appear that the grievant failed to report an allegation of abuse timely.”²

The arbitrator further found that the record clearly and convincingly established that the grievant learned, on the March 20-21 night shift, that Muizulles may have committed resident abuse in her treatment of a patient that night. The grievant’s own state of mind from what she overheard was, “[i]t could have been abuse, but I was not sure.” She was concerned enough about what had happened that she went over to Woodside to see if she could figure out what had happened. Yet, she went home without reporting the information that had come into her possession.

The arbitrator found further that all employees, including the grievant, “are trained that whenever they have information that resident abuse *may* have occurred, from wherever tha[t] information may have come, they must report to a nursing supervisor or higher authority. Frankly, to suggest otherwise flies in the face of why reporting is required, to maximize the protection that can be given to residents to avoid the risk of occurrences or re-occurrences of possibly abusive behaviors.” (Emphasis in original.) The arbitrator continued: “The testimony of the management witnesses, the norms in the training of [certified nursing assistants], and simple common sense confirm that the grievant knew she had an obligation to report in a timely manner, given what she had overheard on the night of March 20, 21, even though she did not personally observe Muizulles’ questionable behaviors.” The arbitrator noted further that, because it was the night shift supervisor, Muizulles, who may have committed the abuse, the grievant was required to report to someone other than Muizulles in the proper line of authority. The grievant had other suitable options available to her, however, such as waiting to see the day shift supervisor who was coming on duty in the morning as the grievant ended her night shift, or calling the director of nursing, the administrator or any other nurse supervisor. Instead, the grievant did not report to anyone until March 23, and that reporting, as the arbitrator found, was not to anyone in the proper line of authority, but to the social worker by telephone messages.

The arbitrator stated that “[q]uite clearly . . . the grievant was guilty of the offense of failing to timely report to a nursing supervisor (or higher authority) the information that had come into her possession on March 20, which information suggested to the grievant

that another staff member may have committed resident abuse. The remaining question is whether that misconduct provided the [plaintiff] with just cause to terminate the grievant's employment."

In answering this question, the arbitrator deemed "fair arguments in support of the requirement of immediate reporting" that "a delay in reporting is almost as bad as not reporting at all. The [plaintiff] notes that it is under a clear, statutory obligation to report immediately to the state regulatory body whenever there has been an event of possible resident abuse. That obligation only can be fulfilled if employees report in a timely manner. Moreover, and more fundamentally, any delay in reporting by a staff member leaves the residents at risk of possible further abuse by the alleged perpetrator; corrective action by [the plaintiff] to assure resident well-being inevitably is delayed if reporting by staff is delayed."

Nonetheless, the arbitrator concluded that it was "an important mitigating fact that the grievant was the one who actually came forward, although belatedly, and made the [plaintiff] aware of the problem. If the grievant had not come forward on March 23, it is quite likely that the [plaintiff] never would have learned of the insensitive treatment given by Muizulles, nor of the failure to report by multiple staff members. It is important to recognize that contribution which the grievant made, then, albeit belatedly, to help assure the well-being of the residents [of the plaintiff]."³

The arbitrator also reasoned that the plaintiff should "not want to create a huge disincentive to reporting, if and when an employee for whatever reason has hesitated or delayed in reporting possible resident abuse. If the disciplinary approach is, once you have delayed you will be terminated even if you then make a belated report, then that creates a perverse incentive to never report. The belated reporter ends up being fired as the direct consequence of not coming forward."

Thus, the arbitrator stated as follows: "The grievant did fail to make a timely report of what she had learned on March 20. She knew the rule that she had to report, and to do so without delay. She failed to fulfill that responsibility in a timely manner. And, she had a poor disciplinary record, so that placed her in a worse position than the other staff members involved in the March, 2010 incident involving CJ. On the other hand, there is the significant mitigating factor that it was the grievant, not the others, who did come forward and report to the [plaintiff], although belatedly; and it was her reporting which allowed the [plaintiff] to take corrective actions." The arbitrator concluded that, because of this mitigating factor, the plaintiff lacked just cause to terminate the grievant's employment.

The plaintiff claims that the arbitrator's award must

be vacated because it violates “the strong public policy of protecting residents in skilled nursing facilities, including the public policy of promptly and properly reporting patient abuse in such facilities.” More specifically, the plaintiff argues that the award violates this public policy “by *de facto* prohibiting the discharge of any employee who reports abuse, no matter how late or improperly, as long as the employee *eventually* reports the abuse, and by ordering the reinstatement of the particular employee in this case, who has definitively demonstrated an unwillingness or inability to meet her obligations to ensure resident safety.” (Emphasis in original.) We agree that the award violates the strong public policy of protecting residents of skilled nursing facilities from abuse.

We first address our scope of review regarding the plaintiff’s claim. Ordinarily, where there is a consensual, unrestricted submission to arbitration,⁴ the only question is whether the award conforms to the submission. *Schoonmaker v. Cummings & Lockwood of Connecticut, P.C.*, 252 Conn. 416, 427, 747 A.2d 1017 (2000). One exception to that rule, however, is where the award violates clear public policy. *Id.*, 428. Where a party challenges an award on the ground that it violates public policy, *de novo* review is in order if the challenge has a legitimate, colorable basis. *Id.*, 429. That *de novo* review is limited, however, to the two critical questions: (1) whether there is an explicit, well-defined and dominant public policy and (2) whether the award violates that policy. *State v. AFSCME Council 4, Local 387, AFL-CIO*, 252 Conn. 467, 476, 747 A.2d 480 (2000). It does not extend to the facts found by the arbitrator. *Schoonmaker v. Cummings & Lockwood of Connecticut, P.C.*, *supra*, 432. This necessarily means, therefore, that, if the plaintiff has established a legitimate, colorable basis for its public policy challenge to the arbitrator’s reinstatement decision, although we defer to the historical facts found by the arbitrator, the arbitrator’s conclusion of no just cause for termination is not entitled to deference but is, instead, subject to our *de novo* review to determine whether it is in violation of public policy. We conclude that, on the basis of these principles, the plaintiff’s claim is subject to *de novo* review.

We agree with the plaintiff that Connecticut has a clear, well-defined and dominant public policy of protecting patients in facilities, such as those of the plaintiff, from abuse, and that this policy includes the prompt reporting of any incident of suspected abuse. Our statutory patients’ bill of rights; General Statutes §§ 19a-550 and 19a-550a; provides that any patient of a “nursing home facility”; General Statutes § 19a-550a (a) (1); shall be “free from mental and physical abuse” General Statutes § 19a-550 (8); see also *State v. New England Health Care Employees Union*, 271 Conn. 127, 138, 855 A.2d 964 (2004) (“there is an explicit, well-defined and dominant public policy against the mis-

treatment of persons in the . . . custody [of the department of mental retardation]”).

Furthermore, this policy includes the prompt reporting of any incident of suspected abuse. Generally speaking, all employees of such facilities who have reasonable cause to suspect abuse of a patient are required by General Statutes § 17b-451,⁵ under criminal penalties, to report the same to the commissioner of social services within seventy-two hours after such suspicion arose. In order for that policy to be effective, there must be strong institutional rules requiring employees who deal directly with patients promptly and properly to report cases of suspected abuse, because they are the ones to whose attention those cases are most likely to come. Thus, the plaintiff has chosen to implement this statutory policy by requiring its employees promptly to report cases of suspected abuse through its own chain of command, so that the employer itself can then meet its statutory responsibility to make such a report, if warranted, to the commissioner of social services within the requisite seventy-two hours.

The obvious purpose of these provisions is to protect from abuse those among us who are most vulnerable and most dependent for their well-being on their institutional caregivers. And the equally obvious purpose of the concomitant prompt and proper reporting requirement is to ensure that incidents of possible abuse are quickly addressed by the responsible institutional actors, so that they do not leave time for their continuation or repetition before serious consequences ensue to the abused resident.

We also conclude that the plaintiff's claim of a violation of this policy has a colorable and legitimate basis. We therefore apply de novo review to the question of whether the reinstatement of the grievant violated public policy. *Schoonmaker v. Cummings & Lockwood of Connecticut, P.C.*, supra, 252 Conn. 428–29.

Applying that review, we conclude that the award violates that public policy. We do so because of a confluence of factors arising under the facts and circumstances of the case. The grievant had a prior incident of patient abuse dating from 2005, which resulted in a final warning. Then, in April, 2009, she received a written warning for an incident that involved, in part, speaking rudely, loudly and in a scolding manner to a resident, and in August, 2009, she received a second final warning for behaving disrespectfully and inappropriately toward a resident. Finally, in the present incident, in March, 2010, despite being fully aware of her obligation promptly to report through proper channels her suspicions of patient abuse, and despite being aware that she was subject to two final warnings, the grievant did not report the suspected abuse until several days later, and then not through the proper channels.⁶ The award, requiring the reinstatement of one who, in a sensitive

position of physical authority over such a vulnerable population, has by her prior record of related disciplinary actions and two prior final warnings demonstrated her inability to meet the demands of the public policy of protection and reporting, violates that policy because, in the very words of the arbitrator, “any delay in reporting by a staff member leaves the residents at risk of possible further abuse by the alleged perpetrator; corrective action by [the plaintiff] to assure resident well-being inevitably is delayed if reporting by staff is delayed.”

Our conclusion in this respect is consistent with the similar result reached by the Illinois Appellate Court in the case of *Illinois Nurses Assn. v. Board of Trustees of University of Illinois*, 318 Ill. App. 3d 519, 741 N.E.2d 1014, leave to appeal denied, 194 Ill. 2d 567, 747 N.E.2d 352 (2001). In that case, the court held that the reinstatement, ordered by an arbitrator, of a nurse in a state university hospital who had engaged in unsafe nursing behavior violated the public policy favoring safe nursing care. A critical basis of the court’s determination was the nurse’s prior history, namely, that she “had displayed an inattentive work attitude and below average nursing skills since 1991.” *Id.*, 531. The court specifically contrasted that nurse’s termination from the treatment afforded another nurse involved in the same case who had been ordered reinstated. The court rejected the employer’s public policy challenge to the reinstatement, based upon that nurse’s “20-year employment record without discipline” *Id.*, 532.

Thus, we reject the defendant’s claim that “[t]his case involves nothing more than a garden variety employee discharge grievance in which the employer is unhappy with the bargained for final and binding arbitrator’s award,” and, therefore, the usual deferential scope of review should apply.⁷ The basis of this claim is that, although the cited public policy of protecting patients in nursing homes “arguably requir[es] prompt reporting of suspected abuse, [it] does not require the unreviewable discharge of employees who have been negligent in their duty to promptly report suspected abuse.”

We agree that the public policy cited does not require the “unreviewable” discharge of an employee who has not complied with her duty promptly to report suspected abuse. We disagree, however, with the suggestion that concluding that this discharge violates the cited public policy means that any such discharge would be unreviewable. That simply is not the case. Any such discharge would certainly be reviewable by the courts, pursuant to our *de novo* review, and each would be decided on the basis of its particular facts and circumstances, as we have done in the present case.

We also reject the defendant’s suggestion that there is no such explicit policy requiring the reinstatement of any employee who has at any time failed even once

promptly to report suspected patient abuse and, therefore, this award must be upheld. We do not suggest that there is such a policy. Instead, the policy is as we have stated previously, and its application to the particular facts and circumstances of the present case requires the vacating of the award reinstating this employee, with a history of inability to comply with the policy and two prior final warnings. Indeed, those facts and circumstances show that the employer did not discharge the other employees precisely because their records were clear of any indication of such a history.

We also disagree with the defendant's reliance on *State v. New England Health Care Employees Union*, supra, 271 Conn. 127. In that case, the court held that, although there is "an explicit, well-defined and dominant public policy against the mistreatment of persons in the . . . custody [of the department of mental health]"; id., 138; the reinstatement of the particular employee there did not violate that policy. Id., 142. That case is factually distinguishable, however.

In *New England Health Care Employees Union*, the court stated: "To conclude that the arbitrator's decision and award violated the public policy of protecting persons in the custody of the department from abuse, the court would have had to conclude that, if a single instance of deliberate conduct results in any injury to a client, no matter how inadvertent or minor, the conduct is grounds for termination, per se. We agree with the union that such a rule is not required to advance the public policy of protecting clients from mistreatment. Rather, an arbitrator reasonably may consider circumstances such as the length of employment, previous instances of harmful conduct by the employee, and the circumstances and severity of the misconduct under review in determining the likelihood of future misconduct and whether discipline less severe than termination would constitute a sufficient punishment and deterrent." Id., 138–39.

In the present case, by contrast, it was not a single case of misconduct that led to the dismissal. There was a history of three incidents of similar misconduct, including two prior final warnings, within a period of five years. In addition, the grievant's failure to report promptly was exacerbated by her failure to report through proper channels, thus increasing the risk that the suspected abuse would not be communicated promptly to the proper persons.

Further, we disagree with the defendant's argument that the award does not violate the public policy because it was the grievant who ultimately came forward with the information, and that, as the arbitrator reasoned, "[i]f the disciplinary approach is, once you have delayed you will be terminated even if you then make a belated report, then that creates a perverse disincentive to never report. The belated reporter ends

up fired as the direct consequence of coming forward.” That argument may have weight in a case, such as *State v. New England Health Care Employees Union*, supra, 271 Conn. 127, in which the employee was dismissed for his very first incident of misconduct. Its weight diminishes greatly, however, in a case such as this, where the grievant has a history of similar misconduct indicating a risk of future misconduct, and where, as the record indicates, the employer did not follow a disciplinary approach of “once you have delayed you will be terminated,” as indicated by the employer’s more lenient treatment of the other employees who also failed to follow the public policy.

Finally, we turn to the contention of the dissent that our conclusion “has the unfortunate result of diminishing this court’s respect for and deference to the private arbitration process, and . . . also results in an expansion of the public policy exception from its intended narrow application in these circumstances.” We disagree.

First, to the extent that the dissent contends that the arbitrator’s conclusion of no just cause for termination is entitled to the usual deference to the private arbitration process, the contention misapplies the public policy exception. As we have explained, our law is clear that, once the party challenging an arbitrator’s award on the ground of the public policy exception has established that the challenge has a legitimate, colorable basis, any such deference disappears and the question of termination becomes one for our de novo determination. That is why it is characterized as the “public policy exception”; it is an exception to the usual rule of deference to the arbitrator’s factual and legal determinations. Indeed, if the dissent were correct in this regard, any determination by an arbitrator of no just cause for termination would be effectively insulated from judicial review and the public policy exception would be little more than a nullity. See, e.g., *State v. AFSCME, Council 4, Local 387, AFL-CIO*, supra, 252 Conn. 473 (public policy exception required termination of correction officer for making racial remarks about state legislator, despite arbitrator’s conclusion of no just cause for termination). Second, we reject the dissent’s contention that our decision is an “expansion of the public policy exception” It is, by contrast, simply an application of the public policy exception to the facts of the present case.

We also reject the dissent’s contention that “[t]aken to its logical conclusion, the majority sets forth a rule that requires an employer to terminate the employment of any employee who does not report a suspicion of elder abuse immediately, without consideration of any mitigating factors or whether the employer itself would be in violation of any public policy.” Of course, any decision of a court, taken to its logical conclusion, might

result in an unwise policy. That is precisely why we have been careful to articulate that our decision does not apply to any such employee. This is, instead, a case of an employee who had a history of three incidents of similar misconduct within five years, including two prior final warnings, who exacerbated her misconduct by failing to report through proper channels, thus increasing the risk that the suspected abuse would not be addressed properly and promptly.

The remainder of the dissenting opinion focuses on the purported violation of the grievant's due process rights. In our view, the dissent's reading of the record on this issue is not sufficiently comprehensive. Accordingly, some further elaboration of the procedural history of the case is required.

During the plaintiff's investigation of Muizulles' conduct, the plaintiff discovered the grievant's, as well as Johnson's and the assistant director of nursing's, failure to report Muizulles' suspected abuse promptly and through proper channels. That investigation also disclosed that, in the course of the grievant's three lengthy telephone messages for the social worker, again in the language of the arbitrator, "the grievant included some comments which the [plaintiff] interpreted as showing that the grievant (and other staff members) prior to March 20 had been aware of other instances of possible patient abuse by . . . Muizulles, but neither the grievant nor anyone else had reported those prior instances."

During the arbitration hearing, the plaintiff urged the arbitrator to take the grievant's comments in those three telephone conversations into account as aggravating circumstances "above and beyond the grievant's pre-existing disciplinary record," as showing that the grievant "had failed to report those situations at all" and, therefore, according to the plaintiff, the termination was for just cause. It was in this context that the arbitrator's statements about the grievant's due process rights arose.

The arbitrator squarely rejected this evidence and expressly gave it "no weight in assessing whether there was just cause to terminate" The explicit reason for this rejection was stated by the arbitrator: "[T]he [defendant] is correct that the [plaintiff] did nothing to further investigate in response to *this information, which the [plaintiff] had learned from the grievant's telephone messages to the social worker.* The grievant never was told that the [plaintiff] was concerned *about these comments she had made in her messages,* and most importantly, she never was given the opportunity to respond with any explanation or clarification that she might wish to provide. . . . Given that absolute lack of any investigation *regarding what the grievant may have intended to convey by her comments in the phone messages,* the [plaintiff] cannot rely at arbitration upon an argument that the grievant in fact had knowl-

edge of possible abuse prior to March 20, but made no report. The grievant in the pretermination investigative process never was made aware of the [plaintiff]’s concern *in that regard*, and never was given any opportunity to respon[d], explain or clarify.” (Emphasis added.)

This passage makes it clear that the evidence regarding whether the grievant’s purported due process rights were violated was expressly rejected by the arbitrator for precisely that reason and, therefore, played absolutely no part in the determination of whether the termination was for just cause. It was, instead, evidence of the grievant’s purported admissions in her three telephone messages to the social worker that the arbitrator refused to consider as aggravating factors against her. It did not contribute in any way to the arbitrator’s decision and, therefore, could not have harmed the grievant in any way. Indeed, it only entered this case on appeal as part of the *plaintiff’s* argument on its *second* claim, namely, that the arbitrator should have considered it and, therefore, exceeded his authority, a claim that, as we have said, we need not consider. See footnote 3 of this opinion.

Furthermore, the record is quite clear that, despite the plaintiff’s failure independently to investigate the grievant’s—as opposed to Muizulles’—conduct, the grievant had her full opportunity to give her side of the story to the arbitrator, which she did. And the record is equally clear that on three occasions the arbitrator expressly disbelieved her.⁸ Moreover, the arbitrator, as we have already explained, found on the basis of all the evidence, including the grievant’s testimony, that “[q]uite clearly, then, the grievant was guilty of the offense of failing to timely report to a nursing supervisor (or higher authority) the information that had come into her possession on March 20, which information suggested to the grievant that another staff member may have committed resident abuse.”

The judgment is reversed and the case is remanded with direction to render judgment granting the plaintiff’s application to vacate the award and denying the defendant’s cross application to confirm the award.

In this opinion DiPENTIMA, C. J., concurred.

¹ Other disciplinary actions are removed from an employee’s personnel file after twelve months.

² The arbitrator also noted that, in contrast to the thorough investigation of possible abuse by Muizulles, the plaintiff did not carry out a separate investigation of the possibility that the grievant had failed to make a timely report of possible patient abuse. Rather, the arbitrator found, the defendant terminated the grievant’s employment as a result of having relied on the information that had come to its attention in the course of the Muizulles investigation, without ever inviting the grievant to respond directly to the plaintiff’s concerns about possible misconduct on her part. Nonetheless, this was not the basis of the arbitrator’s award reducing the grievant’s termination to a suspension. Indeed, the arbitrator specifically found, on the basis of the evidence presented to him, that, as we will discuss, the grievant failed to timely report to a nursing supervisor, or higher authority, that another staff member may have committed resident abuse. And the defendant does not claim that the arbitrator’s finding of fact in this regard

was flawed because of this purported flaw in the plaintiff's investigative process. See also footnote 3 of this opinion. We discuss this finding of the arbitrator more fully in our response to the dissent in this case.

³ The arbitrator rejected the plaintiff's claim that the content of the grievant's telephone calls to the social worker indicated that the grievant had also been aware of prior instances of possibly abusive treatment of residents by Muizulles and had failed to report them. The reason for the arbitrator's rejection of this claim was what he found to be the plaintiff's lack of any further investigation in response to this information that the plaintiff had learned from those calls. The arbitrator stated: "Given that absolute lack of any investigation regarding what the grievant may have intended to convey by her comments in the phone messages, the [plaintiff] cannot rely at arbitration upon an argument that the grievant in fact had knowledge of possible abuse prior to March 20, but made no report." In this appeal, the plaintiff does not rely, in the context of its public policy argument, on the contents of those calls. We, therefore, do not consider them either. See also footnote 2 of this opinion.

⁴ The parties in the present case acknowledge that this was a consensual, unrestricted submission.

⁵ General Statutes § 17b-451 (a) provides in relevant part: "Any . . . registered nurse, any nursing home administrator, nurse's aide or orderly in a nursing home facility, any person paid for caring for a patient in a nursing home facility, any staff person employed by a nursing home facility . . . who has reasonable cause to suspect or believe that any elderly person has been abused, neglected, exploited or abandoned, or is in a condition which is the result of such abuse, neglect, exploitation or abandonment, or is in need of protective services, shall, not later than seventy-two hours after such suspicion or belief arose, report such information or cause a report to be made in any reasonable manner to the Commissioner of Social Services or to the person or persons designated by the commissioner to receive such reports. Any person required to report under the provisions of this section who fails to make such report within the prescribed time period shall be fined not more than five hundred dollars, except that, if such person intentionally fails to make such report within the prescribed time period, such person shall be guilty of a class C misdemeanor for the first offense and a class A misdemeanor for any subsequent offense."

⁶ While the grievant reported the suspected abuse arguably within seventy-two hours, the time period contained in § 17b-451, we emphasize that her report, almost three full days from when she first heard the information, was made to the facility social worker, instead of the requisite nursing supervisor or higher authority, which would have allowed the plaintiff to comply with the statutory reporting policy. Thus, whether the grievant reported within the statutory seventy-two hour time period, she still failed to do so promptly and through the proper channels as required by the plaintiff. Further, our conclusion that the award violates public policy is based not solely on the grievant's failure to report promptly but on her failure to do so through the proper channels and her past record of employee misconduct indicating her inability to meet the demands of the public policy of protection and reporting.

⁷ Indeed, the defendant argues that, so long as the arbitrator has considered a grievant's prior disciplinary record—no matter how egregious—its ultimate conclusion of lack of just cause for termination must be afforded the traditional deference to an arbitrators' fact-finding. This argument fails because it overlooks the necessary consequence of the public policy exception, namely, that once a colorable, legitimate basis for the public policy exception has been established—as it has been here—*de novo* review, not deferential review, is applied to the ultimate question of termination. See *Schoonmaker v. Cummings & Lockwood of Connecticut, P.C.*, *supra*, 252 Conn. 429.

⁸ The grievant testified that, although she was aware of the August, 2009 written warning, she was unaware that it was a *final* warning. The arbitrator found, however, that she received the actual document and that, as a union delegate, she would have read it with care and noted the "final" notations as having important significance.

The grievant also testified before the arbitrator that, before she went home at the end of her shift, she informed the charge nurse about the suspected abuse. The arbitrator expressly "discredit[ed]" this testimony that the grievant reported to [the charge nurse] before the grievant went home at shift end."

Finally, the grievant also testified at the arbitration hearing "that it was her belief . . . she could fulfill her reporting requirement by telling her

charge nurse.” The arbitrator rejected this testimony because the grievant had also testified that the charge nurse on her unit “is *not* her supervisor; the supervisor is the registered nurse who is the designated shift supervisor. The training which the grievant had received regarding the reporting obligation was quite clear, that the report must go to the ‘nursing supervisor,’ or higher authority.” (Emphasis in original.)