

IN THE MATTER OF ARBITRATION BETWEEN

Hennepin County
“Employer”

BMS Case No. 13-PA-0735

and

Decision and Award

International Brotherhood of Teamsters
Local 320, Correctional Unit
“Union”

John W. Johnson, Arbitrator

Date of Hearing:

November 25, 2014

Date of submission of Post Hearing Briefs:

December 15, 2014

Advocates

For the Union:

Kari Seime
Attorney/Business Agent
Teamsters Local 320

For the Employer:

Todd Olness
Labor Relations Representative
Hennepin County

Witnesses:

Fred Bryan, Area Supervisor, Corrections
Pierre Ellis, Corrections Supervisor, County Home School
Angela Cousins, Division Manager, County Home School
Terry Neuberger, Business Agent, Local 320, Teamsters
The grievant, Juvenile Corrections Officer, County Home School
Patrick Klatt, Juvenile Corrections Officer/Steward, County Home School

Statement of Jurisdiction

The hearing was held in the above matter on November 25, 2014 in the Hennepin County Government Center, Minneapolis Minnesota. The Arbitrator, John W. Johnson, was selected by the parties pursuant to the Minnesota Public Employment Labor Relations Act of 1971, as amended (PELRA).

At the hearing each party was given the opportunity to present evidence and arguments. The parties then submitted post hearing briefs, which were emailed on December 15, 2014.

Issue

Was there just cause for the two shift suspension without pay given to the grievant, and if not, what is the remedy?

Background

The grievant is and has been for more than 20 years, a Juvenile Corrections Officer employed in the Hennepin County Home School (CHS). He received a two shift suspension for an incident occurring on October 21, 2012, in which a juvenile resident (hereinafter "Resident") of the CHS claimed that he had urinated on himself because the grievant had refused him permission to use the bathroom.

On October 21, Resident returned from another building at the CHS, where he had been engaged in a group program. The evidence does not show what time Resident returned to the building where his room was, Cottage 7, but it was sometime after 3:31 pm. Joint Exhibit 6. Resident had asked to use the bathroom before returning from the other building, but had been told he could use the bathroom upon his return to Cottage 7. Joint Exhibit 5. Resident did use the bathroom at 3:39 pm. Joint Exhibit 6. At approximately 4:25, Resident spoke to Mr. Brock, asked Mr. Brock to sign off on his special program for passing shifts, and was told that this was not the appropriate time, but that it could be handled later. Joint Exhibit 7. Resident again used the bathroom at 4:31 pm. Joint Exhibit 6. Following the exchange with Mr. Brock, and the 4:31 bathroom visit, Resident began shouting, pressing his buzzer, throwing things in his room, and banging on his door. Joint Exhibit 7. After Resident buzzed at 4:50 pm he was told "no buzzing". He then popped out of his room and asked to use the bathroom but was told no, that since he had used it at 4:30 he would be allowed to use it again at 5:30. Joint Exhibit 7. About 5:11 Resident was pounding on his door, yelling for the bathroom, wearing, and yelling for Mr. Brock.

Testimony of grievant. At approximately 5:15 Resident came out of his room and said “come down here and see how I’m going to get you fired”. Joint Exhibit 7. The grievant went down the wing and saw that the front of Resident’s shorts were wet. Id. Mr. Ellis also came down the wing. Id. Resident claimed that he had wet himself. Id. Mr. Ellis told resident he was going to CIU for seclusion. Id. This was based on Resident’s continuing disruptiveness over approximately the previous 45 minutes, and popping out of his room without permission. Id..

Discussion

The Union and the employer disagree on several questions pertinent to determining if the discipline was for just cause. These include, what kind of facility the County Home School is; whether or not Resident was sufficiently disruptive to justify the manner in which the situation was handled by the grievant: what is the nature and relevance of the grievant’s work history with the County; did Resident actually urinate on himself; and what expectations for the behavior of Juvenile Corrections Officers in situations like the one giving rise to the suspension were or were not communicated to the grievant prior to that incident.

The Union and the employer characterize the County Home School differently. The Union emphasized that it is a secure facility, and that the staff has a responsibility to maintain order and ensure the safety of residents and staff. The Union made a point of referring to those held at the facility as “inmates”, and compared the facility to a medium security prison. This comparison was supported by the testimony of Fred Bryan. The Employer, on the other hand, emphasized that the facility is not just a place to hold juveniles who have been adjudicated as delinquent, but is a treatment facility. In his testimony Mr. Bryan also stated that while it is true that staff must provide a level of supervision that ensures safety and security, it must be done in a manner conducive to conducting the treatment programs. This assertion is supported by Joint Exhibits 8 and 9, which , respectively, identify the Minnesota Rules under which the facility operates, and provide excerpts from those rules. The rules refer to “treatment” in several places, and

make it clear that safety and security are only part of the mission of the facility and its staff.

Regarding the behavior of Resident, it is clear that he is very difficult to deal with. He is frequently disruptive, angry, disrespectful, threatening, and uncooperative. The Union presented a series of incident reports documenting Residents difficult behavior. Union Exhibits 1 through 26. The Union's implication, as I perceive it, is that with someone like Resident, maintaining order and security are paramount considerations, and this is part of the justification for the grievant's actions. The Employer's position is that while Resident is undeniably difficult, so are other residents, the CHS being the kind of facility it is, and that the same standards of behavior, consistent with the therapeutic model, apply to treatment of Resident as to any other resident.

The grievant's work history is documented in Joint Exhibits 11A through 11K, grievant's performance appraisals, spanning the time period from April 2003 through September 2013. Beginning with the earliest of these, covering the time period from April 2003 through July 12, 2003, the performance appraisal shows that the grievant's performance was not up to standards regarding maintaining safety, interaction with residents, and appropriate application of discipline. Joint Exhibit 11K. Over time, his behavior improved, and in the appraisal covering March to July 2006, his performance appraisal showed improvement, and only two areas rated as "needs improvement", one labeled "displays a calm efficient rational and positive attitude under pressure", and the other labeled "displays an appropriate role model for residents". Joint Exhibit 11H. Later, in the rating covering the time period from January 2007 through August 4, 2007, he was rated "fully capable" in all areas, except for "maintains complete accurate records on time" and "demonstrates technical knowledge and skills needed to perform duties effectively", where he was rated as "highly commendable", the next rating above "fully capable". Joint Exhibit 11G. This improving trend continued through the performance evaluation dated July 13, 2010, in which he was rated as "highly commendable" on 17 out of 45 factors rated on that scale. Joint Exhibit 11D. The performance appraisals for the grievant covering the periods from July 2010 through July 2011 (Joint Exhibit 11C)

and July 2011 to July 2012 (Joint Exhibit 11B), following a different format with more narrative, describe both strengths and weaknesses in the grievant's performance. It is clear from the commentary in these performance appraisals that the grievant is viewed by the evaluators as having some difficulty adjusting to a change in the approach being taken at the CHS. Comments include [the grievant] "has struggled with change, and it appears he is reluctant to embrace change in the best interest of service" (Joint exhibit 11C), [the grievant] "can be too firm at times with the residents. He is encouraged to provide more "teaching moments" and opportunities for them to process their behavior...." (Id), [the grievant] "will need further development and use greater resiliency to make this move from a correctional approach to adapt therapeutic principles and interaction while mentoring/coaching the youth" (Joint Exhibit 11B), "His reliability on past practices and punitive approach is unproved as well as ineffective as identified by EBP [evidence based practices]. [the grievant] needs to utilize program interventions more effectively in a manner that empowers and teaches those in our care" Joint Exhibit 11C. At the same time, these two performance appraisals contain many positive comments, including "His strengths are around the fundamentals of corrections, in delivering a consistent and accountable approach with the youth" (Employer Exhibit 11B), [the grievant] "is very knowledgeable in his juvenile correctional officer position. He is very safety conscious, and adheres to policy. He is familiar with all of the treatment components in the STAMP policy and helps to facilitate groups", (Joint Exhibit 11C), [the grievant] "is an excellent team player. He works well with his co-workers and is appreciated by his peers" (Id.), [the grievant] is always clear about his expectations with CHS residents, and consistently holds them accountable for negative behaviors." Id..

Regarding whether or not Resident actually urinated on himself, this is what the evidence shows. When the grievant went down the wing at around 5:15 pm on the day of the incident, he saw that Resident's shorts were wet. Resident claimed to have wet on himself. The grievant's incident report stated that the wet spot was horizontal across the front of Resident's pants, not down. Joint Exhibit 7. Resident's legs were dry and there was no smell of urine. Id. Others besides grievant who went into Resident's room detected no smell of urine. Id. Resident, however, in his complaint stated that he had

urinated on himself. Joint Exhibit 14. Also, in the investigation conducted by Kimberly Johnson, other residents who were near Resident's room during the incident reported hearing Resident ask to use the bathroom several times. The investigation report concludes that "[Resident] is believed to have urinated in his clothing due to his need to go use the bathroom and being ignored as admitted by [the grievant]". Joint Exhibit 5, page 16. The same report also says, "it may have been that [Resident] became so upset that he poured water on himself, however, the focus of this investigation was the act of withholding the opportunity to use the bathroom after numerous requests" Id, page 19. There is also mention in the Investigation Report that Resident was not allowed to change into dry clothing after being sent to the CIU, (Id, page 16 and page 19.), but I find this to be irrelevant to the discipline of the grievant, since grievant was not working in CIU at the time of the incident. I am also concerned that the Investigation Report does not mention that Resident had been allowed to use the bathroom twice upon returning to Cottage 7 after participating in the group program. The Investigation Report states that "during the next couple of hours, [Resident] did in fact ask on numerous occasions to use the bathroom and was denied by [the grievant]". Id, page 17. The facts as presented in the hearing do not support this conclusion. Resident used the bathroom at 3:39 pm and 4:31 pm, (Joint Exhibit 6), and popped out of his room asking to use the bathroom sometime after 4:50 pm, but before 5:15. Joint Exhibit 7.

The next point of contention is over what guidance or instruction the grievant did or did not receive, prior to the incident, about how to deal with behavior like that exhibited by Resident. The performance appraisal covering the time period from July 2011 to July 2012 refers to the culture being "reshaped around the principles of therapeutic interventions", states that the writer of the evaluation had met with the grievant "to develop his understanding on multiple occasions around his skill and comfort level of using the interventions and programming as designed", that the grievant "has admitted that he does struggle with his approach" and that the grievant "will need further development and use greater resiliency to make his move from a corrections approach to adapt therapeutic principles and interaction while mentoring/coaching youth." Joint Exhibit 11B. Since this is the most recent performance appraisal prior to the incident for

which the grievant was disciplined, it is clear that he was aware of expectations that his behavior toward residents should follow a therapeutic model.

Ms Cousins, in her testimony, referred to Joint Exhibit 9, Minnesota Administrative Rule 2960.0080, which applies to the CHS. This Rule states, “the license holder must not subject the resident to ...withholding of basic needs, including ...hygiene facilities”. Ms Cousins characterized the grievant’s actions as denying basic needs. It is not clear from the exhibits or testimony that the grievant was aware of the specific statement in this rule, but I conclude from the evidence that he was aware of the kind of interaction with residents that this rule required. Similarly, the job description for JCO lists the following among essential functions: “Under the direction of supervisory staff, maintains an environment which serves treatment or diagnostic purposes” and “Use techniques of de-escalation to mediate situations.” Joint Exhibit 10. JCO’s receive special training annually on use of re-direction and de-escalation. Testimony of Cousins. In de-escalation training JCO’s learn how to refrain from power struggling with residents, and how to de-escalate instead of escalate. Id.

Conclusion

Considering the above discussion, I conclude that the grievant missed an opportunity he should have taken, which could have de-escalated the situation with Resident, in accordance with how the grievant had been had been advised and trained to respond. There is no question that Resident is very difficult to deal with. That shouldn’t result in him being treated in a manner inconsistent with the therapeutic model, and he was. Allowing Resident to use the bathroom when he insisted that he needed to go, was an easily available opportunity to de-escalate. In the hearing the Union argued that allowing residents to go to the bathroom anytime they want would require a 1 to 1 staff to resident ratio, since bathroom trips are monitored. However, it is unnecessary to go to that ridiculous extreme. There is a lot of room for staff judgment between, any time a resident wants, and the custom of once every hour suggested by the grievant’s testimony.

The CHS is a treatment facility. It may be analogous to a medium security adult prison, as testimony indicates, but clearly its primary mission is treatment, and those treatment expectations were communicated to the grievant. In the incident in question, he didn't follow those expectations. It doesn't matter whether Resident actually wet himself or not. The opportunity to de-escalate came before Resident displayed his wet pants.

Discipline of the grievant was justified. The next question is "how much discipline?". I conclude that two days of suspension is too much. The decision to give a two day suspension was based in part on an error in the investigation report, which indicated that Resident was denied use of the bathroom over a two hour period. He wasn't. The grievant's error was that he missed an opportunity to de-escalate, not that he denied Resident the use of the bathroom over a two hour period. While this error is significant, it's not as extreme as the Investigation Report concludes.

Award

The suspension is reduced from two shifts to one shift. The grievant 's record will reflect a one shift suspension, and he will be reimbursed for one shift.

John W. Johnson
Arbitrator

Date: February 27, 2015