BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between GENERAL TEAMSTERS UNION LOCAL 662 and CLARK COUNTY (HEALTH CARE CENTER)	Case 93 No. 53360 MA-9327

Appearances:

Previant, Goldberg, Uelmen, Gratz, Miller & Brueggeman, S.C., Attorneys at Law, by Ms. Naomi E. Eisman, appearing on behalf of the Union.

Weld, Riley, Prenn & Ricci, S.C., Attorneys at Law, by Ms. Kathryn J. Prenn, appearing on behalf of the County.

EXPEDITED ARBITRATION AWARD

General Teamsters Union Local 662, herein the Union, requested the Wisconsin Employment Relations Commission to designate a member of its staff as an arbitrator to hear and to decide a dispute between the parties. Clark County, herein the County, concurred with said request and both parties mutually requested the Commission to designate the undersigned as the arbitrator. Hearing was held on March 27, 1996, at the Clark County Health Care Center, in Owen, Wisconsin. The parties orally argued at the conclusion of the hearing and requested that the arbitrator issue an expedited award.

ISSUES:

1. Is KM's grievance contesting her three-day suspension procedurally arbitrable?

2. Did the County have just cause to suspend the grievant, KM, for three days without pay for her actions on November 16, 1994? If not, what is the appropriate remedy?

PERTINENT CONTRACT LANGUAGE:

ARTICLE 4 - GRIEVANCE PROCEDURE

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Section D. The time limits set forth in the foregoing steps may be extended by mutual agreement in writing.

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ARTICLE 7 - DISCIPLINE

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Section D. The parties recognize the authority of the Employer to initiate disciplinary action against employees, provided such disciplinary action is for just cause.

Section E. The Employer recognizes the principle of progressive discipline when applicable to the nature of the misconduct giving rise to the disciplinary action.

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BACKGROUND:

This case involves the alleged misconduct of the grievant, KM, on November 16, 1994. On that date, the grievant, along with other Health Care Center Developmentally Disabled Outreach Program staff, took a group of clients to a group home in Greenwood, Wisconsin. Among those clients taken to the facility was G. The staff accompanying the clients to the facility, where a birthday party was being held, were KM, SB and JS. The visit to the group home in Greenwood lasted from approximately 11:00 a.m. until 2:00 p.m.

Client G was an adult developmentally disabled individual. G had a history of acting out idiosyncratic behaviors and one of those behaviors was that when left unattended around food he would uncontrollably grab the food and stuff it in his mouth, causing him to choke on the food. This behavior was well known among the support workers at the Health Care Institution and particularly by those who accompanied the clients to the Greenwood Home. Those workers, including KM, had been instructed by Institution management, either supervisors or unit directors, in how they were to deal with client G and his idiosyncratic behavior. They had been specifically

instructed to utilize what was referred to as a blocking technique. This involved the support worker getting in front of the client and causing him to move in the direction that the support worker wanted him to move. Verbal prompts were also used at the same time. All support workers were given specific instructions that they were not to have physical contact with client G unless he was in imminent physical danger. As witnesses testified, when physical contact was initiated with G, he would resist that contact, become agitated, excited and scared. Over the course of at least two years of contact with client G, SB, JS and RS had either used or observed others using the blocking technique, along with verbal prompts, successfully with client G. In those instances in the past when G would stuff his mouth full of food the support workers would, through use of the blocking and verbal prompts, direct G to a wastebasket and instruct him to spit out the food in his mouth. That technique had worked in the past and G had always complied with their directions.

On the day in question, November 16, 1994, G was in the kitchen of the Greenwood Group Home, along with the group home director, IB, KM, SB and JS. The kitchen area was a dining and living area which was fairly open with doors leading from that area to an outside patio deck. At some time while G was in the kitchen area, he began stuffing crackers from a bowl into his mouth. The group home director, IB, saw what was happening and shouted, or otherwise uttered a noise or comment, which caught the attention of KM. Upon seeing G with crackers stuffed in his mouth, KM went up to him, put her hand behind his neck and took hold of his arm, turned him towards the patio doors and moved him out the doors onto the patio deck. JS testified that she went out to client G's aid once he had been put onto the patio deck because she feared he would choke and was choking on the crackers. SB testified that no one went out on the patio deck with client G for the first two or three minutes after he had been put out on the deck. G expelled the crackers and did not choke. That concluded the incident regarding client G on that day at the Greenwood Home.

After returning to the Health Care Center, SB and JS had a brief conversation at about 3:00 p.m., as they were leaving work for the day, regarding whether KM's handling of the incident was appropriate. SB advised JS that he would be filing a report on the incident because he believed KM had used excessive force with G. Sometime before SB returned to work the following day, he wrote out a report of the incident and gave it to the Health Care Center management. Subsequent to receipt of the report the Health Care Center had employe HH conduct an investigation into the incident. He spoke with individuals who were witnesses to the incident, including the grievant. He reduced his recollection of his questions and their answers to writing and supplied a copy of that information and the results of his investigation to Facility Director Mills. Mills determined that KM had inappropriately handled the situation involving client G and decided to impose a three-day suspension without pay for her misconduct. The written confirmation of that suspension and the reasons therefor appear below.

You were interviewed on November 18, 1994, by Hal

> Hallanger, Associate Director regarding an incident which occurred on November 16, 1994, at a group home in Greenwood. It was reported that you grabbed a client by the back of the neck and left arm and pushed him towards the outside patio door. Once at the door, you apparently pushed the client outside without supervision. It was felt that excessive force was used in this situation. This report was confirmed by 2 staff members and a care provider from the group home who observed the incident.
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> On August 25, 1993, you also received a written warning for using poor judgement when trying to restrain the same client. It was felt that your approach to this client was abusive and contrary to what you have been instructed to do. In that incident it was reported you had pulled the clients (sic) hair. Work instructions were issued at that time on how to properly handle this particular client. You were instructed not to use physical contact when working with this client unless he was in physical danger. You were instructed to use verbal cues when redirecting this individual.
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> The investigation of the incident that occurred on November 16, 1994, resulted in 3 people who had witnessed the incident giving corroborating reports of the situation and each person felt excessive force was used. Also taking into consideration the fact that you were given a written warning regarding an incident that occurred on August 10, 1993, involving the same client, along with the fact you were given work instructions on how to properly handle this client, your behavior in this situation is unacceptable.
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> This memo constitutes a 3 day suspension being issued to you at this time. You will be suspended without pay beginning Monday, November 28, 1994, Tuesday, November 29, 1994 and Wednesday, December 1, 1994. You will be expected to return to work on Thursday, December 2, 1994.

Subsequent to the receipt of the suspension, the subject grievance was filed. That grievance was moved through Step 3 of the grievance procedure where it was denied by the County Personnel Committee on February 27, 1995, and that denial was confirmed in writing to the Union on February 28, 1995. Thereafter, on March 16, 1995, Union Representative Newell sent the following letter to the County:

> Mr (sic) Renne, I have received your notice that the Personnel Committee has denied the above referenced grievance.

> For the record, the Union will hold in abeyance any further processing of this grievance unless more stringent disciplinary action by the Health Care Center results therefrom and/or the results of the two (2) independent agency investigations are achieved.
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> We would appreciate immediate notification of the findings of these investigations once concluded.
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> Please advise in writing to the undersigned should you not concur in the Union's course of action as stipulated herein.

The County Personnel Director informed the County Personnel Committee of the letter, but neither the Committee nor the Personnel Director responded to Newell's letter. The County Personnel Director testified that he assumed that the Union was dropping the grievance and that no further discussions were had between himself and the Union regarding moving the grievance on to arbitration after his receipt of the March 13 Newell letter. At a meeting some months later, regarding a subsequent grievance filed by the grievant in this case, the Union advised the County that it was of the opinion that the grievance contesting KM's three-day suspension was still alive and that it was moving that grievance on to arbitration.

POSITIONS OF THE PARTIES:

Employer

As indicated in KM's testimony and as reflected in Joint Exhibit No. 2, KM commenced her employment as a Personal Support Worker in July of 1992. Testimony has indicated that the Personal Support Workers occupy a unique position in that they work with a population of extremely vulnerable disabled adults. G was one of those persons. At the time KM was transferred to the Personal Support Worker position, she was provided a copy of the job description, the job description was reviewed with her by RS and during that review KM was provided the opportunity to ask any questions she might have regarding the duties and responsibilities of that position.

Not long into her career as Personal Support Worker KM encountered difficulties. Those difficulties are indicated in part by what is marked as Joint Exhibit No. 3. It is indicated in that Exhibit that on January 19, 1993, KM was issued an oral warning regarding poor judgment. Within that same calendar year, on August 25, 1993, KM was issued a written reprimand for an incident involving the same client, G, in which she allegedly pulled his hair. We have testimony from RS that KM, as well as the other support staff workers in the DD program, were not only once, but on, as RS testified, a lot of the occasions met with and had the programs with the

specific clients reviewed with them. This occurred, we know, after the reprimand on August 25, 1993, and it occurred, as RS testified, at various times before and after that. What was discussed with respect to G? We know that what was discussed was that G has some idiosyncratic behavior and that touching him is exactly the wrong thing to do. As RS testified, it only makes matters worse.

RS testified that specifically during one meeting, KM asked, "well, what if G runs in front of a car? Can we use physical contact, physical force at that time?" RS responded that while that would be a very unlikely occurrence, in that situation force would be okay. RS' testimony made it clear that it was only in situations of that degree that it was understood that force would be okay. As it turns out, force with G, unless he's in front of an oncoming car, isn't necessary. RS, SB and JS all testified that G responds very well to the blocking or redirecting technique in which KM and the other persons working with G have received specific instructions.

So this is not a case where we have a worker who was issued generic instructions to apply to a whole group of clients. In this case, we have a specific client, specific training, specific instructions with respect to that client--not once, but several times. Those instructions again included don't use physical contact, use verbal cues, use the blocking or redirecting technique. We had testimony to the affect that on numerous occasions G puts food in his mouth. That's one of his idiosyncratic behaviors. How is that handled? Witnesses testified that they redirect him, block him to a garbage can, ask him to spit, he spits the food out. The grievant would have us believe that somehow that situation with crackers on November 16, 1994, was more like G stepping out in front of an oncoming car. Yet, it was really just like the numerous other times when exactly the same situation had happened, and employes handled it appropriately and there was no problem. The grievant offers no explanation as to why all of a sudden on November 16, she saw the necessity to grab him by the back of the neck, push him toward and through the patio doors. Certainly by the time G had gotten two steps away from the crackers and someone stood between him and the crackers without even touching him, he would have complied. Surely that's the track record that all the witnesses from the County were able to substantiate.

The Union would have the arbitrator believe that somehow the grievant is a victim of vindictive behavior by her sister-in-law. Yet, her sister-in-law was subpoenaed to testify and her difficulty in making the report was the realization that it would involve a relative. Also, there was testimony from the grievant that her relationship with SB was okay. Also, we have no idea why SB would choose to inject himself in this process, but for the fact that he had a real serious concern that G had been roughed up. SB testified that he filed the statement, prepared the complaint without the assistance from JS and that once the report was filed he notified JS after the fact that he had filed the report.

RS testified that the DD program has two components. One, is to have the client in the community and familiar with being in the community; and the second is to have the community become used to the clients, and the type of behavior that should be occurring between clients and

the community. No one present in the hearing room would have personally tolerated KM's treatment of G. We might well be at the DA's office. For whatever reason, it's apparent that this employe had a tough time keeping in control when dealing with G. We had testimony that G is slight of stature, five feet tall, weighs about 146 pounds, and readily complies with a blocking or redirecting move. G could not testify about the situation because he doesn't have the mental capacity to speak on his own behalf. But when persons in the community enroll their family members in the programs and the services of the Center, they have the right to demand that those individuals be provided with caring and respectful treatment. That is spelled out in KM's job description. What the grievant did in this case is despicable; it's not within the Employer's expectations; and the County would suggest that she knew that. She knew that when she talked with HH on November 18. Why do we say that? Because not fewer than ten times when asked did you touch him, were you in the kitchen, were you involved, she said no. To come to the hearing and, after the fact, say well, I really was involved, but it was like standing in front of a car just doesn't wash. We think the only question for the arbitrator should be was three days enough.

Union

The Union's position is that the County did not have just cause to suspend the grievant for three days without pay. It believes the County's position boils down to that KM exercised excessive force and because she did that they had just cause to impose a three-day suspension.

If excessive force is going to justify or going to constitute just cause, I think at the very least the County needs to establish that there was excessive force, which they didn't do. We've got KM's testimony that she didn't exercise excessive force. We have JS' and SB's testimony, the only other two witnesses to the event, who did not testify that she exercised excessive force. They thought there was maybe a slight amount of force used. Their opinion was that there was too much pressure, but they didn't say there was excessive force. The demonstration that JS did on an observer present at the hearing did not show any excessive force. For that reason alone, the County hasn't met its burden of proving just cause because they haven't proven that excessive force was exercised.

There is an explanation for why a different technique other than the blocking technique was implemented by the grievant on this occasion. She testified that she talked with supervision about taking G to the party and there was discussion about the problem of G being around food. The supervisor stated that if there was a problem with the food G would be taken outside. This was obviously known to everyone that G had a problem around food. To say that choking on food is not equivalent to running in front of a car isn't genuine. Everyone knows that you can choke to death on food. You can get hit by a car and not die. They are both dangerous. There isn't any real difference between the two insofar as the danger a person might be in.

This is a situation where you have a care giver who is responsible for the safety of a

patient. Pushing a person who is choking outside is not like being pushed by an unknown person in a bar as management would have us believe. In this case the standard is clear, there was to be no physical contact unless there was fear of physical danger. Here in this case there was.

The County believes excessive force was used. However, based upon her discussion with management about when physical force was okay in dealing with G, KM believed this was a dangerous situation calling for her to do what she did. However, even if the arbitrator finds excessive physical force was used by KM, the penalty doesn't fit the offense. KM didn't act maliciously or carelessly toward G, she believed it was the right thing to do. There was no physical harm to G, and in fact, she may have saved G's life, we don't know. Even if there was excessive force, there was a reason, and a suspension is inappropriate. KM may not be a model employe, but her actions didn't warrant a three-day suspension. Rather, counseling or a warning letter would have been a more appropriate disciplinary action.

DISCUSSION:

The threshold issue in this case is whether the grievance is procedurally defective. The undersigned was asked to give a bench determination of that issue at the hearing and he did so. What follows is a restatement of the essence of the bench ruling.

After the Step 3 hearing, the County Personnel Committee denied the grievance on February 27, 1995, and confirmed that denial on February 28, 1995, which was County Exhibit #1. Thereafter, on March 13, 1995, Newell sent Joint Exhibit #6 quoted above to the County. Article 4, Section D, provides that the time limits may be extended "by mutual agreement in writing." Obviously, one party has to initiate the discussion regarding a request to extend the time limits. In this case, Newell's March 13, 1995 letter to the County was the initiation of that dialogue. He even stated in his letter, "Please advise in writing to the undersigned if you do not concur in the Union's course of action as stipulated herein." Upon receipt of that request, it was incumbent upon the County to either accept or deny the request, or engage in discussion concerning the request. Good business practice and common courtesy dictated that response from the County. However, the County failed to acknowledge receipt of the request or initiate an oral dialogue concerning the request. Consequently, the Union could reasonably rely upon the County's failure to respond to its request as evidence of its acquiescence in the Union's request for an extension. Joint Exhibit #6 and the County's failure to respond represented the mutual agreement to extend the time limits and the document itself constituted confirmation in writing. Therefore, the undersigned was persuaded that the grievance was not procedurally defective and directed hearing to proceed on the merits.

With respect to the merits of this case, the facts are virtually undisputed. KM had been instructed not to use physical contact with client G except when there was danger of imminent physical harm to him. Also, she had been instructed to use verbal cues when redirecting G. The problem of G stuffing his mouth with food had occurred on numerous occasions prior to the incident giving rise to this case. KM had been instructed in, and was familiar with, the techniques which the County had determined were the most appropriate for dealing with that situation.

On the day in question, when it became obvious to KM that G was stuffing his mouth full of crackers, rather than stepping between G and the bowl of crackers, causing him to move away from the crackers, KM placed her hand on the back of G's neck and took hold of his arm with her other hand and physically moved him out of the kitchen and onto the patio. At no time did KM make an attempt to step between G and the crackers or use verbal prompts to have G move away from the crackers and spit into a wastebasket.

Both care workers JS and SB observed the incident involving KM and G, and concluded that KM's handling of the matter was inappropriate and inconsistent with the instructions for dealing with such a situation. Both believed further, that KM used excessive force in dealing with the situation. The undersigned concurs with both care workers and supervision's assessment that the grievant handled the situation inappropriately and not in accordance with how she had been instructed. Was excessive force used? The undersigned believes that the answer to that question is yes, and has nothing to do with the connotation that arises from the use of the words excessive force. The demonstrations at the hearing of exactly how KM physically moved G did not establish that she roughed him up or in any other way physically abused him. However, because the instructions that had been given to all care workers, including KM, for dealing with exactly the situation that arose on this day, did not include physically touching G unless he was in imminent physical danger, KM's putting her hand on the back of his neck, taking hold of his arm, and physically moving him out of the kitchen and onto the patio was excessive force as measured against stepping between G and the crackers and otherwise verbally prompting him to obtain the desired effect. G, by stuffing crackers in his mouth, did not place himself in imminent physical danger. This was, as the testimony established, a common event with G, and easily rectified by using the blocking technique and verbal prompts. Thus, KM's handling of G in this situation did constitute use of excessive force.

The remaining question is whether the County had just cause to impose a three-day suspension without pay against KM for use of excessive force. KM had been involved in two prior incidents involving clients. On January 19, 1993, the grievant received a verbal warning for exercising poor judgment. Also, on August 25, 1993, the grievant was given a written warning for being abusive toward, and not following instructions involving the same client G. Clearly, it was appropriate for the County to take disciplinary action against KM for her conduct on November 16.

What was the appropriate level of discipline for her misconduct? The Union urges that a counseling session or reprimand would be the appropriate discipline. However, the grievant had already received a verbal and written warning regarding her conduct toward clients. Obviously, the County Personal Support Workers are responsible for vulnerable clients and are to be caring and respectful in their interaction with those clients. In this case, KM's supervisor, RS, concluded that KM's conduct was demeaning to client G and also set a bad example for other staff. The undersigned is satisfied that a suspension was appropriate in this case as a part of a progressive discipline procedure being followed by the Employer in an attempt to insure KM's compliance

with the County's rules, regulations and expectations concerning her interaction with clients. In light of that conclusion, the undersigned is not going to substitute his judgment for that of the County's in assessing the duration of the suspension, as long as the suspension was not unreasonable. In this case, I do not believe that a three-day suspension was unreasonable under the circumstances surrounding the incident, and the grievant's prior disciplinary history. Therefore, I conclude that the County did have just cause to impose a three-day suspension without pay upon the grievant KM for her misconduct in dealing with client G on November 16, 1994.

AWARD

1. KM's grievance contesting her three-day suspension was procedurally arbitrable.

2. The County did have just cause to suspend the grievant, KM, for three days without pay for her actions on November 16, 1994. Therefore, the grievance is denied.

Dated at Madison, Wisconsin, this 23rd day of April, 1996.

By Thomas L. Yaeger /s/
Thomas L. Yaeger, Arbitrator