IN THE MATTER OF ARBITRATION	)	
	)	
BETWEEN	)	ARBITRATOR'S OPINION
	)	
ISLAND COUNTY DEPUTY SHERIFF'S GUILD,	)	AND AWARD
	)	
	)	GRIEVANCE OF
Guild,	)	
	)	PAMELA McCARTY
and	)	
	)	
ISLAND COUNTY SHERIFF'S OFFICE,	)	
	)	
Employer.	)	

HEARING SITE:	Island County Administration Office Coupeville, Washington
HEARING DATES:	March 29, 30 & 31, 2016
POST-HEARING BRIEFS DUE:	Postmarked May 6, 2016
RECORD CLOSED ON RECEIPT OF BRIEFS:	May 9, 2016
REPRESENTING THE GUILD:	James M. Cline Sarah E. Derry Cline and Casillas 520 Pike Street, Suite 1125 Seattle, WA 98101
REPRESENTING THE EMPLOYER:	Charles W. Lind Patterson, Buchanan, Fobes & Leitch, Inc., P.S. 2112 Third Avenue, Suite 500 Seattle, WA 98121
ARBITRATOR:	Gary L. Axon P.O. Box 190 Ashland, OR 97502 (541) 488-1573

I. INTRODUCTION

This case arises out of the termination of Pamela McCarty (Grievant) by the Island County Sheriff's Office (Employer) on June 24, 2015. At the time of her termination, Grievant was a Lieutenant at the Island County Jail (Jail). Her immediate supervisor was Jail Chief William "De" Dennis. The Sheriff of Island County is Mark Brown and the Undersheriff is Kelly Mauch. The Island County Deputy Sheriff's Guild (Guild) filed a grievance alleging that Pamela McCarty had been terminated without just cause. When the Employer denied the grievance, the Guild advanced the case to arbitration.

II. STATEMENT OF THE ISSUE

The parties did not agree on a statement of the issue. Based on the submissions of the parties, the Arbitrator formulates the issue to read:

> Did the Employer have just cause to discharge Lieutenant Pamela McCarty for the reasons set forth in the Notice of Termination? If not, what is the appropriate remedy?

The parties stipulated that in the event a remedy is ordered, the Arbitrator shall retain jurisdiction to resolve any disputes that might arise under the implementation of the ordered relief. If the grievance is denied, there will be no remedy.

III. RELEVANT CONTRACTUAL PROVISIONS

ARTICLE 6 DISCIPLINE AND DISCHARGE

> 6.1 Just Cause – The Employer shall not discipline any non-probationary employee unless just cause for such discipline exists. Probationary employees may be disciplined with or without cause.
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> ...

ARTICLE 18 WAGES

...

18.4 When there is no Lieutenant or Sergeant on duty a temporary assignment may be made from among qualified Corrections Deputies designating someone as lead. The Sheriff, under his prerogative to operate and manage its own affairs in all respects in accordance with lawful mandate, would make this assignment. The assignment would be for a particular shift. Pay would be provided for the hours actually performing the lead duties. Compensation for being assigned and performing lead responsibilities would be $0.75 per hour in addition to the Deputy's normal rate of pay as listed in Appendix B.

...

ARTICLE 20 MISCELLANEOUS

20.1 Rules and Procedures Manual – The Employer shall furnish each employee with a copy of applicable Manual(s). New employees shall be provided with the above at the time of their appointment. The Employer shall provide the Guild with a written copy of proposed policy changes at least twenty (20) days before the effective date of the changes and shall discharge its obligation under RCW 41.56.

...

IV. STATEMENT OF FACTS

The Sheriff's Office is a small department in rural Island County, Washington. The focus of this case is the Island County Jail where an inmate (KF) was found dead at 12:30 a.m., Wednesday, April 8, 2015 while in the custody of the county. The Island County Jail is a county jail facility administered by the Island County Sheriff's Office. The Island County Jail contains 58 beds, 52 of which were occupied on April 7, 2015. The Island County Jail has three floors, two of which are used for housing inmates. The lower housing floor has four cell blocks: two cell blocks (A Block and B Block) each containing five beds and a common area for inmates. A third cell block (C

Block) has three beds and a common area for inmates. A fourth cell block (D Block) contains two individual cells with one bed each--these two cells share a common area with a shower.

The upper housing floor, or Floor 2, contains six additional cell blocks to house inmates: E Block and F Block are each open dorm-style blocks containing eight beds and a common area. I Block and J Block are each a double-tiered area with five individual cells on each tier (for a total of ten individual cells) and a common area. G Block contains a common sally port area with three individual cells, one of which has the capacity to house two inmates. G Block is designated for special needs or medical segregation of inmates. H Block similarly is used for special needs or the medical segregation of inmates.

Floor 2 contains the administrative offices, the booking area, a padded safety cell, two interview rooms, five visitation rooms, and the deck station. The deck station is a common work area for deputies where the daily log, passdown log, inmate books, and employee mail boxes are located. This is also where the binder containing Policy 538, necessary documentation forms, and the Chief's memoranda are kept.

During the time period March/April 2015, the Island County Jail had 18 staff assigned. Chief Dennis was responsible for all of the operations of the Jail and in charge of all Jail employees. Grievant McCarty was a member of the administrative team, the only Civil Service Lieutenant working in the Jail during the relevant time period. Until November 2014, McCarty had shared supervisory duties with Operations Lieutenant Steve Timm. Timm stopped working in the Jail around November 2014 when Chief Dennis and Lieutenant McCarty split the responsibilities that Timm had

been overseeing. The remainder of the 16 staff assigned to the Jail were corrections deputies, subordinate to the Chief and Lieutenant. If neither the Lieutenant nor the Chief were on duty, a corrections deputy would work as a lead officer to supervise the shift.

Medical services at the Jail were contracted through the Department of Health. David Young was a physician's assistant and provided medical services and Nancy Barker was the nurse who worked in the Jail. Neither of these employees was assigned to the Jail full time. The nurse worked 32 hours each week but split the time between the Island County Jail and the juvenile detention facility. Both Young and Barker stopped working in the Jail after the April 8, 2015 incident.

The events that ultimately resulted in the termination of Grievant began when KF was first taken into custody on March 21, 2015 at the Snohomish County Jail. KF was a 25-year old man who had significant mental health issues. KF was arrested in Lynnwood on an arrest warrant issued by San Juan County. The Snohomish County Jail's mental health professional approved KF for transport to Skagit County. On March 24, 2015, KF was shuttled to the Skagit County Jail. He arrived at the Skagit County Jail in a restraint chair and would not speak to staff. San Juan County does not have a jail that would accommodate KF so pursuant to an agreement between the two counties, KF was to be held in the Island County Jail. During this period of time, while he moved from jail to jail, KF displayed unpredictable conduct and behaviors that suggested he had significant mental health issues. Prior to his arrival at the Island County Jail, Island County had notice of KF's mental problems.

On Thursday, March 26, 2015, KF arrived at the Island County Jail where he was immediately placed in the safety cell and a safety cell observation log was started. McCarty initiated this log and she gave the reason for watching KF because of his unruly behavior and a description of his clothing. McCarty did not work Friday, Saturday, or Sunday following KF's incarceration. McCarty returned to work on March 30, 2015. McCarty and Dennis talked it over about whether to take KF off safety cell procedures. Corrections deputies documented direct visual observations that occurred while KF was in the safety cell. The deputies documented each time KF was provided fluids and meals. KF was kept in the safety cell for the next four days, from March 26 through March 30. The log showed that over the four days, KF repeatedly refused food and water. None of the Jail supervisors or correction deputies took the time to make an effort to actually observe KF consuming food and water. At 4:15 a.m. on March 30, KF was offered water but refused. He was offered breakfast but he refused it as well.

Nurse Nancy Barker returned to work from a vacation on Monday, March 30, 2015. Nurse Barker did not perform a medical assessment of KF on March 30, 2015. Nor was there a mental health assessment or documentation of a health professional's recommendation. KF's aunt was allowed to visit while he was still confined to the safety cell. Grievant McCarty and Jail Chief Dennis made the decision to move KF out of the padded safety cell. When Grievant and two corrections deputies opened the door to KF's cell and tried to coax KF out, he had food in his hair and food debris scattered around the cell on the floor. KF crawled around the floor and then began eating crumbs of food off the Jail floor. KF was moved to a cell in D Block and

removed from the safety cell procedures. Grievant documented no explanation for her decision to remove KF from the safety cell.

KF was placed in restraints and moved by two deputies to the D Block who noted KF was dirty and covered by food that he had not eaten. One of the deputies obtained a clean smock and a blanket for KF. On either March 31 or April 2, while KF was in his cell, corrections deputies looked in and saw that he had something in his mouth, like a rag or cloth. There is a dispute as to whether KF was coughing into the rag or whether he was choking on the rag. The deputies went to McCarty for guidance. McCarty told them to "leave that man alone," because he did not like being touched as evidenced by his behavior when he was transported between jails.

On April 1, 2015, San Juan County deputies transported KF to the court. While in court, KF saw his mother and refused to speak with his lawyer. The court entered an order that KF be evaluated at Western State Hospital (WSH) to determine his competency. WSH refused to take KF because of limited bed space so he was sent back to the Island County Jail. This was done despite the court order to send KF to WSH for evaluation.

On April 4, KF was noted as not eating or drinking. On April 4, KF flooded his cell D-2. A corrections deputy testified at the hearing that water was running out from the cell to the sally port and KF was found rolling in several inches of water. The corrections deputies were concerned that KF might develop hypothermia, and put KF in a shower to warm him up. KF was also temporarily placed back in the safety cell while D-2 was cleaned and drained. Later that day, KF was found putting his head into the toilet and rolling around the floor. He was taken back to the shower, and then moved to

a new cell in the H Block. All the water was turned off in H-2. KF was once again completely dependent on the deputies for water.

On April 5, 2015, corrections deputies began safety cell procedures again for KF. Neither McCarty nor Acting Lieutenant Bingham was at work when this occurred.

On Monday, April 6, Grievant returned to work after the weekend, as did Nurse Barker. Nurse Barker and McCarty went to KF's cell for his first medical assessment. McCarty did not stay at the cell and returned to the deck station across the hall. Nurse Barker was not allowed into the cell to conduct the assessment. Instead, Nurse Barker was compelled to do her assessment by merely talking to KF through the cell door. Barker concluded her assessment without any hands on contact with KF.

At 10:30 a.m. on Monday, April 6, 2015, a mental health professional came pursuant to the court's order. The mental health professional was there to assess KF's competency for trial. The mental health professional's observation was quick and he did not stay. KF continued to refuse water or would drink some of the water before spilling it on the floor. On April 7, KF refused breakfast. He was documented lying on the floor most of the day. There is no indication he was offered water until lunch at 11:30 a.m. when he was provided lunch and given water. This was the last log observation until 3:00 p.m. At 3:00 p.m. on April 7, 2015, he was noted sleeping on the floor.

KF was found dead at 12:30 a.m., Wednesday, April 8, 2015. A coroner said that KF was likely dead long before the cell check log suggested that he was still

alive. McCarty was not on duty at the time KF's body was discovered. McCarty was called into the Jail immediately following KF's death. Jail Chief Dennis was across the state and not available to come in to participate in the investigation.

Detective Ed Wallace of the Sheriff's Office was designated to conduct the death investigation. He interviewed all of the Jail staff, including Chief Dennis and Lieutenant McCarty. He collected documentation including the coroner's report. Wallace completed his investigation and signed it on June 9, 2015. After reading Detective Wallace's report, Sheriff Brown was stunned to realize that there had been significant failures by his Jail staff in implementing and carrying out the safety cell procedures that might have helped this deceased man. Chief Dennis was placed on unpaid leave and by June 23, 2015, the decision was made that Dennis would leave the Sheriff's Office. It was publicly announced that Chief Dennis retired.

On June 17, 2015, Sheriff Brown notified McCarty that she was believed to have violated Policy 538 and Policy 340.3.8 related to supervisory responsibility. The noticed informed her that the Sheriff was considering demotion from her position as a Lieutenant. On June 19, 2015, the Sheriff sent a supplemental notice that advised McCarty that he was considering discipline up to and including termination. The Sheriff testified at the hearing that he had read the report over and over and had come to the conclusion it was unlikely he was going to be able to retain McCarty in the Sheriff's Office. Prior to the second notice, McCarty believed that she would not be subject to termination based on the fact that the Sheriff and Undersheriff had advised McCarty that she was not going to be terminated. A *Loudermill* hearing was held on June 23, 2015. Sheriff Brown terminated McCarty during her June 23 *Loudermill* hearing. The

Loudermill hearing lasted about 20 minutes. The day after the *Loudermill* hearing, Sheriff Brown sent McCarty a letter stating in relevant part as follows:

...

> On June 17, 2015, you were placed upon paid administrative leave pending the completion of the investigation conducted by Detective Wallace. Detective Wallace's investigation revealed that you:
>
> - Failed to properly supervise jail staff;
> - Failed to take appropriate action to ensure employees adhered to policies and procedures;
> - Failed to inspect safety cell logs for completeness every two hours and to document that action on the safety cell log as required of jail supervisors;
> - Failed to review the appropriateness for continued retention of KF in the safety cell; and
> - Failed to request a medical or mental health assessment of KF if appropriate.
>
> I have thoroughly and repeatedly reviewed the investigative materials which you were provided. In doing so, I have looked at the events leading to KF's death from all perspectives. While I do not question your integrity, you admit that you engaged in the acts and omissions described above, and I have concluded that your acts and omissions violated the following Island County Sheriff's Office Policies:
>
> - Policy No. 538--Safety Cells and Sobering Cells
> - Policy No. 340.3.8--Conduct--Supervision Responsibility
>
> Unfortunately, in addition to violating policy, your acts and omissions contributed to the systematic failures that may have prevented staff from properly recognizing and identifying and addressing the health conditions leading to the death of inmate KF. These acts and omissions, considered individually or collectively, constitute just cause (good cause) for your termination. The primary obligation of

an elected Sheriff is to protect the people of the community we serve, including those we hold in our custody. It is my responsibility to ensure that the Sheriff's Office's supervisors and leadership meet expectations and comply with policies and procedures that have been put in place to protect staff and inmates alike. If our supervisors and leadership fail to adhere to the policy, the safety and security of the jail is compromised and the community's confidence in our work is eroded.

...

Your acts and omissions demonstrate poor professional judgment and a failure to supervise. Of further concern is your lack of awareness of the importance of supervision and maintaining appropriate role modeling that you displayed during our conversation. During the pre-determination meeting you focused solely on whether the failure to check a log every two hours and make a written notation thereof would cause the death of an inmate. Your focus on the singular effect of not checking the logs misses the bigger picture, which is the fact that your failure to properly supervise the deputies who were monitoring KF constitutes a major component of the systematic failure of this office in its housing of KF. It is impossible to predict with certainty, but had KF been properly supervised and monitored, staff may have more quickly identified and addressed the health conditions leading to his death.

...

Your failure to properly supervise jail staff with regards to the care of KF was egregious. You admittedly failed to follow and enforce policies that are key in maintaining the health and safety of inmates. Moreover, your apparent lack of awareness of the importance of your supervisory role in implementing and executing policies that are designed to prevent failures such as those that occurred in the housing of KF is alarming and unacceptable. I find that your conduct rises to the level of just cause, and that termination of your employment is justified and necessary.

...

Er. Ex. 50; emphases added.

The Guild filed a formal grievance concerning the dismissal of Lieutenant Pamela McCarty alleging violations of Article 5 and Article 6 of the Collective Bargaining Agreement claiming the termination was without just cause. In the grievance, the Guild asserted McCarty did not violate the alleged policies and any such violations do not warrant termination. Guild Ex. 17.

Sheriff Brown denied the grievance at Step 3 in a letter dated August 10, 2015. Er. Ex. 51. Sheriff Brown reasoned that Grievant's "failure to properly supervise the deputies who were monitoring KF and failure to abide by office policies constituted a major component of the systematic failure of this office in the housing of KF." Sheriff Brown also restated his claim made in the termination letter that "your failure to properly supervise jail staff with regard to the care of KF was egregious." The Guild notified the Sheriff that it was moving the grievance to arbitration.

A hearing was held at which time both parties presented numerous exhibits and witnesses to support their respective positions. Post-hearing briefs were timely filed. The grievance is now properly before the Arbitrator for a final and binding decision.

Your Arbitrator in this Award has not sought to restate all of the information and times recorded in the logs concerning KF. I have identified key points in the chain of events that led to the tragic death of KF.

There is a major issue in this case concerning the policy violations the Sheriff cited in his termination letter. The Guild asserted that the policies were in a state of disarray regarding their adoption, and the policies were implemented without proper training. The Sheriff's Office subscribed to the Lexipol program and received their

model policies, as well as regular updates to those policies. Lexipol polices are provided by a private company that develops model policies and procedures for law enforcement agencies. Lexipol policy format became the policy format for the Sheriff's Office and appears in several exhibits admitted at the hearing. Lexipol policies are models that can be adopted or modified to meet the needs of a particular agency. The testimony shows that some of the policies could be taken straight off the shelf and applied to the Island County Jail while others had to be modified to fit the Island County Jail. The Sheriff authorized the Undersheriff to work with the Jail Chief to get the Jail's specific Lexipol model policies in place that would revise the Jail's custody manual. Chief Dennis undertook to modify the policies so they could be applied to a small correctional facility such as the Island County Jail. Detective Wallace testified that the implementation of the policies at the Jail was "a train wreck."

The Employer rejected the Guild's arguments that safety cell procedures in Policy 538 had not been properly adopted and implemented. This issue will be addressed later in the Award.

Following Detective Wallace's report, the Sheriff's Office brought in a jail expert, Phil Stanley, to evaluate the Island County Jail. Guild Ex. 1. According to the Sheriff, an outside evaluation was necessary because Wallace's report "revealed errors in documentation" and that they "couldn't prove that we didn't have ownership" of the death. The Stanley Report that was released in September 2015 criticized the Island County Jail for a lack of training and lack of enforcement of policies and procedures. The Stanley Report stressed the importance of the immediate development of a sound operating policy and procedure for the Island County Jail. The Stanley Report identified

specific examples where the Jail required additional resources. The Stanley Report will be discussed in detail in the subsequent sections of this Award.

At the hearing, the parties were given the full opportunity to present written evidence, oral testimony, and argument regarding the issues set forth in this dispute. Both the Guild and the Employer provided the Arbitrator with substantial written documentation in support of their respective positions concerning the termination of Grievant McCarty. Testimony was taken over three full days of hearing. Counsel also submitted comprehensive and detailed post-hearing briefs in further support of their positions taken at arbitration. The approach of your Arbitrator in drafting this Award will be to summarize the major, most persuasive evidence and arguments presented by the parties in this case. Even though I carefully considered all of the evidence and arguments offered by the parties, I will only state the basic findings and reasons that caused your Arbitrator to make an Award in this case.

V. POSITIONS OF THE PARTIES

A. The Employer

The Employer begins by addressing the policy arguments offered by the Guild at the arbitration hearing and expected to be elaborated on in the post-hearing brief. The Guild asserted that Policy 538.3 was not technically a policy, and thus the claim that McCarty violated the policy cannot be sustained. The Guild similarly complains that the procedures of Policy 538 cannot be a directive because the Sheriff or the Undersheriff did not issue it. The Employer believes these claims are without merit.

The procedures of Policy 538.3 were implemented by the Sheriff's Office at the direction and under the authority of both the Sheriff and the Undersheriff. There

was no confusion by either the Jail administration or the Jail staff that they were under an obligation to comply with the procedures. Grievant McCarty testified she clearly understood these procedures were to be followed as staffing and resources would allow. She had an obligation to not only learn these procedures, but to see that the corrections officers were familiar with and followed the procedures. She failed in both respects. The procedures implemented at the Jail were critical to the health and safety of vulnerable inmates, and yet were implemented sloppily and inconsistently by the Jail administration.

The Arbitrator should not lose sight of the fact that KF died of malnutrition and dehydration after spending 11 days in the Island County Jail. The Guild mistakenly contends that:

> (a) 538.3 could not really be a "policy" of the Sheriff's Office because the Sheriff didn't go through the policy-making process;
>
> (b) that Policy 538.3 could not be a "directive" because it was issued by the Chief of the Jail, and not the Sheriff; and
>
> (c) that any real policy would have been vetted through the Guild pursuant to relevant provisions of the Collective Bargaining Agreement.

The Employer counters that the Guild's position is without merit. The Sheriff referred to Policy 538 as a policy in his testimony and his letters to McCarty. No one denied that the policy had been put into place and staff was to follow it. McCarty, herself, called the safety cell procedures "mandatory" and said failure to carry out those requirements would be a disciplinary offense. McCarty acknowledged the safety cell

policy was in effect when she came back from vacation in the middle of November 2014. Corrections deputies who testified and/or provided statements agreed.

Sheriff Brown made it clear in his testimony that the safety cell processes of Policy 538 were issued by Chief Dennis in November 2014 for staff and they were mandatory. Policy 538 was issued through the chain of command. The Sheriff authorized and directed that the procedures from Lexipol be implemented, the Undersheriff worked with Chief Dennis, and the Chief issued the safety cell procedures of Policy 538.

The evidence shows the staff in the Jail was under no misimpression about the safety cell procedures, that they were mandatory and that deputies were to follow the procedures. McCarty readily acknowledged that she read the policies when they were issued and even objected to some of the provisions with the Chief. She was told to make it work.

Finally, any argument that implementation of Policy 538 without having first sent it to the Union is--in this context and under the facts of this case--irrelevant to the issue that is currently before the Arbitrator.

In sum, the Arbitrator should conclude that Policy 538.3 contained a set of procedures required by the Sheriff, implemented by the Jail Chief, and known to all Jail staff including Grievant McCarty, that these procedures were in place and that everyone in the Island County Jail was to follow them.

The Employer next argues there is just cause for the termination of Lieutenant McCarty. The Employer followed the guidelines of the seven tests for just

cause that were articulated by arbitrator Carroll R. Daughtery in *Enterprise Wire Company*, 46 LA 359 (1966). The Employer's arguments are summarized as follows:

1. The Employer gave Grievant McCarty adequate forewarning of the possible disciplinary consequences of her conduct.

The testimony adduced at the hearing showed that the safety cell procedures are intended to ensure that the Island County Jail is a place of safety for inmates who require special attention or pose a danger to themselves or others. As a 30-year employee, Grievant should clearly understand the purpose of the safety cell procedures and the importance of following those procedures. When an inmate dies in a jail's care and custody, the inmate might otherwise be saved through proper execution of protective house procedures in a safety cell. The failure to carry out those protective measures is serious misconduct that could obviously result in significant discipline up to and including termination.

McCarty acknowledged that she was unfamiliar with the procedures of Policy 538, but she knew they were mandatory and needed to be carried out. When KF was placed in a safety cell and the procedures were triggered, Grievant did nothing to review the protective safety cell procedures at the deck station to confirm that she was acting in strict compliance with the Jail's rules. According to the Employer, Grievant was responsible for ensuring that employees adhere to the Jail's policies, procedures, and standards for keeping inmates safe. This conclusion is even more obvious in the instant case where an inmate dies of malnutrition and dehydration while in the facility's custody and care for nearly two weeks.

The Employer argued McCarty's failings were primarily four-fold:

> a. McCarty did not bother to learn or better acquaint herself with the procedures she knew had been implemented and--as she testified--after she was told by the Chief to "make it work, do what you can."
>
> b. McCarty did not enforce or ensure that the corrections officers were following the procedures because she had no general understanding of the procedures herself.
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> c. McCarty did not follow the procedures as required because she was ignorant of the basic requirements.
>
> d. The procedures were readily available in an accessible white binder conveniently located at the deck station. McCarty did not bother to refresh her recollection or confirm that she was correctly following the procedures during the twelve days KF was in the jail.

Grievant did not have KF medically checked out during the four days he was in the safety cell. She did not have Nurse Barker assess him on March 30, even though both Barker and McCarty were working on that day. In addition, McCarty did not insist on having KF assessed regarding his mental health, saying instead that she assumed it would be San Juan County's obligation. McCarty removed KF from the safety cell protections without any sound explanation for doing so on March 30 and transferred him to the D cell without safety cell observations. When McCarty was told by staff that KF had stuffed something in his mouth while in D Block, she never bothered to investigate and even ordered her corrections officers not to enter KF's cell. The Employer submits that Grievant's apathy and neglect in this case were palpable. In summary, the Employer submits Grievant knew or should have known that this pattern of missteps could subject her to serious discipline.

2. The procedures of Policy 538.3 were reasonably related to the orderly, efficient, and safe operation of the Jail and performance that would be expected of the Jail's second in command, Lieutenant McCarty.

The safety cell process is directly related to the orderly, efficient, and safe operation of the Jail. Supervisors must ensure that employees adhere to the policies and procedures of the department and must document or report failures to comply with such policies and procedures. McCarty rendered herself incapable of ensuring that corrections officers were adhering to the procedures of Policy 538.3 because she was ignorant of them and did not bother to review them.

3. Before disciplining McCarty, the Island County Sheriff's Office launched a thorough investigation of KF's death that revealed whether staff (including McCarty) had violated the procedures put in place to protect inmates.

Detective Wallace interviewed McCarty and other staff in May 2015. Wallace's report showed a significant failure to supervise Jail staff and failure to take appropriate action to ensure the employees adhered to the policies and procedures of the department. Sheriff Brown also said the investigation revealed that Jail procedures had not been followed by Grievant McCarty because she failed to inspect the logs as a supervisory person and failed to obtain a medical or mental assessment of KF. The bottom line is that the Sheriff's Office launched a thorough and exhaustive review of the facts, circumstances, and procedural failures that contributed to KF's death with an experienced law enforcement detective. Grievant had the opportunity to consult with counsel and Union representatives to provide additional information or details of which the investigator might not have been aware. No additional details were provided.

The Guild argued that the Stanley Report was still in process and should have been completed before the Sheriff made his decision. However, this claim is without merit as the Stanley Report was begun on July 20, 2015 to analyze the Island County Jail organization and operational practices. In his report, Stanley made no bones about the failings of the Jail Chief and its Lieutenant. There is no evidence that waiting for the Stanley Report would have made any beneficial impact on the Sheriff's decision regarding Grievant's employment.

4. The Employer's death investigation, as well as the audit of the Jail by Stanley, were fairly and objectively conducted.

The investigatory report demonstrates that Detective Wallace showed no impartiality or favoritism when he wrote his findings and conclusions. He candidly revealed through investigations with staff that the safety cell procedures implemented by Chief Dennis, and of which all corrections deputies were aware, were not being consistently followed or enforced. McCarty's role as Lieutenant would have made her the one to work with her Chief, take the initiative, and provide such training to the corrections deputies so they knew and understood the requirements of Policy 538.3. It does not take training to simply read the policy and become familiar with that policy, especially for a 30-year veteran of the Jail. Grievant cannot shift blame to the Acting Lieutenants and lead officers who were merely line officers thrust into the temporary role of a supervisor for limited periods of time.

5. The Sheriff had ample evidence that McCarty had failed to follow the procedures put in place to protect an inmate's health and safety, and had thus allowed a mentally ill inmate to simply die of malnutrition and

dehydration who spent nearly two weeks in the Jail's custody and care.

The record shows the Sheriff had ample evidence that McCarty failed to learn the policy, failed to understand the new requirements for safety cell procedures, and failed to enforce those procedures among her staff. Grievant McCarty demonstrated an utter failure of leadership in the Jail in this area, and an inmate died without having had the medical care, mental health assessment, and nourishment/water that the procedures required. In the middle of Grievant's shift on the day KF would die, there are no recorded cell checks for more than three hours, despite the requirement that KF be checked hourly. He had no water, because the water was shut off, and he died within hours. McCarty was never aware that cell checks were not occurring and water was not being given to KF because she did not check the logs. As McCarty said to Detective Wallace: "I didn't do my job." The Sheriff had ample evidence to make the decision that he did.

6. The County applied its rules and penalties evenhandedly and without discrimination to both of the Jail's senior administrators.

Both McCarty and Chief Dennis were separated from employment. McCarty was second in command of the Jail and all corrections officers were subordinate to her. She is responsible by her job description in Policy 340.3.8 to enforce the policies, procedures, and standards of the Jail and to see that they were carried out. When the institution failed, the Chief and the Lieutenant failed, because they failed to do anything to ensure that the safety cell procedures of Policy 538.3 were followed. Chief Dennis and Grievant were responsible for running the Jail in

accordance with the adopted procedures. Because they failed, the rest of the Jail staff failed to follow the procedures. McCarty was not treated any differently than her Chief. She was not merely a correctional officer, nor was she in a temporary shift role with simply supervisory responsibilities. McCarty was the Lieutenant for the Jail and her discipline reflects the level of responsibility with which she was charged.

7. The decision to terminate Lieutenant McCarty was reasonably related to her significant failures in this matter and the flagrant disregard that she demonstrated for an inmate's well being.

None of the first six tests should be in dispute in this matter. The only question should be whether McCarty's failure to meet professional expectations and the significant consequences that flowed from that failure supported her termination. KF was first housed in a safety cell and McCarty had plenty of advance warning of his mental health condition and behavior. Grievant failed to get KF a medical check or a mental health assessment during his time in the safety cell. She did not enforce that he be given water hourly, as required by the procedures. Although KF was offered meals, Grievant did nothing to confirm that he was consuming the food or drinking the water that he did receive. Grievant did nothing to confirm the cell checks had been occurring hourly, and that KF had been given water every hour in her absence. Grievant did nothing to confirm whether a mental health assessment had occurred or was ever going to occur--she simply assumed the neighboring county where he was charged with a crime would take care of that.

After KF was in the safety cell for four days, Grievant had him removed from the procedures without explanation other than she thought it was not necessary.

This was done despite the fact that KF resisted the movement, laid on the floor, and began eating food debris from the floor. McCarty knew that any cell could be designated as a safety cell under the procedures of Policy 538.3. She removed him from the procedures of Policy 538.3 without documenting why, as required by the procedures themselves.

While in D Block, KF demonstrated that McCarty should never have removed him from the protections and observation inherent in the safety cell. From March 30 to April 4, KF was in D Block without hourly observation. KF was found with something stuck in his mouth by Jail officers, and Grievant did nothing about it when told. In fact, she ordered the officers not to enter the cell to assist KF. KF stuffed his pillow into the toilet and flooded his room twice. The second time he had been lying in the water of his cell for so long that his fingers were pruning and he was so cold that officers rushed him to a warm shower. KF being in D Block without the safety cell procedures was directly related to McCarty's failure of leadership.

On April 6, 2015, the nurse finally visited KF while McCarty stood outside. McCarty herself said that the nurse was not allowed into KF's cell. Had Grievant taken ownership of KF's safety and stayed on-hand for this critical medical check, she might well have realized that Nurse Barker's medical assessment was woefully inadequate. McCarty failed to notice the red flags that KF had sent out with regard to his health. McCarty's flagrant disregard for the effectiveness of Nurse Barker's medical evaluation kept her from being privy to this information as well.

McCarty did nothing to see the cell checks were being done consistently and effectively while KF was in H-2. It is difficult to know whether the cell checks were

truly occurring at all, since two corrections deputies admitted that they had falsely filled out the cell check logs. KF was in a cell with his water turned completely off, and he had to drink what was offered to him by the corrections deputies.

On April 6, he refused breakfast and later refused lunch. He also refused water and his dinner that evening. No more water is documented the rest of the day until 7:30 p.m. For the second day in a row, KF refused breakfast and later was found on his cell floor moaning. The log says he was fed lunch and water at 11:30, but nothing documents that he actually ate or drank. At 4:35 p.m., the deputy who falsified the entry claims that KF took food and water from him. KF was never observed standing again. According to the coroner, KF likely died shortly after the deputy's meal entry.

At no point did McCarty seem concerned about KF's physical and mental well being beyond simply housing him in the Jail. She did not reference the safety cell procedures or confirm that she was following them correctly. She did not take any initiative to see that KF was actually consuming food and water, even though she knew he was mentally ill.

The Employer asserts that McCarty's flagrant disregard of safety cell procedures is shocking for a jail administrator with 30 years of corrections experience. The egregious pattern of failure over nearly two weeks is sufficient to sustain the Sheriff's determination that just cause existed for the termination of both McCarty and the Jail Chief, as well as the medical staff and corrections officers who falsified the logs. McCarty was an integral part of the Jail's failure to keep KF alive while he was in their custody. The Arbitrator should uphold her termination.

Although, the Employer maintains that just cause for the termination has been established by these facts, the Employer recognizes that the Arbitrator could agree with all of the facts proven and still disagree with whether discharge was an appropriate remedy. If that were the case, the Sheriff's Office would respectfully ask the Arbitrator not to return McCarty to her former position as a Lieutenant in the Jail. If the Arbitrator were to return her to employment, the Employer would ask that at most she return as a corrections deputy, where her experience and knowledge could serve her colleagues.

In conclusion, Island County respectfully requests the Arbitrator find the Sheriff had just cause to terminate Pamela McCarty from her employment as a Lieutenant in the Island County Jail. McCarty failed to effectively carry out the mandatory safety cell procedures contained in Policy 538.3. McCarty also failed to properly supervise the Jail's corrections deputies contrary to Policy 340. Her flagrant disregard of the written procedures that were readily available to her when the time came to put them into practice had a serious and horrific impact.

For all of the above-stated reasons, the Arbitrator should sustain the Employer's position and deny the grievance in its entirety.

B. <u>The Guild</u>

The Guild begins by arguing the Employer has the burden to prove that it terminated Pamela McCarty for just cause. Like the Employer, the Guild cited the seven tests for just cause as set forth by arbitrator Daugherty. The Guild argued that over the years the seven tests for just cause have evolved into 19 factors that must be reviewed by an arbitrator in evaluating the propriety of the termination penalty.

The Guild next argued that McCarty did not just lose her job. As a practical matter, a sustained termination will end her career in corrections. Therefore, the Arbitrator should consider applying the beyond a reasonable doubt standard, and at the very least, apply not less than the clear and convincing standard. McCarty has been singled out as the responsible party for the death of a young man, which carries enormous stigma. Until such allegations are dismissed, McCarty would likely be without a future in the law enforcement career that she might otherwise have. The bottom line is the Employer failed to prove even by clear and convincing evidence that management complied with all applicable just cause standards.

The Guild framed its arguments around the seven tests for just cause plus the inclusion of the additional factors that the Guild believes are relevant to this case. The Guild's position is summarized as follows:

1. The Employer failed to prove by clear and convincing evidence that management provided reasonable notice of the revised safety cell rules.

Just cause requires an employer provide reasonable notice of rules. Employees should not be disciplined for a violation of a rule that the employee did not know about. The burden is on an employer to prove that the employee must have had either actual or constructive notice of the rule. Incorporated into the notice requirement is the obligation that the rule be articulated and administered in a clear and consistent manner so that employees may be fairly held accountable for a violation of the rules. The employee must have forewarning that the consequences of the behavior would lead to discipline.

In the present case, the Employer did not provide reasonable notice of the revised safety cell rule because management never properly distributed a final or consistent version of the rule to employees or acquired their acknowledgment that the rule was ever in effect. The only portion of the safety cell rule that the Employer can establish was the name change from the "behavior modification module" to "safety cell." A new form was introduced that required staff to indicate what clothing an inmate was wearing and how often they should be checked. Chief Dennis's memos specifically enacted this policy change. The Guild maintains that this is not the policy McCarty was accused of violating.

Lexipol 538 has been lumped in with these changes, but the Employer has presented no evidence that Lexipol 538 was ever actually implemented. The two memos upon which the Employer bases their argument contain no direct mention of Lexipol policies, including the portions McCarty was terminated under. Guild Ex. 12; Er. Ex. 6, p. 82. Deputies did not remember seeing anything about Lexipol in their passdown log. Grievant did not learn about any changes until mid-November 2014.

Chief Dennis, who promulgated the rule, testified that Lexipol 538 was a "guideline" and was set out for staff feedback. Dennis stated both to Detective Wallace and at the hearing that Lexipol 538 could not be followed because the Jail lacked certain necessary resources to implement Lexipol 538. Dennis further advised Wallace that it would be ridiculous to give the staff marching orders that could not be followed. There were two separate versions of the policy floating around the Jail. The policy is clearly labeled "draft." Both versions of Lexipol 538 were undermined by the form Dennis directed staff to use because the form allowed staff to select whether safety cell

checks could be performed every 15 minutes, every 30 minutes, or every hour. Er. Ex. 7, p. 89. It is no wonder that Detective Wallace candidly admitted that the Jail's policies were a "train wreck."

The Employer simply cannot meet the burden to show that certain changes in the safety cell policy were clearly implemented; Lexipol 538 was never formally implemented. At most, the Employer can show that McCarty stated she read the Lexipol policy at some point, but she apparently did not take in every line. The Employer also argued that McCarty had constructive notice of the rule, but this ignores that Dennis himself was not following the two-hour check requirement. Even if the Employer can demonstrate Grievant had constructive knowledge of the rule, McCarty saw her direct supervisor was not following the rule, so she had no reason to believe it was in effect. This is particularly true given the fact the policy was submitted with the stamp "draft" and was considered a guideline that was circulated for feedback from the correction deputies.

The Employer cannot establish McCarty knew about the medical assessment requirement, one of the alleged failings cited in the termination letter. McCarty discussed the policy with Chief Dennis and asked about the medical assessment portion, which she and Dennis both knew would be impossible for the Jail to implement. Dennis told her the "medical assessment" meant the Jail staff was doing an "assessment" of the individual, even though this directly contradicts the written terms of Lexipol 538.

The Employer has a similar proof problem with the mental health assessment section. Dennis told Detective Wallace during his interview that the mental

health assessment requirement was "not necessarily the Gospel." Dennis explained that the Jail did not have access to a certified medical health professional all the time. Dennis's interview made it clear the mental health assessment portion of Lexipol 538 was not in effect at the time of KF's death. Given that Grievant's supervisor, the person who allegedly promulgated the rule, did not consider the rule to be in effect, violates the just cause standard to terminate McCarty over this rule. The Guild does not dispute that KF should have received better care. There is also no doubt that institutional failure, from the top down, led to his death. But it is quite another thing to terminate the lowest level supervisor in the Jail for failing to follow a "guideline" that was "not Gospel," that was labeled "draft," and was followed by not a single other Jail employee, including Chief Dennis.

The Arbitrator should sustain the grievance based on the first test of just cause.

2. The Employer has failed to prove by clear and convincing evidence that Grievant McCarty violated a duly promulgated rule.

The Employer's claim that an employer can enforce a rule once an employee subjectively believes the rule is in effect has no basis in arbitral precedent. To do otherwise, would be to discipline employees based on their private thoughts rather than on their conduct.

Lexipol 538 was not duly promulgated because it was not adopted under the Jail's past practice or by the express adoption procedure set by Lexipol itself. Proper implementation of rules is required so that employees know what is expected of them, and to ensure that if a rule is violated, employees are disciplined consistently and

fairly. The Collective Bargaining Agreement between the parties contains an express and explicit requirement that notice to the Guild must precede policy changes.

The Employer did not follow the Collective Bargaining Agreement between the parties that required the Employer provide the Guild with any new rules five days before they were to go into effect. No such notice was provided for the Lexipol 538 guideline. Chief Dennis also testified that when he promulgated new rules, he often provided a list of staff names so they could indicate they read the new rule. Dennis testified he did not do so for this draft policy. Lexipol contains its own promulgation requirements including that the policy be put out to comments (which was happening in this instance), and that either the Sheriff or the Undersheriff in writing promulgate the rule. This did not happen in the instant case. Lexipol similarly requires employees to sign that they have been given the rule and that they have been trained on the new policy. None of these steps happened.

The Sheriff admitted that he advocated responsibility for these policies. At the hearing, the Sheriff revealed that he had not read the Lexipol policies at issue in this case, including his own policy governing the implementation of Lexipol, and the safety cell policy over which McCarty was terminated.

McCarty did not intend to fail to follow the Jail's safety cell policy. She stated numerous times that she believed she was following the safety cell policy. It was not until Detective Wallace read her the section about the two-hour supervisor checks that she realized she was not following that portion of Lexipol 538. The Employer argued at the hearing it does not matter whether a rule is properly implemented because McCarty subjectively believed the rule was in effect. Employees cannot be

punished for their thoughts instead of their specific conduct. The Collective Bargaining Agreement is central to any grievance. The CBA in place at the time Chief Dennis put out the Lexipol safety cell rules required the Employer provide the Guild with the proposed rule change five days before it became effective. It is undisputed that this did not happen in the case at bar. The Employer now seeks to terminate an employee for failing to follow a rule the Employer failed to properly implement. Such a proposition violates just cause.

3. The Employer failed to prove by clear and convincing evidence that management consistently enforced the revised safety cell rule.

Management did not consistently enforce the safety cell rule because the rule was not applied to anyone other than McCarty. McCarty was the only supervisor terminated for violating Lexipol 538. McCarty did not review the log every two hours, but neither did any of the Acting Lieutenants or Chief Dennis. The Acting Lieutenants were not terminated. They testified they were not even aware of the two-hour checks until after McCarty was terminated. Furthermore, the logs from when Chief Dennis was supervising the Jail show that he was not doing the two-hour review checks himself. The Sheriff based his termination decision on the fact that someone died, not on the fact that a rule was violated. Singling McCarty out for discipline in this context fundamentally violates just cause.

4. The Employer has failed to prove by clear and convincing evidence that management's treatment of Pamela McCarty was proportional to the treatment of other employees.

No other supervisors were given so much as a verbal reprimand for failing to follow Lexipol 538. McCarty's termination stands in sharp contrast to the utter lack of discipline for Acting Lieutenants.

McCarty's scapegoat role is also logically inconsistent. The Employer seeks to hold McCarty responsible both for the failings of those allegedly "underneath" her and the failings of those above her. The Sheriff and the Undersheriff took no responsibility for anything that happened in the Jail caused by their decisions to let it run itself. None of the responsible managers starting with the Sheriff ever allocated the resources or staffing that would have been needed to comply with the draft policy. The Employer now blames McCarty, a first-level supervisor, for the failings of Chief Dennis, the Undersheriff, and the Sheriff. The singling out of one first-level supervisor for institutional failure that extended to management is not proportional and is fundamentally without just cause.

5. The Employer has failed to prove by clear and convincing evidence that it provided Pamela McCarty progressive discipline.

The Employer admitted it did not follow progressive discipline. Grievant McCarty had never been disciplined for a violation of a rule, policy, or procedure prior to her termination. The Sheriff openly admitted at the hearing that he did not follow progressive discipline. In the Sheriff's view, progressive discipline did not enter into the decision. The Employer cannot demonstrate that McCarty's failure to follow Policy 538, a policy that was never implemented and certainly never trained on or followed by others, could not have been addressed by some lesser form of discipline.

6. The Employer failed to prove by clear and convincing evidence that McCarty violated the rule.

The Employer has not proven that McCarty violated cited rules because management did not establish the Employer had adopted the rule in effect concerning the performance failures it alleged McCarty made. There is no evidence before the Arbitrator to support management's allegation that McCarty failed to review the appropriateness of continued detention of KF in a safety cell. In fact, at hearing, the Employer attempted to argue McCarty had erred by removing KF from the safety cell on March 30 when she and Chief Dennis properly decided to do so. McCarty also testified this review happened continuously throughout the day.

Dennis testified that following Lexipol 538 as written was impossible. Dennis also testified it would be "ridiculous" to implement a policy that the troops could not follow. Dennis told Detective Wallace that Lexipol 538 "is not fully implemented because a large portion of the manual just does not apply to us." Detective Wallace admitted it was "mathematically impossible" to have supervisors check the logs every two hours given that there was not a 24-hour supervisor presence, even with Acting Lieutenants. Wallace also conceded that without a nurse available every day, the medical assessments written into the draft policy could not happen as written.

The Employer's allegation that McCarty failed to ensure that KF was medically assessed within his first 12 hours in the safety cell is literally true. However, this allegation ignores it was impossible for McCarty to have such an assessment take place. The nurse was on vacation the day KF arrived at Island County Jail. The Employer had not provided for a substitute nurse. Even more compelling is the fact

McCarty was not working on Friday, although Chief Dennis and Acting Lieutenant Evans were. On Monday, McCarty and Chief Dennis made a joint decision to remove KF from the safety cell.

Moreover, the mental health evaluation allegation is fundamentally problematic for the Employer. Dennis told Detective Wallace during his interview the mental health evaluation was "not Gospel" because, in essence, the Jail did not have access to a certified mental health professional on a permanent basis and would do so only when they came to the Jail. KF's evaluation on April 6 was only possible because the psychologist from Western State Hospital was already at the Jail evaluating three other inmates. McCarty and Dennis did ensure that KF was examined at the first possible opportunity. The Employer mistakenly charges McCarty for failing to accomplish the mental health evaluation sooner, an impossible task.

The Employer cannot establish that Grievant committed all of the errors alleged in its termination letter. Even for those charges where she did fail to follow the letter of the policy, it would have been impossible for her to do so. Failure to establish any one of these charges weakens the Employer's justification. Apart from the fact the policy was not duly promulgated, the Employer's charges fail by the insufficiency of evidence.

7. The Employer failed to prove by clear and convincing evidence it conducted a thorough investigation.

The Guild alleged the Employer did not conduct a fair or full investigation because it relied on an internal investigation instead of an independent investigation. The Guild asserts the investigative process was fundamentally defective in two ways.

First, the Sheriff failed to appoint an independent investigator and instead appointed someone in the Undersheriff's direct chain of command. Second, the Employer failed to investigate the institutional and managerial failures until after McCarty was fired.

Detective Wallace's report missed key evidence and failed to note anything to do with the Acting Lieutenants. Wallace incorrectly assumed in his interviews that Lexipol 538 was the law of the land, and never asked any questions about whether the policy had been properly implemented. Wallace did not mention in his findings that Chief Dennis, Acting Lieutenant Evans, and Acting Lieutenant Bingham all failed to complete the two-hour supervisor checks. This crucial omission served only to enable the Sheriff and Undersheriff to single McCarty out as a scapegoat, rather than reveal that no one followed Lexipol 538.

Wallace's report also determined that the version of Lexipol 538 that was in place was the version this brief has called the "hourly checks" version, the version on Lexipol letterhead labeled "draft." Wallace did not investigate whether Safety Cell Policy 3.03.000 was still in effect. These oversights contributed to McCarty being singled out as a scapegoat.

The most compelling factor concerning the duty to investigate fairly and thoroughly is the utter failure of the Employer to honestly evaluate the institutional and managerial failures. Ultimately the Sheriff did so by way of the Stanley Report. This is no substitute for a fair and thorough investigation before an employee was fired.

The Stanley Report is an ultimate excoriation of the Sheriff's Office management. At the hearing, the Employer attempted to flip the Stanley Report on its head by arguing that its secondary observations about McCarty supported its decision-

making. The Stanley Report identified innumerable institutional and managerial failures that contributed far more greatly to this situation than McCarty's failure to adhere to "draft" guidelines for which she had never been trained on. The Guild identified sections from the Stanley Report commentary that included:

- The lack of training on Jail policies: "There should be sessions of policy training for line staff so there can be discussion of terminology and clarification of the procedures to enact policy. Without training, line staff often do not understand the relevance of how policy relates to operation of the jail."

- The failure to enforce policies: "If policy and procedure are written and there is no enforcement by management, the policy becomes meaningless. Changing long standing behavior and developing consistency requires tenacious effort by management."

- The policy train wreck: "Apparently there was an 'operations' manual kept in the Jail Chief's office but it was not made available to staff, nor was it in any type of complete form. A policy and procedure manual does not provide guidance to corrections deputies if it is not made available. In essence, without adherence to policy, individual corrections deputies, sergeants and lieutenants will 'do their own thing.'"

- The Sheriff's lack of involvement: "The Sheriff and/or the Undersheriff should be involved enough with the jail to understand major issues. Both the Sheriff and Undersheriff have acknowledged that they may have relied too heavily on the prior Jail Chief's reassurance that the jail was operating effectively within the current budget and that appropriate training and supervision was being provided....This was not the case...." Stanley also noted "The Sheriff and/or the Undersheriff should increase their involvement and oversight of jail

operations. While it is important to support the Jail Chief, there should be enough rigor to the oversight to demand accountability for jail operations."

- The Sheriff's specific lack of involvement with policies: The Passdown Log contains "some recent written directives for corrections deputies from the Sheriff, but there are only a few, and this does not constitute nearly enough appropriate policy direction for staff."

- The lack of leadership training for supervisors: "There is an immediate need to raise the level of training for all supervisors....There has been no focused training to maximize supervisory/management skills beyond [a] week of training" when supervisors are first appointed.

- The lack of 24-hour supervisor presence: "As a twenty four hour operation, there should be a supervisory presence each hour of the day. The appropriate coverage can be provided by the Jail Chief, two Lieutenants and three Sergeants."

- Failure to hire sufficient corrections deputies: Stanley first noted that since 2014, the Jail has experienced a 50% turnover rate and then states even aside from this issue, "there are not enough corrections deputy positions established to adequately provide for the safety of both inmates and staff...At times, during large portions of the day, there are either two corrections deputies or only one corrections deputy on the floor and often this is not sufficient."

- Lack of adequate medical services: Stanley noted that following KF's death, the Jail had already brought on an Advanced Registered Nurse Practitioner, and a Licensed Practical Nurse, but that at least one more nurse is still needed. Nurses should be available from 7:00 am through 9:00 pm. He also emphatically urged the Jail to cease allowing corrections deputies to provide medicine

to inmates. The report mentions the lack of clear medical protocols and the failure to get inmates' medical records from other jails, which "should be a priority since the transfer of medical information between jails was a factor in the recent inmate death."

- The lack of mental health care and training on mental health issues: "The attention paid to those with mental illness at the Island County Jail currently...is not sufficient." Furthermore, "Due to the recent death of an inmate at Island County Jail, this issue has received more attention than in the past. But, there is still more work to be done."

- The failure of management to provide for a trauma debrief following KF's death: "The recent inmate death five months ago hit many staff at the jail hard. The potential for this type of situation to greatly impact staff is not currently recognized in a formal manner. The stress...should be recognized by management."

Guild Brief, pp. 65--67.

The Guild submits with regard to this factor that the Sheriff raced to quickly identify the scapegoat it needed and overlooked the obvious and overreaching explanation. In following this pattern, the Employer fundamentally acted without just cause.

8. McCarty had an excellent record and the Sheriff admitted she had never failed to follow Jail policies and procedures before.

The policy McCarty is alleged to have violated was never ultimately put in place. The Chief testified it was a guideline and there were numerous portions of the policy, which was labeled a "draft," including the mental health portion and the medical assessment portion. In the instant case, McCarty alone has been held accountable for

enforcing the policy, even though the Chief and the Acting Lieutenants were present on many of the same days Grievant was on the shift and on days she was not at the Jail.

The proven conduct does not rise to the level of immediate termination. The Employer cannot establish by clear and convincing evidence that Grievant failed to examine the logs every two hours, just that she did not initial the form. The Employer alleged that Grievant failed to ensure KF was medically assessed within the first 12 hours in his safety cell. This charge ignores that it was impossible for McCarty to have arranged such a medical assessment. There is no dispute the nurse was on vacation the day KF arrived at the Island County Jail. Grievant was not working Friday, although Chief Dennis and Acting Lieutenant Evans were.

The same holds true for the required mental health assessment. Prior to KF's death, the Jail lacked a full time mental health person. Although KF eventually received a mental health evaluation, it had to wait until a psychologist was present at the Jail.

Given the limited resources available to the Jail, even if the Employer could prove some unsatisfactory performance or errors, the Employer has not demonstrated by clear and convincing evidence that McCarty's conduct warranted summary discharge. McCarty worked at the Jail for 26 years with no disciplinary issues. The Sheriff emphasized that Grievant was terminated because of KF's death. There is no question that the circumstances around KF's death, including that he was put in a jail that lacked adequate resources to care for mentally ill inmates, and had policies that were a "train wreck" were tragic. Holding a 26-year employee with a distinguished service record solely accountable is not in keeping with just cause.

Any errors that McCarty made were also made by other supervisors who did not even get a reprimand. The Chief was allowed to resign. In response to the institutional failure that led to a young man's death, the Employer punished one person. The Employer called out a single first-level supervisor as if all errors by managers above her were solely on her shoulders. This scapegoating is fundamentally contrary to just cause.

9. The Employer has failed to prove by clear and convincing evidence that the conduct at issue was not contributed to by the Employer's actions or inactions.

The just cause test requires that the Employer not have contributed to the conduct at issue. Failure on the part of the Employer to adequately train the employees on policies and procedures, when that employee is subsequently disciplined for violating policies, serves as a mitigating factor in assessing the discipline applied. There is no question that the Employer understaffed the Jail. This misallocation of resources by the Employer created the environment in which KF died. Lexipol clearly requires new rules be promulgated by either the Sheriff or the Undersheriff, but the Employer here left Chief Dennis to put the rule out for feedback. It is hard to imagine that Dennis's somewhat unconventional approach to Jail policies would have been permitted had upper management taken a more active role in overseeing the Jail.

The Employer was well aware the Jail lacked certain resources and that contributed to the death of KF. Chief Dennis testified that for years he had told the Sheriff that the Jail needed more supervisors. The Jail is a 24/7 operation, but yet provided supervisors for less than half those operational hours.

The Jail lacked sufficient medical and mental health resources. A nurse was available Mondays, Wednesdays, Thursdays, and Fridays, but split her time with the juvenile detention facility, meaning that she was not at the Jail for the full 32 hours each week. When the nurse went on vacation, no nurse was available Tuesdays, Saturdays, and Sundays, or outside the regular business hours. The Jail also did not have a full time mental health person.

The evidence before this Arbitrator is overwhelming that the Employer created conditions under which KF's tragic death occurred. The Employer half-heartedly attempted to promulgate rules that could not be followed because the Jail lacked the necessary resources to follow them. Because the guidelines Dennis put out could not be followed, there is no question the Sheriff's office management bears some responsibility for Grievant's failure to do so.

10. The Employer has failed to prove by clear and convincing evidence that the Sheriff's motivation and reasoning process were proper.

Just cause means to impose discipline in good faith and in a sensible, reasonable manner.

The Sheriff terminated McCarty, in the context of politics, bad publicity and litigation, as a scapegoat for the institutional failings from the top down, and admitted and demonstrated his decision was based on his emotional reaction to KF's death. The Sheriff terminated McCarty because, politically and perhaps to satisfy the insurance company, he needed to blame someone. Acting on the pressure to scapegoat was in violation of just cause.

The Sheriff admitted he terminated Grievant because up until KF's death, he had failed to realize what the situation was in the Jail. After reading Detective Wallace's report, the Sheriff stated he terminated McCarty because in reviewing the investigatory report, he realized "the jail" had not done everything it could have done. The failure of the Jail includes the Sheriff's own failure to ensure the Jail had appropriate staffing, medical experts, and mental health resources. Before KF's death, the Sheriff was expressly and proudly "hands off" for Chief Dennis's management of the Jail. Stanley roundly criticized this approach in his evaluation of the Jail. The Sheriff terminated McCarty during her *Loudermill* hearing. The hearing was an opportunity to weigh all of the evidence, yet it was clear that the decision had been made before McCarty had ever opened her mouth.

The Guild concludes the Sheriff's emotional reaction to a terrible situation, and to the pressure he was under from outside forces, demonstrated the Sheriff made an emotional decision and failed to rationally weigh the decision to terminate Grievant.

Turning to the remedy, the Guild asks the Arbitrator to reinstate Grievant with back pay and other remedies as appropriate. A make-whole remedy should fairly include the 12% prejudgment simple interest imposed in civil employment cases and by the Public Employment Relations Commission.

In conclusion, the Guild asserts the Employer fundamentally misunderstands the meaning of "institutional failure." Institutional failure does not mean that one first-level supervisor should be terminated because she failed to enforce a policy no one above her had ever bothered to read and was never properly implemented. The Employer's responsibility to the death of KF has been to take the full

weight of the tragedy and place it squarely on the shoulders of Grievant McCarty, ignoring her long and unblemished service record, ignoring the oversights and mistakes made by management, and ignoring the precepts of just cause.

For all of the reasons set forth above, the Arbitrator should conclude that just cause was not present to terminate McCarty and she should be reinstated with all appropriate remedies.

VI. DISCUSSION

The Arbitrator finds the Employer failed to prove by clear and convincing evidence just cause was present for the summary discharge of Pamela McCarty from her employment with the Island County Sheriff's Office. The Arbitrator finds the record evidence did establish just cause existed to demote Grievant McCarty from her job as a Lieutenant to a corrections deputy. This holding is supported by an examination of the contract language and the evidence presented at the arbitration hearing. The parties' detailed arguments in the post-hearing briefs are summarized in Section V, Positions of the Parties, and will not be repeated. Accordingly, the grievance is sustained in part and denied in part. The reasoning of the Arbitrator is set forth in the discussion that follows.

The Guild argued the Arbitrator should apply the beyond a reasonable doubt standard in evaluating the evidence presented by the Employer. I disagree. The grievance before this Arbitrator is based on the parties' Collective Bargaining Agreement. The rights and duties of the parties flow from the contract. Arbitral authority instructs that the clear and convincing standard is appropriate in a discharge case. An arbitration conducted pursuant to the terms of a collective bargaining

agreement is not a criminal case where the appropriate standard is proof beyond a reasonable doubt.

In this case, the Employer bears the burden of proving by clear and convincing evidence (1) Grievant McCarty engaged in the conduct alleged in the notice of termination; and (2) the conduct was such to provide just cause for summary termination.

Sheriff Brown stated in the termination letter that discharge was appropriate based on sustained findings of violations of the following Island County Sheriff's Office Policies:

Policy 538--Safety Cells and Sobering Cells

Policy 340.3.8--Conduct--Supervision Responsibility

The operative facts in each of the alleged violations are chronicled in the Statement of Facts, *supra*, and will not be reiterated in my discussion. Both parties utilized, in their post-hearing briefs, a general format based on the seven tests for just cause as set forth by arbitrator Carroll R. Daugherty in *Enterprise Wire Co.*, 46 LA 359 (1966). The Guild argued in the post-hearing brief there are ten tests that are relevant to this case. The seven tests for just cause are not intended to provide hard and fast rules for deciding if just cause is present for the discharge of an employee. The seven tests for just cause have withstood the test of time and will be utilized by this Arbitrator, as a guide for determining whether just cause was present to summarily terminate the employment of Grievant McCarty. I will break these down and identify each of the seven tests followed by a brief discussion.

1. Did the Employer give the employee forewarning or foreknowledge of the possible or probable disciplinary consequences of the employee's conduct?

The primary conflict around this test is whether Policy 538--Safety Cells and Sobering Cells was properly promulgated. I agree with Detective Wallace's characterization of the circumstances regarding management's adoption of Policy 538, that it was a policy "train wreck." Jail Chief Dennis's testimony about Policy 538 was inconsistent and often contradicted the demands of Lexipol 538. Dennis explained he often published policy changes using handwritten notes and crossed out the portions of Lexipol 538 he believed needed to be modified to fit the Island County Jail. He also described how he cut and pasted by copying the new policy and hand pasted the new text over the old sheet.

The most telling argument against the proper implementation of the policy, is that the version put out for review by corrections officers was stamped with the word "draft" three times on the cover pages. Dennis also described the policy of memos to the staff as "guidelines." Therefore, I am compelled to hold the Employer failed to prove management provided reasonable notice of the revised safety cell rule to employees at the Island County Jail.

Moreover, Grievant testified she observed her direct supervisor, Jail Chief Dennis, was not following the rule. On March 27, 2015, a day Dennis was a supervisor in the Jail, there were no initials that showed he followed the two-hour safety check required of supervisors.

Article 20.1 provides in clear and unambiguous language that the "Employer shall provide the Guild with a written copy of proposed policy changes at

least twenty (20) days before the effective date of the changes and shall discharge its obligation under RCW 41.56." Emphasis added. The parties framed Article 20.1 in mandatory language that leaves no room for doubt of the obligation of the Employer to provide advance notice to the Guild of proposed policy changes. There is no dispute the Employer failed to provide the Guild with advance notice of the proposed rule changes before the safety cell procedures became effective.

The Employer asked the Arbitrator to ignore Article 20.1 based on the facts of the instant case. I disagree. Your Arbitrator has no power to delete from the Collective Bargaining Agreement a provision agreed to by the parties. In all likelihood had the Employer complied with Article 20.1, this whole issue of whether Policy 538 was properly implemented would have disappeared. There is no requirement in Article 20.1 that the Guild has to agree with proposed rule changes.

The Employer also argued Grievant knew, or should have known, Policy 538 was implemented and that she could be disciplined for violation of the policy. While I agree with the Employer that Grievant in her supervisory role should have been familiar with the requirements of the proposed safety cell policy, it is quite another thing to use a policy that had not been properly promulgated to justify summary discharge. This problem with the improper implementation of the safety cell policy is one that calls out for the use of progressive and corrective discipline.

The inquiry into Grievant's failure to properly fulfill her supervisory role does not end with the Arbitrator's finding the rule was not properly promulgated. Grievant's errors and professional deficiencies will be discussed later in this Award.

2. Was the Employer's rule or managerial order reasonably related to (a) the orderly, efficient and safe operation of the company's business; and (b) the performance that the Employer might properly expect of the employee?

I find the safety cell process was specifically related to the health and safety of the inmates and corrections officers who work in the Jail. The safety cell policy is directly related to the orderly, efficient, and safe operation of the Jail. Policy 340.3.8 Conduct--Supervision Responsibility, is directly related to the orderly and efficient operation of the Jail that the responsibility of supervisors is to ensure that employees adhere to the policies and procedures. I disagree with the Employer that McCarty's failures justified the imposition of immediate discharge.

3. Did the Employer, before administering discipline to the employee, make an effort to discover whether the employee did, in fact, violate or disobey a rule or order of management?

I hold the Sheriff's Office conducted a thorough investigation that revealed staff (including McCarty) had violated rules and procedures put in place to protect inmates. In May 2015, Detective Wallace interviewed McCarty and other staff. Detective Wallace's report dated June 15, 2015, noted significant failures to provide adequate supervision to the Jail staff and failure to take action to ensure employees adhered to the policies and procedures of the Jail, all in violation of Policy 340.3.8. While Detective Wallace's investigation was not perfect, I find it provided a thorough and exhaustive review of the facts, circumstances, and procedural failures that contributed to KF's death. I find there was a basis for the Sheriff to conclude Grievant's acts and omissions demonstrated poor professional judgment and a failure to supervise.

The Guild faulted the Sheriff for not waiting until he had the results of the Stanley investigation. I disagree. The Sheriff had the results of the investigation conducted by Detective Wallace. Detective Wallace's investigation provided ample evidence for the Sheriff to move forward with discipline of McCarty. While I disagree with the Guild that the Sheriff should have waited for the Stanley Report, this Arbitrator will review the Stanley Report to discover what, if any, mitigating circumstances exist to reduce the penalty of summary discharge.

4. Was the Employer's investigation conducted fairly and objectively?

I hold that Detective Wallace's investigation into the circumstances surrounding the death of KF was conducted in a fair and thorough manner. The Guild faulted the investigation on two major grounds. First, the Guild asserted the Sheriff failed to appoint an independent investigator and instead appointed Wallace who was in the Undersheriff's direct chain of command to conduct the investigation. Detective Wallace testified he agreed to do the investigation only if he were allowed to do it without interference by the Sheriff and he would allow the investigation to go wherever the facts led. There was no showing that Detective Wallace had any animus toward Grievant McCarty. A close review of Detective Wallace's report showed no impartiality or favoritism when he wrote his findings and conclusions. It is important to note that the investigation did not focus solely on Grievant McCarty, but also included the role of Jail Chief Dennis and others in the circumstances surrounding the death of KF.

The Guild next alleged that the Employer failed to investigate the institutional and managerial failures until after McCarty was terminated. I agree with the

Guild that Wallace's report can be criticized by its failure to investigate fairly and thoroughly the institutional and managerial failures of the Sheriff and Undersheriff. I do find that the investigation was fairly and objectively conducted as far as it went. Wallace's investigation showed there were supervisory failures on the part of Grievant McCarty. The Stanley Report was the appropriate vehicle for examining the institutional and managerial failures of the overall operation of the Jail. The Stanley Report provides insights into those institutional failures that will be discussed in the remedy section of this Award.

5. After investigation did the "judge" obtain substantial evidence that proved that the employee was guilty as charged?

In the termination letter, Sheriff Brown accepted the report from Detective Wallace that revealed the following allegations against Grievant:

...

> On June 17, 2015, you were placed upon paid administrative leave pending the completion of the investigation conducted by Detective Wallace. Detective Wallace's investigation revealed that you:
>
> - Failed to properly supervise jail staff;
> - Failed to take appropriate action to ensure employees adhered to policies and procedures;
> - Failed to inspect safety cell logs for completeness every two hours and to document that action on the safety cell log as required of jail supervisors;
> - Failed to review the appropriateness for continued retention of KF in the safety cell; and
> - Failed to request a medical or mental health assessment of KF if appropriate.

> I have thoroughly and repeatedly reviewed the investigative materials which you were provided. In doing so, I have looked at the events leading to KF's death from all perspectives. While I do not question your integrity, you admit that you engaged in the acts and omissions described above, and I have concluded that your acts and omissions violated the following Island County Sheriff's Office Policies:
>
> - Policy No. 538--Safety Cells and Sobering Cells
>
> - Policy No. 340.3.8--Conduct--Supervision Responsibility
>
> Unfortunately, in addition to violating policy, your acts and omissions contributed to the systematic failures that may have prevented staff from properly recognizing and identifying and addressing the health conditions leading to the death of inmate KF. These acts and omissions, considered individually or collectively, constitute just cause (good cause) for your termination. The primary obligation of an elected Sheriff is to protect the people of the community we serve, including those we hold in our custody. It is my responsibility to ensure that the Sheriff's Office's supervisors and leadership meet expectations and comply with policies and procedures that have been put in place to protect staff and inmates alike. If our supervisors and leadership fail to adhere to the policy, the safety and security of the jail is compromised and the community's confidence in our work is eroded.
>
> ...
>
> Er. Ex. 50; emphases added.

The Sheriff observed in his termination letter that he did not question Grievant McCarty's integrity, but that she had engaged in the acts and omissions described above. Based on those factual findings, the Sheriff concluded that Grievant's acts and omissions violated the following Island County Sheriff's Office Policies:

- Policy No. 538--Safety Cells and Sobering Cells
- Policy No. 340.3.8--Conduct--Supervision Responsibility

The Sheriff reasoned that if the supervisors fail to adhere to the Island County Sheriff's Policies, the safety and security of the Jail is compromised and the community's confidence in the Jail's work is eroded.

The Sheriff noted in the termination letter that at a minimum, Grievant's acts and omissions violated Policy 538.3(c)(g)(h) and (i). The opening sentence to Policy 538.3 reads: "The following guidelines apply when placing any inmate in a safety cell:" Emphasis added. Jt. Ex. 6. In clear and unambiguous language, the purpose of the safety cell procedures, are described as "guidelines," rather than hard and fast rules that were to be applied in a rigid and unwavering manner.

Setting aside the Employer's failure to properly implement Policy No. 538.3, I find that Chief Dennis's statements to Grievant that Policy 538.3 was a guideline and not necessary the "Jail bible," runs counter to the standard to which the Sheriff held McCarty. Your Arbitrator will next address the four specific allegations of policy violations set forth by the Sheriff in his notice of termination.

Policy 538.3(c):

> A safety check consisting of direct visual observation that is sufficient to assess the inmate's well-being and behavior shall occur as indicated on the log but hourly as a minimum. Each safety check of the inmate shall be documented. Supervisors shall inspect the logs for completeness every two hours and document this action on the safety cell log.

There is no evidence to show Grievant did not check the logs. It is undisputed Grievant did not document her actions on the safety cell log. Chief Dennis did not document his actions on the safety cell log, nor did the Acting Lieutenants. There is no place on the log for supervisors to enter their initials.

Policy 538.3(g):

> The Shift Supervisor shall review the appropriateness for continued retention in the safety cell at least every eight hours. The reason for continued retention or removal from the safety cell shall be documented on the safety cell log.

Grievant McCarty and Chief Dennis reviewed the appropriateness of the continued retention of KF in the safety cell before moving KF to another cell. The guidelines required the supervisor to review the continuing retention of KF in the safety cell at least every eight hours. There is no doubt McCarty and Dennis failed to follow this guideline to the letter. The Acting Lieutenants and the leads did not follow the safety cell policy.

It should be noted at this point that Grievant was at work on Thursday, March 26, when KF was first brought to the Island County Jail. McCarty did not work on the following Friday, Saturday, or Sunday. McCarty returned to work on March 30. On March 30, 2015 Dennis and McCarty jointly agreed to take KF off safety cell procedures.

Under Subsection (g), it is the responsibility of the Shift Supervisor to review the appropriateness for continued retention in the safety cell at least every eight hours. While Dennis was on duty on Friday, Grievant could not have performed the review of the appropriateness for continued retention because she was not on duty as the Shift Supervisor for the following three days.

Policy 538.3(h):

> A medical assessment of the inmate in the safety cell shall occur within 12 hours of placement or at the next daily sick call, whichever is earliest. Continued assessment of the inmate in the safety cell shall be conducted by a qualified

> health care professional and shall occur at least every 24 hours thereafter. Medical assessments shall be documented.

The evidence is uncontradicted that when Grievant pointed out to Chief Dennis the Jail was without 24-hour nurse coverage, Grievant stated, there is "no way we can do this." Chief Dennis instructed McCarty to do the best she could to make the policy work. Chief Dennis also told Detective Wallace that he could not follow Policy 538 because the Jail lacked certain necessary resources to implement the policy, and that it would be "ridiculous" to give the staff marching orders that could not be followed. The nurse was on vacation and not available to examine KF within 12 hours of his placement in the safety cell. A nurse was available Mondays, Wednesdays, Thursdays, and Fridays. However, the nurse split her time with the juvenile detention facility, meaning that she was not in the Jail for the full 32 hours each week. No nurse was available Tuesdays, Saturdays and Sundays, or outside of regular business hours. A Physician's Assistant was available for prescriptions if the nurse was gone or the nurse would call the Physician's Assistant when the situation required additional attention.

In sum, it is difficult on this record for the Arbitrator to conclude that Grievant McCarty's alleged violations of Subsection (h) based on the failure to supervise charge were "egregious."

Policy 538.3(i):

> A mental health assessment shall be conducted within 24 hours of an inmate's placement in the safety cell. The mental health professional's recommendations shall be documented.

The majority of my observations in Subsection (h) also apply to Subsection (i). The policy requires a mental health assessment to be conducted within 24 hours of an inmate's placement in the safety cell. The Jail had no mental health professional on staff. Instead, the Jail relied on a clinical psychologist sent by Western State Hospital. Corrections officers at the Island County Jail had limited training in handling mentally ill inmates.

On March 1, 2015, KF was taken to San Juan County to appear in court. The court entered an order that KF was to be evaluated at Western State Hospital to determine competency. Detective Wallace stated that WSH refused to take KF because of limited bed space so KF was sent back to the Island County Jail. As a result of WSH's refusal to comply with the court order, KF was returned to the Island County Jail. The return of KF to the Island County Jail in contradiction of the court order allowed KF, a man with serious mental issues, to be returned to the Island County Jail, a jail that did not have the resources to address KF's mental health issues.

A subsequent court order was entered on April 6, 2015 that allowed KF to be evaluated by a qualified expert from Western State Hospital in the Island County Jail. The revised court order was secured because a clinical psychologist from WSH was in the Jail the same day to see another patient and Dennis asked him to take a look at KF. Dennis was able to convince the psychologist to call KF's public defender to get an order that the evaluation could take place in the Jail, so that he could be seen on April 6, 2015. The psychologist told Dennis that unless this procedure was followed, it would "be June before we'd even see the guy."

The lack of an ability to get a mental health professional to the Jail and the original court order, which found that KF needed a mental assessment at Western State Hospital, causes this Arbitrator to reject the Sheriff's conclusions that Grievant's acts and omissions were egregious.

While I reject the Sheriff's conclusion that Grievant's violations of the "guidelines" were egregious, I do find that the seriousness of Grievant's conduct warrants discipline short of termination. Grievant failed to adequately familiarize herself with the safety cell procedures and failed in many respects to carry out those procedures.

Grievant was the second in command of the Jail directly under Chief Dennis, which meant she was part of the Jail leadership and bore a heavier burden of responsibilities with regard to inmate safety than corrections officers. As a leader in the Jail, McCarty was responsible for failures of the Jail in implementing the policies. The Arbitrator cannot ignore the undisputed fact that a mentally ill inmate was in the Island County Jail for nearly two weeks, died of malnutrition and dehydration, in a cell where the water had been cut off. As previously discussed, while significant failures in the leadership occurred, to lay the responsibility entirely at the feet of Grievant by summarily discharging McCarty, is a termination that is not for just cause.

Based on the evidence and argument, the Arbitrator concludes that the Employer proved that Grievant violated her supervisory responsibilities under Policy 340.3.8--Conduct--Supervision Responsibility. Section 340.3.8(a) reads as follows:

> Failure of a supervisor to take appropriate action to ensure that all employees adhere to the policies and procedures of

this department and the actions of all personnel comply with all laws.

The evidence adduced at the hearing showed Grievant did fail to take appropriate action to ensure that all employees adhere to the policies and procedures. However, the Grievant's failure to properly supervise the Jail staff with regard to the care of KF fell short of justifying summary termination.

6. Has the Employer applied its rules, orders, and penalties evenhandedly and without discrimination to all employees?

The Guild asserts that summary termination of Grievant McCarty was not proportional to the treatment of other employees. First, no other employee in the Jail was given so much as a reprimand for their failure to follow Policy 538.

Second, the Acting Lieutenant and lead officers were not issued any form of discipline for not performing the two-hour supervisory checks.

Third, a 30-day suspension for Jail Chief Dennis was proposed. Jail Chief Dennis retired and was never formally disciplined.

Fourth, none of the responsible managers from the Sheriff on down suffered any penalty for failing to allocate the resources or staffing needed to comply with the "draft" policy.

I conclude that fundamental due process was denied Grievant McCarty when the Sheriff meted out the penalty of summary termination on McCarty without prior warning or opportunity for correction. Grievant McCarty was the only Lieutenant in the Jail. Grievant was the second in command under Jail Chief Dennis. A critical part of her job was to see that corrections deputies carried out the policies, procedures, and

standards. I disagree with the Guild that Acting Lieutenants and leads should be held to the same standard as the person who was second in command of the Jail.

I concur with the Employer that Grievant's acts and omissions in her role as second in command at the Jail, by failing to see the corrections deputies followed the rules and performed their duties warranted discipline. To the extent that McCarty's job reflects a higher level of responsibility, I find it warrants greater discipline than those of the corrections deputies. The problem with the Employer's actions in the instant case is that no other employee was disciplined for the events surrounding the death of KF while in the custody of the Island County Jail.

Therefore, I must conclude in the context of this case, the summary discharge of Grievant McCarty was not applied in an evenhanded fashion. However, this does not mean that McCarty's acts and omissions excuse her from responsibility and substantial discipline.

7. Was the degree of discipline administered by the Employer in this case reasonably related to (a) the seriousness of the proven offense; and (b) the record of the employee in her service with the Employer?

The Sheriff in this case meted out the most serious discipline possible under the just cause test, that of summary discharge. Progressive discipline is an essential element of just cause. Arbitral authority teaches that summary discharge should be reserved only for the most egregious offense or that progressive discipline was attempted and failed. The Sheriff in his termination letter concluded, "Your failure to properly supervise jail staff with regards to the care of KF was egregious." Emphasis added.

While I agree with the Sheriff that Grievant's acts and omissions were serious and justified substantial discipline, I find the record evidence did not prove Grievant McCarty's conduct was so egregious as to justify for summary discharge. When considering the totality of Grievant's conduct and mitigating factors, I find the following:

> (1) The failures and deficiencies in the adoption and implementation of Policy 538.3 undercut the Employer's claim there was just cause to summarily terminate Grievant's employment. See the discussion under Test Number 1.
>
> (2) Grievant McCarty was a long-term employee with some 26 years of service to the Employer, first as a corrections deputy and later as the Lieutenant. A long-term employee with a good record merits special consideration when reaching a decision that summary discharge is the appropriate remedy. Grievant's long and faithful service to the Employer argues for a lesser form of discipline.
>
> (3) During Grievant's 26 years of service, she had a good record free of discipline. Prior to her termination in June 2015, McCarty had never been disciplined. It is particularly noteworthy that Grievant was never disciplined for failing to follow Jail rules or directives. Grievant was first appointed a supervisor in 1993. For 22 years Grievant performed her job as a Lieutenant in a satisfactory manner. When Grievant McCarty's 26 years of service is coupled with a discipline free record, summary discharge was not for just cause.
>
> (4) The testimony and evidence adduced at the hearing demonstrated that resources and staff available to the Jail provided major barriers to complying with the rules, particularly regarding medical assessment and mental health assessment. This is a strong mitigating factor against summary discharge.
>
> (5) The Arbitrator is particularly troubled by the fact that the San Juan County judge ordered KF to be evaluated as an in-patient at Western State Hospital. Western State Hospital refused to accept KF as a patient because of lack of bed space. As a result of Western State Hospital's failure to

comply with the court order, KF, a man with substantial mental health problems was returned to the Island County Jail. While this fact does not excuse Grievant's conduct, it does provide powerful evidence that Grievant should not be the only employee to be disciplined as a result of the death of KF. The discipline meted out by the Sheriff was immediate termination.

If Western State Hospital had complied with the court order, it is unlikely KF would have been returned to the Island County Jail without a mental health assessment "by a qualified expert from Western State Hospital." Er. Ex. 9. The court ordered that the evaluation take place as an "IN-PATIENT at WESTERN STATE HOSPITAL."

The court found:

> ... that an evaluation outside the jail setting is necessary for the health, safety, or welfare of the defendant;
>
> Emphasis added.

The judge went on to order that:

... the defendant (KF) is hereby committed to the care of the Division of Social and Health Services for up to fifteen days from the date of admission to the hospital.

Emphasis added.

To lay all of the institutional failures concerning the death of KF at the feet of the Grievant does not comport with the principles of just cause.

(6) At the arbitration hearing, the Employer faulted Grievant for failing to ensure that corrections deputies observed KF actually consuming the water and food provided to him while in the safety cell. The problem with this argument is there are no rules or policies that require corrections deputies to observe the inmate actually consuming the water and/or food. In addition, the evidence showed there were only two managers to cover a 24/7 operation. Staffing limitations made this purported requirement difficult to follow, if not impossible.

> (7) This Arbitrator cannot ignore the comments and conclusions from the Stanley Report that pointed out the many institutional failures in the death of KF. The Stanley Report correctly pointed out that medical health assessments and mental health assessments were lacking in the Island County Jail. See discussion in Test Number 1.
>
> The Arbitrator does hold the Employer proved by clear and convincing evidence that Grievant violated Policy 340.3.8 by failing "to take appropriate action to ensure that all employees adhered to policies and procedures; ..."

The Arbitrator agrees with the Employer that McCarty was unable to perform the Lieutenant job in a satisfactory manner during the 11 days KF was in the custody of the Island County Jail. In the judgment of this Arbitrator, McCarty failed to recognize the critical role she played in providing for the safety of KF who was suffering from significant mental health problems. It is because of this lack of concern and indifference for the well being of KF that I am compelled to conclude Grievant McCarty should be demoted back to a corrections deputy position. I remain unconvinced that a severe suspension could reasonably expect to correct Grievant's failures as a supervisor.

By returning Grievant McCarty to a corrections deputy position, the Employer will benefit from her 26 years of experience and knowledge in the furtherance of the successful operation of the Jail. Grievant McCarty will benefit in that she will be able to remain employed in a position at Island County Jail.

The Arbitrator will enter an Award ordering the Employer to return Grievant to a corrections deputy position and to make her whole for all wages and benefits lost as a result of the unjust termination. The back pay and benefits should be at the Lieutenant rate until Grievant returns to work as a corrections deputy or refuses to

accept the demotion to a corrections deputy position. The Guild requested interest on the make-whole remedy. Given this is a divided Award and the make-whole remedy orders that Grievant be compensated at the Lieutenant rate until she returns to work as a corrections deputy or refuses to accept the demotion, I will not order interest on the make-whole remedy.

AWARD

Having reviewed all of the evidence and argument, and having had the opportunity to observe the demeanor of the witnesses while testifying, the Arbitrator concludes the Employer did not have just cause to summarily terminate Grievant Pamela McCarty from her employment under Article 6.1 of the Collective Bargaining Agreement. The Employer did prove just cause was present to demote Grievant from her position as a Lieutenant to a corrections deputy for the proven violation of Policy 340.8.3--Conduct--Supervision Responsibility. Grievant shall be reinstated and made whole for all wages and benefits lost as a result of the unjust termination. The back pay and benefits of the make-whole order shall be calculated at the rate Grievant was compensated as a Lieutenant. The back pay and benefits shall be compensated at the Lieutenant rate until Grievant returns to work as a corrections deputy or refuses to accept the demotion to a corrections deputy position. No interest is payable under the make-whole portion of this Award.

The fees and expenses of the Arbitrator are payable equally by the parties. The Arbitrator will retain jurisdiction for a period of sixty (60) days from the date of this Award to address any disagreements arising out of the remedy so ordered.

Respectfully submitted,

Gary L. Axon
Arbitrator
Dated: June 16, 2016