

IN THE MATTER OF THE VETERANS  
PREFERENCE HEARING BETWEEN

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State of Minnesota, Department of Human Services,  
Employer,

and

Dewayne E. Dubey, *pro se*,  
Veteran.

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FINDINGS AND DECISION

BMS Case No. 12-VP-0582

HEARING OFFICER/ARBITRATOR:

Gerald E. Wallin, Esq.

DATE OF DECISION:

March 26, 2012

HEARING SITE:

MSOP, Moose Lake, Minnesota

HEARING DATES:

March 13, 2012

RECORD CLOSED:

March 13, 2012

REPRESENTING THE EMPLOYER:

Paul A. Larson  
Department of Employee Relations  
200 Centennial Office Building  
658 Cedar Street  
St. Paul, Minnesota 55155

## **INTRODUCTION**

The Veteran's Preference Hearing provided by the Minnesota Veteran's Preference Act<sup>1</sup> was held on March 13, 2012 at the Employer's facility in Moose Lake, Minnesota. The undersigned had been selected to serve as hearing officer pursuant to that law and the procedures of the Minnesota Bureau of Mediation Services.

Documentary evidence submitted by the Employer showed the Veteran was honorably discharged from the Marine Corps. The Veteran elected to have his statutory hearing heard by a single hearing officer/neutral arbitrator instead of a three-person board permitted by the law.

Because the Veteran chose to proceed *pro se*, the undersigned provided him with an explanation of the format for a typical arbitration hearing to familiarize him with the process that would be followed. An explanation of expected commonly-used terminology, such as the order of presentations, cross-examination, rebuttal, and the like was also provided at the outset of the hearing.

No procedural issues were raised by the Employer or the Veteran. Persons providing testimony were sworn and their testimony was subject to cross-examination. The parties closed the record with verbal summations at the conclusion of the evidentiary presentations and the matter was taken under advisement.

## **ISSUES**

The parties stipulated to the following statement of the Issues:

On September 14, 2011, the Employer gave notice to Dwayne Dubey of its intent to terminate his employment. Was this intent to terminate based on misconduct or incompetence of Mr. Dubey? If not, what shall be the remedy?

## **BACKGROUND AND SUMMARY OF THE EVIDENCE**

The Veteran had been hired as a Security Counselor on June 4, 2007 to serve at the Minnesota Sex Offender Program ("MSOP") facility located in Moose Lake, Minnesota. The

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<sup>1</sup> Minn. Stat. §197.46.

program provides comprehensive services to individuals who have been court-ordered to receive sex offender treatment in a civil confinement environment.

The Veteran was discharged from his employment after three successive violations of applicable policies that occurred during his last thirteen months of employment. The violations resulted in a written reprimand in September of 2010, a 7-day disciplinary suspension in July of 2011, and termination following the third infraction that occurred that same month. The notice imposing the 7-day disciplinary suspension included a “Last Chance” warning of immediate termination for any further policy violations.

The Employer’s evidentiary presentation consisted of 38 numerically tabbed exhibits in a 3-ring binder as well as testimony from four staff members at the MSOP facility. The exhibits provided a detailed description of the operations and procedures of the MSOP facility. They also depicted the Veteran’s employment history as well as the training, counseling, and coaching he received during his term of employment somewhat in excess of four years. The investigative reports and related documents that led to the three disciplinary events previously noted were also among the tabbed exhibits. The testimony of the Employer’s witnesses paralleled the information contained in the exhibits and provided clarification for certain terminology used in the reports.

The Veteran provided testimony on his own behalf to portray what he characterized as a hostile work environment in which he felt singled out for discipline. He did not call any witnesses to testify on his behalf. Nor did he direct any challenges to the testimony of the Employer’s witnesses via cross-examination questions. Moreover, he did not dispute the authenticity of any of the Employer’s exhibits that dealt with the three policy violations in question.

No useful purpose would be served by providing a detailed description of the entire record of evidence and testimony. The record has been carefully reviewed and considered. Instead, this summary attempts to confine itself to those material considerations that are pertinent to making the requisite factual findings and conclusions necessary to determining the stipulated issues.

The MSOP facility uses a number of security procedures to account for and control the activities of the clients it has in civil confinement. At the time of hearing, there were some 480 offenders housed at the facility.

In very general terms, it may be said that the security procedures used at MSOP have a two-

fold purpose: To secure the facility to prevent escapes as well as the entry of contraband or inappropriate media into the facility and, secondly, to safeguard the well-being of the clients housed at the facility.

It is undisputed that the Veteran had been trained on and was familiar with the contents of the policy documents in question. One set prescribed the procedures to be used for conducting the headcount of clients four times per day. A second set prescribed the procedures to be used to account for tools and other equipment that are used within the secured perimeter of the facility. In accordance with the policy, items that can be used as a potential weapon or to aid in escape fall into the category of “sharps.” Finally, the attendance policy, among other things, prescribed the standards for reporting for work as scheduled.

The Veteran bid to work on what was described as Shift I. The facility uses three 8½-hour work shifts each day. They overlap by one-half hour with adjacent shifts. Shift I started at 10:00 p.m. each day and ran until 6:30 a.m. the following morning. Because the majority of hours on the shift fell after midnight, the shift for a given date was associated with the date on which the majority of hours fell. For example, a Shift I that actually began at 10:00 p.m. on the evening of July 15<sup>th</sup> was both referred to and shown on work schedules as Shift I for July 16<sup>th</sup>. This had been the practice for many years and the Veteran was well aware of the practice.

The first charge of alleged policy violation by the Veteran arose out of an incident that occurred during the early morning of July 12, 2010. The Veteran was responsible for conducting a population count, or headcount, of the clients residing in his housing unit at approximately 5:30 a.m. At this time of the morning, each client is locked into his living unit and is usually asleep.

The door to each living unit has a small rectangular viewing window. It is taller than it is wide and is too small for a person to crawl through. The window is covered with a privacy shade, or flap, on the exterior that may be lifted up by either of its lower corners to observe the clients inside. The composition of the flap material is such that it will quickly fall back down to cover the window as soon as it is released.

The subject housing area had a total of forty-nine living units on two floors. The first floor had twenty-three living units with twenty-six on the second. Each living unit can house two clients. On the day in question, three of the units were unoccupied and twelve had single clients. The remaining thirty-four living units had two occupants each. There was a total of eighty clients.

According to policy, two Security Counselors assigned to the housing area were each to separately go from room to room to ensure that each living unit contained the correct number of clients. By counting separately, the two Security Counselors could effectively cross-check and verify the accuracy of the count for each other.

The policy required that each Security Counselor begin the count process by obtaining a clipboard with a Count Report. The Count Report was to be verified by the Security Counselor to be accurate. The Count Report listed the room number of each living unit as well as the names of the clients. It showed whether a given room had one, two, or no occupants.

With the clipboard and Count Report plus a flashlight, each Security Counselor would separately visit each living unit and lift the shade. The procedure called for shining the flashlight on the ceiling or back wall of the unit to illuminate it enough to make the required observation of each client. The policy called for the observer to see both skin and movement. This was to ensure that a real person occupied each bed and that they were alive without apparent distress. The movement customarily observed was the rising and falling of the chest of the sleeping client due to normal breathing. After each client's presence and body motion was observed, the Security Counselor was to place his initials on the Count Report next to the client name before moving on to visit the next living unit. At the end of the process, the number of initialed spaces would be counted, the total written on the form, and the form turned in to the Group Supervisor.

Later that day, after the Veteran and his co-worker had conducted their headcounts, a supervisor reviewed the Count Reports and noticed that they were inaccurate. Both reports showed that a particular client was present in Room 122. Both reports were initialed to verify that the client had been observed during the 5:30 a.m. headcount. However, the particular client had been moved to a different housing area on July 9<sup>th</sup>, three days before the Veteran and his co-employee performed their separate headcounts and documented their results.

Both reports were further inaccurate in that they showed a total of 80 clients having been present. This was the correct number. But if they had been counted, the number of initialed spaces totaled 81 and not 80. If the initialed spaces had been counted as they should have been, the discrepancy should have been detected and reconciled.

An investigation ensued during which the Veteran was interviewed. In response to questions,

he maintained that he had spent 6 to 7 seconds at each viewing window to observe clients. He admitted that he had not carried a clipboard and a Count Report during the procedure. He did not claim any lack of familiarity with the requirements of the applicable policy.

The housing areas are equipped with a number of cameras that continuously record activity. The video showed how much time the Veteran actually spent at each viewing window while he performed the headcount. During the viewing, the undersigned used a “one thousand one, one thousand two” method to estimate the amount of time the Veteran actually spent at each viewing window. The consistent time observed by the undersigned was estimated to be less than one second. The video recordings also showed how much time the other Security Counselor spent at each window during his separate headcount.

Upon concluding its investigation, the Employer issued a Written Reprimand to the Veteran on September 9, 2010. The reprimand warned the Veteran of further discipline, up to and including termination of his employment, in the event of future policy violations.

The co-employee was issued a Verbal Reprimand for similarly violating the headcount policy. Because the video showed that the co-employee actually spent considerably more time actually looking in each viewing window, he was assessed the lesser form of discipline.

The second incident, which led to the 7-day suspension and last chance warning, involved two different forms of alleged misconduct: First, non-compliance with the policies for the accountability for tools and other controlled equipment and, second, abandonment of work assignment.

As previously noted, the three work shifts at the facility overlap each other by one-half hour. This permits each staff member going off shift to coordinate with the incoming staff members on the succeeding shift.

The Employer’s policies for accountability of tools and controlled equipment call for Security Counselors to account for these items during the period of overlap. The applicable Equipment Inventory form to be used covers the three inventories to be taken each day. It has spaces for each of two staff members to sign off at 6:15 a.m., 2:15 p.m., and 10:15 p.m. to verify that the tools and equipment are present. The signatures are to be from one outgoing staff member on one shift as well as an incoming person on the next shift. In this way, the three inventories verify that all items are

present at the beginning and end of each work shift.

The applicable form for the Veteran's work station, the "CHI" location, listed twenty different items of equipment to be present at the time the joint inventory is conducted. These items included flashlights, scissors, handcuffs, mobile radios, keys, and the like. Handcuffs are categorized as one of the "sharps" types of controlled equipment because they can be used as a weapon or to aid an escape. Accounting for their whereabouts is a priority.

On the evening of June 21, 2011, the Shift III Security Counselor for the CHI location inadvertently took the handcuffs home with her. Her shift ended at 10:30 p.m. She noticed she still had the handcuffs when she arrived home sometime later. According to her statement in Employer Exhibit 21, she called in to the Officer of the Day ("OD") and reported the situation. She was directed to immediately return the cuffs to the facility. She returned them to Master Control at approximately 11:35 p.m.

The Veteran came on duty at 10:00 p.m. that night (Shift I of June 22, 2011). The CHI Equipment Inventory form does not contain a signature from a staff member from the outgoing Shift III of June 21<sup>st</sup>. It does contain the Veteran's signature in the space for "1<sup>st</sup> 10:15 p.m." However, the form only shows the first three of the twenty listed items as being present. One of those three items shown as being present are the handcuffs that were actually missing as of that time.

After the handcuffs were returned, they were given to another supervisor to return them to the CHI unit. At approximately midnight, the supervisor arrived at the CHI unit with them. She asked the Veteran when he had conducted the inventory. According to her written statement and testimony, the Veteran replied, "... just a minute ago, but I knew the cuffs weren't here ..." because somebody had taken them home.

According to the Employer's other evidence, a Security Counselor Lead, DN, telephoned the Veteran after the cuffs had been returned to let him know they were back. DN did not know the cuffs were missing until after they had been returned to the facility. As previously noted, they were returned at approximately 11:35 p.m.

The supervisor found two separate CHI Equipment Inventory forms at the Veteran's work station and made copies of them shortly after midnight because of how they read. The contents of

the form for the inventory to have been conducted at 10:15 p.m. that evening<sup>2</sup> has already been described. The other form was for the three inventories to be made on June 22nd. This second form, however, was already signed by the Veteran for the 6:15 a.m. inventory and all twenty items were already marked in as being present. This was some six hours ahead of the time when the inventory was to be taken. The form also contained the Veteran's signature for the 10:15 p.m. inventory to be conducted the following evening. Although signed, the equipment inventory column for that 10:15 p.m. inventory was still blank.

After the supervisor discussed the situation with the Veteran, he asked if the incident would be reported. She said, "Yes, this needed to be reported."

After the supervisor left him, the Veteran left his work station and walked into the OD office. He told the OD, "I'm done." The Veteran repeated, "I'm done." He then turned in his keys to Master Control and said, "I'll let HR know," as he left the facility. The OD assumed the Veteran was resigning.

At approximately 1:25 a.m., the Veteran called in to the facility from an outside telephone line. He inquired of the OD who he needed to turn in his "stuff" to. According to the OD's written statement, the OD said, "I'm assuming you resigned." The Veteran replied, "It's not the smart thing to do ... I have VA issues, mental issues ... you have no idea. ... It wasn't the smart thing to do ... but getting written up for that shit is just crazy." When asked again if he had resigned, the Veteran replied that he had. The OD said, "Dubey - I mean, you walked outta here." The Veteran replied, "Yea, I guess I did." The Veteran said again that he would let HR know tomorrow.

Employer's Exhibit 37 is a doctor's statement dated May 13, 2011 that said the Veteran could return to work his usual duties with no limitations.

The Employer allowed the Veteran to return to service notwithstanding his verbal resignation. The applicable collective bargaining agreement permits employees to withdraw written resignations within three days of submission.

The Employer conducted another formal investigation of the incident of June 21-22, 2011. During an interview of the Veteran, he said he believed he conducted the inventory at 10:30 p.m.

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<sup>2</sup>This time fell during the one-half overlap between Shift III of June 21<sup>st</sup> and Shift I of June 22<sup>nd</sup>)

He had no response to questions about why only three of twenty items were marked as present on the form. He admitted to "... jumping the gun ... by completing the 6:15 a.m. inventory early.

After the Employer completed its investigation into the events of evening of June 21<sup>st</sup> and the early morning hours of June 22<sup>nd</sup>, the Employer assessed the 7-day suspension and last chance warning by letter dated July 14, 2011. The letter specified that the suspension would be served beginning July 19, 2011 and that the Veteran would "... return for your scheduled shift on Thursday, July 28, 2011." MSOP supervisors discussed the contents of the letter with the Veteran to make sure its provisions were understood. The Veteran admitted he knew this required him to report for work at 10:00 p.m. on the evening of Wednesday, July 27<sup>th</sup>.

The Veteran did not report for work as scheduled nor did he call in to notify the Employer that he would be absent that night. His only explanation for his absence was that it was an honest mistake or an oversight. The Employer did not accept this explanation and the Veteran was discharged from his employment as a result.

During his testimony, the Veteran contended that few staff members fully comply with the applicable policies. He asserted that only two people use a clipboard for the headcount procedure. He contended that it was the responsibility of the Lead Security Counselor to produce accurate headcount forms. Most people do not check the accuracy of the form. He claimed that the headcount policy did not specify how much time to spend at each viewing window.

Regarding the second incident, the Veteran said he was just guessing at the time when he was asked when he did the sharps inventory. He said there was no set policy on when the sharps count had to be done. He admitted that most people do it at the beginning of a shift, but not everybody. He confirmed he pre-signed the 6:15 a.m. equipment inventory form but contended "... everybody else does it in this facility too." He asserted that Shift I never has two people "... doing sharps ..."

The Veteran maintained his failure to report for work as required on July 27<sup>th</sup> was "... a screw-up ... an oversight ... an honest mistake ..." He admitted he knew he was on a last chance warning that was serious.

As previously noted, the Veteran believed he was in a hostile work environment. He worked well with an employee that he believed was not liked by supervision. He felt he was singled out as a result.

He acknowledged knowing and having been trained on the policies involved in the three disciplinary incidents. He did sign his position description and was aware of his responsibilities. He was aware of the skin and movement requirements for the headcount process, but he thought he looked into each window long enough.

The subject of pending grievances under the applicable collective bargaining agreement was discussed at the hearing. Apparently one or more grievances had been filed in response to the discipline, but they were not being pursued.

In addition to the foregoing considerations, the Employer's exhibits included three decisions of the Minnesota Supreme Court. Each of the decisions<sup>3</sup> provided explanations of the standard of review to be applied under the Veteran's Preference Act.

## **FINDINGS OF FACT AND RESULTING CONCLUSIONS**

In accordance with the Veteran's Preference Act and the parties' stipulated issue statement, the principal issue in this matter is the question of whether the Veteran was removed from his employment for incompetency or misconduct shown at the hearing? The Minnesota Supreme Court has determined that incompetency or misconduct, within the meaning of the Veteran's Preference Act, is equivalent to the "just cause" standard that applies to arbitral review of discharges of public employees under the Minnesota Public Employment Labor Relations Act (PELRA).<sup>4</sup>

A just cause standard requires a two-fold examination of the evidence. First, the evidence must show the Employer had a proper basis for determining that some form of discipline was warranted. Second, the evidence must show that the disciplinary sanction assessed was reasonable in light of all of the relevant circumstances. This second stage of a just cause examination incorporates the Court's requirement, expressed in *Shrader*, that the Veteran's Preference Hearing must "... determine whether extenuating circumstances exist justifying a modification in the disciplinary sanction." To satisfy these responsibilities, each of the three disciplinary incidents

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<sup>3</sup>*Ekstedt v. Village of New Hope*, 292 Minn. 152, 193 N.W.2d 821 (Minn. 1972)  
*AFSCME Council 96 v. Arrowhead Regional Corrections Board*, 356 N.W.2d 295 (Minn. 1984)  
*Schrader v. Southern Minnesota Municipal Power Agency*, 394 N.W.2d 796 (Minn. 1986)

<sup>4</sup>Minn. Stats. Chapter 179A.01 - .25

involved in this matter will be separately examined.

The evidence surrounding the headcount incident on July 12, 2010 leaves no doubt about the nature of the Veteran's performance. By his own admission, he had been trained on the applicable policy and knew its purpose as well as what it required. Yet he did not comply with the requirements in multiple respects. He did not verify the accuracy of the Count Report he used. It was at least three days out of date and did not reflect that the client formerly in Room 122 had been moved to another location. The Veteran did not use a clipboard with a Count Report when he made his count. As a result, he did not contemporaneously place his initials by each client's name immediately after each viewing to verify that he had accounted for their presence and well-being. Although the Veteran claimed that most other employees did not comply with these procedures, there is no credible evidence to support his assertion. Moreover, there is no credible evidence that supervisors knew of or condoned such non-compliance.

The amount of time the Veteran spent at each viewing window is especially disturbing. Although he thought he spent 6-7 seconds at each viewing window, the actual video recording completely undermines this estimate. His estimate does show, however, that he knew approximately how long each viewing stop should have taken to comply with policy. While it is true that the applicable policy does not numerically specify the number of seconds that must be spent looking in each window, it is clear that the amount of time required is a function of illuminating the room and verifying the presence of the client as well as the requisite body movement. Rooms with two clients would be expected to take approximately twice as long as those with only one client. The video clearly shows that the Veteran did not spend anywhere near the amount of time necessary to actually look in any of the rooms to properly observe their contents.

Finally, after returning to his work station, the Veteran did not accurately count the number of initials he placed on the Count Report. If he had, he should have noticed the discrepancy between the number of initialed spaces and the total count of 80 that he wrote on the form.

Given the Veteran's improper performance on the headcount incident, the Employer's response was not unreasonable. When compared with the performance of his co-employee, the Veteran's performance was worse. The video showed the co-employee to have spent enough time at each window that he could have satisfied the observation requirements. Accordingly, the

Employer had a rational basis for imposing a Written Reprimand upon the Veteran while assessing the co-employee with a Verbal Reprimand. Nonetheless, the Employer's disciplinary sanction was sufficiently light, in terms of severity, to satisfy the doctrine of progressive discipline. The finding on the headcount incident, therefore, is that the Employer had just cause to discipline the Veteran as it did.

The sharps inventory incident on June 21, 2011 raises a significant credibility issue. It arises out of the timing of when the Veteran actually conducted the inventory. It is undisputed that a supervisor returned the missing handcuffs to the CHI location at approximately midnight. The Veteran had not previously reported them to be missing as policy required. This led the supervisor to ask when the Veteran had completed his sharps count. According to her testimony and statement, the Veteran replied, "... just a minute ago ...". During the Employer's later investigation, the Veteran put the completion time in the 10:30 p.m. time frame.

The CHI Equipment Inventory forms the supervisor observed caused her to make copies of them. The form for the 10:15 p.m. inventory was only partially completed. Only the first three items had been filled in with the number "1" in each space. The remaining seventeen spaces for the other items were blank.

If the Veteran had really completed the inventory at approximately 10:30 p.m., why had he shown the handcuffs to be present? The cuffs were not yet known to be missing. The staff member who inadvertently took them home did not report this fact until approximately 11:15 p.m. and they were not returned to the property for another twenty minutes. It was only after the cuffs were returned that a co-employee notified the Veteran of their status.

If the Veteran had really completed the inventory at approximately 10:30 p.m., why were the spaces for the remaining seventeen items left blank and still were blank when the supervisor arrived at the CHI location at midnight?

Thirdly, if the Veteran had really completed the inventory at approximately 10:30 p.m., why had he not obtained the signature of the Shift III employee who was going off duty at that time? The form shows that the previous inventories that day each had two signatures as required.

The record does not contain proper explanations for these questions. Accordingly, the record favors the testimony of the supervisor to the effect that the Veteran did not begin the 10:15 p.m.

inventory until shortly before the supervisor arrived at midnight. This is consistent with the seventeen blank spaces on the form resulting from the Veteran having been in the process of filling in the form when the supervisor walked in and interrupted him.

Once again, the sharps inventory reflects several violations of the applicable policies. The Veteran failed to complete the inventory when he should have. He failed to coordinate with a staff member from the previous work shift. He failed to detect the missing handcuffs at the beginning of his work shift. Although he contended that he knew the cuffs were missing, he failed to comply with the alert and search procedures required when such items are found missing.

In addition, the Veteran effectively falsified the CHI Equipment Inventory form for the following day by completing and signing it some six hours prior to the proper time. He also pre-signed the same form for the 10:15 p.m. inventory for the following evening.

Separately, upon learning that the incident would be reported, he abandoned his position.

The record does not contain any evidence of extenuating circumstances that would operate to mitigate these policy violations. Given the nature of the Employer's responsibilities at the MSOP facility, his failure to comply with these policies constituted serious misconduct. The Employer had just cause to take disciplinary action. The level of discipline imposed by the Employer for this misconduct was not unreasonable in light of his previous discipline and the gravity of the infractions. An escalation in the level of the disciplinary sanction was clearly warranted. Accordingly, the 7-day suspension and last chance warning were consistent with the doctrine of progressive discipline and were not unreasonable.

The facts surrounding the third incident are not in dispute. Although he knew when he was scheduled to return to work following the suspension, he neither reported or notified the Employer he would be absent. The only explanation for this incident was mistake or oversight.

The record does not contain any evidence of extenuating circumstances that would serve to mitigate the seriousness of the third incident. The Veteran admitted he knew the last chance warning was serious. The record does not substantiate the existence of any physical or emotional condition that may have impaired his ability to comply with applicable policy.

The Employer viewed the Veteran's "no-call, no-show" as yet another incident that was consistent with the Veteran's previous demonstrations of indifference to his work responsibilities.

After the undersigned's due consideration of the relevant circumstances, the overall findings are, first, that the Veteran was removed from his position for misconduct and, second, that no extenuating circumstances existed to justify any modification of the Employer's decision to terminate his employment. The Employer's handling of the overall matter was consistent with the doctrine of progressive discipline and did not constitute disparate discipline.

### **DECISION**

On September 14, 2011, the Employer gave notice to Dwayne Dubey of its intent to terminate his employment. The Employer's intent to terminate was based on the repeated misconduct of Mr. Dubey. The Employer had just cause to remove Mr. Dubey from his employment position for misconduct within the meaning of the Minnesota Veteran's Preference Act.



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Gerald E. Wallin, Esq.  
Hearing Officer/Arbitrator  
March 26, 2012