AMERICAN ARBITRATION ASSOCIATION
AAA Case No. 01-19-0001-5507

In the Matter of the Arbitration	:	
	:	
Between:	:	Opinion and Award
	:	
AFSCME District Council 47, Local 2187	:	Grievance: Karimya Beckham Discharge
	:	
and	:	
	:	
City of Philadelphia	:	
	:	

Before: Lawrence S. Coburn
Arbitrator

Appearances:

For the Union:

Willig, Williams & Davidson
By: James Glowacki, Esquire

For the City:

Benjamin Patchen, Assistant City Solicitor

* * * *

I. Introduction.

Pursuant to the Collective Bargaining Agreement between the parties, I was designated to arbitrate the grievance in this case, which involves a claim by AFSCME District Council 47 (the "Union") that the City of Philadelphia (the "City" or the "Employer") violated the Collective Bargaining Agreement by discharging Karimya Beckham ("Grievant") without just cause. On February 14, 2020, I conducted a hearing at which both parties were afforded full opportunity to present evidence and argument in support of their respective positions. The parties made oral arguments at the close of the hearing, at which time the hearing was declared closed.

II. The Issues.

The issues for determination, as stipulated by the parties, are as follows:

1. Did the City have just cause to discharge Grievant, Karimya Beckham?
2. If not, what shall be the remedy?

III. Pertinent Contractual Provisions.

The Collective Bargaining Agreement between the City and AFSCME District Council 47, Local 2187, provides in pertinent part:

> Section 16. <u>Discipline and Discharge</u>
>
> > A. <u>Just Cause.</u> It is agreed that management retains the right to impose disciplinary action or discharge provided that this right, except for an employee in probationary status, is for just cause only.

IV. Pertinent Policies and Procedures of the Philadelphia Department of Human Services ("DHS"), Children and Youth Division ("CYD").

The DHS, CYD Policy and Procedure Guide issued March 15, 2011 provides in pertinent part:

POLICY
Use of FACTS, FACTS², and the Electronic Case Management System

> Maintaining accurate information on the children, youth, and families that are served by the Department is essential. Having accurate information electronically is particularly critical during emergencies or other crises, especially after-hours and on weekends and holidays. It is also critical to the Department's ability to accurately report out on data regarding the families it serves. This is essential to maintaining state and federal funding resources.
>
> * * * *
>
> All SWSS [Social Worker Services Staff] are to use the Electronic Case Management System (ECMS) to directly input all Structured Progress Notes (SPN) on cases or investigations
>
> Structured Progress Notes must be completed in a timely way and not later than six business days after the visit or contact they are detailing.

> The Contact log in FACTS² must be used to document all other contacts and activities not documented in an SPN. Contact should be documented immediately but no later than six business days after the contact occurred.
>
> * * * *
>
> When cases or investigations are assigned, SWSS are expected to review FACTS² for prior DHS reports, their allegations and determinations, Contact Log entries, ECMS for prior SPNs, and the case record.

Policy 3200, General Protective Service Assessments, provides in pertinent part:

> The CYD social worker reviews the report [of alleged abuse or neglect] and schedules an appointment with the family for a home visit within one working day of assignment unless otherwise directed by his/her supervisor. All GPS assessments require at least one home visit during the assessment period.
>
> - the appointment to see the family must be within six working days of receiving the assignment . . .

V. Background.

The Union represents professional employees employed by the City, including Social Workers in the Department of Human Services (the "Department" or "DHS") Grievant worked for the Department as a Social Worker Trainee, a Social Worker I, and a Social Worker II for about 11 years. According to Grievant, after being assigned to a case involving alleged abuse or neglect of a child, an intake social worker's responsibilities were to: (1) investigate the allegations of abuse/neglect; (2) determine if the allegations were true; (3) make a safety assessment to ensure that the child is in a safe environment; (4) determine if the child needs services to be provided with respect to underlying issues; and (5) although the focus is on the child, work with the family as well.

In 2006, a child who was being served by the Department died. Following an investigation, it was determined that certain documentation had been falsified, stating that children were seen by case workers when they had not been. Some case managers were criminally charged, arrested and convicted.

In the wake of these discoveries, the Department embarked upon improving quality control, including training on providing prompt and effective services to children who are alleged to have been abused or neglected and on the importance of accurate and timely documentation. In that connection, the Department conducts training of social workers upon their hire, and then requires an additional 20 hours of training annually. Moreover, according to F M ,

Director of Intake, Region 2 for the Department, accurate and timely documentation also is emphasized in regional staff meetings every six months. Such documentation is necessary not only for the general safety of the children served, but also as a foundation for accurate testimony in court proceedings, in which social workers frequently participate.

At all relevant times, Grievant reported directly to [redacted] [redacted], a Social Worker Supervisor. Each supervisor had approximately 6-7 Social Workers reporting to her.

VI. The Facts Surrounding Grievant's Discharge.

Social workers are required to document in detail each visit and contact in connection with an investigation of the abuse or neglect of a child. The chronology of events, including relevant portions of documents, relating to the victim child in this case, L[redacted], is as follows:

A. Social Worker J[redacted] R[redacted] visited the residence of L[redacted]'s [redacted] in the spring of 2016 to investigate a claim of abuse or neglect.

On [redacted], Social Worker J[redacted] R[redacted] conducted a home visit at the residence of L[redacted]'s [redacted], F[redacted] H[redacted] to investigate a claim of abuse or neglect. Following the visit, R[redacted] prepared an SPN[1] to document her findings:

> **a. Extent of Maltreatment:**
> According to the R/S [reporter of abuse/neglect], the Victim Child [L[redacted]]has been passed off to several family members. The R/S is concerned about the V/C [victim child] welfare and is unaware if V/C is attending scheduled medical appointments. The R/S also reports that VC's Parents abuse substances and have been arrested for using as well as selling. The R/S reports that AP's do not interact appropriately with V/C and are always out "running the streets." The R/S reports that the home that the Parents live in is abandoned and is condemned. The R/S reports that the home is a fire hazard. The R/S reports that the V/C does not reside in this residence but does frequent the environment.
>
> [redacted] with whom the child now lives] reports that MOT [mother] and FAT [father] come to her home sporadically since the MOT left the home . . . [redacted] reports that parents got into a physical altercation in her home in Feb, so she has not allowed them to sleep at her home at the same time. [redacted] reports that she did not put MOT out, she left on her own because she will not allow MOT and FAT to "be a couple" in her home. [redacted] wants parents to work

---

[1] "SPN" signifies Structured Progress Notes that are completed by a social worker who visits a child or the child's family members in connection with an investigation of alleged abuse or neglect of the child.

and get themselves together so they can care for child. MOT left child in ’s care . . .

b. Circumstances Surrounding Maltreatment:
FAT reports that he and PGM [parent grandmother] had a verbal altercation on New Year’s because he would not allow PGM to see VC. FAT reports that both parents were drinking because of the new year celebration, but deny alcohol abuse. FAT reports that L was not with parents at that time anyway. FAT states that he will never allow PGM to visit VC because she does nothing to support MOT or FAT and he feels that she wants him to fail . . .

c. Child Functioning:

The child is one yr old, walks without holding on and appears to be appropriately bonded with . reports that she calls her mom mom because they spend so much time together. Child is able to say some words and is able to express herself in an age appropriate manner. L appears to be happy in the care of . Child has a mark on her face that was reported to be ring worm. reports that she took child to the doctor and received a cream.

d. Adult Functioning for all Caregivers:

reports that parents engaged in a physical altercation in her home back in Feb and MOT stopped living with her by her own choice. reports that MOT is still unemployed and does not feel she is making any efforts to better herself. also reports that FAT is also not making any efforts to better himself for the sake of his child. reports that the information in the report regarding parents is valid, however, the baby has not been in harm’s way because she is with .

e. Parent/Caregiver Parenting Practices (exclude disciplinary practices):

reports that she ensures that child’s daily basic needs are met and parents call and check on child randomly. reports that parents are doing whatever they want to do. MOT has not provided WIC or SNAP for child. reports that she is fine taking care of child on her own without the assistance of parents or DHS intervention. will contact DHS if parents come to take child, however they have not made any mention to take child nor do they seem to be concerned with caring for child.

2. Safety Assessment, Decision and Plan (what actions occurred and why):

L appeared safe in the home with . . .

B. Report in 2017 that L███ was living in substandard housing with her father.

According to F███ M███, Director of Intake, Region 2 at DHS, in 2017 a report was lodged that L███ was living in substandard housing with her father at ███ in Philadelphia. Social Worker L███ M███ was assigned to investigate.

Meanwhile, according to J███ J███, L███'s ███ who lived around the corner from L███'s father, on ███ L███'s father asked her to do him a favor: to take on L███'s care because DHS was trying to take L███ away from him. J███, who regularly had watched L███ while she was living with her father, agreed to do so. L███'s father then introduced J███ to DHS Social Worker L███ M███, who was at the father's residence to investigate L███'s living conditions. When J███ agreed to temporarily take responsibility for L███'s care, M███ told J███ that she would do a background check on her so that L███ could move into her home at once.

J███ testified credibly at the arbitration hearing that L███'s father's living room was stacked to the ceiling with "stuff," the house was dark inside, and one could easily trip over the debris. According to J███, the house was not safe for L███, who was then three years old.

J███ also testified credibly that, at the time, L███ appeared to be very thin, with protruding ribs, and wore clothes that were dirty and too small. Social Worker M███, having completed the background check, informed J███ that DHS projected that L███ would stay with J███ for 60 days. According to J███, L███ was not potty trained when she moved into her 2house, but with guidance from J███ L███ learned to use the toilet.

In accordance with standard procedure, M███ prepared an SPN relating to her ███ home visit at J███'s residence (the "███ SPN"), and entered the ███ SPN data into the Electronic Case Management System ("ECMS") on ███:

> **a. Extent of Maltreatment:**
>
> RS stated that AP FAT and VC, L███ (3 yr) are residing in an unfit home. RS stated that the home is dirty and cluttered with debris (clothes and trash). RS reported that there is no clear path to the door and the debris is causing a fire hazard . . . Home has no running water and FAT and VC have to go to aunt's home to wash up . . . There may not be any heat in the home and FAT recently purchased a space heater. RS also reported that FAT is abusing marijuana and opiates and has been using for years and it has been affecting his ability to care for L███.
>
> **b. Circumstances Surrounding Maltreatment:**
>
> AP FAT reported that the home does have operable utilities and that the home is

currently being renovated. FAT stated that the home used to be in worse condition, but they just had repairs done. FAT stated that he knows the home is not perfect, but he is doing the best he can for VC.

FAT denied drug use allegations stating that he is on probation and that he takes randomly a drug test.

SW observed the home being unfit for a young child to live in. The home was cluttered with debris and trash such as RS stated and the home did appear to be a fire hazard. FAT appeared to not be under the influence of any substance at the time of the visit.

c. Child Functioning:

L███ was observed in the home dressed seasonally appropriate. L███ appeared to be developing on target and was able to tell SW her name and her favorite color. L███ is not enrolled at a daycare program, but is watched by FAT all day. FAT stated that L███ enjoys playing on his tablet and doing creative activities such as coloring and painting. FAT reported that L███ does not have any medical, behavioral, or mental health issue.

d. Adult Functioning for all Caregivers:

FAT reports being unemployed at this time, but stated that his income is from selling his art work. FAT reported not receiving any public assistance. FAT denied any substance abuse, mental health, or DV in the home.

MOT was called while SW was in the home.
MOT reported that she lives in West Philly where she is renting a room out from a friend. MOT stated that VC is usually with her on some days, but she works retail and due to Christmas Holiday her hours have been extended so she has not been getting her. MOT is employed at Forman Mills and receives food stamps and cash assistance.

e. Parent/Caregiver Parenting Practices (exclude disciplinary practices):

Both MOT and FAT stated that they are doing their best to raise the child. FAT reports his ████████ as his support.

2. Safety Assessment, Decision and Plan (what actions occurred and why)

SOOVI has been identified for safety threat # 9. It is serious, observable and specific, and out of control that FAT is not performing duties in the home to

ensure VC's safety. The home is a fire hazard, with property damage, exposed wires and is cluttered with trash and debris. FAT also did not have proper bedding for the VC.

A safety plan has been implemented with [redacted], J[redacted] J[redacted]] as the safety provider stating that VC is not to return back to the [father's] residence.

3. Information about progress made on Family Service Plan/Single Case Plan and/or other significant information, to include Risk Factors.

The home visit has been conducted and case parties have been interviewed. A safety plan has been put into place.

4. Other planned activities or concerns to include next scheduled contact.

Obtain medical collaterals.

C. Safety Plan prepared by L[redacted] M[redacted] on [redacted].

The Safety Plan prepared by M[redacted] on [redacted] provided that L[redacted]'s [redacted], J[redacted] J[redacted], would become L[redacted]'s caregiver for 60 days. Specifically, the Safety Plan outlined the responsibilities that J[redacted] would assume on L[redacted]'s behalf, including all educational and medical basic needs and proper supervision at all times. The Plan also required J[redacted] to notify DHS if L[redacted] could no longer reside in her home and if L[redacted] returned to her father's residence. J[redacted] signed the Plan on [redacted], but L[redacted]'s parents did not sign the Plan in the section entitled: Parental / Legal Custodian Waiver, as required.

D. Contact Log Entry on [redacted] documenting telephone conversation between J[redacted] J[redacted] and D[redacted] G[redacted], SW Supervisor.

On [redacted], D[redacted] G[redacted], a Social Work Supervisor, documented a telephone call she made to J[redacted] J[redacted]. According to the Contact Log entry, which was inputted into ECMS on the same day, G[redacted] had telephoned J[redacted] to explain that L[redacted] should not have been allowed to go to the home of L[redacted]'s paternal grandmother, D[redacted] G[redacted] and that if the care of L[redacted] was too much for J[redacted], DHS would make other arrangements. When J[redacted] replied that it was not too much trouble for her to care for L[redacted], G[redacted] informed her that it would be fine if the grandmother, L[redacted]'s parents or anyone else visited L[redacted] at J[redacted]'s house. J[redacted]'s telephone number was listed with the Contact Log entry.

E. On ██████, Grievant was assigned to investigate L███'s case because M███ left DHS.

Grievant was assigned to L███'s case on ██████[2] because M███ resigned from DHS. According to Grievant, when the case was assigned to her, she was given the report of alleged abuse/neglect, one SPN[3] and the Safety Plan, all of which she reviewed. According to Grievant, there was no documentation to support L███'s move from her father's residence to that of J███ J███ on ██████. Grievant testified that she promptly met with her supervisor, ███ ███, who told her to contact L███'s mother.

Grievant testified that because the ███ SPN did not contain J███ J███'s contact information, she could not visit L███. Moreover, because her supervisor had directed her to contact L███'s mother, Grievant focused on that task.

F. Grievant's SPN documenting her unscheduled visit to L███'s mother's residence on Saturday, ███.

The first documentation prepared by Grievant relating to her handling of L███'s case was an SPN documenting Grievant's unscheduled trip to L███'s mother's residence, ███ ███ in Philadelphia on Saturday, ███ and her unsuccessful attempt to meet with the mother (the "███ SPN"). In the ███ SPN, Grievant completed the section of the form relating to Circumstances Surrounding Maltreatment confirming that L███'s mother was not home:

> **b. Circumstances Surrounding Maltreatment:**
>
> SW was assigned this case on ███. SW reached out to mother via telephone and was communicating back and forth but mother had difficulty scheduling a specific time for SW to complete a home assessment so as per my supervisor ███ ███ SW had me do an unannounced visit.
>
> SW arrived at the home and knocked. A male answered and stated that S███ (case mom) was not home. SW left a letter for mom with him asking him to inform mom that she needed to contact SW and that the information was on the letter.

---

[2] All dates hereinafter will be in 2018 unless otherwise stated.

[3] Presumably, the SPN Grievant referred to was the ███ SPN prepared by L███ M███, inputted into ECMS on ███, which provided certain background facts, but did not state the address or contact information for J███ J███ who had agreed to take care of L███ for 60 days.

In the original version of the ███ SPN, which was not entered into the ECMS until ███ ██,[4] the section addressing Child Functioning stated:

> L███ is 3 years old and appears to be in good physical health. Initially when I arrived L███ wasn't home, she was with her cousin. She was brought home during the visit so SW could see the child. SW engaged with L███ who was nice and friendly. She was dressed appropriately, proper hygiene and clean clothes. She appeared comfortable in her living arrangements and bonded with cousin.[5]

Under the sections entitled Adult Functioning for all Caregivers and Parent/Caregiver Parenting Practices (excluding disciplinary practices), the ███ SPN suggested that she had conversations with the mother and the father on ███:

> **d. Adult Functioning for all Caregivers:**
>
> Father is not working at this time, denied MH/BH concerns. No D/A issues, no DV and no medical concerns.
>
> Mother states she works at Forman Mills Mall. She denied mental health and or drug and alcohol concerns. She stated she resides with her friend and is paying rent for her space (one bedroom for her and L███).
>
> **e. Parent/Caregiver Parenting Practices (excluding disciplinary practices):**
>
> Father stated that mother is the caregiver for most of the time, and that she is a good mother. Father stated that he supports the mother with watching his child and occasionally buying her things, when he can afford it.

---

[4] Grievant explained that she did not input the ███ SPN into the ECMS until ███, although required to be inputted within six business days, was because periodically the system crashed, causing her to lose everything she had been inputting. She provided the same explanation for failing to input subsequent SPNs in a timely fashion.

[5] This description of L███'s condition was entered by Grievant to describe L███ on a subsequent SPN documenting Grievant's first visit on ███ to J███ J███'s residence, where Grievant saw L███ for the first time and where L███ had been staying since ███ ███. Somehow, this entry was inserted into the SPN that documented Grievant's prior visit to L███'s mother's residence on ███, when Grievant saw neither L███'s mother nor L███. When Grievant finally presented the SPN on ███ for her supervisor's approval, ███ ███ found the error and required Grievant to correct that section of the form by stating that "The child was not seen."

As the SPN previously had stated, however, when Grievant visited the mother's residence on , she spoke to neither the mother nor the father. Instead she claimed that she left a letter with an unidentified man, asking him to tell the mother to contact her.

G. Grievant made another unscheduled visit to L's mother's residence on Monday, .

Grievant completed an SPN documenting a second visit to the mother's residence on Monday, (the SPN"). In the SPN, Grievant stated that a female identifying herself as D answered her knock. Grievant gave her a letter addressed to the mother, and D agreed to pass it on to L's mother.

The sections on the SPN relating to Child Functioning, Adult Functioning for all Caregivers, and Parent/Caregiver Parenting Practices (excludes disciplinary practices) were completed with the identical incorrect information that was on the SPN.

H. Between and , when Grievant left on vacation, Grievant submitted no documentation of working on L's case.

Grievant did not complete any SPNs or contact logs on L's case between and , when she went on vacation until .

Her supervisor, , however, completed a Supervisory Conference Log confirming a discussion with Social Worker C H on , confirming that "sw", whether H or Grievant, " . . . has made attempts with mother and mother has not been able to meet with worker. Worker is to continue." The supervisor added under Directives and Action Items, that "investigation and collaterals are pending."

also completed a Supervisory Conference Log confirming a discussion with Social Worker C H on stating that Grievant had not located L and had not met with the mother despite repeated attempts:

> Report was validated on the notes from prior sw with regards to the housing conditions of the home. Sw - Mrs. Beckham still does not know where L is at, she has been talking back and forth with mother and has went out to see mom at the place where she is living at but still failed to meet up with mother. Mother had set up appt with worker and had not kept up with them. The child is with an aunt on a safety plan, sw will need to find out where.

I. While Grievant was on vacation, Social Worker M V temporarily handled L's case, conducting a home visit with L, J J and L's father on at J's residence.

On , M V, who was temporarily assigned to fill in for Grievant while she was on vacation, visited L J J and L's father at J's residence at , Philadelphia for about an hour. While there, she took a photograph of L. V completed an SPN to document the visit (the " SPN"), which was entered into the ECMS on .

In the Child Functioning section of the SPN, V commented that L appeared to be age appropriate, well dressed and well cared for. She also observed L happily drawing and coloring with her little cousin. L told V that she felt safe in J's home and was not afraid of her father or mother.

J informed V that she was glad to care for L temporarily, but was about to have work done on her house which would prevent her from continuing to care for her. J suggested that L's grandmother, (mother of L's father), who has a home, would be a good caregiver for L because she is the only grandchild. V told J that she would pass on this information to Grievant.

V also reported that L's father told her that L's mother would soon have a suitable home in which to care for L. V informed the father that she would have to complete a safety plan to ensure that L's next home was safe. According to V, the father signed the safety plan that V prepared.

J. Grievant met with L and J J at J's residence on .

After returning from vacation, Grievant promptly went to J's residence on from 1-2 p.m. to see L and to talk with J. She found L to be well cared for in a safe living environment. Grievant documented her visit in an SPN (the " SPN (1-2 pm)"),[6] which provided a detailed description of what Grievant learned from the visit:

> **b. Circumstances Surrounding Maltreatment:**
>
> SW followed up with the caregiver. SW sat and discussed the case with Ms. [J] J. SW asked Ms. J how was things since L has been with her and she said things were ok. She said the parents have shown minimum support and that she hasn't seen mom in a month and that dad rarely comes and

---

[6] The SPN (1-2 pm) was entered into the ECMS on .

when he does it's for 10 mins. She said that she takes care of her grandbaby and that PGM [father's mother] was willing, able and capable of caring for the child. She said PGM has been helping her with the child. SW informed Ms. J that following the home assessment and the clearing PGM of her clearances that she could take L to her. SW informed her that SW would notify her during the process. SW completed home assessment; the home has all operating utilities; food and appropriate bedding; there are no active safety threats.

Initially when I arrived L wasn't home; she was with her cousin. She was brought home during the visit so SW could see the child. SW engaged with L who was nice and friendly. She was dressed appropriately, proper hygiene and clean clothes. She appeared comfortable in her living arrangements and bonded with cousin.

During the visit Ms. J called PGM. SW obtained her infor: D G [tel. No.], , DOB [xxxxx]; ss # [xxxxxxx] to run her clearances for possible responsible party/kinship. We scheduled for tomorrow to complete a home assessment.

c. Child Functioning:

L is 3 years old and appears to be in good physical health. Initially when I arrived L wasn't home, she was with her cousin. She was brought home during the visit so SW could see the child. SW engaged with L who was nice and friendly. She was dressed appropriately, proper hygiene and clean clothes. She appeared comfortable in her living arrangements and bonded with cousin.[7]

In the SPN (1-2 pm) sections relating to Adult Functioning for all Caregivers and Parent/Caregiver Parenting Practices (exclude disciplinary practices), Grievant added no new information. Instead, she copied verbatim the wording that V had inserted in these sections. Likewise, in the section of the SPN (1-2 pm) relating to Parent/Caregiver Disciplinary Practices, Grievant repeated verbatim what V had inserted in that section of her SPN:

> Father stated that mother is the caregiver and that she normally speaks to her child when the child needs to be disciplined.

Despite this language suggesting that she had spoken with the father on , Grievant makes clear at the beginning of the SPN (1-2 pm) that she did not speak to L's father that day.

---

[7] This is the identical language that had appeared on the SPN and the SPN.

Toward the end of the SPN (1-2 pm), Grievant states that her next action would be to perform a home assessment at the residence of the mother of L 's father, D G

K. Later on from 3:30-4 p.m., Grievant went to the residence of L 's mother.

Later on , from 3:30-4:00 p.m., Grievant again visited the residence of L 's mother, who was not there. Grievant documented that visit in a second SPN on (the " SPN (3:30-4 pm)") that she left a letter for, texted and telephoned L 's mother that afternoon.

In the sections of the SPN (3:30-4 pm) relating to Adult Functioning for all Caregivers, Parent/Caregiver Parenting Practices (exclude disciplinary practices), Parent/Caregiver Disciplinary Practices, Grievant described detailed conversations she allegedly had with L 's father and mother, although she did not meet with them that day.

In the section of the SPN (3:30-4 pm) relating to Other planned activities or concerns to include next scheduled contact, Grievant wrote: "home assessment for PGM."

L. On , Grievant visited the residence of D G , L 's paternal grandmother, to assess its safety.

Having visited D G 's residence, Grievant prepared an SPN (the " SPN") which reported, among other things that: (1) Having found that the home was safe, needing only a fire extinguisher, Grievant discussed with G her plan to obtain the appropriate clearances so that they could proceed with a kinship arrangement; (2) Grievant learned that G worked for a mortgage company in Fort Washington from 8:30 a.m. to 4:00 p.m., earning a salary more than sufficient to cover her expenses; (3) Grievant informed G that, if kinship were approved, she would be able to get DHS assistance toward daycare; (4) Pending approval, G agreed to be the responsible party for L ; (5) G told Grievant that "she didn't want the parents at her home" and that she didn't want to deal with the parents; and (6) Grievant informed G "that at this time the parents have their parental rights and are entitled to visitation but they would be monitored by DHS and a kinship care worker."

In the section of the SPN relating to "Other planned activities or concerns to include next scheduled contact," Grievant wrote: "To follow up with PGM clearances."

M. On , Grievant again visited G 's residence to prepare for L 's move there.

On , Grievant revisited G 's home to prepare for L 's move there. The SPN completed by Grievant (the " SPN") documented that G needed or would be

provided a fire extinguisher, reviewed a Safety Assessment and Plan, and confirmed that there were proper sleeping arrangements for L[redacted]. Grievant described her interaction with G[redacted] on [redacted] regarding the transfer of L[redacted] from J[redacted]'s home to hers:

> SW went out to the home to complete the kinship care packets. SW sat and discussed the forms with Mrs. G[redacted] as well as her role as kinship caregiver. We completed the following forms: emergency kinship assessment and options form; kinship care options and requirements as well as a safety plan. SW discussed visitations for parent and child, daycare assistance once urgent petition is filed on Monday and kinship is granted via the courts, and we discussed Ms. [J[redacted]] J[redacted] as being able to continue to help PGM since she is already cleared. PGM said that [redacted] Ms. J[redacted] agreed to watch L[redacted] during the day while she works. We discussed the parents; she said that father is on probation and that she thinks both parents are using drugs. She said she doesn't have a good relationship with father or mother and that she didn't want them in her home. Following the visit SW called Supervisor to inform all documents were signed and SW was given the okay to allow PGM to get L[redacted]. SW then called Ms. J[redacted] to inform her PGM was allowed to get her grand daughter and that she could continue to support PGM with helping out with L[redacted] until court grants PGM kinship.

In the Child Functioning section of the [redacted] SPN, Grievant stated:

> **c. Child Functioning:**
>
> L[redacted] is 3 years old and appears to be in good physical health. She is non school age and is not in daycare. She appears to be developmentally on target.

Later, in the Safety Assessment section, Grievant clarified:

> L[redacted] was seen on [redacted] with Ms. J[redacted]. Her basic needs were being met.

Under Other planned activities or concerns to include next scheduled contact, Grievant wrote: "To file urgent petition for PGM to obtain kinship care."

N. After unsuccessfully attempting to contact L[redacted]'s parents, Grievant was placed on restricted duty on [redacted] because of a shooting incident in the field on [redacted].

After meeting with G[redacted], according to Grievant she made some attempts to reach L[redacted]'s mother and father. However, those attempts were not documented in ECMS on Contact Logs, as required.

Then, on , while on assignment in the field Grievant was caught in the middle of a shootout. According to Grievant, the incident shook her up so she took off from work and went to a doctor, G H , M.D. referred to her by the Human Resources Department. Because of the incident, DHS restricted Grievant to desk duty effective until early . Dr. H issued a "Consultation Request" dated confirming that he had seen Grievant:

The Department elected not to follow either of the recommendations because it was believed that Grievant would be free to work in an unrestricted fashion within a couple of weeks. Instead, she was kept on desk duty status indefinitely, which enabled her to work within the DHS facility but kept her from going into the field.

O. On , from 6:00 - 7:30 p.m., Grievant oversaw a parental visit of L by both parents at DHS.

Grievant documented the parental visit in an SPN (the " SPN"), which was entered into the ECMS on . Present for the visit were both parents and L . The paternal grandmother, D G , who was continuing to care for L at her home, was at DHS but did not sit in on the parental visit. According to the SPN, Grievant discussed separately with G weekly visits by the parents, which G said she would prefer to take place on weekends. Grievant then asked the parents to sign the safety plan to allow L to remain with G When they refused, Grievant explained that DHS could go to court to obtain a court order. The parents still refused to sign the safety plan. According to Grievant, L appeared to be happy with her parents as the three watched a movie, played with her toys and talked. G provided L with her dinner. At the end of the visit, L was visibly upset and wanted to go with her mother, who consoled her.

In the section of the SPN devoted to Child Functioning, the same exact language that had been in the SPN and several others appeared:

> **c. Child Functioning:**
>
> L is 3 years old and appears to be in good physical health. Initially when I arrived L wasn't home, she was with her cousin. She was brought home during the visit so SW could see the child. SW engaged with L who was nice and friendly. She was dressed appropriately, proper hygiene and clean clothes. She appeared comfortable in her living arrangements and bonded with cousin.

In the section on Adult Functioning for all Caregivers, Grievant stated that L[redacted]'s mother told her that she was not working, and denied domestic violence or drug or alcohol concerns. Grievant also learned that the mother had completed high school and had taken some college courses. L[redacted]'s father told Grievant that, although he did not have a residence suitable for L[redacted], her mother soon would have a suitable place. Grievant told the father that DHS would be reaching out to the mother soon "to make arrangements." The father then signed a safety plan to ensure L[redacted]'s safety until the mother met with her social worker. The father was not working, and denied mental health or drug/alcohol issues.

In the section on "Other planned activities," Grievant wrote that she would retract the urgent petition and provide the mother with assistance through a Community Umbrella Agency or an Order of Protective Custody.

P. On [redacted], SW C[redacted] H[redacted] made an unannounced visit at G[redacted]'s house where she met with G[redacted] and L[redacted].

According to the SPN completed by H[redacted] relating to her [redacted] visit to G[redacted]'s Rugby Street residence (the "[redacted] SPN"), G[redacted] told H[redacted] that she and L[redacted]'s father did not get along. For example, he threatened to put a gun to her head during an argument, but that he has never physically harmed her. G[redacted] described him as "lazy, immature, arrogant and haughty." According to G[redacted] L[redacted]'s father is without work, but is a talented rap artist who uses opiates. G[redacted] also reported that both of L[redacted]'s parents smoke marijuana, and that the father, who lives in a crack house, is on probation for selling drugs to an undercover police officer. According to G[redacted], L[redacted]'s mother is a pole dancer, or stripper. G[redacted] reported that L[redacted]'s parents did not teach L[redacted] anything, and that L[redacted] was very thin when she moved in with G[redacted]. G[redacted] also told H[redacted] that she had enrolled L[redacted] in daycare at [redacted]. H[redacted]'s walkthrough of G[redacted]'s home showed that the house was safe and that L[redacted] had her own bedroom.

H[redacted] described L[redacted] as follows:

> L[redacted] is 3 yrs old. She appeared to be happy and playful during the visit. L[redacted] attends daycare . . . Mon - Fri from 7 am to 5 pm. PGM stated that she had to take L[redacted] to Temple emergency room 3 weeks ago because she had a [redacted] [redacted] PGM was not sure of L[redacted]'s medical coverage and where her PCP was located.

L[redacted] told H[redacted] that she loved school and did not want to go home when she was picked up.

H[redacted] described "Adult Functioning for all Caregivers as follows:

> L[redacted] is currently placed with PGM. Father lives in North Phila and Mother lives in West Phila. The parents do not have suitable housing for VC. Neither parent is

employed at this time. PGM denies mental health and drug/alcohol issues at this time. PGM works for a mortgage company . . . as a loan specialist. PGM applied for food stamps and cash assistance for VC. PGM was granted $328.00 emergency food stamps and $102.50 bi-weekly cash assistance.

Q. L’s mother telephoned F M at DHS on to complain about DHS’s handling of L’s case.

On , L’s mother S P telephoned F M, Director of Intake, Region 2, to complain about how DHS had handled L’s case. M memorialized the telephone call in a memorandum dated to C H. During the telephone call, S told M that Grievant had told her that SW M’s removal of L from her father’s home was illegal because the parents’ signatures were not on the safety plan and that she planned to report this to the Judge at the court hearing scheduled for . M replied that L’s father assisted in the transfer of L to the house of his , J J, and that the father’s house, where L had been living, was unfit for a child. S also complained to M that DHS did nothing for her, having provided her with no referrals or other help. When M told S that Grievant had visited S’s residence twice, leaving letters for her, S replied that she had received no such letters. S also claimed that she repeatedly called DHS for assistance and received none.

R. As a result of the telephone call from L’s mother, M investigated the handling of L’s case, charges were lodged against Grievant, and she was discharged following a panel hearing.

Following the phone call from S, M conducted an investigation of her allegations and the general handling of L’s case. After the investigation was completed, DHS charged Grievant on July 31 with a variety of policy violations including falsification of records, breach of confidentiality, leaving a child at a safety risk, and poor performance for failing to properly assess the safety of a child and properly assess the functioning of her parents. On September 21, a transcribed hearing before a panel was held at which M, Grievant and others testified. At the close of the hearing, the panel did not sustain the charge alleging a breach of confidentiality, but did sustain the charges of: (1) leaving a child at a safety risk; (2) poor work performance, including failure to properly assess the safety of a child; (3) falsification of the case record; and (4) failure to properly assess the functioning of the parents. The panel recommended that Grievant be suspended for 30 days, subject to the approval of the Commissioner.

Deputy Commissioner Vongvilay Mounelasy reviewed the transcript of the hearing and the recommendations of the panel. She then submitted a detailed analysis of her conclusions in a memorandum dated October 16 to Commissioner Cynthia Figueroa, and recommended that Grievant be suspended for 30 days with intent to discharge. When asked at the arbitration hearing why she did not accept the recommendation of the panel, Mounelasy stated that Grievant displayed a lack of accountability and ownership expected of a social worker. Instead,

Mounelasy found that Grievant repeatedly stated that she simply did what her supervisor directed her to do, which she apparently believed absolved her from any responsibility to provide the services expected of her.

In a December 7 notice to Grievant, Commissioner Figueroa discharged Grievant effective December 7, 2018. Commissioner Figueroa determined that Grievant had engaged in all the violations as charged, including the breach of confidentiality. The Notice included:

> On [redacted] the Department received a call from Ms. S[redacted] P[redacted], . . . mother of L[redacted] . . . You had inappropriate conversations with Ms. P[redacted] that violated Confidentiality . . . You denied making these statements. As a result of the [redacted] call, an audit of the case . . . occurred. It had been found that you had been assigned this case on [redacted] to [redacted]. You did not see the victim child until [redacted], thirty-seven (37) days after assignment. You admitted during the 7/3/2018 investigative interview . . . that you did not read the Contact log to ascertain the name and telephone number of the caregiver. You also admitted that you did not read the old case record that contained pertinent information on the family, extended family, and who had been caring for the child for significant periods of time in the past.
>
> The structured progress notes you entered in ECMS had been entered 4 to 5 months after visits occurred. You entered them in the ECMS system on [redacted] and [redacted]. The information you entered in some of your progress notes was false and could not have been collected on the specific dates of your [redacted] & [redacted] home visits. You did not know the location of the child until [redacted] and you never met or spoke with the parents. You failed to obtain a medical exam for this child to address caregiver's concerns that she could see the child's bones. You failed to complete and document daycare collateral for this child although the child had been attending day care since [redacted]. You did not document medical collateral in ECMS and Community Behavioral Health collateral for the parents in ECMS. You admitted at the 7/3/2018 Investigative Interview that you never visited the father's home or provided him with any housing, substance abuse, parenting or counseling referrals. You never completed a criminal clearance on the father. You never provided the mother with housing, parenting, counseling or substance abuse referrals. In the old record, the mother had admitted to using marijuana on a daily basis, admitted to not being the primary caregiver for her child and had a history of transience. You never collected information about how frequently the parents had been visiting the child, the quality of those visits and whether they had been providing support to the caregiver. In addition, there are no copies of GPS notification letters in ECMS, or in the file of your attempted visits to the mother or father when the case had been reviewed on [redacted]. There are no GPS determination letters sent to the parents despite the fact that the GPS had been determined valid on [redacted].

> You did not inform the parents in writing the reasons why the case had been accepted for services and provide them an opportunity to appeal the decision.
>
> You never completed a safety assessment worksheet and risk assessment tool on this case. The safety plan you formulated on [redacted] did not have the parents' signatures and you failed to pursue an Order of Protective Custody for this child on that day. You acknowledged at the 7/3/2018 Investigative Interview that you never met the mother at that time. She had not made herself available as of [redacted]. The father acknowledged to a previous worker that he could not care for the child as well. You also did not provide the child and family with formal CUA or prevention services despite the fact that this case had been accepted for services and the child resided with relatives since [redacted]. Lastly, despite the fact that you had not been able to interview and assess the mother's functioning for three months you provided an inappropriate recommendation to place the child back with mother despite her lengthy period of instability. Your recommendation had been based on inadequate data collection and a poor assessment of her functioning.
>
> Based on the documentation and evidence presented at the hearing and in recognition of the seriousness of these charges, a thirty (30) day suspension with the intent to dismiss is imposed.

The Union grieved the dismissal. Because the parties were unable to amicably resolve the matter, it was referred to arbitration for a final and binding determination.

VII. Discussion.

The issue before me is whether the City had just cause to discharge Grievant. In a discharge case, I must determine whether the City has met its burden of proving that: (1) Grievant was aware of the policies, the breach of which resulted in her discharge; (2) Grievant engaged in the policy breaches with which she was charged; and, if so, (3) the penalty of discharge is appropriate under all the circumstances. I will address each of these elements in turn.

A. Was Grievant aware of the policies that she was alleged to have violated?

Grievant was charged with violating numerous policies, which allegedly placed L[redacted] at a safety risk. During the pre-discharge hearing before a panel, and at the arbitration hearing, Grievant, an 11-year veteran, did not claim ignorance of any of the policies in question. Rather, acknowledging the policies, she testified that she merely followed the directives of her supervisor.

For example, Policy 3200 required that Grievant schedule a home visit with the family of

the allegedly abused or neglected child within one working day of the assignment. The home visit must take place within six working days. When asked why she did not visit L, who was living with J J, , until 37 calendar days after being assigned the case, Grievant testified that she did not know how to reach J and that her supervisor directed her to try to meet with L's mother, who was living elsewhere. Notably, Grievant did not protest that she was unfamiliar with the policy requiring her to conduct a home visit with the child within six working days of receiving the assignment.

Similarly, when Grievant was confronted about why she had not inputted her SPNs within six business days into the ECMS on several occasions, she replied, not that she was unaware of the requirement, but that the computer system crashed periodically, causing one to lose what one was inputting, and she did not want to risk losing what she was inputting.

Moreover, the City established that it had engaged in extensive training of staff so that they were familiar with the policies governing their work. That training included extensive training upon their hire, followed by 20 hours of annual training and semiannual staff meetings at which training was conducted on the various applicable policies.

Under these circumstances, I find that the City met its burden of proving that Grievant, a social worker with 11 years of experience, had notice of the multiple policies that she was charged with breaching.

B. Did Grievant engage in the policy breaches that resulted in her discharge?

Grievant was charged with, among other things, (1) leaving a child at a safety risk; (2) poor work performance, including failure to properly assess the safety of a child; and (3) falsification of the case record. I will address each charge in turn.

1. Leaving a child at a safety risk.

a. Failing to conduct a home visit with L within six business days.

It is undisputed that Grievant was assigned L's case on , and that she failed to meet with L until , 37 days later. It is also undisputed that Grievant was on vacation from to .

As stated above, Grievant produced two excuses as to why she did not conduct a home visit of L within the prescribed six business days: (1) she did not know how to find out where L was living because she had neither the address nor the telephone number of J J, at whose house Grievant knew L was staying; and (2) Grievant's supervisor directed her to conduct a home visit with L's mother, S.

Grievant's first excuse – that she did not know how to reach J[redacted] – reflects, at best, Grievant's failure to perform a fundamental aspect of her job: to review the file, including the ECMS, when assigned a case. The evidence shows that J[redacted]'s telephone number had been inputted into a Contact Log, which was in the case file and ECMS to which Grievant had ready access.

Morever, when Grievant went on vacation on [redacted], a month after she had been assigned the case, another social worker, M[redacted] V[redacted], who was temporarily assigned to fill in for Grievant, promptly conducted a home visit on [redacted] at J[redacted]'s house where she met with L[redacted], J[redacted] and L[redacted]'s father. Unlike Grievant, V[redacted] apparently had little or no trouble locating L[redacted] and arranging a home visit at J[redacted]'s within six business days of her temporary assignment.

Grievant's second excuse for not conducting a home visit at J[redacted]'s is no more persuasive: that her supervisor directed her to try to conduct a home visit with L[redacted]'s mother. Notably, Grievant did not state that her supervisor told her not to conduct a home visit at J[redacted]'s residence to assess L[redacted]'s safety and well-being. Rather, Grievant testified that her supervisor told her to conduct a home visit with the mother. Because an early assessment of the safety and well-being of the child is a fundamental requirement of the job, Grievant's failure to do so cannot be explained away by the fact that her supervisor directed her to conduct a home visit with the mother.

Grievant knew from the [redacted] SPN prepared by M[redacted] that L[redacted], whose ribs were showing, was exceedingly thin and had been living with her father in deplorable conditions. Under these circumstances, Grievant's failure to conduct a prompt home visit at J[redacted]'s residence was all the more irresponsible.

b. Failing to enter Contact Logs and timely SPNs into the ECMS.

Grievant does not dispute that she failed to enter into the ECMS confirmation of the telephonic and written correspondence that she allegedly conducted in connection with her handling of L[redacted]'s case. In situations where Grievant failed totally to enter into the ECMS such information, Grievant explained that she wrote down everything in a notebook to which her supervisor had access. A fundamental problem with that explanation is that the Policy and Procedure Guide issued March 15, 2011 required social workers to input the data into the ECMS no later than six business days of the date on which the contact or correspondence took place:

> The Contact log in FACTS[2] must be used to document all other contacts and activities not documented in an SPN. Contact should be documented immediately but no later than six business days after the contact occurred.

The Policy and Procedure Guide issued March 15, 2011 makes clear that the children and families whom DHS serves depend on the prompt and accurate entry of current data into the

ECMS:

> Maintaining accurate information on the children, youth, and families that are served by the Department is essential. Having accurate information electronically is particularly critical during emergencies or other crises, especially after-hours and on weekends and holidays.

In light this policy, knowledge of which Grievant did not deny, her failure to properly document contacts and correspondence she made in L's case exhibited her contempt and utter disregard for the requirement. Moreover, her failure to input the necessary documentation into ECMS had adverse consequences. For example, Grievant stated in her and SPNs that she left letters for L's mom to contact her. Because of Grievant's failure to input those letters into the ECMS, DHS was unable to effectively rebut L's mother's claim that Grievant made no attempt to meet with her and that no DHS letters had been left for her. Indeed, Grievant's failure to follow the ECMS inputting procedures regarding those letters casts doubt on whether she left the letters for L's mother as Grievant claimed.

Likewise, it is undisputed that Grievant failed to input her SPNs into ECMS in a timely fashion or in close to a timely fashion. Grievant's excuse – that she was afraid that the data she was entering into ECMS would be lost if the system crashed – does not withstand scrutiny. Other social workers who filled in for Grievant when she was on vacation and was confined to desk duty inputted their SPNs into the ECMS without apparent problems within or close to within the six-day limit. For example, SW M inputted her SPN on , well within the six business day limit. Likewise, SW M V inputted her SPN on ; SW C H inputted her SPN on (four days late); C H inputted her SPN on (three days late); and C H inputted her SPN on . Even Grievant inputted her SPN on , showing that she was capable of inputting an SPN in a timely fashion. Accordingly, I find Grievant's excuse for inputting all but one of her SPNs in this case late to be invalid.

Notably, Grievant was woefully late in submitting the rest of her SPNs in the L case: her SPN was inputted on ; her SPN was inputted on ; her SPN (1-2 pm) was inputted on ; her SPN (3:30-4 pm) was inputted on ; her SPN was inputted on ; and her SPN was inputted on . Thus, with one exception (her SPN), Grievant took months, instead of the required six business days, to input her SPNs in this case.

These substantial delays, like Grievant's failure to input any Contact Logs into the ECMS, are significant, because the DHS team working on L's case was kept from being apprised of what Grievant had done in connection with L's case. For example, SW V and SW H were kept in the dark as to what Grievant had accomplished, or had not accomplished, while she was working on L's case.

c. Failure to arrange for a medical checkup for L.

Grievant was charged with failing " . . . to obtain a medical exam for this child to address caregiver's concerns that she could see the child's bones." It is undisputed that Grievant took no steps to arrange for a medical exam of L. This is a serious failure, which undermined DHS's mission to provide care for children alleged to have been neglected or abused.

2. Falsifying entries on the SPNs.

It is undisputed that the information that Grievant inserted on many of her SPNs in the L case was incorrect and misleading. Examples of such incorrect and misleading information include:

a. Grievant's SPN relating to her attempted visit of L's mother.

Grievant's SPN detailing her unsuccessful attempt to meet with L's mother at her residence included, in the Child Functioning section, Grievant's detailed description of L's demeanor and dress. However, it is undisputed that Grievant did not see L on , and that the description of L was identical to her description of L in her SPN (1-2 pm), when she saw L for the first time.

In addition, in the Adult Functioning for all Caregivers section, Grievant described what L's father allegedly told her about his status and what L's mother allegedly told her about her status. However, it is undisputed that Grievant met neither the father nor the mother on her attempted visit at the mother's residence, rendering her statement false and misleading.

b. Grievant's SPN relating to a second attempted visit of L's mother.

The SPN, like her SPN, described what L's father allegedly told Grievant about his status and what L's mother allegedly told her about her status. However, it is undisputed that Grievant met neither the father nor the mother on her second attempted visit at the mother's residence. Likewise, the SPN misleadingly described what the father allegedly told Grievant about the mother's and father's parenting practices. Because Grievant did not meet with either the father or the mother on , these entries on the SPN were false and misleading.

c. Grievant's SPN (1-2 pm) describing her home visit with J J and L.

Grievant's SPN (1-2 pm) describing her visit at J J's residence, where she met with J and L for the first time, has entries in the Adult Functioning for

all Caregivers section describing a conversation with L█'s father.

> SWSM met with father, and father told the SWSM that although he did not have an appropriate place for his child, that the mother would have a place soon and that her SWSM should reach out to her to make arrangements. The SWSM told the father that someone would be reaching out to mother today or tomorrow to make the arrangements. Father was explained that a safety plan had to be implemented to ensure the safety of the VC until m other met with her SWSM. Father understood and signed the safety plan.
> Father is not working at this time, denied MH/BH concerns, no D/A issues, no DV and no medical concerns.

However, it is undisputed that the father was not present. Notably, the above-quoted language is taken verbatim from M█ V█'s █ SPN. By not attributing the language to V█, the above-quoted excerpt from Grievant's █ SPN (1-2 pm) is false and misleading, as Grievant did not speak with the father that day.

In addition, in the █ SPN (1-2 pm) sections relating to Adult Functioning for all Caregivers and Parent/Caregiver Parenting Practices (exclude disciplinary practices), Grievant added no new information. Instead, she copied verbatim the wording that V█ had inserted in these sections. Likewise, in the section of the █ SPN (1-2 pm) relating to Parent/Caregiver Disciplinary Practices, Grievant repeated verbatim what V█ had inserted in that section of her █ SPN:

> Father stated that mother is the caregiver and that she normally speaks to her child when the child needs to be disciplined.

Despite this language suggesting that she had spoken with the father on █, Grievant makes clear at the beginning of the █ SPN (1-2 pm) that she did not speak to L█'s father that day. Accordingly, the language is false and misleading.

d. Grievant's █ SPN (3:30-4 pm) describing her unsuccessful attempt to meet with L█'s mother.

Grievant made clear in the █ SPN (3:30-4 pm) that she went to L█'s mother's residence and left her a letter requesting that she contact her. However, in the █ SPN (3:30-4 pm), in the sections on Adult Functioning for all Caregivers, Parent/Caregiver Parenting Practices (excluding disciplinary practices), and Parent/Caregiver Disciplinary Practices, Grievant provided detailed information about conversations she had with L█'s mother and father. It is undisputed, however, that Grievant saw neither the mother nor the father on █, rendering much of the information on the █ SPN (3:30-4 pm) false and misleading.

e. Grievant's [redacted] SPN relating to her home visit with D[redacted] G[redacted].

In Grievant's [redacted] SPN, Grievant described in detail her meeting with G[redacted] and review of G[redacted]'s residence. In the section on Child Functioning, Grievant inserted the same language as had been on Grievant's [redacted] SPN and her [redacted] SPN (1-2 pm), implying falsely that she saw L[redacted] on [redacted] at G[redacted]'s residence:

> **c. Child Functioning:**
>
> L[redacted] is 3 years old and appears to be in good physical health. Initially when I arrived L[redacted] wasn't home, she was with her cousin. She was brought home during the visit so SW could see the child. SW engaged with L[redacted] who was nice and friendly. She was dressed appropriately, proper hygiene and clean clothes. She appeared comfortable in her living arrangements and bonded with cousin.

This statement is false and misleading, as Grievant did not see L[redacted] on [redacted].

Thus, I find that Grievant made false and misleading statements in her [redacted] SPN, [redacted] SPN, [redacted] SPN (1-2 pm), [redacted] SPN (3:30-4 pm) and [redacted] SPN. The City concluded that these false and misleading statements constituted falsification of records. I agree. And even if Grievant did not intend to deceive anyone with these false statements, her failure to correct the numerous false statements shows that, at best, she was grossly negligent and grossly incompetent in carrying out her fundamental job duties.

C. Was the penalty of discharge appropriate?

I have found that the City has satisfied its burden of proving that Grievant engaged in multiple serious breaches of policy in connection with her assignment to the L[redacted] case, thereby placing her at a safety risk.[8] The question then becomes whether there are mitigating circumstances that mandate the reduction of the penalty of discharge.

The Union raises several potentially mitigating circumstances: (1) the errors in Grievant's SPNs were attributable to the computer system prepopulating the erroneous entries, one of which the supervisor caught and Grievant corrected; and (2) Grievant was restricted to desk duty effective [redacted], shortly after the date of the shooting while she was in the field. I will address each in turn.

---

[8] I have not addressed, and need not address, several other charges lodged against Grievant, including failure to properly assess the functioning of the parents and failure to properly assess the safety of the child, because of the overwhelming evidence discussed above.

1. The errors in Grievant's SPNs were attributable to the computer system prepopulating the erroneous entries, one of which the supervisor caught and Grievant corrected.

Grievant explained that, in her view, the erroneous entries were caused by the computer software prepopulating the field. F M, however, who was familiar with the system, denied that any entries could be prepopulated, and instead had to be inserted each time by the social worker, either by typing the text or by copying and pasting it. I find M's testimony more credible in this regard. But even if the system had a prepopulating feature, it was Grievant's obligation to input truthful and current information into the system. This she failed to do again and again, exhibiting, at worst, an intention to deceive, and, at best, gross neglect and gross incompetence.

The Union also emphasizes that Grievant, at the request of her supervisor, corrected one erroneous entry on her SPN, clarifying that she did not see L on . But this correction was on , more than four months after she had wrongly stated that she had seen L on . And the correction was made only because her supervisor had directed her to make it. Furthermore, Grievant failed to correct the other false information on the SPN regarding what L's father and mother told her that day, when she spoke to neither one. Accordingly, I conclude that Grievant's correction of one error, at her supervisor's direction, on the SPN is not a mitigating factor.

2. Grievant was restricted to desk duty effective , the date of the shooting while she was in the field.

As the Union points out, Grievant was placed on desk duty on or about , shortly after an incident where a shooting took place while she was in the field. The question then becomes whether her restriction to desk duty at that time contributed significantly to her breaches of policy found above.

It is undisputed that Grievant's failure to promptly visit L after Grievant was assigned the case on was not impacted by her placement on desk duty almost two months later. Her breach of the policy requiring that she visit the child promptly had taken place long before.

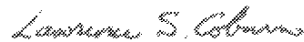
As for failing to enter Contact Logs and timely SPNs into the ECMS, Grievant's restriction to desk duty afforded her more time to accomplish these desk tasks. Instead, she never submitted Contact Logs, and she submitted the late SPNs on , and . In fact, the vast majority were submitted on , three months after she was placed on desk duty. Likewise, Grievant's submission of false statements on SPNs took place on , and , long after she had been placed on desk duty. Because Grievant's placement on desk duty in put her in a better, not worse, position to submit Contact Logs and accurate SPNs into the system, I conclude that her placement on desk duty does not constitute a mitigating factor.

As stated above, I have not addressed other alleged infractions of policy for which Grievant was discharged. Those addressed above, however, constitute more than sufficient basis for the City to have had just cause to discharge Grievant. Therefore, I conclude that the grievance must be denied.

VII. Award

For the foregoing reasons, I conclude that the City had just cause to discharge Grievant, Karimya Beckham. Accordingly, the grievance is denied.

March 13, 2020



Lawrence S. Coburn