Issue: Group III Written Notice with Termination (gross negligence that resulted in serious injury to inmate); Hearing Date: 07/18/13; Decision Issued: 08/30/13; Agency: DOC; AHO: Sondra K. Alan, Esq.; Case No.10095; Outcome: No Relief – Agency Upheld; **Administrative Review: EDR Ruling Request received 09/12/13; EDR Ruling No. 2014-3710 issued 10/09/13; Outcome: AHO's decision affirmed; Administrative Review: DHRM Ruling Request received 09/12/13; DHRM Ruling issued 10/11/13; Outcome: No basis to conduct policy review.**

DECISION OF HEARING OFFICER

IN RE: CASE NO.: 10095

HEARING DATE: July 18, 2013

DECISION ISSUED: August 30, 2013

PROCEDURAL HISTORY:

The Incident occurred on March 17, 2013. An investigation was commenced by a Special Investigator. On March 25, 2013 the investigative report was reviewed by Grievant. On March 26, 2013 Grievant returned to respond to matters under investigation and on March 27, 2013 Grievant was issued a Written Notice of disciplinary action for gross negligence resulting in serious injury to an offender. Grievant filed for a hearing before a Hearing Officer. The Hearing Officer was appointed on May 15, 2013. The preconference hearing was scheduled for May 29, 2013 and the hearing commenced on July 18, 2013.

APPEARANCES

Agency's advocate
Agency representative as witnesses
Agency (4) four witnesses
Grievant's counsel
Grievant as witness
Grievant (5) five witnesses

ISSUES

1. Whether Grievant violated Standard of Conduct section 135.1 by exhibiting gross negligence in permitting the serious injury to a Ward of the State.

2. Whether a Group III discipline with termination was warranted and consistent with law.

3. Whether there were mitigating circumstances justifying a reduction or removal of the disciplinary action.

BURDEN OF PROOF

The burden of proof is on the Agency to show by a preponderance of the evidence that its disciplinary action against the Grievant was warranted and appropriate under the circumstances.

Grievance Procedure Manual ("GPM") § 5.8. A preponderance of the evidence is evidence which shows that what is sought to be proved is more probable than not. G.P.M. § 9.

FINDING OF FACTS

After reviewing the evidence presented and observing the demeanor of each witness, the Hearing Officer makes the following finding of facts.

Grievant had been a correctional officer for fifteen (15) years. He had one active Group III disciplinary action on his record with the facility.

On March 17, 2013 Grievant was assigned to C-2 pod day shift duty as a floor officer[1]. Another officer was assigned to C-3. There are three (3) pods in C building. C-1 had no officer assigned. The facility was short staffed on that day. Testimony was given that the facility was always short staffed on "Race weekends" that being the two (2) annual NASCAR races held in [city and state] in March and August of each year. Grievant was not assigned to the C-1 pod on the day of the incident. However, it is not uncommon for officers to pair up in a pod during movement of offenders to and from cells.

On March 17, 2013 at approximately 9:25 a.m., Grievant and another officer were present in C-1 pod for the return of offenders to their respective cells at the end of an indoor recreation period. During this time three (3) offenders from C-1 pod entered cell number 117 which was not their assigned cell. The three (3) offenders, unauthorized to be in cell 117, had entered cell 117 for the purpose of causing physical harm to cellmate "A". Apparently, there was a gang controversy regarding A's use of the phone the gang members had designated as "their phone". The time between the end of the recreation period when the perpetrators entered the cell and the next time the cell doors were open was approximately one (1) hour. During this one (1) hour time A was repeatedly beaten while his intimidated cellmate watched. Records introduced as evidence show offender A was severely beaten[2].

Grievant was charged with gross negligence for not observing the three (3) unauthorized offenders enter A's cell at the close of the recreation period. Grievant stated he was focused on another offender who had not returned to his cell on time due to returning late from his shower. The rapid eye camera recording[3] of the offenders returning to their cells was not very focused. From the vantage point of the camera, the door to cell number 117 was not observable. The camera did show Grievant and another officer present at all times during the offenders return to their cells.

There was no controversy to the fact that (5) five offenders were in cell 117 leaving three (3) other cells with only one (1) offender per cell. Clearly four cells namely 105, 106, 115 and 117 were not properly observed.

[1] Agency Exhibit 1

[2] Agency exhibit #1 medical reports

[3] Agency exhibit #17 disc

Upon a view by this Hearing Officer of the actual cell block from the cell floor where Grievant and another officer stood, the view to the door of cell 117 was clear[4]. As stated earlier, the cell block rapid eye camera was placed high on the wall near the control tower and could not "see" the door to cell number 117 as it was obscured by the stairs. Grievant's view of cell 117 was not obscured at the time of the incident.

After the offenders were returned to their cells Grievant went on break and was gone most of the time that A was being beaten. When Grievant returned he stated he did a scheduled check of all cells at about 11:15 am.[5] He stated he saw nothing out of the ordinary in any of the cells. He stated he observed A on the upper bunk with his face to the wall. Fifteen (15) minutes later at the next scheduled indoor recreation period, A's cellmate came to Grievant and advised that A needed attention. Grievant stated he found A curled up on the upper bunk. According to Grievant, A made a verbal response to him. Grievant was not permitted by facility rules to enter the offender's cell. Grievant, concluding A was injured, called for emergency medical assistance. When medical staff arrived, A was lying on the cell floor.[6] Grievant stated he had no idea how A had gotten from the bunk bed to the floor. A was unresponsive and unconscious when examined by the medical staff. A was transported to a local facility and from there transferred to intensive care in another medical facility where his condition was considered serious.

CONCLUSION OF POLICY

Unacceptable behavior is divided into three groups, according to the severity of the behavior. Group I offenses "include types of behavior less severe in nature, but [which] require correction in the interest of maintaining a productive and well-managed work force." Group II offenses "include acts and behavior that are more severe in nature and are such that an accumulation of two Group II offenses normally should warrant removal." Group III offenses "include acts and behavior of such a serious nature that a first occurrence normally should warrant removal."

Group III offenses include, "gross negligence on the job that results in the escape, death, or serious injury of a ward of the State or the death or serious injury of a State employee."[7]

The Supreme Court of Virginia has described three (3) levels of negligence in the law[8]

> "The law recognizes three degrees of negligence, (1) ordinary or simple, (2) gross, and (3) willful, wanton, and reckless. We have defined [***10] ordinary or simple negligence as the failure to use "that degree of care [**213] which an ordinarily prudent person would exercise under the same or similar circumstances to avoid injury to another." *Perlin v Chappell, 198 Va. 861, 864, 96 S.E. 2d 805,*

[4] Agency exhibit 8 Grievant of cell #17
[5] Agency exhibit 4
[6] Agency exhibit 11 (Charity Collins, Vicki Harbor)
[7] Agency exhibit 14 OP 135.1 (o)
[8] Agency exhibit 18 (227 Va. 317; 315 S.E.2d 210; 1984 Va. Lexis 249 ¶ 3, 4, 5)

808 (1957)) (quoting Montgomery Ward and Co. v Young, 195 Va. 671,673, 79 S.E.2d 858,859) (1954)).

[4] Gross negligence is "that degree of negligence which shows indifference to others as constitutes an utter disregard of prudence amounting to a complete neglect of the safety of [another]. It must be such a degree of negligence as would shock fair minded men although something less than willful recklessness." *Ferguson v Ferguson, 212 Va. 86, 92, 181 S.E.2d 648, 653 (1971) (emphasis omitted); Haymore v Brizendine, 210 Va. 578, 581, 172 S.E.2d 774,777 (1970).*

[5] Willful and wanton negligence is acting consciously in disregard of another person's rights or acting with reckless indifference to the consequences, with the defendant aware, from his knowledge of existing circumstances and conditions, that his conduct probably would cause injury to another. *Friedman v Jordan, 166 Va. 65, 68, [*322] [***11] 184 S.E. 186, 187 (1936).* "Willful or wanton negligence involves a greater degree of negligence than gross negligence, particularly in the sense that in the former an actual constructive consciousness of the danger involved is an essential ingredient of the act or omission…." *Boward v Leftwich, 197 Va. 227, 231, 89 S.E.2d 32, 35 (1955)."*

Security Post Order 79[9] related to C-1 pod states,

"34. The Floor Officer is responsible for ensuring that unauthorized inmates do not enter cells that they are not assigned to. During pod recreation, inmates are not to sit on the steps. The Pod Floor Officer will position himself/herself on the floor to watch when inmates are entering or leaving their cells, watching for fights, assaults, etc."

OPINION

There are twenty (20) cells on the first floor of C-1, eight (8) on each side and four (4) at the back wall. The testimony of the Control Officer was that when recreation period ended all cell doors were opened at the same time. This would logically mean each officer could watch a chosen side of the room, i.e. ten (10) cells. Grievant and the other officer were observed by the rapid eye camera both looking in the same general direction while the offenders returned to their cells. It appeared their job was to simply see that the recreation area was cleared. Indeed, Grievant stated his attention was on one offender who had failed to return to his cell after the cell doors were closed.

It should be noted that even if an officer diligently observed the movement of twenty (20) offenders returning to ten (10) cells it would be difficult to account for each of twenty (20) offenders as they drifted to their cell doors. While the task maybe difficult, it was one assigned to Grievant to carry out.

[9] Grievant exhibit 3 PO 79

It appeared the facility was short staffed on the day of the incident. However, at the time of the occurrence there was no absence of necessary staff in C-1 pod. Indeed, there were two (2) officers present. Present also was a third person trainee to which neither of the officers gave any attention. This trainee was actually watching the recreation room television giving none of his attention to the cell block movement. The rapid eye camera recorded what appeared to be a very relaxed scene.

It was not only cell 117 that had an incorrect number of offenders in the cell but also cells 105, 106 and 115 each of which lacked one (1) cellmate. Observing an irregularity in any one of these four (4) cells should have given the officers reason to believe there was a problem. Further, on Grievant's 11:15 am round, he noticed none of these inconsistencies.

An officer should be expected to have "…….. consciousness of danger involved[10]…" if five (5) offenders were in one (1) cell and the danger that might present. Offender A was seriously injured. Grievant stated in testimony that A was on an upper bunk bed and spoke to him prior to medical staff arriving. The medical staff found A on the floor of the cell and unresponsive and unconscious. In light of the manner in which the medical staff found A, Grievant's testimony is difficult to believe.

This Hearing Officer has given consideration to the level of negligence that might be assigned to Grievant's behavior. Security Post Order #79 for pod C-1 states a Floor Officers duty is to:

> "34. The Floor Officer is responsible for ensuring that unauthorized inmates do not enter cells that they are not assigned to. During pod recreation, inmates are not to sit on the steps. The Pod Floor Officer will position himself/herself on the floor to watch when inmates are entering or leaving their cells, watching for fights, assaults, etc."

This is a very specific duty. In watching the rapid eye camera and observing the two (2) officers, it is clear neither were carefully watching the movement of the offenders as they moved into respective cells. Rather, they appeared to be generally watching that no offenders were out of their cells after the recreation period ended. The stated duty was not to see that the recreation floor was clear but to observe each offender as he returned to his cell. Grievant and his coworker not only did not see movement into cell 117 but also failed to observe cells 105, 106 and 115 in that they did not have a proper number of offenders in the cell. This does "shock"[11] this Hearing Officer that such a serious task would be taken so lightly. The result was a serious injury to offender A. This lack of doing one's duty with the possibility of such a severe outcome is gross negligence.

In considering mitigation, there would have been more than one procedure to make observation of offenders movements more efficient such as, opening fewer cell doors at a time or providing for offenders to stand in front of their cells and be visually counted before the cell doors were open. The facility should be fully staffed. It appears that understaffing is chronic on "Race weekends" and should be accounted for in advance. However, the lack of sufficient staff

[10] Agency exhibit 18 (227 Va. 317)
[11] Agency exhibit 18 (227 Va. 317)

was irrelevant to this specific incident as two (2) officers were present for the return of the offenders. While Grievant was not assigned to the C-I pod the day of the incident he was not disciplined for leaving his post. Floor officers often pair up for movement of offenders in another pod when the offenders in their assigned pod are secured.

The Hearing Officer finds no mitigating factors that would be relevant to Grievant's actions between 9:25 am and 9:35 am on the morning of the incident that would warrant reducing the disciplinary action.

DECISION

For the reason stated herein, the Agency's issuance to the Grievant of a Group III Written Notice of disciplinary action with removal is **upheld**.

APPEAL RIGHTS

You may file an administrative review request within **15 calendar** days from the date the decision was issued, if any of the following apply:

1. If you believe the hearing decision is inconsistent with state policy or agency policy, you may request the Director of the Department of Human Resource Management to review the decision. You must state the specific policy and explain why you believe the decision is inconsistent with that policy. Please address your request to:

Director
Department of Human Resource Management
101 North 14th St., 12th Floor
Richmond, VA 23219

or, send by fax to (804) 371-7401, or e-mail.

2. If you believe that the hearing decision does not comply with the grievance procedure or if you have new evidence that could not have been discovered before the hearing, you may request that EDR review the decision. You must state the specific portion of the grievance procedure with which you believe the decision does not comply. Please address your request to:

Office of Employment Dispute Resolution
Department of Human Resource Management
101 North 14th St., 12th Floor
Richmond, VA 23219

or, send by e-mail to EDR@dhrm.virginia.gov, or by fax to (804) 786-1606.

You may request more than one type of review. Your request must be in writing and must be **received** by the reviewer within 15 calendar days of the date the decision was issued. You must provide a copy of all of your appeals to the other party, EDR, and the hearing officer. The hearing officer's **decision becomes final** when the 15-calendar day period has expired, or when requests for administrative review have been decided.

You may request a judicial review if you believe the decision is contradictory to law. You must file a notice of appeal with the clerk of the circuit court in the jurisdiction in which the grievance arose within **30 days** of the date when the decision becomes final.[12]

[See Sections 7.1 through 7.3 of the Grievance Procedure Manual for a more detailed explanation, or call EDR's toll-free Advice Line at 888-232-3842 to learn more about appeal rights from an EDR Consultant].

_____

Sondra K. Alan, Hearing Officer

[12] Agencies must request and receive prior approval from EDR before filing a notice of appeal.