Issue: Administrative Review of Hearing Officer's Decision in Case No. 10283; Ruling Date: August 29, 2014; Ruling No. 2015-3956; Agency: Department of Corrections; Outcome: Remanded to AHO.

COMMONWEALTH of VIRGINIA
Department of Human Resource Management
Office of Employment Dispute Resolution

ADMINISTRATIVE REVIEW

In the matter of the Department of Corrections
Ruling Number 2015-3956
August 29, 2014

The Department of Corrections (the "agency") has requested that the Office of Employment Dispute Resolution ("EDR") at the Department of Human Resource Management ("DHRM") administratively review the hearing officer's decision in Case Number 10283. For the reasons set forth below, EDR remands the case to the hearing officer for further consideration and clarification.

FACTS

The relevant facts in Case Number 10283, as found by the hearing officer, are as follows:[1]

> The Department of Corrections employed Grievant as a Lieutenant at one of its Facilities. The purpose of his position was "[p]rovides first line supervision to Corrections Officers and Corrections Officer Trainees in an intuitional setting." He had been employed by the Agency for approximately nine years.
>
> Grievant reported to the Captain. The Captain worked sometimes as the Watch Commander at the Facility when other senior managers such as the Warden were not at the Facility. As Watch Commander, The Captain was the highest ranking security employee and in charge of the Facility.
>
> Grievant's Post Order provided, "[e]nsure all reports are completed, have been reviewed, signed, and forwarded to your supervisor for any incidents in the area of control."
>
> VACORIS is the Agency's electronic database containing information such as reports of events occurring at each prison. It is possible for staff of one prison to read the reports written by staff of another prison. If facility employees enter scandalous or unseemly information into VACORIS and that information is viewed by employees of another facility, employees at the first facility may feel they are at risk of ridicule.

[1] Decision of Hearing Officer, Case No. 10283 ("Hearing Decision"), July 15, 2014, at 2-7 (citations omitted).

DOC Operating Procedure 038.1 governs Reporting Serious or Unusual Incidents. An Incident is defined as:

> An actual or threatened event or occurrence outside the ordinary routine that involves the life, health, and safety of employees, volunteers, guests, or offenders (incarcerated or under Community supervision), damage to state property, or disrupts or threatens security, good order and discipline of a facility or organizational unit.

Incident Reports (IR) are different from Internal Incident Reports (IIR) under the Agency's practices. An IIR would be written by those observing an incident. A supervisor would take IIRs written by employees and create an Incident Report. The Incident Report along with the IIRs would be included in VACORIS and presented to Agency managers.

Internal Incident Reports are typically entered into VACORIS but the Facility's practice is to allow handwritten IIRs on some occasions.

On Saturday December 14, 2013, the Captain was working at the Facility as the Watch Commander. The Warden was at his home and was not working. The Captain had questions about certain issues so the Captain called the Warden several times at his home.

On Sunday December 15, 2013 at approximately 7:30 a.m. or 8 a.m., the Offender was being escorted from his Housing Unit through the Breezeway and into the Medical Waiting Area. The Offender claimed to have had a seizure and needed medical assistance. The Offender was seated in a wheelchair and wearing restraints. Grievant, Sergeant I, and the Officer were escorting the Offender. They entered the Medical Waiting Area.

The Captain was making rounds in the Medical Unit and was accompanied by Sergeant T as they exited the Medical Unit and entered the Medical Waiting Area and met the Offender as well as the employees escorting him. Officer W was inside the Medical Unit initially but he also entered the Medical Unit Waiting Area with the Captain.

Several nursing employees of the Medical Unit walked through the Medical Unit Waiting Area and into the Breezeway. As the employees passed through the Medical Unit Waiting Area, the Offender spoke to them in an offensive manner. He was not otherwise disruptive.

The Captain wanted to discern the Offender's problems or concerns and asked the Offender "What's going on?" The Captain put his hand on the

Offender's shoulder. The Offender put his head down and did not answer the Captain. Officer W did not like the fact that the Offender was not responding to the Captain's questions. Officer W approached the Offender and yelled, "When the Captain asks you a question you better answer!" Officer W began to slap the Offender in the face with the palm of his open hand and the back of his hand. Officer W was slapping the Offender from right to left and from left to right. Officer W slapped the Offender many times, possibly six to eight times.

The Captain told Officer W to stop and moved in a position to block some of Officer W's blows. Officer W hit the Captain as he continued to try to slap the Offender. Grievant initially had his back to Officer W but turned and observed Officer W. He told Officer W to stop. Sergeant T told Officer W to stop.

Officer W stopped hitting the Offender. The Captain instructed Officer W to leave the Medical Unit Waiting Area and go to the Medical Unit Control Room. Officer W remained at the Facility in the Medical Unit Control Room and worked the rest of his shift until 6 p.m.

Officer W's behavior was a simple assault and battery of the Offender. Officer W's behavior was a criminal act and such a conclusion should have been obvious to all of the staff who observed Officer W.

The Captain and some of the other employees moved the Offender into the Medical Unit. Nurse S asked the Offender about his concerns. The Offender said that he had had a seizure. None of the security staff told the medical staff that the Offender had been slapped by Officer W. The nursing staff examined the Officer but without the knowledge that Officer W had slapped the Offender.

The Captain and Grievant went to the Watch Commander's office and began to look over the Agency's policies regarding how to report the incident. The Captain looked at DOC Operating Procedure 038.1 and was confused regarding how he was to report Officer W's behavior. He asked for help from Grievant but neither could discern how to properly report the incident. The Captain decided he would not notify the Warden until the following Monday morning when the Warden returned to the Facility.

On December 15, 2013 at 8:49 a.m., Grievant wrote an IIR in VACORIS stating that the Offender said he had had a seizure and was escorted to the Medical Unit for assessment. Grievant wrote that the Offender was returned to his cell after the assessment. Grievant did not write about Officer W assaulting the Offender.

The Captain chose not to report the incident to Ms. S who was working as the Administrative Duty Officer on December 15, 2013. He did not report the incident to her "due to the nature of the incident."

The Captain left the Facility for the day at approximately 3 p.m. on December 15, 2013.

At approximately 4 p.m. on December 15, 2013, the Offender falsely reported to the LPN that he had been sexually assaulted by Agency employees. Lieutenant M2 ordered that the Offender be taken to the Medical Unit for evaluation as required by the federal Prison Rape Elimination Act. The Offender refused to leave his cell to go to the Medical Unit. Grievant recorded on video tape the Offender's statement that he refused to leave his cell. Lieutenant M2 called Lieutenant M1 who instructed Lieutenant M2 to obtain incident reports from staff. Lieutenant M1 was the Facility Investigator.

On December 15, 2013 at 6:03 p.m., Grievant wrote an IIR in VACORIS stating that he had not seen anyone sexually assault the Offender. Grievant did not mention Officer W assaulting the Offender.

On December 15, 2013 at 5:39 p.m., Sergeant I wrote an IIR in VACORIS stating that he had not seen anyone sexually assaulting the Offender. Sergeant I did not mention Officer W assaulting the Offender.

On December 15, 2013 at 5:36 p.m., Sergeant T wrote an IIR in VACORIS stating that the Offender was not sexually assaulted. Sergeant T did not mention Officer W assaulting the Offender.

The Officer filed an IIR in VACORIS at 5:50 p.m. and again at 6:07 p.m. on December 15, 2013 indicating that the Offender was not sexually assaulted. The Officer did not disclose that Officer W had slapped the Offender earlier that morning.

On December 16, 2013, the QMHP observed that the Offender's face had become swollen. He contacted Lieutenant M1 at approximately 10:03 a.m. and said that the Offender claimed to have been assaulted by staff. Lieutenant M1 notified the Warden who directed that the Offender be taken to the Medical Unit for evaluations. While waiting for the Offender to arrive at the Medical Unit, Lieutenant M1 called the Captain at his residence and told the Captain that he had received a report of injuries to the Offender and that the Offender had alleged he was assaulted. Lieutenant M1 asked if there was any more information the Captain could give him. The Captain said the Offender had a seizure the day before and had been brought to the Medical Unit.

On December 16, 2013, the Major took a picture of the Offender at approximately 10 or 10:30 a.m. The picture showed the Offender's face and that his face was heavily swollen and bruised. The Offender caused much of the

injuries to himself later in the day on December 15, 2013 and after Officer W had hit him.

Between 11 a.m. and noon on December 16, 2013, the Captain called the Facility and spoke with the Warden. The Captain said there was something he needed to talk about with the Warden. The Captain told the Warden of the physical assault on the Offender by Officer W. The Warden asked why he was just learning about this now. The Captain said he wanted to talk to the Warden personally.

On December 16, 2013 at 1:39 p.m., the Warden sent the Special Investigation Unit Head a picture of the Offender. The Investigator was working at another Facility and was contacted at 2:09 p.m.

At 3:37 p.m. on December 16, 2013, Lieutenant M1 sent the Warden an email stating:

> Based on a report from staff, [Offender] was examined by medical and interviewed today at approximately 10:00 a.m. During this interview, the offender alleged that he had been assaulted by staff yesterday morning, just inside the entrance to medical. Subsequent interviews with staff have indicated that [Offender] was assaulted by [Officer W] and was stopped by the other staff present. Incident reports continue to be received from all staff present during this incident. All information, includ[ing] the available video, will be forwarded to SIU as directed.

All of the employees involved in the incident were asked to come to the Facility and fill out internal incident reports.

On December 16, 2013, the Captain wrote a handwritten IIR describing Officer W slapping the Offender. The Captain added, "I take responsibility for failure to report in a timely manner in accordance with policy."

On December 16, 2013, Grievant wrote a handwritten IIR describing Officer W smacking the Offender.

On December 16, 2013, Sergeant I wrote a handwritten IIR describing Officer W smacking the Offender.

On December 16, 2013, Sergeant T wrote a handwritten IIR describing Officer W smacking the Offender.

> On December 17, 2013, the Officer wrote a handwritten IIR stating that Officer W smacked the Offender several times on December 15, 2013 at approximately 7:35 a.m.
>
> The Investigator began his interviews of employees knowledgeable of the incident on December 18, 2013.
>
> If the Captain had reported the incident immediately to the Warden, the Warden would have contacted the Special Investigations Unit to have an investigator begin investigation on Sunday. A picture of the Offender could have been taken to document his limited injuries from the assault.

In the hearing decision, the hearing officer assessed the evidence as to whether the grievant engaged in acts that undermined the effectiveness of the agency and concluded that he had not done so.[2] The hearing officer did, however, determine that the grievant failed to follow policy because he did not report the incident by the end of his shift on December 15.[3] Based on these findings, the hearing officer reduced the Group III Written Notice with termination to a Group II Written Notice with a ten-day suspension and ordered the grievant reinstated with back pay, less the ten-day suspension.[4] The agency now seeks administrative review from EDR.

DISCUSSION

By statute, EDR has been given the power to establish the grievance procedure, promulgate rules for conducting grievance hearings, and "[r]ender final decisions . . . on all matters related to . . . procedural compliance with the grievance procedure."[5] If the hearing officer's exercise of authority is not in compliance with the grievance procedure, EDR does not award a decision in favor of either party; the sole remedy is that the hearing officer correct the noncompliance.[6]

Hearing Officer's Consideration of the Evidence

In its request for administrative review, the agency claims that the hearing determination that the the grievant did not engage in acts that undermined the effectiveness of the agency is not supported by the evidence in the record. Specifically, the agency asserts that the hearing officer applied an "unreasonably narrow" interpretation of the phrase "[a]cts that undermine the effectiveness of the agency," and that it presented evidence to show the grievant had done so.

---

[2] *Id*. at 7-9.
[3] *Id.*
[4] *Id.* at 10; *see* DHRM Policy 1.60, *Standards of Conduct*, Attachment A (classifying a "[f]ailure to . . . comply with written policy" as misconduct warranting a Group II Written Notice); Department of Corrections ("DOC") Operating Procedure 135.1, *Standards of Conduct*, § V(C)(2)(a) (stating that "[f]ailure to . . . comply with applicable established written policy" would ordinarily result in the issuance of a Group II Written Notice).
[5] Va. Code §§ 2.2-1202.1(2), (3), (5).
[6] *See Grievance Procedure Manual* § 6.4(3).

Hearing officers are authorized to make "findings of fact as to the material issues in the case"[7] and to determine the grievance based "on the material issues and the grounds in the record for those findings."[8] Further, in cases involving discipline, the hearing officer reviews the facts *de novo* to determine whether the cited actions constituted misconduct and whether there were mitigating circumstances to justify a reduction or removal of the disciplinary action, or aggravating circumstances to justify the disciplinary action.[9] Thus, in disciplinary actions the hearing officer has the authority to determine whether the agency has established by a preponderance of the evidence that the action taken was both warranted and appropriate under all the facts and circumstances.[10] Where the evidence conflicts or is subject to varying interpretations, hearing officers have the sole authority to weigh that evidence, determine the witnesses' credibility, and make findings of fact. As long as the hearing officer's findings are based upon evidence in the record and the material issues of the case, EDR cannot substitute its judgment for that of the hearing officer with respect to those findings.

In this case, the hearing officer concluded that, even if the grievant "had complied with DOC policy and filed an IIR" on December 15, "it [was] not clear that Agency managers would have acted differently or initiated an investigation sooner."[11] The hearing officer determined, for example, that an IIR filed by the grievant "would not have been read by the Warden or anyone else in senior management that day."[12] While the hearing officer did recognize that, "[h]ad the matter been reported immediately to the Warden" by the Captain or someone else, Officer W would have been removed and an investigation would have been initiated, he also concluded that there was "[n]o credible evidence . . . to show that Grievant had a duty to . . . contact the Warden directly."[13] As a result, the hearing officer determined the evidence did not show that the grievant had undermined the effectiveness of the agency by failing to report the incident before the end of his shift on December 15.

At the hearing, agency witnesses testified about how the grievant's actions undermined the effectiveness of the agency. The Warden, for example, testified that the grievant's failure to complete an IIR by the end of his shift prevented agency management from taking action on December 15 and created doubt as to the details of the incident.[14] The facility's Human Resource Officer ("HRO") explained that the agency is obligated to treat offenders "fairly and humanely" and the grievant's failure to report the incident created a perception that the offender was mistreated.[15] The Regional Operations Chief testified that the agency depends on supervisors to follow policy and that the grievant's failure to complete an IIR by the end of his shift jeopardized the agency's ability to trust its supervisory staff to maintain the safety of employees and offenders at the facility.[16]

---

[7] Va. Code § 2.2-3005.1(C).
[8] *Grievance Procedure Manual* § 5.9.
[9] *Rules for Conducting Grievance Hearings* § VI(B).
[10] *Grievance Procedure Manual* § 5.8.
[11] Hearing Decision at 8.
[12] *Id.* at 9.
[13] *Id.* at 8-9.
[14] Hearing Recording at 1:15:31-1:18:18.
[15] *Id.* at 2:53:32-2:54:26.
[16] *Id.* at 1:38:16-1:39:01.

In its request for administrative review, the agency argues that the hearing officer's determination about whether the grievant had undermined the effectiveness of the agency applied an "unreasonably narrow" standard. The agency effectively claims that the hearing officer should have considered the broader implications of the grievant's conduct. For example, the agency's ruling request describes the following information:

> When staff are involved in criminal behavior that directly threatens the safety and physical well-being of an offender (e.g, abuse of a restrained offender), failing to report the offense contributes to a culture of silence that intimidates staff from reporting wrongdoing and ultimately supports criminal, violent behavior by preventing the Department from holding those wrongdoers accountable. Employees who ignore serious, unethical, illegal, and violent behavior of other staff directed towards those they are sworn to protect contributes to the mentality that one will be protected from consequences by his or her fellow officers and that this behavior will be ignored or even condoned. This disturbing message is not only broadcast to other staff but also to the offenders they supervise, contributing to increased tension and mistrust between officers and offenders in a facility and consequently creating safety and security risks.
>
> . . . .
>
> . . . By failing to report the abuse of the offender, the Grievant was complicit in the crime. This complicity has a much more dangerous and long-term effect than just simply delaying an investigation into the incident; it undermined the Department's published Values and Mission . . . . According to these central pillars, providing safe environments, ensuring the physical and psychology safety of offenders, behaving ethically, promoting accountability, having appreciation for the dignity of others, and not remaining silent when the truth is being hidden is vital to the effectiveness of the Department. Silence in the face of such reprehensible, criminal behavior contributes to an unraveling of the Department's Mission and Values and the orderly operation of the facility.

The agency further claims that, by failing to report the incident on December 15, the grievant "placed other staff and offenders in jeopardy by his lack of reporting an obvious criminal assault. The Grievant's lack of truthfulness, being forthcoming, and acceptance of the basic responsibilities of his job promotes a culture of apathy, unaccountability, and violence." While all of this information is clearly relevant to the question of whether the grievant engaged in acts that undermined the effectiveness of the agency, there is little evidence in the record on these points. It cannot be said, however, that there is no evidence in the record relating to these issues.

The Written Notice issued to the grievant states that the grievant engaged in "Acts that Undermine the effectiveness of the Agency by failing to report acts of offender abuse."[17] An

[17] Agency Exhibit 1 at 1.

attachment to the Written Notice further explains the following with regard to the grievant's actions:

> The Agency is charged with protecting all Offenders housed under their authority. Our Mission is to ensure their safety by utilizing sound correctional principles. Abuse and maltreatment of an inmate is not considered by any source, sound correctional principles. Policies requiring the reporting of such instances are required to ensure the safety and security of offenders and staff and to ensure the orderly operation of the facility. Your failure to report this undermines the effectiveness of the agency by weakening the overall safety and security for all offenders and employees at [facility], as well as the safety of the public. Your failure to report undermines the integrity of the Department of Corrections and the principles for which we stand.[18]

Having reviewed the hearing decision, it appears that the hearing officer did not address this evidence from the Written Notice, and other corresponding testimony related to these issues, in determining whether the grievant's actions may have undermined the effectiveness of the agency. In short, the hearing officer addressed only how the grievant's conduct may have undermined the effectiveness of the agency's response to the incident, rather than the possibly broader potential impacts on the agency and its mission as indicated in the discussions above.

Based on EDR's review of the hearing record, the agency appears to have focused its presentation of evidence on how the grievant's actions were a violation of policy and how his failure to follow policy limited the agency's response to the incident. Because the testimony of witnesses focused on these issues, it is understandable that the hearing officer based his decision on those arguments. However, there is evidence in the record relating to whether the grievant undermined the effectiveness of the agency and its mission that the hearing officer does not seem to have considered in making his decision.

Accordingly, the hearing decision must be remanded to the hearing officer for further consideration of that evidence. Specifically, the hearing officer must include in his remand decision a discussion of the evidence presented by the agency in the Written Notice, and any corresponding testimony, as it relates to how the grievant's actions on December 15 may have undermined the effectiveness of the agency more broadly. In addition, the hearing officer must consider this evidence in light of the provisions of DHRM Policy 1.60, *Standards of Conduct*, which provides that conduct that "undermines the effectiveness" of the agency's activities "in the **judgment** of agency heads or their designees"[19] may be appropriately addressed as unacceptable behavior under the provisions of the policy. [20]

---

[18] *Id.* at 3.
[19] DHRM Policy 1.60, *Standards of Conduct*, § B(2) (emphasis added).
[20] The hearing officer's decision must be based on the evidence in the hearing record. *See Rules for Conducting Grievance Hearings* § V(C) ("In reaching a decision, the hearing officer must consider de novo all evidence admitted into the hearing record."). Any additional evidence presented by the agency in its request for administrative review may not, therefore, be considered in the remand decision.

Aggravating Circumstances

The agency further argues that the hearing officer failed to "recogniz[e] management's responsibility to increase the severity of discipline issued when aggravating circumstances are present." By statute, hearing officers have the power and duty to "[r]eceive and consider evidence in mitigation or aggravation of any offense charged by an agency in accordance with rules established by [EDR]."[21] The *Rules for Conducting Grievance Hearings* further state that a hearing officer must "give deference to the agency's consideration and assessment of any . . . aggravating circumstances" that might demonstrate mitigation of the discipline is not warranted.[22] "The agency has the burden to demonstrate any aggravating circumstances that might negate any mitigating circumstances."[23] Aggravating circumstances, therefore, are properly considered by the hearing officer only as a part of his mitigation analysis where they are relevant to the question of whether the discipline should be reduced.

In this case, the hearing officer considered evidence presented by the grievant regarding mitigating circumstances and determined that "they would not be sufficient to lower the disciplinary level below a Group II Written Notice with suspension."[24] Because the hearing officer declined to mitigate, there was no reason for him to consider evidence of any aggravating circumstances that may have been presented by the agency.[25] There is nothing to indicate that the hearing officer's consideration of mitigating and aggravating circumstances was flawed in any way or is otherwise not supported by the evidence in the record. Accordingly, EDR will not disturb the hearing officer's decision on that basis.[26]

CONCLUSION AND APPEAL RIGHTS

This case is remanded to the hearing officer for further consideration of whether the evidence in the record demonstrates that the grievant undermined the effectiveness of the agency as set forth above. The hearing officer is directed to issue his remand decision **within 21 calendar days of the date of this ruling.** Pursuant to Section 7.2(d) of the *Grievance Procedure Manual*, a hearing officer's original decision becomes a final hearing decision once all timely requests for administrative review have been decided.[27] Within 30 calendar days of a final hearing decision, either party may appeal the final decision to the circuit court in the jurisdiction

[21] Va. Code § 2.2-3005(C)(6).
[22] *Rules for Conducting Grievance Hearings* § VI(B)(2).
[23] *Id.*
[24] Hearing Decision at 9-10.
[25] Furthermore, EDR has not identified anything in the hearing record to show that the agency presented evidence about aggravating circumstances of this nature.
[26] To the extent the "aggravating circumstances" presented by the agency are more appropriately considered as support for defining how the grievant's conduct undermined the effectiveness of the agency or the "unique impact" the grievant's conduct had on the agency to justify elevating the level of offense under the *Standards of Conduct*, such issues would be appropriately considered by the hearing officer on the matters to be addressed on remand as directed above.
[27] *Grievance Procedure Manual* § 7.2(d).

in which the grievance arose.[28] Any such appeal must be based on the assertion that the final hearing decision is contradictory to law.[29]

Christopher M. Grab
Director
Office of Employment Dispute Resolution

[28] Va. Code § 2.2-3006(B); *Grievance Procedure Manual* § 7.3(a).
[29] *Id.*; *see also* Va. Dep't of State Police v. Barton, 39 Va. App. 439, 445, 573 S.E.2d 319, 322 (2002).