COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

Office of Employment Dispute Resolution

DECISION OF HEARING OFFICER

In re:

Case number: 12147

Hearing Date: August 22, 2024
Decision Issued: September 26, 2024

PROCEDURAL HISTORY

On May 23, 2024, Grievant was issued a Group III Written Notice of disciplinary action with termination.

On May 29, 2024, Grievant timely filed a grievance to challenge the Agency's action. The matter advanced to hearing. On June 24, 2024, the Office of Employment Dispute Resolution assigned this matter to the Hearing Officer. On August 22, 2024, a hearing was held at the Facility.

APPEARANCES

Grievant
Agency Advocate
Agency Party Designee
Witnesses

ISSUES

1. Whether Grievant engaged in the behavior described in the Group III Written Notice of disciplinary action?

2. Whether the behavior constituted misconduct?

3. Whether the Agency's discipline was consistent with law (e.g., free of unlawful discrimination) and policy (e.g. properly characterized as a Group I, II or III offense)?

4. Whether there were mitigating circumstances justifying a reduction or removal of the disciplinary action, and if so, whether aggravating circumstances existed that would overcome the mitigating circumstances?

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. The employee has the burden of raising and establishing any affirmative defenses to discipline and any evidence of mitigating circumstances related to discipline. 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. GPM § 9.

FINDINGS OF FACT

After reviewing the evidence presented and observing the demeanor of each witness, the Hearing Officer makes the following findings of fact:

Prior to his termination, Grievant was a Corrections Sergeant at a Department of Corrections Facility. Grievant had been employed by the Agency for approximately five years and had held the position of Corrections Sergeant for approximately one year.

Naloxone is a prescription medication and is an opioid antagonist drug that reverses the effects that opioids have in the brain. As a Corrections Sergeant, Grievant had been equipped with naloxone and had received training on its use.[1]

As a Corrections Sergeant, Grievant also was equipped with oleoresin capsicum (OC) spray, commonly referred to as pepper spray, and trained on its use.[2]

On December 31, 2023, Grievant was working in a Housing Unit at the Facility. Video footage from Grievant's body worn camera showed that at approximately 22:46:10 on December 31, 2023, Grievant entered a bathroom in a pod of the Housing Unit.[3] Testimony during the hearing indicated that Grievant and Lieutenant both responded to the bathroom following a report of a potential medical situation involving an inmate.

Grievant was the first officer to arrive to the bathroom. When Grievant entered the bathroom, Inmate 1 was lying on the floor of the bathroom. Inmate 2 and Inmate 3 also were in the bathroom. The limits of the video footage made it difficult to view Inmate 1 while he was lying on the floor.

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[1] *See* Agency Ex. at 149-159 and see Agency Ex. at 65-70.
[2] See Agency Ex. at 65-66, 69, 110 Agency Ex. at 98-109.
[3] See Axon_Body_3_Video_2023_12-31_2246. The video from the body camera is set to a 24-hour clock as hours: minutes: seconds, so references to observations from the video footage also are made in the same manner.

Lieutenant entered the bathroom at approximately 22:46:31 and observed Inmate 1 lying on the floor and Inmate 2 and Inmate 3 also standing in the bathroom. Lieutenant appeared to call for medical assistance and briefly exited the bathroom. Grievant remained in the bathroom with the inmates, and Inmate 2 and Inmate 3 appeared to begin to try to assist Inmate 1. The angle of Grievant's body camera made it difficult to view exactly what Inmate 2 and Inmate 3 were doing when they would bend or kneel down toward Inmate 1 lying on the floor.

Lieutenant re-entered the bathroom at 22:47:39 and observed Inmate 2 and Inmate 3 attempting to assist and observe Inmate 1. Grievant began to direct other inmates to stay out of the bathroom. Lieutenant exited the bathroom by 22:48:26. Inmate 2 and Inmate 3 appeared to continue to try to assist and observe Inmate 1.

At 22:48:42, Lieutenant entered the bathroom again with Correctional Officer 2 and observed Inmate 1 on the floor and Inmate 2 and Inmate 3 attempting to assist and observe Inmate 1. By 22:49:03, Lieutenant and Correctional Officer 2 appeared to exit the bathroom. At approximately 22:49:06, Lieutenant instructed Grievant to "stay right here" and Grievant responded, "I'm here, I'm here … there's nothing I can do." It appeared that Lieutenant and Correctional Officer 2 then exited the pod. Based on testimony during the hearing, Lieutenant, who was Shift Commander that evening, left the pod to open a gate for the responding nurses from the Facility's medical unit.

Correctional Officer 1 remained in the Housing Unit pod and near the bathroom throughout the incident.

Grievant continued to stay in the doorway area of the bathroom while Inmate 2 and Inmate 3 continued their efforts to assist Inmate 1. The video does not provide a view of what the inmates were doing to assist Inmate 1.

At approximately 22:50:08, Inmate 3 asked Grievant, "Ya'll got medical coming?" Grievant responded "They are coming when we talk about drugs when we talk about all these things, that is it . . . man."[4]

Grievant then directed Correctional Officer 1 to "check to see if they are coming." Correctional Officer 1 returned and advised Grievant that "they are still going to get them." When Grievant asked Correctional Officer 1 if the nurses were here yet, Correctional Officer responded "no."[5]

At approximately 22:53:48, Inmate 2 asked Inmate 1 if he wanted some water and then Inmate 2 took a cup from a shelf and he and Inmate 3 appeared to offer its contents to Inmate 1. They can be heard telling Inmate 1 to "drink some of this" and "drink some water, man." Grievant did not inspect the contents of the cup or prevent Inmate 1 from consuming the contents of the cup.[6]

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[4] See Axon_Body_3_Video_2023_12-31_2246.
[5] See Axon_Body_3_Video_2023_12-31_2246 at 22:51:16-22:51:21.
[6] See Axon_Body_3_Video_2023_12-31_2246.

At approximately 22:55:06, Grievant first directed Inmate 2 and Inmate 3 to exit the bathroom as two nurses entered the bathroom. Inmate 3 immediately complied with the directive to exit the bathroom. Inmate 2 stepped away from Inmate 1 and out of the way of the entering nurses but remained in the bathroom. Grievant repeatedly instructed Inmate 2 to exit the bathroom and at approximately 22:55:24 Inmate 2 finally followed the instruction and exited the bathroom.[7]

At approximately 22:55:50, Nurse 1 appeared to begin to speak to Grievant and then asked Inmate 2 to back up. Inmate 2 was holding back the curtain for the doorway to the bathroom and standing in the doorway. Grievant then instructed Inmate 2 to back up, which Inmate 2 appeared to do, continuing to hold back the curtain.[8]

At approximately 22:56:00, Nurse 1 asked Grievant if he had "Narcan."[9] Nurse 1 then said to Grievant "well he's alert" and then, "oh, I can't give it, you've got to give it." Grievant at this point, however, appeared to have turned his attention away from Nurse 1 and back to Inmate 2. Inmate 2 was no longer holding the curtain to the doorway; another Inmate apparently was holding back the curtain at this point. When Grievant turned his attention to Inmate 2, Inmate 2 was standing outside, and to one side of, the doorway of the bathroom. Inmate 2 was not moving forward toward the doorway of the bathroom. It is difficult from the video to understand what Grievant said to Inmate 2 when Grievant yelled at him, but as Grievant did so, Inmate 2 stepped further back and away from Grievant and the bathroom doorway and said "I'm watching man" at which point Grievant sprayed Inmate 2 with OC spray. As he was being sprayed, Inmate 2 backed further away from Grievant and the bathroom doorway. An inmate seated at a table near where Inmate 2 had been standing when Inmate 2 was sprayed, jumped up from the table and also backed away from the area.[10]

A stretcher was then brought into the bathroom and Lieutenant entered the bathroom at approximately 22:56:58. Grievant told Lieutenant that Grievant had sprayed an inmate and appeared to point to the area where Inmate 2 had retreated.[11]

By 22:57:06, Inmate 1 appeared to be standing and Grievant directed and assisted Inmate 1 onto the stretcher.[12]

At approximately 22:58:10, Lieutenant was in the bathroom and assisting with the stretcher. Lieutenant asked Grievant who Grievant sprayed and then appeared to confirm that Grievant sprayed Inmate 2.[13]

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[7] See Axon_Body_3_Video_2023_12-31_2246.
[8] See Axon_Body_3_Video_2023_12-31_2246.
[9] "Narcan" is a brand name for naloxone.
[10] See Axon_Body_3_Video_2023_12-31_2246.
[11] See Axon_Body_3_Video_2023_12-31_2246.
[12] See Axon_Body_3_Video_2023_12-31_2246.
[13] See Axon_Body_3_Video_2023_12-31_2246.

By 22:58:32, the video showed Grievant and Correctional Officer 1 pushing the stretcher carrying Inmate 1 out of the Housing Unit pod.[14]

Later that same evening, at approximately 11:57 pm, Grievant submitted an Internal Incident Report related to his use of OC spray on Inmate 2. Grievant identified the type of incident as "Use of force; including physical force, electronic devices, chemical agents, canines (Institutions)." In his description of the incident, Grievant wrote the following:

> On 12/31/23 at approximately 10:55 pm, I [Grievant] gave [Inmate 2] an direct order to clear the area from the incident that was occurring. [Inmate 2] refused to moved after I gave him several direct orders to clear the area. He started being combative and trying to force himself inside the rest room where the nurses were trying to take care of the medical emergence and saying, "I have the right to watch and see what's going on I then had to gain control of the situation and of [Inmate 2] by using 1 and 1/2 second burst of OC directly to [Inmate 2's] face to gain Compliance, [Inmate 2] refused medical treatment and the decontamination begin for [Housing Unit pod].[15]

Grievant also submitted a Disciplinary Offense Report against Inmate 2 charging Inmate 2 with "Acting in a manner that significantly disrupts the operation of the [institution]." Grievant described the offense as follows:

> On 12/31/23 at approximately 10:55 pm, I [Grievant] gave [Inmate 2] an direct order to clear the area from the incident that was occurring. [Inmate 2] refused to moved after I gave him several direct orders to clear the area. He started being combative and trying to force himself inside the restroom where the nurses were trying to take care of the medical emergence and saying, "I have the right to watch and see what's going on I then had to gain control of the situation and of [Inmate 2] by using 1 and ½ second burst of OC directly to [Inmate 2's] face to gain compliance. Therefore, this charge is written.[16]

CONCLUSIONS OF POLICY

Unacceptable behavior is divided into three types of offenses, according to their severity. Group I offenses "include acts of minor misconduct that require formal disciplinary action." Group II offenses "include acts of misconduct of a more serious and/or repeat nature that require formal disciplinary action." Group III offenses "include acts of misconduct of such a severe nature that a first occurrence normally should warrant termination."[17]

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[14] See Axon_Body_3_Video_2023_12-31_2246.
[15] Agency Ex. at 11.
[16] Agency Ex. at 12-13.
[17] *See* Agency Ex. at 71-97, Virginia Department of Corrections Operating Procedure 135.1.

Operating Procedure 750.4, Naloxone Administration Program is the Agency procedure that sets forth the procedures for the administration of naloxone by trained and authorized Agency staff.[18] The procedure provides that

> A. Authorized [Agency] staff may administer naloxone to inmates/probationers/parolees, themselves, other [Agency] staff, first responders, and members of the public when, based upon their training, they reasonably believe that the intended recipient is experiencing adverse health effects caused by either a fentanyl exposure or an opioid-induced overdose.
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> B. Upon arriving at a scene of a medical emergency where it has been determined that an overdose has likely occurred, the responding [Agency] staff member(s) will ensure the safety of the scene and request the response of emergency medical services (EMS) personnel. Naloxone will only be administered to members of the public when it is safe to do so.
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> C. When using the naloxone administration device, authorized [Agency] staff will first adhere to the following:
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> 1. Exercise universal precautions to protect against bloodborne pathogens and other communicable diseases.
> 2. Use bloodborne pathogens/PPE exposure kit items as needed, but at a minimum, the nitrile gloves must be worn.
> 3. Assess the patient to determine unresponsiveness and other indicators of an opioid-induced overdose.
> 4. The decision to transport by van or ambulance will be made by the Medical Authority or designee following a detailed evaluation of the problems, symptoms, complaints, and vital signs.
> 5. Prepare and administer the naloxone in accordance with program training protocols. Multiple doses of naloxone may need to be administered to the patient depending on fentanyl analogue or opioid exposure.
> 6. Provide cardiopulmonary resuscitation if needed utilizing an appropriate barrier mask.[19]

The Security Post Order for the post Grievant was working included the following directive regarding medical emergencies:

> In the area of control: Notify the Shift Commander by radio or telephone, and give the alarm for a medical emergency. Notify the medical staff, (Officer), (Nurse) and provide them with the information regarding the exact location, type of medical emergency (bleeding, unconscious, offender or staff etc.). Maintain security and surveillance in your area of control.[20]

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[18] *See* Agency Ex. at 149-159, Virginia Department of Corrections Operating Procedure 750.4.
[19] *See* Virginia Department of Corrections Operating Procedure 750.4, Procedure VIII.
[20] Agency Ex. at 146.

Operating Procedure 420.1 sets forth Agency procedures for the use of force.[21] The copy of the Operating Procedure included in the Agency's exhibits was heavily redacted. The remaining text provided the following:

> A. Employees have a responsibility, consistent with their self-protection, to protect offenders, other employees, and members of the community who are threatened by the actions of any facility offender. Facility employees are also required to prevent escapes, maintain order and control within the facility, and protect state property.
>
> 1. Employees may use all necessary and suitable means to perform these duties, including the use of physical force.
>
> B. The use of force is restricted to instances of justifiable self-defense, protection of others, protection of property, prevention of escapes, and to maintain or regain control, and then only as a last resort and in accordance with appropriate statutory authority.[22]
>
> . . . .
>
> Employees are permitted to use as much force as they reasonably perceive necessary to perform their duties and to protect themselves and others from harm.[23]

Although Operating Procedure 420.1 as provided by the Agency did not address the use of chemical agents, like OC spray, the Security Post Order for the post Grievant was working included the following directive regarding the use of chemical agents:

> Chemical agents CS/OC may be useful to control the following situations:
>
> 1. In self-defense or in the defense of other persons
> 2. When an immediate threat to the security of any part of the facility exists
> 3. To quell a disturbance that is likely to develop into a serious disorder or riot when lesser methods prove ineffective or are not feasible
> 4. To prevent an escape
> 5. To control violent or unmanageable offenders in situations where there is substantial danger for offenders to injure themselves or other persons
> 6. For cell extraction (must comply with OP 420.1.V.D.7.a-f)
> 7. In a contained area to compel an offender to comply with direct orders when no alternative method of persuasion is effective and other types of force are deemed not to be appropriate.

[21] Agency Ex. at 111-126, Department of Corrections, Operating Procedure 420.1, Use of Force. Most of the text of this Agency policy was redacted by the Agency and was not reviewable by the Hearing Officer.
[22] Agency Ex. at 113.
[23] Agency Ex. at 116.

> Chemical agents shall be used in accordance with DOC training. Chemical agents shall only be used as a control mechanism and shall never be used as punishment.
>
> Except when there is immediate danger of physical violence toward other persons by an offender or group of offenders, or in the event of an attempted escape, the use of chemical agents by an employee shall be authorized only by the Chief of Security or above.[24]

The Facility also provided security personnel with a memorandum dated March 9, 2020, regarding "Designees to Authorize the Use of Chemical Agents." The memorandum included the following:

> The Warden, Assistant Warden and Chief of Security are the official designees to authorize the use of chemical agents as per Operating Procedure 420.1. The Administrative Duty Officers (CHAP, Unit Managers, Operation Manager and Institutional Program Manager) should contact the Warden, Assistant Warden or Chief of Security for authorization to use chemical agents if time permits.
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> If immediate danger of physical harm towards other person(s) or in the event of an escape or an attempted escape, the authorization of the use of chemical agents are automatically implied.
>
> Certified Corrections Officers whom are assigned to the following posts at [the Facility] (Security Supervisors, Housing Unit Floors, Yard Officers, Transportation, Visitation, Medical, DOE, Kitchen, Intake and Special Housing) … are authorized to routinely carry the DOC approved chemical agent . . . for use at the officer's discretion in accordance with Operating Procedure 420.1.
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> The following procedure will be used when it is deemed necessary to deploy OC.
>
> 1. Apply Force (spray) – Primary target when deploying OC is the facial area assuring coverage of the EYES, NOSE and MOUTH
>
> - Spray the subject with a ½ to 1 second bursts until it is determined that the liquid has been delivered onto the target.
>
> 2. Command – Give loud repetitive, clear commands that are easy to follow, such as;
>
> - "Get down on the ground"
>
> 3. Evaluate – Quickly evaluate two elements.

[24] Agency Ex. at 144-145.

- The level of compliance. (Is the subject making any effort to comply?)
- Was the force used (spray) effective.

At this point you have four options:

- Repeat the same amount of force – spray the subject again. (no more than 3 bursts)
- Initiate a different force option or escalate to a higher level of force.
- Continue with commands.
- Disengage and retreat (if feasible)

4. Decontamination – The subject shall be given the opportunity to be evaluated by medical and the decontamination process should be done as soon as possible per manufacturers' recommendations.[25]

Whether Grievant engaged in the behavior and whether the behavior constituted misconduct

Negligence

The Agency asserted that Grievant violated the standards of conduct by engaging in "negligence on the job that results (or could have resulted) in the death, or serious injury of persons, including . . . inmates" when he failed to administer naloxone to Inmate 1. The Agency also asserted that Grievant violated Operating Procedure 750.4, Naloxone Administration Program and American Red Cross Adult and Pediatric First Aid CPR AED Training. Operating Procedure 750.4 leaves the administration of naloxone to the discretion of Agency personnel based on their assessment of the situation, including the inmate's responsiveness. Although the Agency exhibits included a certification showing that Grievant had received training in First Aid, the Agency did not provide a copy of the information provided during the training or information as to the instruction provided for determining when to administer naloxone. Assistant Warden testified that staff are trained to administer naloxone whenever they suspect drug use because administration of naloxone will not harm anyone and will help someone who is experiencing an opioid-induced drug overdose. Lieutenant testified, however, that his understanding was that naloxone should be administered when an inmate is unresponsive.[26] Lieutenant also testified that when Lieutenant was in the bathroom, he observed that Inmate 1 was on the floor, "but awake."[27] Lieutenant's testimony about his observation and his understanding of when naloxone should be administered is consistent with the fact that Lieutenant did not administer naloxone or direct that naloxone be administered to Inmate 1.

The Agency argued that it was Grievant, and not the Lieutenant, who was responsible for managing the situation in the bathroom and therefore, the Agency appeared to argue, only Grievant was responsible for determining whether administration of naloxone was appropriate and only Grievant was negligent for failing to do so. This Hearing Officer cannot agree. If an inmate was in such distress that naloxone should be

[25] Agency Ex. at 110.
[26] Hearing recording at 2:27:20-2:28:48.
[27] Hearing recording at 2:22:04-2:22:15.

administered, Lieutenant also had a responsibility to either administer naloxone or instruct that it be administered. Further, it is not clear that, as the Agency suggested, Lieutenant left Grievant in charge of the situation until Lieutenant directed Grievant to "stay right here" as Lieutenant left to go open the gate, which was after they both had arrived at the bathroom and observed Inmate 1's condition and neither of them, at that time, administered, or directed the administration of naloxone. From the time that Lieutenant left the bathroom and directed Grievant to "stay right here" until the nurses arrived, it is unclear whether Inmate 1's condition changed such that a different assessment of whether naloxone should be administered should have been made. At one point, it appeared, based on the actions of Inmate 2 and Inmate 3, that Inmate 1 was capable of drinking from a cup offered by the inmates.

The Agency also argued that after the nurses entered the bathroom, Nurse 1 instructed Grievant to administer naloxone to Inmate 1 and, according to the Agency, Grievant's failure to do so at that point was negligence that could have resulted in death or serious injury to Inmate 1. The video footage from the incident, however, showed that after Nurse 1 asked Grievant if he had administered naloxone, she then said, "well he's alert" and then, "I can't give it, you've got to give it." When Nurse 1 was telling Grievant "I can't give it, you've got to give it," it appeared the Grievant already was turning his attention back to Inmate 2. The nurse did not again suggest that naloxone be administered and moments later, Inmate 1 appeared able to stand and assist with getting himself onto a stretcher.

The Agency argued that Grievant engaged in misconduct and negligence when he failed to immediately remove Inmate 2 and Inmate 3 from the bathroom and allowed them to continue to try to assist Inmate 1 rather than providing assistance to Inmate 1 himself. The Agency's concerns about two inmates continuing to assist or engage with an inmate in medical distress is reasonable. As a Correctional Sergeant working a security post, Grievant was responsible for maintaining the security, custody, control, and safety of all offenders within his care.[28] Grievant had a duty of care to Inmate 1 to ensure his safety while he was in medical distress and waiting for medical staff to arrive. Grievant argued that Lieutenant also observed Inmate 2 and Inmate 3 engaging with, and assisting, Inmate 1 and Lieutenant, like Grievant, did not take steps to remove the inmates or direct that they be removed. Although Lieutenant, like Grievant, did not immediately remove Inmate 2 and Inmate 3 from the bathroom, Lieutenant was in the bathroom for less than three minutes. Grievant allowed Inmate 2 and Inmate 3 to remain in the bathroom and continue to engage with Inmate 1, for the approximately six minutes after the Lieutenant left. Grievant also allowed those inmates to provide Inmate 1 with the unknown liquid contents from a cup when there was already a suspicion of drug use related to Inmate 1's condition. Grievant appeared to argue that he was responsible for ensuring that no other inmates entered the bathroom and maintaining general security of the area and was thus unable to both ensure the security of the area and attend directly to Inmate 1. Although Grievant described Correctional Officer 1 as "new," he did not explain why he could not have directed Correctional Officer 1 to provide more assistance, either by helping to remove Inmate 2 and Inmate 3 from the area while Grievant attended to Inmate 1 or by directing Correctional Officer 1 to provide direct assistance to Inmate 1 while Grievant ensured the

[28] Agency Ex. at 140.

security of the area. The Agency has met its burden of proving that Grievant neglected his duty of care to Inmate 1 when he allowed Inmate 2 and Inmate 3 to remain in the bathroom and continue to engage with Inmate 1.

Use of Force

The Agency argued that when Grievant sprayed Inmate 2 with OC spray, Grievant used inappropriate or excessive force. A determination of whether the Agency's policies make clear that use of OC spray is considered a use of force may have been simpler and more straightforward if the Agency had included more of the text of Operating Procedure 420.1, Use of Force. Even with the heavily redacted version of Operating Procedure 420.1, the preponderance of the evidence shows that Facility security personnel, like Grievant, are aware that the Agency considers spraying an inmate with OC spray a use of force.[29] The Grievant did not dispute that spraying an inmate with OC spray is a use of force and his submission of an Internal Incident Report regarding his use of OC spray on Inmate 2 supports that understanding. Although the Grievant did not appear to argue that use of OC spray was a use of force, he did, at times, appear to dispute that his use of OC spray on Inmate 2 was an inappropriate or excessive use force. Agency witnesses consistently testified that use of force on an inmate, including OC spray, is allowed only when necessary and as a last resort when other methods of persuasion will not work. In this case, Inmate 2 was repeatedly standing close to the doorway of the bathroom in an effort to continue to observe the medical situation with Inmate 1. While Inmate 2 was standing outside of the bathroom, but near the doorway, Grievant repeatedly told Inmate 2 to "back-up" and each time Grievant gave Inmate 2 that direction, Inmate 2 complied. Although Grievant's words on the video were unclear, at the time Grievant sprayed Inmate 2 with OC spray, Grievant had not given Inmate 2 a directive with which Inmate 2 had failed to comply. If Grievant had again directed Inmate 2 to back-up, Inmate 2 may have complied. Additionally, there was no immediate threat posed by Inmate 2, he was not being violent or threatening Grievant or anyone else, he was not posing an immediate threat to security, creating a disturbance, or trying to escape. Inmate 2 was attempting to observe the on-going medical treatment of Inmate 1 whom Grievant had allowed Inmate 2 to observe and assist for approximately nine minutes while waiting for medical personnel to arrive to treat Inmate 1. The preponderance of the evidence shows that Grievant's use of OC spray on Inmate 2 was an inappropriate or excessive use of force.

The Agency also asserted that Grievant falsified records when he submitted an Internal Incident Report and Disciplinary Offense Report which described Grievant's need to use OC spray on Inmate 2 because Inmate 2 "started being combative and trying to force himself inside the rest room where the nurses were trying to take care of the medical emergence…." Grievant testified that he would never falsify a document or report. Grievant asserted that his use of the word "combative" to describe Inmate 2's behavior was an inadvertent error and that his use of the term was intended to mean that Inmate 2 was "resistant to" or "resisting" Grievant's instructions. Grievant also testified that based on his knowledge of Inmate 2 and earlier observations, he believed that Inmate 2 was trying to get into the bathroom to discourage Inmate 1 from seeking medical treatment, and potentially being subjected to a drug test. Grievant's use of the word "combative" may

[29] See Agency Ex. at 110, 144-145.

have been an unintentional misuse of the term, but his description of Inmate 2 as "trying to force himself inside the rest room" was inaccurate and inconsistent with the video evidence of the event. Although Grievant may have genuinely believed that Inmate 2 had ulterior motives and a desire to re-enter the bathroom, Inmate 2's behavior and actions at the time of the incident were not as described by Grievant in the Internal Incident Report and the Disciplinary Offense Report. And Inmate 2's actual behavior at the time of the incident was the key information for both the Internal Incident Report and the Disciplinary Offense Report. Grievant's inaccurate description of Inmate 2's behavior, if accepted by the agency, could justify Grievant's use of force on Inmate 2 and justify discipline for Inmate 2.

The Agency has met its burden of proving that Grievant engaged in misconduct.

Whether the Agency's discipline was consistent with law and policy

Group III offenses include acts and behavior of such a serious nature that a first occurrence normally should warrant termination. This level is appropriate for offenses that, include, but are not limited to, endangering others in the workplace, constituting illegal or unethical conduct, indicating significant neglect of duty; resulting in disruption of the workplace; or other serious violations of policies, procedures, or laws.

Operating Procedure 135.1 identifies examples of Group III offenses[30] as including, but not limited to:

> 2. Falsifying any records either by creating a false record, altering a record to make it false, or omitting key information, willfully or by acts of negligence including but not limited to all electronic and paperwork and administrative related documents generated in the regular and ordinary course of business, such as count sheets, vouchers, reports statements, insurance claims, time records, leave records, or other official state documents.
>
> 15. Negligence on the job that results (or could have resulted) in the death, or serious injury of persons, including, but not limited to, employees, supervisors, volunteers, inmates/probationers/parolees, visitors, and /or students, or the escaping/absconding of inmates/probationers/parolees.
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> 18. Physical abuse, inappropriate, unauthorized, or excessive use of force, or other abuse, either verbal or mental, which constitutes recognized maltreatment of inmates/probationers/parolees.

Grievant appeared to argue that the Agency's discipline of him was discriminatory in nature. Grievant did not present evidence to support this allegation. The preponderance of the evidence showed that the Agency took disciplinary action because it believed Grievant engaged in behavior justifying disciplinary action.

[30] Virginia Department of Corrections Operating Procedure 135.1, Procedure XIV, B.

The Agency has presented sufficient evidence to support the issuance of a Group III Written Notice. Upon the issuance of a Group III Written Notice, an agency may remove an employee. The Agency has met its burden of proving that its issuance of a Group III written notice with termination for Grievant's misconduct was consistent with law and policy.

Mitigation

Grievant argued that termination for a first offense was too harsh a punishment and that a demotion with opportunity for more training would be more appropriate. Grievant argued that the Agency failed to appropriately consider mitigating factors, including the Grievant's years of service with a history of good performance, his dedication to the Agency's mission to rehabilitate offenders, and his support, mentorship, and encouragement of his colleagues in their career development. Indeed, it appeared that Grievant was a dedicated employee who cared about the Agency's mission.

The Standards of Conduct provide that an Agency may reduce the level of a disciplinary action if there are mitigating circumstances, such as conditions that compel a reduction to promote the interests of consistency, equity and objectivity, or based on an employee's otherwise satisfactory work performance.

In this case, the Agency considered mitigating factors, including Grievant's years of service and history of satisfactory performance.[31] But, because of the nature of Grievant's misconduct, the Agency determined that it was not appropriate to reduce the discipline. That the Agency could have mitigated the discipline but determined that it was inappropriate to do so, is not a reason for the Hearing Officer to conclude that the Agency action exceeds the limits of reasonableness.

Virginia Code § 2.2-3005.1 authorizes hearing officers to order appropriate remedies including "mitigation or reduction of the agency disciplinary action." Mitigation must be "in accordance with rules established by the Department of Human Resource Management…."[32] Under the Rules for Conducting Grievance Hearings, "[a] hearing officer must give deference to the agency's consideration and assessment of any mitigating and aggravating circumstances. Thus, a hearing officer may mitigate the agency's discipline only if, under the record evidence, the agency's discipline exceeds the limits of reasonableness. If the hearing officer mitigates the agency's discipline, the hearing officer shall state in the hearing decision the basis for mitigation." A non-exclusive list of examples includes whether (1) the employee received adequate notice of the existence of the rule that the employee is accused of violating, (2) the agency has consistently applied disciplinary action among similarly situated employees, and (3) the disciplinary action was free of improper motive. In light of this standard, the Hearing Officer finds no mitigating circumstances exist to reduce the disciplinary action.

[31] See Agency Ex. at 39-41 and Hearing Recording at 3:43:42-3:48:23.
[32] Va. Code § 2.2-3005.

DECISION

For the reasons stated herein, the Agency's issuance to Grievant of a Group III Written Notice with termination is **upheld**.

APPEAL RIGHTS

You may request an administrative review by EDR within **15 calendar** days from the date the decision was issued. Your request must be in writing and must be **received** by EDR within 15 calendar days of the date the decision was issued.

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 must also provide a copy of your appeal to the other party 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.

A challenge that the hearing decision is inconsistent with state or agency policy must refer to a particular mandate in state or agency policy with which the hearing decision is not in compliance. A challenge that the hearing decision is not in compliance with the grievance procedure, or a request to present newly discovered evidence, must refer to a specific requirement of the grievance procedure with which the hearing decision is not in compliance.

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.[33]

Angela Jenkins

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Angela Jenkins, Esq.
Hearing Officer

[33] 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.