COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

Office of Employment Dispute Resolution

DECISION OF HEARING OFFICER

In re:

Case number: 12181

Hearing Date: December 10, 2024
Decision Issued: January 13, 2025

PROCEDURAL HISTORY

On August 27, 2024, Grievant was issued a Group III Written Notice of disciplinary action with termination for sleeping while assigned to a transportation security post at a hospital.[1]

On September 18, 2024, Grievant timely filed a grievance to challenge the Agency's action. The matter advanced to hearing. On October 7, 2024, the Office of Employment Dispute Resolution assigned this matter to the Hearing Officer. On December 10, 2024, a hearing was held at the Facility.

APPEARANCES

Grievant
Agency's Legal Advocate
Agency's Legal Advocate
Agency Party Designee
Witnesses

ISSUES

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

[1] Agency Ex. at 1-2.

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 removal, Grievant was a Corrections Officer at a Department of Corrections Facility. Grievant was employed with the Agency for more than two years. Prior to the incident giving rise to this disciplinary action, Grievant's performance had been satisfactory to the Agency. No evidence of prior active disciplinary action was introduced during the hearing.[2]

Grievant and Officer A were assigned to a transportation security post in a Room at the Hospital. Grievant and Officer A were responsible for monitoring an inmate-patient receiving treatment at the Hospital.

Grievant and Officer A worked an overnight shift in the Room beginning on July 31, 2024. Their shift began at approximately 6:00 p.m. on July 31, 2024, and was scheduled to end at approximately 6:00 a.m. (or when their relief arrived) on August 1, 2024.

Grievant and Officer A also worked an overnight shift in the Room the next night, beginning on August 1, 2024. Their shift began at approximately 6:00 p.m. on August 1,

[2] *See* Agency Ex. at 3.

2024, and was scheduled to end at approximately 6:00 a.m. (or when their relief arrived) on August 2, 2024.[3]

Hospital Security Officer 1 and Hospital Security Officer 2[4] worked at the Hospital and were responsible for conducting security rounds at the Hospital. Hospital Security Officer 1 and Hospital Security Officer 2 made security rounds to the Room overnight during the nights July 31 to August 1, 2024, and August 1 to August 2, 2024.

At some point during the two nights when Grievant and Officer A were on duty at the Hospital, Officer A had to step out of the Room to take a call from the Chief of Security regarding technical issues related to a required check-in with the Facility. While Officer A was out of the Room, the inmate-patient told Grievant that he had to urinate. The inmate-patient also called a nurse to the Room to assist him. Grievant told the inmate-patient to use a bottle he had been provided for urinating, but the inmate-patient insisted on using a toilet. According to Grievant, after the nurse entered the Room, she asked Grievant to release the inmate-patient's restraints in order to allow the inmate-patient to use the toilet. Grievant testified that he advised the nurse that he would have to wait for Officer A to return to the Room so that he could follow Facility procedures and call the Facility to request permission to remove the restraints in order to allow the inmate-patient to use the toilet. Grievant again suggested that the inmate-patient use the bottle that he had previously been provided for urination. Grievant described that the inmate-patient then urinated and spilled urine on himself creating a mess. According to Grievant the nurse became annoyed and angry because of the mess that had to be cleaned up.[5]

During the hearing, Hospital Security Officer 1 testified that she could not recall her observations of Grievant sleeping during the overnight shift that began on July 31, 2024, and ended on August 1, 2024. Hospital Security Officer 1, however, was able to recall and testify to the observations she made during the overnight shift that began on August 1, 2024, and concluded on the morning of August 2, 2024.

Hospital Security Officer 1 recalled that during the early morning hours of August 2, 2024, she made multiple security rounds to the Room with her partner, Hospital Security Officer 2. Hospital Security Officer 1 testified that she observed Grievant asleep on at least two separate rounds during that shift.[6]

Hospital Security Officer 1 recalled that during the first round when she observed Grievant asleep, she observed that Officer A was awake, and that the inmate was sitting on the side of bed. Hospital Security Officer 1 testified that at that time she observed that Grievant's eyes were closed, his hands were relaxed in his lap, and his head was positioned down.[7]

Hospital Security Officer 1 also recalled observing both Grievant and Officer A asleep during a subsequent round to the Room. Hospital Security Officer recalled that a

[3] Hearing Recording at 1:17:25-1:18:24.
[4] Hospital Security Officer 2 did not testify during the hearing.
[5] Hearing Recording at 1:33:00-1:35:50, 1:45:58-1:50:15 and *see* Agency Ex. at 9-10.
[6] Hearing Recording at 13:23-20:10, 26:43-32:55.
[7] Hearing Recording at 13:23-20:10, 26:43-32:55.

nurse contacted the security office to report that she believed the correctional officers in the Room were asleep. Hospital Security Officer 1 testified that after receiving that report, she and Hospital Security Officer 2 made another round to the Room. Hospital Security Officer 1 recalled that she and Hospital Security Officer 2 entered the Room one at a time so that they each could make their own observations of the officers in the Room. Hospital Security Officer 1 testified that when she entered the Room, she observed that both Grievant and Officer A were asleep in the Room. Hospital Security Officer recalled that Grievant was asleep seated in a chair near the sink and bathroom and Officer A was asleep seated in a chair near the window. Hospital Security Officer 1 testified that she could tell that Grievant was asleep at that time by the way that he was sitting, with his head down, his eyes closed, and his hands relaxed.[8]

After Hospital Security Officer 1 and Hospital Security Officer 2 left the Room, they returned to their office and attempted to reach an Agency employee to report their observation that both officers had been asleep. When they could not reach the Agency employee, they contacted their Hospital security supervisor to determine the appropriate next steps.[9]

The Hospital security supervisor contacted the Facility's Chief of Security during the morning of August 2, 2024, and reported that Hospital staff had observed the correctional officers on duty in the Room sleeping.

At approximately 9:48 a.m. on August 2, 2024, the Hospital security supervisor provided the Facility's Chief of Security with statements from Hospital staff regarding observations of Grievant and Officer A sleeping while on duty in the Room.

The information provided by Hospital security supervisor included the written statements from Hospital Security Officer 1 setting forth her observations during the overnight shifts on July 31-August 1, 2024, and August 1-August 2, 2024, including the following:

> On August 1, 2024, at 0107 security was rounding [a floor of the Hospital] and noticed that the door to [the Room] was wide open, and [Grievant] was sitting by the door asleep. The inmate in the room was sitting on the side of the bed with his feet on the floor. Security knocked on the door and asked if the Officers needed anything, both officers stated that they did not and that they were okay. At 0206 security did another round on [the Room] to have the Officers sign paperwork and found [Grievant] asleep again and the door still wide open. Again, security asked if they needed anything and both officers stated they were okay. At 0346 security received a phone call from the Charge Nurse stating that while she was rounding, she noticed that [Grievant] was asleep. Security came straight up to the floor and walked to the room and the officer was still sleeping. The other CO, [Officer A], was

[8] Hearing Recording at 13:23-20:10, 26:43-32:55.
[9] Hearing Recording at 13:23-15:30, 29:48-32:20.

> on his phone the entire time. At 0558 security did another round on [the Room] and both officers were wide awake waiting for their reliefs to come.[10]
>
> On August 2, 2024, at 0050 security rounded on [the Room] and noticed that [Grievant] was in the room sleeping while [Officer A] was eating his dinner. The Inmate was sitting on the side of the bed eating as well. Security rounded on [the Room] again at 0232 to get paperwork signed and this time both officers were sleeping, and [Officer A] was sitting in the chair with his boots completely off. At 0414 security rounded on [the Room] again to make sure the officers didn't need anything and found [Grievant] asleep again. It was unsure if [Officer A] still had his shoes off or not. The inmate was still asleep then. At 0605 security did a final rounding on [the Room] and both officers were awake when security entered the room.[11]

The Hospital's security supervisor also provided the Chief of Security with written statements from Hospital Security Officer 2 setting forth her observations on July 31-August 1, 2024, and August 1-August 2, 2024, including the following:

> On August 01, 2024, [Hospital Security Officer 1] and I went to check in on the officers that were with [the Room]. The first time checking on them (approximately 0107), the officer closes to the door [Grievant] was asleep in the hard back chair, the door to the room was wide open for anyone to see, and the inmate was sitting on the side of the bed facing door. The second time we checked on the officers (approximately 0206), it was in the same state as the previous time with [Grievant] sleeping again. Later that shift (approximately 0346), the charge nurse for that unit called the security office stating that the officer was again asleep. We both went up to the unit to check on them and to state that the door needs to be at least cracked and not wide open. During all three visits, [Officer A] was on his phone the entire time. The last time we checked on them at this date was approximately 0558 and both officers were awake.[12]
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> On August 2, 2024, we checked on the officers at approximately 0028. [Grievant] was asleep again and the inmate was again on the side of the bed (with metal restraints) while [Officer A] was eating. The door to the room was closed all the way this time. We checked on both officers again at approximately 0232, where both officers were asleep, along with the inmate and [Officer A] had his boots off. When we checked on the officers at approximately 0413, [Grievant] and the inmate were asleep. After talking with the nursing staff for the unit (after the 0413 visit), they also stated that during their rounds, they have found [Grievant] sleeping a lot. At approximately 0605, both officers were awake with the inmate.[13]

[10] Agency Ex. at 43.
[11] Agency Ex. at 44.
[12] Agency Ex. at 42.
[13] Agency Ex. at 43.

The Hospital security supervisor also provided the following information from a Hospital director of nursing setting forth information they received from a nurse and a tech:

> . . . here is what we were able to obtain from the nurse and the tech caring for the [inmate-patient].
>
> Nurse
> "The patient presented considerable challenges throughout the night, frequently making requests for items or services that we were unable to provide. Each time the patient made a request, I took the opportunity to explain the limitations and reasons behind our inability to fulfill these requests, aiming to provide clarity and manage expectations. Additionally, I observed that the D.O.C. personnel assigned to monitor the patient became increasingly argumentative with him after I had provided this information. It appeared that their responses were influenced by one another, which seemed to exacerbate the situation and contribute to a heightened sense of tension."
>
> PCT
> "While providing care to the patient, I noticed that his pants were soaked with urine. As I approached to assist him in removing the pants, he reacted aggressively, appearing as if he might strike me. I immediately stepped back to allow him to calm down. Despite my efforts to de-escalate the situation, the security personnel [in] the room continued to escalate the interaction, which made me feel increasingly unsafe."[14]

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."[15]

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

When Grievant was asleep while on duty in the Hospital Room, Grievant was not alert and was not observing the inmate-patient. Sleeping while on duty is misconduct. Grievant was expected to report for duty in the mental and physical condition to perform the duties of his post. The post that Grievant was working on July 31-August 1, 2024, and August 1-August 2, 2024 required that he maintain constant sight supervision of the

[14] Agency Ex. at 45.
[15] *See* Virginia Department of Corrections Operating Procedure 135.1.

inmate-patient.[16] If Grievant was unable to perform his duties because he had insufficient rest or was feeling sleepy, he was expected to notify the Facility so that relief could be provided without compromising security.[17]

Grievant denied sleeping while on duty in the Room at the Hospital and asserted that the reports from the Hospital security officers were "lies." During the hearing, Hospital Security Officer 1 credibly testified that she observed Grievant asleep during at least two of her rounds to the Hospital Room during the early morning of August 2, 2024. Hospital Security Officer 1 testified that during the first round when she observed that Grievant was asleep, she observed that Officer A was awake, and that the inmate was sitting on the side of bed. Hospital Security Officer 1 testified that she observed that Grievant's eyes were closed, his hands were relaxed in his lap, and his head was positioned down. Hospital Security Officer 1 testified that she recalled observing both Grievant and Officer A asleep during a subsequent round to the Room. Hospital Security Officer 1 recalled that Grievant was asleep seated in a chair near the sink and bathroom and Officer A was asleep seated in a chair near the window. Hospital Security Officer 1 testified that at that time she could tell that Grievant was asleep by the way that he was sitting, with his head down, his eyes closed, and his hands relaxed.[18] Although Hospital Security Officer 1 was unable to recall her observations of Grievant sleeping while on duty at the Hospital on July 31-August 1, 2024, this Hearing Officer found Hospital Security Officer 1's testimony and recollection of her observations on August 2, 2024, to be credible and consistent the written statement she provided on August 2, 2024. Hospital Security Officer 1's testimony also was consistent with the written statement provided by Hospital Security Officer 2 on August 2, 2024.

Grievant argued that the Hospital security officers' reports of him sleeping were based on "lies" from the nurse who had been angered by the incident when the inmate-patient urinated and spilled urine on himself. Hospital Security Officer 1 testified that one of the Hospital security officers' rounds to the Room was prompted by a call the security office received from a nurse reporting that the nurse believed the correctional officers in the Room were asleep. Both Hospital Security Officer 1's written statement on August 2, 2024, and her testimony during the hearing, however, were based on Hospital Security Officer 1's own observations of Grievant sleeping. Hospital Security Officer 1 testified as to her recollection of Grievant's position in the Room when she herself observed him. Hospital Security Officer 1 also testified to the observations she herself made that led her to determine that Grievant was asleep at that time, including that Grievant was sitting with his head down, his eyes closed, and his hands relaxed.[19] Even assuming that a nurse was motivated to lie, as Grievant argued, there was no evidence that Hospital Security Officer 1 had motive to lie. Hospital Security Officer 1 credibly testified regarding Hospital Security Officer 1's own observations of Grievant sleeping.

Grievant argued that the evidence was not sufficient to prove that he was asleep because there was no physical evidence, such as a photograph or video, to corroborate

[16] See Agency Ex. at 63-64, 70-71 and see Hearing Recording at 45:51-47:00, 52:53-54:25, 1:08:27-1:13:22, 1:20:09-1:21:03.
[17] *See* Hearing Recording at 50:23-51:23.
[18] Hearing Recording at 13:23-20:10, 26:43-32:55.
[19] Hearing Recording at 13:23-20:10, 26:43-32:55.

the reports of the hospital security officers. This Hearing Officer does not find Grievant's argument to be persuasive. Even in the absence of a photograph or video of Grievant sleeping, the Agency has presented sufficient evidence to meet its burden of proving by a preponderance of the evidence that Grievant was asleep while on duty at the Hospital. A preponderance of the evidence is evidence which shows that what is sought to be proved is more probable than not. Hospital Security Officer 1 provided credible testimony of her observations of Grievant sleeping. Hospital Security Officer 1's testimony of her observations was consistent with, and supported by, the written statement she provided on August 2, 2024, and the written statement provided by Hospital Security Officer 2 on August 2, 2024.

The Agency has met its burden of proving by a preponderance of the evidence that Grievant engaged in misconduct by sleeping while he was on duty at the Hospital.

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

Sleeping during working hours is a Group III offense.[20] Group III offenses include acts and behavior of such a serious nature that a first occurrence normally should warrant termination.[21]

The Facility's Chief of Security and the Warden testified that when security personnel fall asleep and are not alert or aware of their surroundings while on a transportation security post, it presents the opportunity for an inmate to escape and puts the officers, Hospital staff and patients, and the public at risk. This is especially true in an otherwise unsecured setting, like the Hospital, where the only security measures are the correctional officers monitoring the inmate-patients. The Agency witnesses also testified that a transportation security post at a hospital is a dangerous post because the officers are armed with weapons that could be used against them if they are not sufficiently alert or are somehow overcome by an inmate or other bad actor.[22]

The Agency has met its burden of proving that the discipline it issued to Grievant was consistent with law and policy.

Grievant argued that the Agency did not conduct a sufficient investigation of the allegations against Grievant and did not properly consider the information Grievant provided during the investigation. Grievant essentially argued that the Agency did not provide him adequate due process. The hearing process cures any such deficiency. Grievant had the opportunity to present any evidence and arguments he wished during the hearing.

Mitigation

Virginia Code § 2.2-3005.1 authorizes hearing officers to order appropriate remedies including "mitigation or reduction of the agency disciplinary action." Mitigation

[20] *See* Virginia Department of Corrections Operating Procedure 135.1., Procedure XIV.B.8.
[21] *See* Virginia Department of Corrections Operating Procedure 135.1., Procedure XIV.A.
[22] Hearing Recording at 49:12-52:52, 1:05:17-1:06:53.

must be "in accordance with rules established by the Department of Human Resource Management…."[23] 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.

DECISION

For the reasons stated herein, the Agency's issuance to Grievant of a Group III Written Notice of disciplinary action 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.

[23] Va. Code § 2.2-3005.

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.[24]

Angela Jenkins

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Angela Jenkins
Hearing Officer

[24] 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.