`VERMONT LABOR RELATIONS BOARD

GRIEVANCE OF:	)	
	)	DOCKET NO. 05-24
PHILIPPE DUCAS, JR.	)	

FINDINGS OF FACT, OPINION AND ORDER

Statement of Case

On July 20, 2005, the Vermont State Employees' Association ("VSEA") filed a grievance on behalf of Philippe Ducas, Jr. ("Grievant"). Grievant alleges that the State of Vermont Department of Corrections ("Employer") violated Articles 14, 15 and 17 of the collective bargaining agreement between the State of Vermont and VSEA for the Corrections Bargaining Unit, effective July 1, 2003 – June 30, 2005 ("Contract") by dismissing him from his position as a Correctional Officer I at the Chittenden Regional Correctional Facility.

Hearings were held in the Labor Relations Board hearing room in Montpelier on February 9 and 10, 2006, before Board Members Edward Zuccaro, Chairperson; Carroll Comstock and Joan Wilson. Jes Kraus, VSEA Staff Attorney, represented Grievant. Assistant Attorney General Julio Thompson represented the Employer. Grievant and the Employer filed post-hearing briefs on March 2 and 3, 2006, respectively.

In addition to the Findings of Fact contained herein, the Labor Relations Board also has made additional findings of fact sealed from the public record numbered 1 Sealed, 2 Sealed and 3 Sealed.

FINDINGS OF FACT

1. The Contract provides in pertinent part:

ARTICLE 14
DISCIPLINARY ACTION

1. No permanent or limited status employee covered by this Agreement shall be disciplined without just cause. The parties jointly recognize the deterrent value of disciplinary action. Accordingly, the State will:

. . .

. . .

c. impose a procedure of progressive discipline . . .

d. In misconduct cases, the order of progressive discipline shall be:

(1) oral reprimand;
(2) written reprimand;
(3) suspension without pay;
(4) dismissal.

. . .

f. The parties agree that there are appropriate cases that may warrant the State:

(1) bypassing progressive discipline . . .
(2) applying discipline . . . in different degrees;
(3) applying progressive discipline for an aggregate of dissimilar offenses, except that dissimilar offenses shall not necessarily result in automatic progression; as long as it is imposing discipline . . . for just cause.

. . .

3. . . . the appointing authority . . . may dismiss an employee immediately without 2 weeks' notice or 2 weeks pay in lieu of notice for any of the following reasons:

. . .

a. gross neglect of duty;
b. gross misconduct;

. . .

e. conduct which places in jeopardy the life or health of a person under the employee's care.

. . .

(State's Exhibit 1)

2. Grievant certified on October 21, 1996, that he read and fully understood the Work Rules of the Employer. The Work Rules provide in pertinent part:

1. No employee shall violate any provision of the collective bargaining agreement or and(sic) State or Department work rule, policy, procedure, directive, local work rule or post order.

. . .

4. Employees shall be honest and complete in their descriptions, whether given orally or in writing, to the employer of events occurring in the work place and in all other circumstances related to their employment.

. . .
8. No employee shall report to work under the influence of alcohol or with the odor of alcohol on the breath . . .
9. No employee, whether on or off duty, shall comport himself or herself in a manner that reflects discredit upon the Department.
. . .
(State's Exhibit 2)

3. Prior to beginning employment with the Employer, Grievant worked as an emergency medical technician in Waterbury, Vermont. He received training in first aid and anatomy from Central Vermont Hospital. He spent approximately six months responding to emergency medical calls. On one occasion, Grievant performed CPR on a patient. He first suspected that the patient was not breathing because he could not see the rise and fall of the patient's chest.

4. Grievant completed correctional officer training at the Vermont Correctional Academy in Pittsford, Vermont, in the fall of 1996. He received instruction among other things in first aid, security procedures and assisting inmates with substance abuse problems, including heroin addiction. Grievant received refresher training on these subjects over the course of his career with the Employer. Grievant received training during his career with the Employer on the importance of dealing with the welfare of inmates.

5. After completing the Academy, Grievant began working as a probationary employee in the Employer's correctional facility in St. Johnsbury. During his orientation period, Grievant was instructed on how to conduct 30 minute and 15 minute special observation checks on inmates. In December 1996, when Grievant was in his probationary period, he was relieved from duty with pay pending an investigation into allegations regarding his performance. One of the allegations concerned failure to follow

custody procedures by not conducting special observation checks on an inmate that attempted suicide. On January 6, 1997, Grievant was terminated from his position as a probationary employee for not meeting expectations (State's Exhibit 22).

6. Approximately one month later, Grievant was hired as a probationary correctional officer at the Chittenden Regional Correctional Facility ("CRCF"). Grievant successfully completed his probationary period and became a permanent Correctional Officer I.

7. Grievant received a two-day suspension on June 19, 2002, for reporting to work with alcohol on his breath on May 17, 2002. Grievant filed a grievance over the suspension. On January 9, 2003, Grievant was sent home by Assistant Superintendent Jay Simons for coming to work with alcohol on his breath (State's Exhibits 25, 31).

8. The Employer, VSEA and Grievant entered into a Stipulation of Agreement on March 5, 2003, concerning the May 17 and January 9 incidents which provided in pertinent part:

> . . .
> 1. This agreement is a complete settlement of all issues related to the Step III grievance filed on behalf of CO Ducas dated September 20, 2002 and the "odor of alcohol" incident of January 9, 2003. The grievance decision dated February 7, 2003, is withdrawn and the grievance shall be dismissed with prejudice.
>
> 2. CO Ducas admits to violation of DOC work rule #8 by coming to work with the odor of alcohol on his breath on May 17, 2002 and on January 9, 2003;
>
> 3. CO Ducas agrees to accept the following conditions as a consequence of his actions outlined in #2 above:
>
>   a. Undergo an assessment by a Certified Alcohol Counselor . . .
>   b. Participate fully in a treatment program recommended by such assessment . . .
>
> . . .

4. CO Ducas agrees that if any further events of a similar nature to #2 above occur in the future or if he fails to completely fulfill the conditions outlined in #3 above, his employment with the Department will be terminated. . .

. . .

7. CO Ducas agrees to accept a disciplinary (involuntary) demotion to CO I without a reduction in pay . . .

8. This stipulation is entered into for the convenience of the parties only, and shall not serve as a precedent for any pending or future labor relations matter. Agreement hereto shall not be construed as an admission by either party as to any fact except as noted in #2, or as to legal liability with respect to the circumstances leading to this agreement.

. . .

(State's Exhibit 31)

9. On September 2, 2003, then CRCF Superintendent Sue Blair informed Grievant that she was suspending him for three days for refusing to work overtime after his supervisor had ordered him to report to work to work overtime. Grievant did not file a grievance over the suspension (State's Exhibit 32).

10. During his tenure at CRCF, Grievant received overall satisfactory ratings on performance evaluations that he received (Grievant's Exhibit 4).

11. During his tenure at CRCF, Grievant served as a field training officer for more than a dozen new correctional officers. Included among his duties was to teach officers how to perform observation checks on inmates so that they were looking out for the welfare of inmates. Grievant understood that 15-minute checks on inmates assigned such checks were important due to suicide possibilities. He also understood that an inmate with medical issues warranted heightened scrutiny.

12. Correctional officers at CRCF are assigned to work a specific post in the facility. A post refers to an area of responsibility in the facility supervised by a correctional officer or officers. Each post is governed by a post order which are written

instructions setting forth the operations of the post. CRCF policy requires officers to read the applicable post order each time they work a post, and to sign a form indicating that they have done so.

13. On February 5, 2005, Grievant was assigned to work the A, or "Alpha", Unit at CRCF. The Alpha Unit is a high-supervision unit with eight two-man cells. It is divided into two sections, AA and BB, each of which contains four cells. As space allows, the AA wing typically houses inmates in the Alpha Unit for non-disciplinary reasons such as medical issues, while the AB wing houses inmates that are in the unit for disciplinary reasons (State's Exhibit 3, p. 8-9).

14. The Alpha Unit Post Orders that applied on February 5, 2005, provided in pertinent part:

> A Unit is a one officer, 24 hour daily post . . . The purpose of this unit is to supervise those inmates who must be confined or who require a higher level of security. . .
>
> The officer is responsible for maintaining a high level of security and observation at all times. These post orders are designed to ensure a consistently high level of security.
>
> . . .
>
> All officers will enter the unit at the beginning of their shift. . . S/he will be briefed by the officer being relieved. This briefing will contain, at minimum, the following information: The number of inmates in the unit, the physical location of any inmates who are out of the unit, whether or not any inmates in the unit are on special observation for any reason and any ongoing problems or issues in the unit.
>
> All inmates in the unit will be on 30 minute confinement checks. Inmates deemed to be potentially suicidal or otherwise needing extra observation shall be placed on 15 minutes checks in accordance with normal procedure.
>
> . . .
>
> The officer shall maintain a log book . . . Officers should include the following in their logbook:
>
> . . .
>
> 9. Any inappropriate behavior demonstrated by inmates will be noted.
>
> . . .

> A confinement sheet will be maintained for each inmate in the unit. This sheet will contain, at minimum, the inmate's name, the day's date, the time the checks started, the type of checks (15 or 30) . . . The officer will log the time each check was conducted and what the inmate was doing at this time. Entries will be specific, i.e., sleeping on left side, sleeping on right side, etc. . .
> . . .
> A Unit inmates are not allowed out of their cells on third shift. Cell doors may not be opened without the presence of two officers and the permission of the shift supervisor.
> . . .
> (State's Exhibit 3, p. 8 – 10, 15; Grievant's Exhibit 6, p. 57 – 59, 64)

15. Grievant had worked the Alpha Unit many time prior to February 5, 2005. He was familiar with the unit's Post Orders.

16. At approximately 3:35 a.m. on February 5, 2005, Grievant assumed his post on the Alpha Unit. He relieved Richard Nicholson, a probationary correctional officer, who had been supervising the unit since 11:30 p.m. on February 4. Nicholson told Grievant that the unit was quiet. He informed Grievant that offender RN in cell AA02 was "detoxing" and was lying nude on his bed. Cell AA02 is 7 feet wide and 14 feet, eight inches long. When Grievant assumed the post, he had the following items needed to perform his duties: Alpha Unit keys, a portable two-way radio, a flashlight, the unit logbook, the post orders, and special confinement sheets for the offenders in the unit. The flashlight was a properly working, 12 inch, Maglite powered by D-cell batteries. It casts a bright beam, which may be focused by rotating the head (State's Exhibit 11, p.72).

17. At the beginning of Grievant's shift, he read entries in the Alpha Unit logbook that correctional officers had made during the past day. He read an entry, made February 4 at 2:55 p.m., which stated that RN was "on 15's till seen and cleared by MH". "15's" referred to 15 minute observation checks. "MH" referred to Mental Health. He read a further entry on the same page that stated: "Note RN is Detoxing off from Heroin

Keep Eye on him". In addition, Grievant read the special confinement report form for RN that reflected checks performed on him since 11:30 p.m. on February 4. The form indicated that RN was on 15-minute checks due to "drug withdrawal". Cell AA02 was the only cell in the Alpha Unit in which Grievant was conducting 15-minute checks. The A Unit was full during Grievant's shift, meaning there were 16 inmates in the unit. The only duties Grievant had in the Alpha Unit were performing observation checks and documenting them. Grievant did not have any distractions while he working in the Alpha Unit (State's Exhibit 11, p. 70; State's Exhibit 12, p. 79).

18. Between 3:44 a.m. and 5:30 a.m. on February 5, Grievant conducted a total of seven 15-minute checks on RN and his cellmate, JC, in cell AA02. At the time of the checks, the cell lights in the unit were turned off. Grievant made the observations by shining his flashlight through a small window (5.5 inches wide by 4 inches high) on the door to the cell and peering into the cell. The bed in which RN was lying was 9 feet from the door. The cell door window was made of lexan, which was scratched. Nevertheless, Grievant was able to see RN through the window by placing the flashlight flush against the glass. Grievant should have been able to observe whether RN's chest and abdomen were rising and falling or whether RN was otherwise moving. The length of observations Grievant made of RN and JC varied from approximately one to four seconds during each check. Grievant observed that RN did not appear to change positions during the checks. Grievant did not hear RN make any sounds or see him move. He did not check to see if he could detect if RN, who was nude, was breathing by observing his chest rise and fall. Grievant did not attempt to get a response from RN by making a loud noise, turning on the lights, pointing his flashlights into RN's eyes, calling for a backup officer so he could

open the door to the cell, or by viewing RN through a larger window to the cell that was in an outer courtyard (2 feet wide and 4 feet high) (State's Exhibit 12, p. 79; State's Exhibit 19; State's Exhibit 21, p. 134; State's Exhibit 34).

19. It is the practice of CRCF correctional officers performing observation checks conducted at night to see the skin of inmates and to detect some kind of movement of inmates. If officers cannot detect movements of inmates, they do things such as attempting to get a response from the inmate by making a loud noise, turning on the lights, pointing a flashlight into the inmate's eyes, calling for a backup officer so the officer can open the door to the cell, or by viewing the inmate through a larger window to the cell that is in an outer courtyard. It is easier for an officer to see whether an inmate's chest and abdomen are rising and falling if the inmate is nude.

20. On five of the seven occasions that Grievant performed checks on RN and JC on the morning of February 5, the checks were more than 15 minutes after the previous check. A check at 3:41 a.m. was 17 minutes, 54 seconds after the previous check. One at 4 a.m. was 18 minutes, 39 seconds after the previous check. A check at 4:45 a.m. was 22 minutes, 16 seconds since the previous check. Grievant did a check at 5 a.m. that was 15 minutes, 36 seconds after the previous check. Finally, the check that Grievant did at 5:29 a.m. was 28 minutes, 40 seconds after his previous check (State's Exhibit 21, p. 134).

21. Grievant was required to conduct a 15-minute observation check on RN and JC at approximately 5:15 a.m. on February 5. He did not conduct that check. Although Grievant did not conduct the check, he wrote on the special confinement reports of RN and JC that he did conduct a check at 5:15 a.m. He indicated on the reports

that each inmate appeared to be asleep at that time (State's Exhibit 12, p. 79, 83; State's Exhibit 21, p. 134; State's Exhibit 34).

22. Between 3:44 a.m. and 5:30 a.m. on February 5, Grievant conducted four 30-minute special observation checks on two inmates located in cell AB01, and documented these checks on the two inmates' special confinement reports. The unit clipboard given to Grievant at the beginning of his shift also contained a special confinement report form for inmate CK. The form indicated that CK also was housed in cell AB01. However, CK had been moved out of the Alpha Unit at 10:36 p.m. on February 4. This movement was documented on the Alpha Unit log that Grievant had reviewed at the outset of the shift. However, the special confinement report on CK had been left behind in the Alpha Unit. Correctional Officer Nicholson, who was on the Alpha Unit post prior to Grievant, did not catch the oversight and mistakenly completed CK's special confinement report even though CK was no longer in the unit. Grievant also did not catch the error, and erroneously recorded on the special confinement report form that he had conducted 30-minute checks on CK in cell AB01 (State's Exhibit 11, p. 71; State's Exhibit 13).

23. When Grievant completed the special confinement reports on February 5, he believed that all of inmates in the Alpha Unit were sleeping. He went through the stack of special confinement reports and wrote "appears asleep" next to the time of the check on each sheet. He did not count the stack when he completed the reports, and thus did not realize that he was completing an extra report (State's Exhibits 12, 13).

24. CRCF Superintendent Jay Simons subsequently terminated Correctional Officer Nicholson due to his conclusion that Nicholson had not adequately supervised

RN and because Nicholson had erroneously completed a special confinement report on CK when he was no longer in the unit.

25. At approximately 5:50 a.m. on February 5, Correctional Officer II Darryl Graham entered the Alpha Unit with a food cart so that he and Grievant could begin serving the inmates' breakfast. At approximately 5:54 a.m., Grievant and Graham entered cell AA02 to serve breakfast. Grievant entered the cell first and saw that RN was lying on his bed motionless with his eyes open. Grievant called out to RN. When he received no response, he drew Graham's attention to RN. When Graham looked at RN, he concluded that he was dead. He so concluded because there was no chest movement to indicate breathing, RN's limbs were in a fixed and rigid position indicating rigor mortis, RN's skin was deeply mottled and discolored from blood pooling, RN's eyes were open and unmoving, and Graham could see between RN's legs that his bowels had released. The feces on the mattress was readily discernible. Graham told Grievant that RN was dead. Graham then broadcast an emergency medical call on his two-way radio, and also removed JC from the cell. Within five minutes of discovering RN's body, Graham took numerous photographs of RN from various angles and distances with the lights on in the cell [State's Exhibit 15, p. 96-98; State's Exhibit 39 (*sealed exhibit*)].

26. Approximately one minute after receiving the emergency call, on-duty nurse Robyn Van Sant responded to the scene. Upon entering the cell, Van Sant concluded that RN was dead. She saw signs of mottling on his extremities and abdomen, observed that his hands and feet were purple, and noted that his eyes were open and fixed. She checked for a pulse, found none, and found that he was cool to the touch. Van

Sant estimated that RN had been dead for at least one hour (State's Exhibit 15, p. 97; State's Exhibit 16, p. 105, 113).

27. Two officers who worked in the Alpha Unit on February 5 after Grievant was relieved of that post also erroneously documented special observation checks on inmate CK in cell AB01. The errors were made after RN had been found dead in the Alpha Unit. While the officers were on duty in the Alpha Unit, there was a lot of activity in the Unit as managers of the Employer, police investigators and personnel from the Medical Examiner's office entered the unit to investigate the incident. After the traffic lessened later in the morning, the second officer discovered the error and reported it. Superintendent Simons did not discipline either officer (State's Exhibit 13, p. 85).

28. RN's cellmate, JC, reported to Superintendent Simons and the State Police that RN had vomited probably three times that night, including a last time that may have been around 3 to 3:30 a.m. Officer Nicholson had written on RN's special confinement report that RN was sitting on his bunk at 1:45 a.m. on February 5. For the balance of his time as the Alpha Unit officer, Nicholson reported that RN appeared to be asleep (State's Exhibit 12, p. 79; State's Exhibit 16, p. 116-18).

29. The Employer assigned Peter Canales, Agency of Human Services Investigation Unit Chief, to conduct an investigation of RN's death. During the investigation, Grievant told Canales that he believed that he had done all his required checks on February 5. Grievant also told Canales that he would not have reported doing a check if he had not done it.

30. Superintendent Simons sent Grievant a Loudermill letter on June 3, 2005.

The letter provided in pertinent part:

> The Department of Corrections is contemplating a serious disciplinary action up to and including your dismissal from the position of Correctional Officer I. . .
>
> The following charges of misconduct are based upon an investigation report prepared by Peter Canales, Chief, AHS Investigation Unit, dated May 13, 2005, (copy attached) which may be consulted for further information regarding the basis for the charges summarized below.
>
> **I. Failure to Conduct Proper and Timely Special Observation Checks on Offenders RN and JC on February 5, 2005 – Gross Misconduct and/or Gross Neglect of Duty, Conduct Placing in Jeopardy the Life or Health of Offenders, Violation of A Unit Post Orders.**
>
> CRCF Post Orders for A Unit 314A provide that A Unit is a unit for male offenders who require a higher than normal level of supervision. A Unit offenders are subject to 30 minute special observation checks unless 15 minute checks have been ordered, and the A Unit officer is responsible for maintaining a Special Confinement Report documenting those checks. Post Order 314A states that, "(t)he officer will log the time each check was conducted and what the inmate was doing at the this time. Entries will be specific, i.e., sleeping on left side, sleeping on right side etc."
>
> Article 14, Section 3 of the Corrections Unit Agreement provides that an employee may be dismissed
>
> > . . . immediately without 2 weeks' notice or 2 weeks' pay in lieu of notice for (a) gross neglect of duty; (b) gross misconduct; . . . (e) conduct which places in jeopardy the life or health of a . . . person under the employee's care.
>
> DOC Work Rule #1 states that: "No employee shall violate any provision of the collective bargaining agreement or and (sic) State or Department, work rule, policy, procedure, directive, local work rule or post order."
>
> DOC Work Rule #9 states that: "No employee, whether on or off duty, shall comport himself or herself in a manner that reflects discredit upon the Department."
>
> You worked A Unit from 0341 until 0625 hours on February 5, 2005. Offender RN was in cell AA02 and was on 15 minute checks because of withdrawal from heroin. Offender JC was in the same call with RN, and

was also on 15 minute checks because of issues identified during his booking.

You made extremely brief checks on cell AA02 on seven occasions between 0341 and 0529 hours on February 5, 2005. On those seven occasions, you spent a combined time of about 16 seconds observing cell AA02. The time spent observing cell AA02 was as follows: 2 seconds at 03:41; 4 seconds at 0400; 3 seconds at 0410; 2 seconds at 0422; 2 seconds at 0445; 1 second at 0500; and 2 seconds at 0529.

The time you spent on such checks was not sufficient to comply with Post Order 314A's requirement to determine what each offender was specifically doing at the time of the check. You were on notice both from the unit log and from discussions with CO Nicholson that RN was detoxing from heroin, and that you should keep a close eye on him. Your checks on RN should have been sufficient to determine whether he was OK given his circumstances, or whether there were obvious signs that he was in distress. Given the brevity of those checks, they were inadequate to satisfy the requirements of Post Order 314A.

You were responsible for conducting special observation checks at least every fifteen (15) minutes on cell AA02, but failed to satisfy that requirement on five occasions on February 5, 2005. You conducted late checks at: 0341 (17:54 since last check); 0400 (18:39 since last check); 0445 (22:16 since last check); 0500 (15:36 since last check); and 0529 (28:40 since last check). You did not conduct any checks between 0500 and 0529; so you missed entirely a check that should have been done at about 0515 hours.

When you and another officer delivered RN's breakfast at about 0555 hours on February 5, 2005, you found RN dead on his bed. You failed to conduct timely and thorough checks on Offender RN.

DOC has been under intense public scrutiny in the past year following a number of offender deaths and investigative findings faulting DOC practices and performance. There is no more essential duty of a CO in Unit A than making special observation checks on offenders who are at special risk. When an offender is at risk due to drug detoxification, the 15 minute checks are among the most important steps that DOC takes to ensure the health and safety of the offender.

Therefore, it appears you committed misconduct by:

- conducting checks on cell AA02 that were inadequate, given their brevity and RN's circumstances, to constitute legitimate special observation checks

- failing to conduct timely special observation checks on cell AA02 on five occasions
- failing to conduct any check on AA02 at about 0515 hours.

Your actions constitute gross neglect of duty and/or gross misconduct and/or conduct that placed in jeopardy the life or health of both offenders in cell AA02. Your actions have the potential to undermine the reputation and credibility of DOC, and reflect discredit on DOC, and therefore violated DOC Work Rule 9. You also violated DOC Work Rule # 1 because you failed to conduct your 15 minute checks in accord with Directive 314A.

II. Violation of DOC Work Rules 4 – Falsification of February 5, 2005, Special Confinement Reports for Offenders RN and JC:

DOC Work Rule #4 provides that:

Employees shall be honest and complete in their descriptions, whether given orally or in writing, to the employer of events occurring in the work place and in all other circumstances related to their employment.

Your Special Confinement Reports for both RN and JC on February 5, 2005, reflected that you had conducted such a check on cell AA02 at 0515 hours, when, in actual fact, you conducted no check at all between 0500 and 0529 hours. It appears that you falsified these official DOC reports, and, in doing so, violated DOC Work Rule #4.

III. Failure to Conduct Thorough and Accurate 30 Minute Checks on Offender CK – February 5, 2005.

On February 5, 2005, between 0402 and 0530 hours, you purported to conduct thirty (30) minute checks on offender CK in cell AB01, and indicated on your Special Confinement Report that CK appeared to be asleep in cell AB01 at 0402, 0430, 0500, and 0530 hours. However, the A Unit Log reflects that, at 2236 hours on February 4, 2005, offender CK had been moved to F Unit, so he was never in A Unit during your shift.

It is inconceivable that an experienced Correctional Officer acting with due diligence would have counted three offenders instead of two in cell AB01 over the course of four different special observation checks. It is impossible to overstate the extent of your neglect of duty in this instance. It appears that your conduct violated A Unit Post Order 314A and DOC Work Rules 1 (violation of post order), and 9 (conduct reflecting discredit on DOC), and constituted gross neglect of duty.

IV. Falsified and/or Inaccurate Special Confinement Report for Offender CK on February 5, 2005:

Despite the fact that offender CK was never present in A Unit during your shift on February 5, 2005, you completed a Special Confinement Report indicating that four checks were performed and he appeared asleep. As such, your Special Confinement Report for CK was inexplicably inaccurate or was a further example of a pattern of falsified official DOC reports you prepared on February 5, 2005. You were either grossly neglectful of your duties or were dishonest in clear violation of DOC Work Rule #4.

It appears that your conduct provides just cause for bypassing progressive discipline and for a serious disciplinary action up to and including your dismissal. There can hardly be a more serious offense against DOC than failing to perform the essential task of conducting meaningful special observations on offenders. The seriousness of the matter is exacerbated by the falsification and/or grossly neglectful completion of official DOC reports.

You must notify me within twenty-four (24) hours after receiving this letter whether you wish to respond to the above allegations. . . (State's Exhibit 4, Grievant's Exhibit 2)

31. Superintendent Simons notified Grievant by letter dated June 24, 2005, that he was dismissed effective June 24, 2005. He stated: "You will not receive two weeks pay in lieu of two weeks notice. . . The reasons for this action are those that are enumerated in the letter of June 3, 2005" (State's Exhibit 6, Grievant's Exhibit 3).

32. On September 17, 2004, Superintendent Simons imposed a disciplinary demotion on CRCF Correctional Officer Scott Sprano. Sprano had missed a number of 15-minute checks while he was booking officer during a busy period. Simons determined that Sprano's failure was mitigated because he was running a busy unit alone and had many distractions. Although Simons originally made allegations against Sprano that he had been dishonest about his checks, he ultimately did not conclude that Sprano had been dishonest (Grievant's Exhibit 16, p. 128).

33. In September 2001, a correctional officer at the Northern State Correctional Facility in Newport received a written reprimand from the facility Superintendent for not remaining current with special observations on inmates, and not logging pertinent information on an attempted suicide, on July 25, 2001. In the letter of reprimand, the Superintendent noted the officer's explanation that he was very busy on the shift, and stated: "You are an experienced senior officer. You are expected to be able to handle confusing situations or to consult with appropriate staff if events require. Knowing the importance of observation checks, I would have expected you to either call in other officers to assist you if you were unable to do them yourself, or at that time to inform your supervisor of the situation if you were unable to otherwise assure that they were done" (Grievant's Exhibit 17).

OPINION

Grievant alleges that the Employer violated Article 14 of the Contract by dismissing him. Specifically, Grievant contends that: a) his dismissal was not based in fact or supported by just cause, b) the Employer improperly bypassed progressive discipline, and c) the Employer failed to apply discipline with a view toward uniformity and consistency.

In fulfilling our duty of deciding whether just cause exists for an employee's dismissal, the Board has power to police the exercise of discretion by the employer and to keep such action within legal limits. In re Goddard, 142 Vt. 437, 444-45 (1983). The ultimate criterion of just cause is whether an employer acted reasonably in discharging an employee for misconduct. In re Grievance of Brooks, 135 Vt. 563, 568 (1977). There are two requisite elements which establish just cause for dismissal: 1) it is reasonable to

discharge an employee because of certain conduct, and 2) the employee had fair notice, express or fairly implied, that such conduct would be grounds for discharge. Id. In re Grievance of Yashko, 138 Vt. 364 (1980).

The burden of proof on all issues of fact required to establish just cause is on the employer, and that burden must be met by a preponderance of the evidence. Colleran and Britt, 6 VLRB 235, 265 (1983). Once the underlying facts have been proven, we must determine whether the discipline imposed by the employer is reasonable given the proven facts. Id. at 266.

The Employer has made various charges against Grievant, as detailed in Finding of Fact No. 30. The Employer first charges Grievant with gross neglect of duty, and/or gross misconduct, and/or conduct that placed in jeopardy the life or health of both offenders in cell AA02 in the Alpha Unit on February 5, 2005. Specifically, the Employer charges Grievant with misconduct by: a) conducting checks on cell AA02 that were inadequate, given their brevity and offender RN's circumstances, to constitute legitimate special observation checks; b) failing to conduct timely special observation checks on cell AA02 on five occasions; and c) failing to conduct any check on AA02 at about 5:15 a.m.

The Employer has established that Grievant's checks on cell AA02 were inadequate to constitute legitimate special observation checks given their brevity and offender RN's circumstances. Alpha Unit Post Orders provide that the unit officer is "responsible for maintaining a high level of security and observation at all times." Further, Grievant was on notice, both from the unit log and from discussions with the unit officer that he was replacing, that RN was "detoxing" from heroin and that he needed to be observed closely.

Nonetheless, Grievant made extremely brief checks on cell AA02 on seven occasions on February 5, averaging just over two seconds per check. In making these checks, Grievant did not detect movement by RN and did not take any steps to ensure he could detect movement. This was contrary both to the requirement of the Post Orders that the officer maintain a high level of observation at all times and the practice of CRCF correctional officers performing observation checks conducted at night to see the skin of inmates and to detect some kind of movement of inmates.

If officers cannot detect movements of inmates, they do things such as attempting to get a response from the inmate by making a loud noise, turning on the lights, pointing a flashlight into the inmate's eyes, calling for a backup officer so the officer can open the door to the cell, or by viewing the inmate through a larger window to the cell that is in an outer courtyard. Grievant's cursory checks were insufficient to meet his obligation to protect RN's welfare and constituted serious negligence.

The Employer also has established that Grievant failed to satisfy the requirement to conduct special observation checks at least every fifteen minutes on cell AA02 on five occasions on February 5. He conducted late checks four times and missed a check entirely on one occasion. When Grievant's late checks and missed check are considered together with the inadequacy of his checks, we conclude that the Employer has proven its charge against Grievant to the extent of establishing that Grievant committed misconduct through serious neglect of duties that placed in jeopardy both the life and health of offenders in cell AA02, particularly offender RN.

Grievant alleges that the Employer improperly characterized Grievant's actions on February 5 as a misconduct issue rather than a performance issue. We disagree. It was

reasonable for the Employer to treat Grievant's failings as misconduct given the serious neglect of duties by him which placed in jeopardy the life or health of inmates under his care. Our conclusion in this regard is consistent with the provision of Article 14 of the Contract that allows immediate dismissal of an employee for conduct that places in jeopardy the life or health of a person under the employee's care.

The Employer next charges Grievant with violation of Employer Work Rule #4, which requires employees to be honest with the employer of events occurring in the workplace. The Employer contends that Grievant violated this rule by indicating on the special confinement reports he completed on RN and JC on February 5 that he had conducted a check on them at 5:15 a.m. when he had conducted no such check. The Employer has proven this charge. Grievant indicated on the confinement reports that he conducted such a check, the evidence indicates that he did not conduct such a check, and Grievant has provided no satisfactory explanation to explain the discrepancy. The unit was quiet, and nothing distracted Grievant from conducting the check. Accordingly, we conclude by a preponderance of the evidence that Grievant did falsify the special confinement reports on RN and JC.

Finally, the Employer charges Grievant with gross neglect of duties, and falsification and/or grossly neglectful completion of official reports, by indicating on a special confinement report completed on inmate CK that he appeared to be asleep in a cell in the Alpha Unit on four separate checks when, in fact, CK had been moved out of the Alpha Unit prior to Grievant's shift. The Employer has demonstrated the underlying facts of the charge that Grievant incorrectly indicated on a special confinement report on

CK that he appeared to be asleep in an Alpha Unit on four separate checks when he had been moved out of that unit prior to the checks.

However, it was not reasonable for the Employer to conclude that Grievant engaged in falsification and/or grossly neglectful actions through his failings in this regard. Grievant's actions followed from an error committed on the previous shift of CK's special confinement sheet being mistakenly left behind in the Alpha Unit the previous evening after CK was transferred to another unit. It was reasonable for the Employer to conclude that Grievant demonstrated some degree of negligence in not discovering the mistake, but for the Employer to elevate his offense in this regard to a gross neglect of duty was beyond tolerable limits of reasonableness. Further, the Employer has not demonstrated that Grievant was being dishonest in completing the special confinement sheet on CK. Grievant made a mistake and was negligent, but not dishonest, in this regard.

Our conclusion that the Employer went outside the bounds of reasonableness with respect to this charge is bolstered by the fact that the two officers that followed Grievant as Alpha Unit officers on February 5 received no disciplinary action even though they too incorrectly indicated on CK's special confinement report that he was present in the unit. As discussed below, there was a significant mitigating factor differentiating the two officers' actions from those of Grievant in this regard. Nonetheless, the fact the officers received no discipline belies the reasonableness of the Employer's charge of falsification and/or gross negligence against Grievant.

In sum, the bulk of the charges against Grievant have been established. The fact that all of the charges against Grievant have not been proven in their entirety does not

necessarily mean that his dismissal was without just cause. Failure of an employer to prove by a preponderance of the evidence all the particulars of a dismissal letter does not require reversal of a dismissal action. Grievance of McCort, 16 VLRB 70, 121 (1993). In such cases, the Board must determine whether the proven charges justify the penalty. Id.

We look to the factors articulated in Colleran and Britt to determine whether the Employer exercised its discretion within tolerable limits of reasonableness. 6 VLRB at 268-69. The pertinent factors here are: 1) the nature and seriousness of the offenses and their relation to Grievant's duties and position, 2) the clarity with which Grievant was on notice of any rules that were violated in committing the offenses, 3) the effect of the offenses upon supervisors' confidence in Grievant's ability to perform assigned duties, 4) Grievant's past disciplinary record, 5) Grievant's past work record, including performance on the job, 6) the consistency of the penalty with those imposed upon other employees for the same or similar offenses, 7) the potential for Grievant's rehabilitation, and 8) the adequacy and effectiveness of alternative sanctions to deter such conduct in the future.

Grievant's offenses were serious. Although we have concluded that Grievant's offenses were not as serious as alleged by the Employer, nonetheless Grievant engaged in a high level of misconduct through serious neglect of duties that jeopardized both the life and health of inmates under his care. He exacerbated his misconduct by his dishonesty in completing special confinement reports on two inmates. Dishonesty is a serious offense by an employee against an employer. In re Carlson, 140 Vt. 555, 559 (1982). The nature of a correctional officer's duties requires accurate and truthful reporting of incidents involving offenders, including providing testimony concerning interactions with

offenders in various forums where credibility is crucial, and in previous cases we have upheld dismissals of correctional officers where their dishonesty to the employer has been a proven charge. Grievance of Johnson, 9 VLRB 94 (1986). Grievance of Pretty, 22 VLRB 260 (1999). Grievance of Corrow, 23 VLRB 101 (2000). Grievance of Newton, 23 VLRB 172 (2000). Grievant's offense regarding mistakenly completing a special confinement report on an inmate who no longer was in the unit was less serious, but did constitute negligence.

Grievant had fair notice that his offenses could result in his dismissal. Fair notice exists when the employee knew or should have known that the conduct was prohibited. Grievance of Towle, 164 Vt. 145, 150 (1995). Grievance of Brooks, 135 Vt. at 568. Knowledge that certain behavior is prohibited and subject to discipline is notice of the possibility of dismissal. Towle, 164 Vt. At 150. Grievant knew that he was obligated to maintain a high level of observation in the Alpha Unit, and specifically knew that offender RN required a high level of observation. He knew that being negligent in this regard was prohibited and should have known he could be disciplined for such negligence.

Also, Grievant should have known his dishonesty was prohibited. Honesty is an implicit duty of every employee, and thus an employee should know that dishonest conduct is prohibited. Carlson, 140 Vt. at 560. Moreover, Grievant had explicit notice through Employer Work Rule #4 that dishonesty was prohibited.

Grievant's offenses undermined supervisors' confidence in his ability to perform assigned duties. His serious negligence in performing observation checks of inmates on February 5 adversely impacted the confidence of supervisors that Grievant would

adequately fulfill his obligations to look out for the welfare of inmates. His dishonesty had a detrimental effect on supervisors' confidence that Grievant would accurately and truthfully report incidents.

Grievant's past disciplinary record does not operate in favor of his continued employment. In the three years preceding his dismissal, Grievant had received a two-day suspension for reporting to work with alcohol on his breath, a demotion for reporting to work on a subsequent occasion with alcohol on his breath, and a three-day suspension for refusing a supervisor's order to work overtime.

Although these offenses differ in nature from the offenses for which Grievant was dismissed, Grievant's past disciplinary record still may be given significant weight in evaluating the reasonableness of his dismissal. Prior to his dismissal, Grievant had placed himself in a tenuous position given three significant disciplinary actions in the preceding three years. His satisfactory performance evaluations during his tenure operate in his favor, but do not overcome the multiple incidents of misconduct in recent years resulting in discipline against him.

In examining the consistency of the penalty imposed on Grievant with those imposed upon other employees for similar offenses, we conclude that the Employer committed no violation of the Contract in this regard. The employee that committed offenses most similar to Grievant was probationary officer Nicholson, the officer who worked the Alpha Unit immediately prior to Grievant. Like Grievant, Nicholson conducted inadequate special observation checks on offender RN and incorrectly recorded checks on the offender who no longer was in the unit. Like Grievant, Nicholson

was terminated from his employment. Thus, there was no inconsistent treatment with respect to the officer whose offenses were most similar to Grievant.

Grievant contends that inconsistent treatment occurred with respect to the two officers who succeeded Grievant in the Alpha Unit on February 5. Both officers incorrectly documented checks for the inmate who was no longer in the unit. Yet, they received no discipline. This difference in treatment does not cause us to conclude that Grievant received inconsistent treatment from them. The most important factor in this conclusion is that Grievant had offenses that went well beyond, and were more serious than, the negligence of incorrectly documenting checks for the absent offender. He engaged in a serious neglect of duties that jeopardized the life or health of inmates under his care and was dishonest in completing special confinement reports on two inmates. The other two officers had not engaged in such offenses.

Also, the errors of the two officers documenting checks for the absent offender were mitigated by the distraction caused by the high level of traffic in the Alpha Unit resulting from the death of RN. This factor was not present when Nicholson and Grievant made their errors in documenting checks.

Grievant also contends that a lack of consistency is evident by another CRCF officer, Scott Sprano, receiving a demotion rather than dismissal when he missed 15-minute checks in 2004. Once again, we do not find inconsistent treatment because of significant differences in the two situations. Sprano missed the checks when he was running a busy unit alone and there were many distractions. Also, there was not a conclusion that Sprano had been dishonest. The circumstances involving Grievant differed in both respects.

Grievant further contends that inconsistent treatment was demonstrated by a correctional officer at the Northern State Correctional Facility receiving a written reprimand for failures in observation checks and documentation. However, the evidence presented by Grievant on that situation falls well short of allowing us to make a determination as to the comparability of the two situations.

In determining whether Grievant's offenses were sufficient for the Employer to reasonably bypass progressive discipline and dismiss him, we have considered Grievant's potential for rehabilitation and the adequacy and effectiveness of alternative sanctions. Grievant's serious neglect of duties and dishonesty that precipitated his dismissal, along with his past disciplinary record, indicate that Grievant is not a good candidate for rehabilitation. Given the seriousness of the misconduct engaged in by Grievant on February 5, 2005, taken together with his disciplinary record, the Employer acted reasonably in concluding that a lesser sanction than dismissal would not be effective or adequate. In sum, just cause existed for Grievant's dismissal.

ORDER

Based on the foregoing findings of fact and for the foregoing reasons, it is ordered that the Grievance of Philippe Ducas, Jr., is dismissed.

Dated this 8th day of May, 2006, at Montpelier, Vermont.

VERMONT LABOR RELATIONS BOARD

_____
Edward R. Zuccaro, Chairperson

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Carroll P. Comstock

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