VERMONT LABOR RELATIONS BOARD

GRIEVANCE OF:	)	
	)	DOCKET NO. 22-11
SUZANNE DUBUC	)	

FINDINGS OF FACT, OPINION, AND ORDER

Suzanne Dubuc ("Ms. Dubuc" "Grievant"), a Probation and Parole Officer who worked for the Department of Corrections ("DOC" "State" "Employer") since November 1998, and the Vermont State Employees' Association ("VSEA"), grieve her termination for misconduct involving failure to follow procedures while serving a hospital coverage post and being untruthful during the investigative process. Grievant alleges the Employer violated Article 14 of the Collective Bargaining Agreement ("Agreement") between the State and VSEA for the Bargaining Unit by terminating her without just cause, 2) improperly bypassing progressive discipline and progressive corrective action in terminating her, and 3) failing to apply discipline with a view toward uniformity and consistency in terminating her from the Department of Corrections.

The Vermont Labor Relations Board held hearings on the grievance on January 26 and February 23, 2023, before Board members, Richard Park, Chair, Alan Willard, and David Boulanger. Grievant appeared and was represented by VSEA Attorney Kelly Everheart, the State was represented by Assistant Attorney General, Alison Powers. The hearings were held on the Microsoft Teams Platform, with all three panel members in the hearing room at 6 Baldwin. The parties filed post-hearing briefs on April 30, 2022. Timothy Belcher, VSEA General Counsel filed the post-hearing brief for VSEA.

FINDINGS OF FACT

Background

1. Grievant has worked as a Probation and Parole Officer ("PPO"), for the Department of Corrections since October 1998. She has spent most of her career in the Burlington office and served as a liaison for the Northern Lights Treatment Center for Women for about two years.
2. Grievant's duties as a PPO included overseeing parolees, probationers, and people on furlough to ensure their compliance with conditions of release. She fulfilled these duties primarily by meeting with offenders, communicating with employers, family members, and other community contacts. Her caseload included offenders involved with sexual assault, domestic violence, and substance involved crimes.
3. Most of her work was conducted in the Burlington office where she met with offenders once a week or once a month as determined by their conditions of release or parole orders.
4. Grievant compared her work as a PPO to that of a guidance counselor or treatment provider. The PPO position involves case management as opposed to security.
5. Grievant provided mental health, employment, and substance use referrals to the people she supervised. She prepared pre-sentence investigations and reports, which required her to research an offender's background, connect with community members, interview victims, and obtain character references. She also appeared in Court to answer questions about her reports.

6. The Burlington Probation and Parole Office also employed Community Correctional Officers ("CCO"), that worked primarily in the field, serving as the eyes and ears of the PPOs in the community. The CCOs are considered security positions.
7. During her tenure, Grievant never worked in a correctional facility.
8. Corrections Officers maintain security and minimize risk in a correctional facility. In contrast, Grievant's position was more preventative. She helped people prepare to succeed in the community.
9. During her tenure, PPOs were not required to attend the Vermont Correctional Academy. They were not required to maintain core competencies for Correctional Officers.
10. Prior to the events leading to her termination, Grievant had not received training in use of force, although it was offered in the early 2000s. Use of force training was not mandatory for PPOs.
11. During her career as a PPO, Grievant never restrained or cuffed an individual. In the early 2000s Grievant attended a training about handcuffing. She never received handcuffs.
12. Earlier in her career, Grievant had wanted to work overtime shifts in transport, but was informed she could not because she was not trained in use of force. PPOs wishing to earn overtime pay on hospital or transport duty, needed to successfully complete use of force training.
13. Grievant participated in optional trainings and programs related to domestic violence or sexual assault offenders, women as offenders, and substance use issues.
14. Grievant had a good rapport with the people she supervised and the parents of younger offenders. She did not have a high return rate for her offenders.

15. Grievant got along well with her colleagues and received Satisfactory or Excellent performance evaluations throughout her career.
16. Supervisors never noted or commented on her failing to complete required or mandatory training. Grievant was never disciplined.
17. Glenn Boyde is the District Manager of the Burlington Probation and Parole Office and has been employed with the Department of Corrections for thirty-six years. He started as a temporary Correctional Officer and during his tenure served in various roles in correctional facilities and probation and parole offices. In 2018, he served as interim Superintendent of the Chittenden Regional Correctional Facility. He has served as a supervisor of state employees for approximately eleven years. In 2021, he assumed his current position as District Manager.

Hospital Coverage

18. In the summer of 2021, the Department of Corrections experienced staffing shortages at correctional facilities. To address the staffing shortages, CCOs were reassigned to correctional facilities. PPOs assumed some of the duties of CCOs, including electronic monitoring checks, alcohol monitoring, and field checks. Field work was suspended, and PPOs did remote checks by phone.
19. CCOs were first assigned to assume duties within the correctional facilities because they are considered correctional facility positions.
20. In late July or early August 2021, DOC began placing PPOs in hospital duty posts. PPOs were informed that they would be placed on a standby list for covering hospital duties for detainees in hospitals.

21. At a September 2021 staff meeting, PPOs were instructed to read the post orders for hospital coverage. The post orders were emailed to PPO employees and placed in a shared file accessible to PPOs.
22. Post orders describe the duties for each position in a correctional facility. There are specific duties for each post. According to Glenn Boyde, District Manager of the Burlington Probation and Parole office, PPOs did not have prior experience with post orders, nor were they assigned post orders as PPOs.
23. Prior to the incident leading to Grievant's termination, DOC did not provide any training to PPOs about hospital coverage or the post orders. Grievant was not required to obtain any training prior to the incident that precipitated her termination.
24. Grievant was never required or instructed to sign the post orders for hospital coverage.
25. Grievant's supervisor Glenn Boyde, found it problematic that PPOs were not provided with any training prior to being assigned to hospital coverage. It was problematic because staff should be trained prior to being assigned to wherever they have to work.
26. The duties and directives for hospital coverage are contained in the State of Vermont Agency of Human Services Department of Corrections CRCF [Chittenden Regional Correctional Facility] Procedure: 403.00.10. The Procedure Scope section provides:

> This is a designated COI or COII post depending on custody level and status of the inmate This post operates as needed and/or assigned by the CFSS or above. It encompasses the whole area around the inmate's bed and/or room or area the inmate is held within the hospital. These post orders provide instruction to officers assigned to maintain custody of inmates who have been admitted to the hospital.
>
> State's Exhibit A.

27. The Responsibility/Duties/Procedures outlined in the Hospital Coverage post order include the following: "Hospital coverage Officers will remain in direct visual

observation of the inmate at all times and are not permitted to leave their post until properly relieved." State's Exhibit A.

28. Glenn Boyde testified that although the post order scope designated CO I and COIIs only, the hospital coverage was a new assignment for PPOs and "we had no choice."

29. The hospital coverage post order Standard Practices provide in pertinent part:

> **Standard Practices:**
>
> 3. DOC staff will interact with hospital/medical staff with the highest standards of professionalism and respect. The CFSS will be notified if issues cannot be resolved between security and hospital/medical staff so that additional guidance can be provided.
> . . . .
>
> 7. One leg iron will be removed from one leg and secured to the bed.
> 8. If the inmate cannot be restrained to the bed by a leg, due to an injury to the leg for example, one arm will be secured in a handcuff and the other cuff will be secured to the bed.
> 9. The inmate is to remain restrained to the bed from one leg to the bed.
> . . . .
>
> 11. Both legs are to be in restraints when the inmate needs to use the bathroom unless contradicted by current medical condition. The leg iron secured to the bed is removed and applied to the inmate's free leg, securing the two legs.
> 12. The officer will keep the inmate in view at all times with the exception when the inmate must shower or use the bathroom.
> . . . .
>
> 16. As noted above, restraints are to remain on at all times with the exception of pregnant inmates.
>
> State's Exhibit A.

30. Grievant did not review the post orders when they were originally distributed because the coverage or duty was originally voluntary, and she did not think it applied to her because it was a Chittenden Regional Correctional Facility post order that applied to COIs and COIIs.

31. At some point in late August or September 2021, hospital duty became mandatory for PPOs. These Officers could find a replacement or substitute for the coverage, but it was their responsibility to find replacement coverage. Grievant understood that hospital coverage was mandatory.
32. According to Glenn Boyde, a number of Standard Practices were not applicable to PPOs, although there is nothing in the post orders that distinguishes between those Practices that apply and those that do not.
33. PPOs did not handle duties related to transporting the inmate. Standard Procedures 7, 8, and 9, would be completed by the CO transporting the incarcerated person. The transport CO is responsible for initially restraining the inmate.
34. The transporting CO would shackle the inmate and restrain them to the bed before the PPO assumed their hospital duty.
35. The Standard Procedures do not prohibit an inmate from leaving the room.
36. An extra set of leg irons is kept in a bag in the hospital room next to a chair for the Officer during the shift. The contents of the bag are specified in the post order.
37. Prior to September 9, 2021, Grievant had two shifts on hospital duty; a pregnant woman and a man who was unconscious.
38. In August of 2021, Grievant was assigned to hospital coverage for a patient who was pregnant and told to review post orders for pregnant women. The Standard Procedures provide that restraints should be used on pregnant women in the third trimester only when "there is an imminent risk of escape or harm to the pregnant woman, her fetus/newborn, or others, and these risks cannot be managed by other reasonable means." State's Exhibit A.

39. During Grievant's shift, the pregnant woman was in labor and compliant. She was not shackled or restrained to the bed. She took a bath and walked around to advance her labor.

40. The unconscious or sleeping person was covered in blankets when Grievant entered the room, and she could not tell if he was shackled to the bed.

41. In September 2021, Grievant was notified that she needed to be trained in use of force to qualify for hospital duty. She signed up for one of the two training dates which was scheduled on a date after the incident leading to her termination.

September 9, 2021, hospital coverage

42. On September 8, 2021, Grievant worked her full eight-hour shift at the Burlington Probation and Parole Office. At the end of her shift, at around 4 p.m., Grievant was told by her supervisor that she was scheduled for hospital coverage to begin eight hours later at midnight at the University of Vermont Medical Center ("UVMMC" "hospital"). Grievant asked for the name of the inmate and whether Grievant was still responsible for working her scheduled PPO shift the following morning. The supervisor did not know the policy and told Grievant if she did not come in the following morning for her regular shift, she would need to take her own leave.

43. Around 6 p.m., on September 8, 2021, Grievant texted her supervisor seeking the inmate's name and room number. The supervisor did not have the inmate's name but provided the hospital room number.

44. Grievant ran errands with her grandson and tried to take a nap later in the evening.

45. Grievant arrived at the hospital at 11:45 p.m. Security buzzed her into the hospital and escorted her to the female inmate's hospital room.

46. Upon arrival Grievant met her colleague, PPO Jonathan Teske. She observed a radio and a black bag on the floor near a chair in the inmate's room.

47. Grievant asked Teske about the inmate and was told that she had been good and quiet. Grievant asked if she was cuffed to the bed, Teske advised no, because she doesn't have to be she is medium custody. He notified Grievant that there was a suspicion the inmate was packing drugs in her body cavity, and that Grievant should be aware in case the inmate attempted to remove the drugs.

48. PPO Teske had replaced PPO Supervisor Shaun McCuin, in monitoring the inmate. Supervisor McCuin had not restrained or cuffed the inmate to the hospital bed.

49. Consistent with Grievant's testimony, Glenn Boyde believed that this information was forwarded to Grievant and that she was following PPO Supervisor McCuin's orders by not restraining the inmate.

50. Grievant was not provided with hospital coverage post orders at the hospital nor did she ever memorialize that she had read and understood the hospital coverage post orders.

51. During Grievant's shift at the hospital, the inmate communicated through curses and profanity. She cursed when she interacted with the nursing staff or Grievant.

52. During the night, the inmate announced she was hungry. The nurse noted that the inmate knew where the kitchenette was, had previously retrieved food, and could help herself to food from the kitchenette. The inmate left the room with Grievant following and walked to the kitchenette to retrieve ice cream. At that time, hospital staff did not object to the inmate entering the kitchen to retrieve ice cream.

53. At around 6 a.m., the inmate became agitated and said she was hungry, in pain, and wanted food. She announced she was going to the kitchenette to get food.

54. Grievant had been sitting in a chair, writing notes, and reviewing paperwork related to her PPO duties. Grievant had taken her shoes off and had a blanket around her because she was cold. When the inmate left the room, Grievant stood up, placed her paperwork on the floor and followed her out of the room.

55. The hospital kitchenette is in the middle of the floor and accessed by and connected to the two patient hallways. Grievant testified that the distance between the inmate's room and kitchenette was approximately 25 feet.

56. Grievant testified that she had eyes on the inmate as she left the room, entered the hallway, and entered the kitchenette.

57. The inmate was agitated, yelling, and cursing in the kitchenette. She had shackles on her ankles, her gown was falling off, and she was not wearing a mask. At the time, UVMMC required everyone to wear a mask as a COVID-19 mitigation measure. The UVMMC staff had the responsibility to ensure people were masked in the hospital.

58. Nurse Manager Jenna Page had just come on duty at approximately 6:30 a.m. and went to the kitchenette after hearing of a disturbance there. Another nurse was in the kitchenette. Ms. Page attempted to calm the inmate down and tried to direct her back to her room. The inmate was not moving back to the room.

59. Ms. Page observed the Grievant in the corner of the kitchenette between the hallway and the kitchenette and asked her if she was with the inmate and if she could assist with getting the inmate back to her hospital room. Nurse Manager Page was unaware Grievant was the PPO assigned to hospital coverage.

60. Grievant began nodding her head to the inmate and verbally encouraging her back to her room. The inmate continued to yell profanities and did not immediately move toward her hospital room. The inmate eventually began to move in the direction of her room.

61. Nurse Manager Page followed the inmate through the hall. The inmate began posturing, threw her arms up, and became verbally aggressive, using profanities towards Nurse Manager Page, and threatened to do to Ms. Page what got the inmate incarcerated in the first place.
62. Numerous hospital employees came to the hallway and vicinity, witnessing the disruption.
63. The Nurse Manager was concerned for her own safety and the safety of other hospital staff and called for hospital security to assist.
64. Grievant used verbal de-escalation techniques to calm the inmate down and she successfully induced the inmate to move out of the hallway and back to her room. Grievant returned with her to the patient room and began writing down notes on the interaction while they were fresh in her mind.
65. The Nurse Manager acknowledged that by the time the inmate was moving back to the room the situation was under control.
66. By the time hospital security arrived, the inmate was back in her room in bed. Security personnel never witnessed the incident in the hallway or kitchenette.
67. The inmate did not physically harm herself or others, come in physical contact with anyone, or destroy or harm hospital property during the incident.
68. Nurse Manager Page testified that patients are allowed in the kitchenette to get food, drinks, ice cream, etc.
69. Nurse Manager Page asked that the Grievant not return for hospital coverage.
70. Security Officer Supervisor Johnson arrived on the floor after the inmate had returned to her room.
71. When he entered the room he observed the inmate in bed, and Grievant in the room. Grievant was not sleeping when he went into the inmate's room. Supervisor Johnson called out several times, "Ma'am, I'd like to talk to you" with no response.

72. Grievant testified that when Mr. Johnson entered the hospital room, he was standing by the inmate's bed and asked several times what happened. Grievant did not initially respond because she thought he was talking to the inmate, not Grievant. When Grievant did respond, Supervisor Johnson was in her face repeating that the inmate needed to be shackled to the bed. Grievant responded that the inmate had not been shackled during the previous shift and was not required to be shackled. He advised the Grievant that he would be contacting "her supervisor" about the incident. He left at approximately 6:48 a.m.
73. Supervisor Johnson then called the Chittenden Regional Correctional Facility and spoke with supervisor Tyler and asked that a replacement for Grievant be sent immediately to the hospital.
74. After the interaction with Security Supervisor Johnson, Grievant continued to write up the details of the events that occurred in the hospital during her shift.
75. Corrections Officer Ruthie Holmes works as a correctional living unit supervisor at the Chittenden Regional Correctional Facility. On the morning of September 9, 2021, around fifteen to thirty minutes before her 7:00 a.m. shift. Officer Holmes was briefed by the Chief of Security and directed to relieve the Grievant on hospital coverage at UVM, and to restrain the inmate's foot and wrist to the bed.
76. She grabbed the hospital bag that contained shackles and cuffs and traveled to the hospital.
77. When Officer Holmes arrived at the hospital, she reported to hospital security and was escorted to the inmate's hospital room.

78. When Officer Holmes entered the room at approximately 7:30 a.m., the overhead lights were off, but the security lights were on in the room. She pulled back the patient curtain and observed the inmate sleeping. As Ms. Holmes moved the patient curtain at the entry of the room, she observed Grievant in a chair leaning against the wall and appeared to jerk or awaken when the curtain was pulled back.

79. Grievant asked Ms. Holmes what she was doing, Holmes responded, "I am here to relieve you, to take over."

80. Ms. Holmes took advantage of the inmate sleeping to restrain her. As she was being restrained, the inmate woke up and cursed at Ms. Holmes. Ms. Holmes needed a second set of shackles to restrain the inmate's legs. She restrained the inmate in two places, her wrist shackled to the bed, and one foot/ankle shackled to the bed.

81. Holmes did not ask Grievant for assistance in restraining the individual. She did not ask the security guards that escorted her to the room for assistance.

82. Commissioner Deml testified that he was unaware of any rule or policy requiring that Grievant assist with restraining the inmate.

83. Grievant asked Officer Holmes if there was anything else she needed, hearing nothing from Holmes, Grievant left. There was no end of shift briefing that communicated overall behavior or other details.

Investigation

84. In the morning of September 9, 2021, Glenn Boyde received a call on his cell from the Superintendent of the Chittenden Regional Correctional Facility that she was sending a Correctional Officer to the hospital to relieve Grievant. He was informed that Grievant

had fallen asleep and the hospital no longer wanted Grievant back providing hospital coverage.

85. When he arrived at the parking lot of the Burlington Probation and Parole Office, he encountered Grievant who asked to talk with him. Glenn Boyde informed Grievant he could not talk with her, he recommended she talk to a Union Steward, and directed her to write a report detailing the incident. Grievant informed Mr. Boyde that she had already written a report and he encouraged her to review it with the Union Steward. Mr. Boyde did not review Grievant's report.
86. On September 9, 2021, Glenn Boyde referred the incident at the hospital to the Human Resources Investigative Unit based on the allegation that Grievant fell asleep during her shift which allowed the inmate to leave the room walk to the kitchenette and become belligerent with nursing staff.
87. Grievant wrote and submitted her report within hours of the incident detailing the events that occurred in the morning of September 9, 2021.
88. Human Resources Investigator Canales interviewed Grievant on October 13, 2021. During the interview Grievant denied she was sleeping or lost sight of the inmate. She also indicated that she had not lost control of the inmate.
89. According to her District Manager, Glenn Boyde, failing to restrain the inmate was not misconduct by Grievant.
90. Neither PPO Teske nor PPO Supervisor McCuin received any discipline for failing to restrain the inmate to the bed.

91. Glenn Boyde referred Supervisor McCuin to the Human Resources Investigative Unit believing McCuin's conduct to be gross misconduct because he was a supervisor that did not restrain the inmate and directed the subsequent PPO not to restrain the inmate.
92. Glenn Boyde did not refer PPO Teske to the Human Resources Investigative Unit because he was directed by his supervisor that the inmate did not need to be shackled.
93. On December 20, 2021, DOC Commissioner Deml wrote Grievant advising her that the DOC was contemplating imposing serious disciplinary action against her, up to and including termination. The Loudermill letter alleged she engaged in misconduct for failing to follow the CRCF Procedure 403.00.10, for Hospital Coverage, by falling asleep during her shift, failing to shackle the inmate to the bed, allowing the inmate to leave her room and failing to maintain control of the inmate.
94. Grievant was notified that she may have violated the following relevant Collective Bargaining Agreement provisions, personnel policies, and DOC Work Rules of Department Administrative Directives:

    - CBA Article 14: disciplinary Action
    - Policy 5.6: Employee Conduct
    - Policy 8.0 disciplinary Action
    - Policy 0.1: Immediate Dismissal
    - Policy 17.0: Employment Related Investigations
    - DOC Work Rules, 1,4, and 9.
    - CRCF Procedure 403.00.10: Hospital Coverage

    State's Exhibit I.

95. On March 2, 2022, Commissioner Deml terminated Grievant from her position as Probation and Parole Officer with the Department of Corrections for failing to follow post orders during her hospital shift, and for being untruthful during the investigative process.

96. Commissioner Deml terminated Grievant because the failure to properly supervise and manage an inmate at the hospital is serious misconduct. He believed her actions began as negligence, then willful disregard, then ended with her intentional obfuscation of the facts to avoid ownership or acceptance of responsibility.

97. Commissioner Deml concluded Grievant lost control of the inmate because the inmate left the room.

98. Grievant's not wearing shoes was not a factor in Commissioner Deml's decision to terminate Grievant.

99. The Commissioner supported his decision to terminate Grievant because having worked for the DOC, he believed Grievant was "certainly aware of the importance of following Department post orders and directives."

100. According to Commissioner Deml, Grievant's blaming the Department for not providing her with sufficient training to perform the post has contributed to the erosion of her "supervisors' confidence in her ability to perform the standard duties assigned to any Department staff member."

101. Commissioner Deml considered important the employee's long years of service and absence of past discipline, but determined the positive work history was outweighed by the seriousness of the offenses and the multiple allegations of misconduct.

OPINION

Grievant alleges the Employer dismissed her without just cause, improperly bypassed progressive discipline, and failed to discipline her with a view towards consistency and uniformity. Just cause for dismissal is some substantial shortcoming detrimental to the employer's interests which the law and sound public opinion recognize as a good cause for dismissal. In re Grievance of Brooks, 135 Vt. 563, 568 (1977). The ultimate criterion of just cause is whether an employer acted reasonably in discharging an employee for misconduct. Id. 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 carrying out our function to hear and make a final determination on whether just cause exists, the Labor Relations Board determines *de novo* and finally the facts of a particular dispute, and whether the penalty imposed on the basis of those facts is within the law and the contract. Grievance of Colleran and Britt, 6 VLRB 235, 265 (1983). 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. Id. 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 terminated Grievant because of the misconduct described in the Loudermill letter of December 20, 2021. The State alleges Grievant engaged in the following misconduct which warrants just cause for termination: 1) failing to follow CRCF [Chittenden Regional Correctional Facility] Procedure 403.00.10, hospital coverage post orders by falling asleep, not shackling the inmate to her bed, allowing the inmate to leave her room, and failing to

maintain control of the inmate; and 2) failing to be truthful or forthcoming during the investigation when she said she denied falling asleep, failed to maintain eyes on or control of the inmate.

Regarding the first allegation, the State claims that Grievant violated the CRCF post orders for hospital coverage duty. The State alleges Grievant fell asleep during her night shift. Although staying awake is not explicitly listed on the post orders, the requirement that "[h]ospital coverage Officers will remain in direct visual observation of the inmate at all times," necessitates that the officer be awake in order to fulfill that duty. State's Exhibit A. In making his termination decision, Commissioner Deml relied on the "multiple reports from hospital staff" that Grievant was asleep. He also relied on the information provided by District Manager Boyde.

None of the hospital staff, however, testified that they observed Grievant sleeping. Although a number of witness statements referenced or relied on other witness assertions, none of the hospital staff observed Grievant sleeping. Nurse Manager Page admitted she never saw Grievant sleeping. She observed Grievant in the kitchenette or at the corner of the kitchenette and hallway and watched Grievant escort the inmate back to her hospital room. None of the UVM Security personnel saw Grievant asleep or sleeping or testified that they saw her sleeping. Instead, they relied on and repeated their impressions of what the charge nurse observed. The UVM Security personnel reports of the incident incorrectly stated that the charge nurse had said Grievant was sleeping or that the charge nurse believed Grievant was sleeping. State's Exhibit C. The email from the charge nurse, however, does not mention that Grievant was sleeping. The charge nurse did not testify, and the Board does not rely on, nor does it find credible, the statements referencing or relying on assumptions or beliefs of someone who did not testify at the hearing.

Probation and Parole District Manager Glenn Boyde also did not observe Grievant sleeping. In his memorandum referring the incident for investigation, he repeated that it was "alleged Suzanne [Dubuc] fell asleep during her shift in which time the individual left their hospital bed and room and was discovered by nursing staff in the nursing kitchen area." Mr. Boyde, however, was not at the hospital and could not observe Grievant sleeping.

The State bears the burden of establishing by a preponderance of the evidence, or more likely than not, that Grievant was sleeping or not maintaining a visual on the inmate. Officer Holmes testified that when she entered the hospital room, the overhead lights were off, but the lights for the equipment were on. The inmate was asleep and Grievant was in a chair with her head leaning back against the wall. In her report written soon after relieving Grievant and returning to the CRCF, Officer Holmes stated that Grievant opened her eyes and "appeared to awaken" when her name was called. At the hearing, Ms. Holmes initially testified that when she first came into the room, Grievant appeared to be sleeping with her eyes closed but opened them when her name was called, or the patient curtain opened. She later acknowledged that Grievant appeared to awaken. Officer Holmes was directed by her supervisor to restrain the inmate by her hand and ankle. Officer Holmes was focused on restraining the inmate when she entered the room, and her attention was on the inmate. As she restrained and interacted with the inmate, Holmes was unaware of Grievant, her location, or what she was doing. Any focus on Grievant was diverted or secondary.

Grievant testified that she was not sleeping. When Officer Holmes entered the room, the interaction with the inmate in the kitchenette had only recently ended after which she was subjected to questioning by the hospital Security Supervisor. There were monitors beeping in the room and nurses continued to come in and out checking on the inmate. After returning to the

inmate's room, Grievant began writing a report detailing what had just transpired. Trained in the importance of documenting incidents as close in time to the event as possible, she wanted to write down what had occurred when the events were fresh in her mind. She had completed this report by the time she met District Manager Boyde in the parking lot of the Burlington Probation and Parole Office. Given the shortness in time between the incident and Officer Holmes arriving in the room, Officer Holmes' diverted focus and attention on the inmate, and Grievant's testimony that she remained awake and drafted her report in the time between the incident and arriving at the Burlington office, the Board finds the testimony of the Grievant to be more credible and it is more likely than not that Grievant was not sleeping. The State has not proven by a preponderance of the evidence that Grievant was sleeping.

The State has also not proven by a preponderance of the evidence that Grievant failed to keep a visual on the inmate. Grievant continued to observe and follow the inmate as she left the hospital room and crossed the hallway to the kitchenette. The inmate walked to the kitchenette, a location into which hospital staff had previously invited her. Throughout the brief walk in the hallway and time in the kitchenette, the inmate's legs remained shackled together. The inmate did not escape or harm herself or others. She did not break hospital property. Grievant implemented her training and de-escalation techniques to compel the inmate to leave the kitchenette and return to her hospital room. Grievant exercised her power and influence over the inmate to guide her back to the room. Once in the room, Grievant continued to observe the inmate who went back to bed and fell asleep.

The State asserts that Grievant was unable to maintain control of the inmate and that Grievant lied when she said she maintained control of the inmate. The post order neither defines the term "control" nor does it require that the Officer maintain control of the inmate. The

information on the "loss of control" came from the Nurse Manager and Grievant. The word control may have a different connotation in a hospital environment than it does in a corrections environment. To Nurse Manager Page, the detainee and her behavior may have appeared out of control. From Grievant's perspective the detainee was in view and under her control the entire time she was out of her hospital room.

The inmate's use of verbally offensive or aggressive language does not establish that Grievant lost control of the inmate. Although such language may be out of place in the quiet halls of a hospital ward, it was not uncommon for the inmate. The inmate was posturing but did not act on that bravado and instead acquiesced to the direction and control of Grievant to return to the room. Contrary to the allegations of the State, Grievant did not require the help of security. She compelled the inmate to move back to the room before security arrived. Nurse Manager Page acknowledged that the inmate was under control when she was walking back to the room. When security arrived, the inmate was already in her room. The State has not proven by a preponderance of the evidence that Grievant failed to maintain control or that she lied when she said she had control of the inmate.

The State has proven by a preponderance of the evidence that Grievant did not restrain the inmate to the bed as required in the CRCF post order for Correctional Officers on hospital duty. As a result of failing to shackle the inmate, the inmate was able to leave her room, enter the kitchen, and disrupt the unit and hospital staff. This failure allowed the inmate to engage in threatening behavior toward hospital staff and disruption on the unit.

The State alleges that Grievant's failure to comply with the CRCF post order for hospital duty, violated Personnel Policy 5.6, which requires the following:

REQUIRED CONDUCT

1. It shall be the duty of employees to fulfill to the best of their ability the duties and responsibilities of their position.
….

3. Employees shall conduct themselves in a manner that will not bring discredit or embarrassment to the State of Vermont, whether on or off duty.

Grievant was employed as a Probation and Parole Officer. The position for which she was trained and served was that of a Probation and Parole Officer, not a Correctional Officer. Grievant's duties involved case management, not security or assessment and control of risk. The DOC represented that the scope of the hospital coverage post orders had changed to include PPOs. This change, however, did not immediately instill in PPOs the requisite training needed to perform hospital coverage. Grievant received no training as a Correctional Officer generally and none specifically geared toward the role of hospital coverage. Grievant had never cuffed an individual before and had never received training in use of force.

In performing her hospital coverage duties on September 9, 2021, Grievant used the tools and training she had available to her as a PPO. Grievant employed her communication and de-escalation training and experience dealing with women offenders with substance use and other issues to remove the inmate from the kitchenette and back to her room without the use of force. Although the inmate was loud, posturing, and disruptive in the hallway, she did not physically harm herself, others, or hospital property. Throughout the evening, Grievant talked with the inmate, escorted her to the restroom, and kept her under watch and control. She performed these tasks to the best of her ability.

Although Grievant did not conform to the requirements of a Corrections Officer I or II, educated at the Vermont Correctional Academy, Grievant is not a Correctional Officer. She did

not, nor was she required to attend the Vermont Correctional Academy. She did not need to maintain the core competencies of a Correctional Officer. She fulfilled to the best of her abilities the duties of a Probation and Parole Officer and used that training to get the inmate to comply with her directions to return to the room. The State has not sustained its burden of proving Grievant failed to perform to the best of her abilities the duties of her position.

The State has also failed to prove by a preponderance of the evidence that Grievant engaged in conduct that could bring discredit to the State of Vermont. Commissioner Deml sites the hospital's request that Grievant not return to the hospital as proof of such conduct. He also claims that the interaction jeopardized the relationship with the community partner UVMMC. Commissioner Deml was also concerned Grievant's sleeping on her shift would bring discredit to the State. The Board has found, however, that the State has not proven that Grievant was sleeping on shift.

Grievant did not cause the hospital to discontinue or sever its relationship with the DOC. The relationship between the State and UVM is long and rich enough that this one incident did not damage it. Nurse Manager Page acknowledged that relations and confidence with DOC have been restored. Requesting that Grievant not return does not bring embarrassment or discredit to the State or DOC. Grievant was not trained for the position and the request that DOC refrain from sending untrained staff to provide hospital coverage is reasonable.

The State alleges that Grievant was rude or unprofessional because she did not respond to the Security Supervisor. The Security Supervisor entered the inmate's room and repeated "Ma'am" three times. Grievant believed the question was directed at the inmate and did not immediately respond. After realizing the prompt was meant for her, Grievant responded to his questions. She reported the basis of her knowledge regarding why the inmate was not restrained.

Grievant also responded to Nurse Manager Page by moving the inmate back to her room. Through use of de-escalation techniques and motioning, Grievant compelled the inmate back to her room. The State has not proven by a preponderance of the evidence that Grievant was unprofessional or rude.

The State also alleges that Grievant violated DOC Work Rules, 1, 4, and 9, by failing to restrain the inmate. DOC Work Rule 1 prohibits DOC employees from violating any provision of the Collective Bargaining Agreement, Work Rule, policy, procedure, directive, or post order. The State has not demonstrated that Grievant violated the Collective Bargaining Agreement, Policy Directive, or Work Rule. Although the post order requires that the inmate be restrained, the directive from the supervisor was that the inmate did not need to be restrained. Because the work order and directive conflict, the State has not proven by a preponderance of the evidence that Grievant violated DOC Work Rule 1.

As outlined in the discussion of Personnel Policy 5.6, the State has also failed to prove that Grievant violated Work Rule 9. Her conduct did not bring discredit to the DOC. DOC retained its positive relationship with the hospital. DOC can continue to send its staff to the hospital to conduct hospital coverage.

Employer next alleges that Grievant was not truthful and did not cooperate fully during the investigation in violation of DOC Work Rule 4, and Personnel Policy 17.0. The Employer alleges Grievant lied when she denied falling asleep, losing control of the inmate, and losing site of the inmate.

The Board has found that the State has not proven by a preponderance of the evidence that Grievant was asleep during her hospital shift, or lost control or sight of the inmate. The

Board found credible Grievant's testimony that she was not sleeping, and that she maintained control and sight of the inmate. Grievant provided this information to the investigator and the State has not proven by a preponderance of the evidence that Grievant lied or was untruthful when she said she was not sleeping or had maintained control or sight of the inmate.

Reasonableness of Termination Decision

In determining whether the proven charges justify the termination decision, the Board applies the factors announced in Grievance of Colleran and Britt, 6 VLRB 235, 268-69 (1983). The factors include: 1) the nature and seriousness of the proven offenses, 2) the Grievant's job level, 3) the Grievant's past work record including length of service, performance on the job, and past disciplinary record, 4) the effect of the offenses upon Grievant's ability to perform at a satisfactory level and their effect on supervisors' confidence in Grievant's ability to perform assigned duties, 5) the consistency of the penalty, 6) the clarity of notice, 7) the notoriety of the offense or its impact upon the Employer's reputation, 8) the potential for Grievant's rehabilitation, 9) mitigating factors, 10) the adequacy and effectiveness of alternative sanctions to deter such conduct in the future, and 11) mitigating factors. See Id. at 268-69 (1983).

The Colleran factors provide a means of assessing the reasonableness of the employer's decision. The Employer is not required to prove each factor to support the reasonableness of its decision, "only that 'on balance the relevant factors support management's judgment.'" In re Jewett, 2009 VT 67, ¶ 23, 186 Vt. 160, 170 (quoting In re Colleran, 6 VLRB at 269).

We first consider the nature and seriousness of Grievant's offenses and their relation to Grievant's duties, position, and responsibilities. The just cause analysis centers upon the nature of the employee's misconduct. Grievance of Merrill, 151 Vt. 270, 273 (1989); In re Morrissey,

149 Vt. 1, 13 (1987). In deciding whether there is just cause for dismissal, the Board determines the substantiality of the detriment to the employer's interests. Merrill, 151 Vt. at 273-74.

The Colleran and Britt factors focus on the seriousness of the misconduct as it relates to the Grievant's "duties, position and responsibilities, including whether the offense was intentional or technical or inadvertent, or was committed maliciously or for gain, or was frequently repeated." Grievance of Colleran and Britt, 6 VLRB at 268. Grievant did not act with malice or for personal gain when she followed the practice established by Supervisor McCuin and did not restrain the inmate's leg to the bed. She adhered to the training she had available to her throughout the evening. The State has not proven that Grievant willfully or intentionally defied the post order. Grievant was not trained on the post orders nor was she required to demonstrate or memorialize that she read or understood them.

Grievant is a probation and parole officer. Grievant's failure to restrain the inmate to the hospital bed does not impact her position as a PPO. Grievant did not receive the same training as Correctional Officers, did not attend the Correctional Academy, and does not have the same job duties or responsibilities as a Correctional Officer. Grievant's duties are to manage, oversee, and shepherd parolees, and probationers through their conditions of release and transition to the greater society.

Grievant's many years of public service undermines the reasonableness of the termination decision. Grievant had served the State of Vermont as a PPO for twenty-two years when she was terminated. She is a skilled PPO who has developed a good rapport with her colleagues and clients. She has demonstrated a talent for working with the parents of the young people she supervised and supporting her colleagues. Grievant has received positive employee

evaluations throughout her career and has never received any discipline. Commissioner Deml recognized the importance of these two factors.

The State has failed to prove by a preponderance of the evidence that Grievant cannot perform her Probation and Parole duties. Commissioner Deml's loss of confidence in Grievant's ability to perform her assigned duties relies in part on his belief she was untruthful, fell asleep, and needed hospital security to assist her in moving the inmate back to her room. The Board has found that Grievant did not lie or provide untruthful information during the investigation. The State has also failed to prove that Grievant was asleep and the findings do not support that Grievant needed security to assist her in returning the inmate back to her room.

Also influencing the Commissioner's decision was that Grievant, as an experienced PPO, was aware of the importance of following post orders and had the necessary training to perform hospital coverage. There is no evidence that Grievant was aware of the need to follow post orders. In fact, the findings support the opposite conclusion. Mr. Boyde conceded that PPOs were not exposed to post orders and did not have post order responsibilities as part of their duties. Grievant also never received the requisite use of force training or any training on the requirements of the post orders related to hospital coverage. Because the basis for the Commissioner's lack of confidence in Grievant is not supported by the findings, his lack of confidence in Grievant is not reasonable. In addition, Grievant's Director, Glenn Boyde does not believe Grievant engaged in misconduct by not restraining the inmate.

The consistency of penalty does not support the reasonableness of the termination decision. In two of the cases cited by DOC, as supporting the consistency of its decision, the employee received a written reprimand. In case no. 2019-0181, a Correctional Officer was issued a reprimand for failing to follow a post order regarding unit tours and for failing to follow

a directive to add late entries to the log. A written reprimand was also imposed for dishonesty during an investigation and for creating a conflict of interest and engaging in unprofessional behavior in case no. 2021-0142. The five cases that warranted termination involved dishonesty alone or dishonesty or falsifying records combined with other misconduct. Grievant was not untruthful during the investigative process. Terminating Grievant for not restraining the inmate to the bed is not consistent with the discipline DOC imposed on other employees for the same or similar offenses.

Moreover, a supervisor in Grievant's PPO office also failed to restrain the inmate and directed his subordinate not to restrain that inmate. The State did not impose any discipline on that supervisor. Terminating Grievant for the same omission is not consistent or reasonable.

There was no clarity of notice about the consequence for failing to adhere to the post order nor the requirements for the hospital coverage itself. Grievant did not receive training on the post orders. She also had never shackled anyone nor used restraints prior to being assigned the hospital coverage duty. PPOs, unlike Correctional Officers, do not rely on post orders to prescribe or govern their duties. The Department of Corrections did not ensure that those PPOs being assigned to the hospital shift had the requisite training, certifications, and had read and understood the post orders applicable for that post. Although training in use of force was a prerequisite for filling the hospital duty post, Grievant never received such training before she was assigned to that post.

There was no clarity of notice about the requirement for restraining an inmate to the bed. The supervisor set the standard for how this inmate should be guarded during her hospital stay. Her successor Teske did not restrain the inmate and Grievant followed this directive and did not restrain the inmate. There was no clarity of notice that she would be disciplined for following

the standard set by her supervisor. Director Boyde identified a number of Standard Practices that would not apply to PPOs, but there was nothing in the post order, that notifies a PPO which Standard Procedures apply to them. Grievant's personal experience on hospital coverage prior to the September 9, also undermines the clarity of notice. The two inmates Grievant monitored prior to the events of September 9, were not restrained.

There has been no notoriety of the offense. Commissioner Deml repeatedly referred to UVMMC as a DOC community partner. The interaction between hospital staff, Grievant, and the inmate has not become public or infamous. The interaction has not permanently harmed the relationship between UVMMC and DOC. Nurse Manager Page is comfortable and confident in the hospital coverage provided by DOC.

Grievant has worked as a successful and effective PPO for over twenty-two years. The State's conclusion that there is no potential for rehabilitation is not reasonable. Grievant did not conform to a post order for which she was not sufficiently trained. The State has failed to prove by a preponderance of the evidence that Grievant lied or was untruthful. With the proper training and clear direction, Grievant can continue to be a productive PPO.

There are several mitigating factors that undermine the reasonableness of the termination decision. Grievant was notified at 4 p.m., the end of her eight-hour shift., that she was required to cover a hospital shift starting at midnight, eight hours later. Although use of force training was required to serve hospital coverage, Grievant lacked use of force training. A PPO Supervisor directed that the inmate not be restrained and that direction was provided to Grievant. There was no training on post orders generally, the requirements of the hospital coverage post order specifically, nor any requirement that Grievant memorialize that she read and understood the hospital coverage post order.

There are alternatives to termination to prevent a repeat of the events of November 9, 2021. Given Grievant's lack of training on use of force and the hospital coverage post orders, and inconsistent directions regarding restraining the inmate, a written reprimand is adequate to deter similar conduct by the Grievant or other employees in the future.

ORDER

Based on the findings and reasoning stated above, it is ordered:

1. The Grievance of the VSEA and Suzanne Dubuc is sustained in part;

2. Grievant shall be reinstated to her position with the Department of Corrections Probation and Parole Office, and receive a written reprimand consistent with this ruling;

3. Grievant shall be awarded back pay and benefits from the effective date of her dismissal until her reinstatement, for all hours of her regularly assigned shift plus the amount of overtime Grievant would have worked, minus any income (including unemployment compensation received and not paid back) received by Grievant in the interim;

4. The interest due Grievant on back pay shall be computed on gross pay and shall be at the legal rate of 12 percent per annum and shall run from the date each paycheck was due during the period commencing from Grievant's dismissal, and ending on the date of her reinstatement; such interest for each paycheck date shall be computed from the amount of each paycheck minus income (including unemployment compensation) received by Grievant during the payroll period;

5. The parties shall file with the Labor Relations Board by October 2, 2023, a proposed order indicating the specific amount of back pay and other benefits due Grievant; and if they are unable to agree on a proposed order, shall notify the Board in writing of specific facts agreed to

by the parties, specific areas of factual disagreement and a statement of issues which need to be decided by the Board, and any proposed exhibits.

6. If the parties do not submit a proposed order, a hearing on disputed issues shall be scheduled via the Microsoft Teams platform; and

7. The Employer shall remove all references to Grievant's dismissal from her personnel file and other official records.

Dated this 21st day of August 2023, at Montpelier, Vermont.

VERMONT LABOR RELATIONS BOARD

/s/ Richard W. Park

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Richard W. Park, Chairperson

/s/ Alan Willard

_____

Alan Willard

/s/ David Boulanger

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David Boulanger