FILED
OFFICE OF ADMINISTRATIVE HEARINGS
10/18/2021 2:48 PM

STATE OF NORTH CAROLINA

COUNTY OF PASQUOTANK

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
21 OSP 01390

Christopher L Stockli Petitioner, v. North Carolina Department of Public Safety Respondent.	**FINAL DECISION**

THIS CONTESTED CASE came on for hearing before the Honorable Karlene S. Turrentine, Administrative Law Judge, on July 20 and 21, 2021, in the Historic Halifax County Courthouse in Halifax County, North Carolina, pursuant to N.C. Gen. Stat. § 150B-23 and Petitioner's contested case petition appealing Respondent's discharge for just cause pursuant to N.C. Gen. Stat. §§ 126-34.02 and 126-35.

THE PARTIES

The parties to this contested case are the Petitioner Christopher L. Stockli (hereinafter, "Petitioner" or "Mr. Stockli") and Respondent North Carolina Department of Public Safety (hereinafter, "Respondent" or "DPS").

APPEARANCES

For Petitioner: Jennifer J. Knox
Attorney for Petitioner Christopher L. Stockli

For Respondent: Adrina G. Bass
Assistant Attorney General

WITNESSES FOR RESPONDENT

Christopher L. Stockli, Petitioner
Jeffrey Keith Baker, Captain overseeing special operations
Tana Hill-Dillard, Administrative Captain III, Investigator
John Kishbaugh, Correctional Officer III (transport, medical and educational officer)
Georgia Aydlette, Correctional Officer III (transport)
Jerry Byrum, Correctional Lieutenant III, Investigator
Brandeshawn Harris, Assistant Commissioner of Prisons

WITNESSES FOR PETITIONER

None.

EXHIBITS

For Petitioner:

EXHIBIT NO.	PETITIONER'S EXHIBITS ADMITTED INTO EVIDENCE
1	NC DPS Pasquotank Correctional Institution Website (4 pp)
2	DPS/Pasquotank Correctional Institution/3740–Post Order Chapter II–.1900 Restrictive Housing Officer (Issue Date 09/27/19; 7 pp)

For Respondent:

EXHIBIT NO.	RESPONDENT'S EXHIBITS ADMITTED PURSUANT TO PARTIES' STIPULATION
1	DPS/Pasquotank Correctional Institution/3740–Standard Operating Procedures (hereinafter, "SOP") Chapter II, Custody & Operations–.2900 Correctional Officer (Issue Date 05/20/20; 6 pp)
2	SOP: Chapter III, Mental Health–.0511 Self Injurious Behavior (Issue Date 03/11/20; 19 pp)
3	DPS/Pasquotank Correctional Institution/3740–Policy & Procedure Chapter F–.1100 Transporting Offenders (Issue Date 03/18/20; pp. 1, 2, & 4)
4	DPS Internal Investigation Report #: 1000006471 by Tana Hill-Dillard (Bates stamped pp. 198-205)
5	DPS Internal Investigation Report #: 1000007843 by Jerry Byrum (Bates stamped pp. 115-197)
6	State Human Resources Manual, § 7–Disciplinary Action Policy (Effective Date: 10/1/2017; pp. 1-16)
7	DPS Notification of Pre-Disciplinary Conference, dated 11.9.20 (Bates stamped pp. 108-114)
8	DPS Dismissal Letter to Petitioner, dated 11.13.20 (Bates stamped pp. 063-069)
9	DPS Final Agency Decision Letter, dated 3.11.21 (Bates stamped pp. 328-331)
10	Employee Grievance–Step 1 Mediation, dated 11.26.20 (Bates stamped pp. 92-95)

11	Notice of Mediation, dated 12.16.20 (Bates stamped p. 78)
12	Notice of Mediation Impasse, dated 12.21.20 (Bates stamped p. 79)
13	Employee Grievance—Step 2 Hearing (Bates stamped p. 20)

PREHEARING MOTIONS

On the first day of hearing, Petitioner motioned the Tribunal to sequester the witnesses, which motion was granted without objection.

ISSUES

1. Did Respondent discharge Petitioner on November 13, 2020, for unacceptable personal conduct and grossly inefficient job performance, without just cause in violation of N.C. Gen. Stat. § 126-35(a)?

2. If the answer to issue #1 is affirmative, to what remedy is Petitioner entitled?

STANDARD OF REVIEW

Petitioner's complaint alleges that he was terminated without just cause. In personnel cases, pursuant to N.C. Gen. Stat. § 150B-25.1(c), the State agency bears the burden of showing by a preponderance (or the greater weight) of the evidence that Petitioner was discharged for just cause. Thus, in the present case, Respondent had the burden of proof to demonstrate by a preponderance of the evidence that it had just cause to dismiss the Petitioner from employment for unacceptable personal conduct and/or grossly inefficient job performance.

APPLICABLE STATUTES AND REGULATIONS

N.C. Gen. Stat. § 150B-1, *et seq.*
N.C. Gen. Stat. § 126, *et seq.*
25 NCAC 1J.0600, *et seq.*

BASED UPON the pleadings, all the documents and exhibits received and admitted into evidence and, having carefully considered the sworn testimony of the witnesses presented at the hearing, and the entire record in this proceeding, the Undersigned makes the following Findings of Fact and Conclusions of Law. In making the following Findings of Fact, the Undersigned weighed all the evidence and assessed the credibility of the many witnesses, taking into account the appropriate factors for judging credibility including but not limited to: a) the demeanor of each witness; b) any interests, bias, or prejudice the witness may have; c) the opportunity of the witness to see, hear, know or remember the facts or occurrences about which the witness testified; d) whether the testimony of the witness is reasonable, and; e) whether the witness' testimony is consistent with all other believable evidence in the case.

AFTER CAREFUL CONSIDERATION of the sworn witness testimony presented at the hearing, the documents and exhibits admitted into evidence, and the entire record in this proceeding, the Undersigned makes the following:

FINDINGS OF FACTS

1. The parties stipulated: a) that Petitioner exhausted his administrative remedies prior to filing his petition for a contested case hearing in this matter (T. Vol. 1, p. 6, lines 10-20, p. 8, lines 11-19; b) that the filing of the Petition was timely, *Id.*; c) that the hearing of this matter is properly before the Undersigned, *Id.* at lines 17-20; d) that they each received adequate and proper notice of the date, time, and place of hearing *Id.* at 9, lines 7-11, and; e) that there was no objection to the Undersigned hearing the matter. *Id.* at lines 12-15.

2. Petitioner was continuously employed by the North Carolina Department of Public Safety ("DPS") from April 15, 2019 until he was terminated on November 13, 2020. *See Respondent's Exh. 4*, p. 7 and *Respondent's Exh. 8*, p. 1.

3. Our statutes define a "career State employee" to mean, in pertinent part, "a State employee…who: (1) Is in a permanent position with a permanent appointment, and (2) Has been continuously employed by the State of North Carolina…in a position subject to the North Carolina Human Resources Act for the immediate 12 preceding months." N.C. Gen. Stat. § 126-1.1.

4. Petitioner is a career State employee.

5. Respondent is a state agency within the government of North Carolina and, at all times herein relevant, has been subject to N.C. Gen. Stat. § 126-1, *et seq*.

6. Petitioner's entire time working for Respondent was as a Correctional Officer III assigned to Pasquotank Correctional Institution ("PCI"). T. Vol. 1, p. 13, lines 5-11.

7. Petitioner testified that, at the relevant time, PCI housed medium, close, and minimum custody level inmates. T. Vol. 1, p. 41, lines 11-17. PCI's Administrative Captain Tana Hill-Dillard testified that "we only have close custody at [PCI]. They shut down the minimum custody." *Id.* at p. 183, lines 17-22. However, she did not know if that was the case during both incidents. Correctional Officer III John Kishbaugh testified that for the duration of both incidences presently at issue, PCI was "a close custody facility with some minimum out back…." *Id.* at p. 214, lines 19-21. However, he went on to state, "If [PCI] ha[s] any medium custody inmates, it means they've been promoted [from being designated close custody to medium custody] and just haven't shipped out yet." *Id.* at p. 216, lines 13-25. He then acknowledged that there still could be some medium custody inmates at PCI. *Id.* at p. 217, lines 13-18.

8. According to Respondent's website, PCI "houses close and minimum custody adult male felons in a close custody building and a minimum custody unit." *Petitioner's Exhibit 1*, p.4. "Close custody" is for inmates who present (or appear to present) the highest risk to the public's safety. (The parties' stipulated that the Tribunal could take judicial notice of the website's definition of "close custody".) *Id.* at p. 43, lines 6-21.

9. While at PCI, Petitioner worked in master control supervising inmate feedings, pat-downs, driving around the facility "to make sure nobody was throwing contraband over the fence." T. Vol. 1 at p. 12, lines 16-19. After that, Petitioner was transferred to Unit 5, the minimum security unit, where he was charged with doing rounds, head counts and random searches, and; Petitioner also was responsible for picking up breakfast, lunch, and dinner from the main facility to the Unit. *Id.* at lines 20-25.

10. On January 23, 2020, Petitioner was transferred to Unit 1, the Restrictive Housing Unit. *Id.* at p. 13, lines 2-4.

11. At hearing, witnesses testified without contradiction that there are (at least) two purposes for the Restrictive Housing Unit ("RHU"):

> *i*) To segregate inmates who may be at risk of harm from other inmates (i.e., a threat has been made against their bodily safety by another inmate), and;
>
> *ii*) To segregate inmates who have exhibited self-injurious behaviors so that they may be constantly monitored to prevent them from causing harm to themselves.

T. Vol. 1, p. 20, lines 1-14, p. 65, lines 14-25, p. 66, lines 1-6, p. 154, lines 5-8, T. Vol. 2, p. 330, lines 6-11, p. 381, lines 4-16, p. 384, lines 11-20.

12. However, the Pasquotank Correctional Institution Post Order .1900 Restrictive Housing Officer also reflects that inmates may be "placed in Restrictive Housing for disciplinary purpose[s]." *See Petitioner's Exhibit* #2, Chapter 2(VI)(F), p. 2. There was no testimony at hearing regarding how inmates are monitored when in RHU for disciplinary purposes.

13. The RHU has regular cells as well as one or more self-injurious behavior (hereinafter, SIB") cells—the main difference of which is that the SIB cells "have a camera in the[m]." T. Vol. 1, p. 28, lines 3-9, p. 153, lines 23-25, p. 154, lines 1-4. Capt. Baker testified that PCI has "four SIB cells…one in each dorm." T. Vol. 2, p. 295, lines 17-18.

14. The monitoring of inmates within the RHU differs depending on whether the inmate is placed there to secure his safety from other inmates or from himself. T. Vol. 2, p. 330, lines 5-11. There was no testimony as to how inmates are monitored when in RHU for disciplinary purposes (as outlined in Paragraph 12 above).

15. When an inmate is brought to RHU because he is a danger to himself, protocol requires that he be monitored (constantly watched) every minute of every day and an officer is assigned to do nothing but that ("line of sight" monitoring) and to record in an iPad what, if any, movement (or if none) the inmate makes every fifteen (15) minutes. This is called level 1 monitoring. T. Vol. 1, p. 20, lines 13-14, p. 159, lines 20-21, p. 160-161.

16. When an inmate is brought to RHU because he is believed to be in danger from other inmates, protocol requires that he be monitored (checked on) every fifteen minutes and the officer assigned may step away so long as he records the inmate's movement (or non-movement)

in the iPad every fifteen (15) minutes. This is called level 2 monitoring ("irregular intervals" monitoring). *Id.*

17. Therefore, the recording obligation for the two is the same, but the actual watching and monitoring of the two is significantly different and the decision as to whether an inmate requires constant line-of-sight monitoring is determined by the facility psychiatrist and passed on to the "higher-ups" (i.e., OICs, lieutenants and/or sergeants) via email. **Lower level correctional officers (such as Petitioner) are not privy to those emails**. T. Vol. 1, p. 161, lines 1-16.

18. Policies & Procedure *Chapter F .1100 03/18/20 Transporting Offenders* reads, in pertinent part:

> Mechanical Restraints. Handcuffs and leg cuffs will be used when the officer-in-charge of the offenders or responsible line staff deem the restraints necessary for custodial reasons. The restraints will be frequently and carefully examined. No offender classified in control status, close custody or medium custody will be transported without leg cuffs, handcuffs with black box and security chain in a non-security vehicle ["full restraints"]. **If** offenders classified in control status, close custody and medium custody are transported with minimum custody offenders, [**then**] all offenders will be handcuffed.

Chapter F .1100 03/18/20 Transporting Offenders, Resp. Exh.3, Page 2 of 7 (emphasis added).

Petitioner's Relevant Work History—the First Incident—March 8, 2020

19. At the time of the first incident in question, on March 8, 2020, Petitioner was assigned to work in RHU (and had been assigned to RHU for "a little over a month[]"). *Id.* at p. 20, lines 8-10.

20. Prior to March 8, 2020, Petitioner had never before been assigned to a level 1 inmate and had only had one level 2 assignment. *Id.* at lines 8-14. The first time Petitioner worked RHU/SIB, he was assigned to monitor an inmate for approximately one (1) hour and was instructed by the sergeant on duty to look in on the inmate every 15 minutes and record his observations on an iPad. (T. Vol. 1, p. 20, lines 8-14, p. 26, lines 2-3). This was level 2 monitoring.

21. On March 8, 2020, at "approximately 7:00 in the morning" during Petitioner's "bullet" shift, inmate Antonio Baskins[1] was brought to the RHU, "placed in a non-SIB cell" and Petitioner was assigned to monitor him. *Id.* at p. 27, lines 15-20, p. 28, lines 10-16, p. 67, lines 9-23. At hearing, Petitioner testified that when Baskins was brought into the RHU he was placed into a "non-SIB cell[,]" that he was wearing his "regular prison clothes." T. Vol. 1, p. 67, lines 9-19.

[1] This Tribunal notes that there is a discrepancy as to whether this inmate's name is Antonio **B**askins or Antonio **V**askins. *See* T. Vol 1, p. 67, lines 3-6, and Respondent's Exhibit 4, p. 5 of 8. The Undersigned utilizes the name referenced most throughout this contested case's filings and transcript, Antonio Baskins.

22. At no time did anyone tell Petitioner why Baskins had been brought to the RHU. Petitioner did not ask and was not told whether Baskins was to be monitored as a level 1 or level 2 inmate. *Id.* at p. 24, lines 22-25, p. 25, lines 1-17, p. 68, lines 15-17.

23. Petitioner testified credibly that the only correctional sergeant present at the time Baskins was placed into the SIB cell was Sergeant James Vanhorn (*Id.* at p. 71, lines 20-24), and Sgt. Vanhorn gave him no information or instructions concerning Baskins. *Id.* at p. 67.

24. Sgt. Vanhorn did not testify at hearing and no evidence to the contrary was offered.

25. Having only monitored one inmate prior, and that for only an hour and, having received no instructions from Sgt. Vanhorn, Petitioner monitored Baskins the same way he had done his previous monitoring—as level 2 irregular interval monitoring—checking in on Baskins every 15 minutes and recording his observations on the iPad. T. Vol. 1, p. 24, lines 9-25, p. 25, lines 1-4.

26. Petitioner walked around because he wanted to stay alert. The iPad was set to alert him every fifteen minutes. At one point, after stepping away and returning, Petitioner observed Baskins with "a clothesline[…,] basically strings of sheets that they unwind and they tie together and they put them around the…fluorescent shop light…. [Baskins] had that loosely around his neck and on…the end of the light." T. Vol. 1, p. 29, lines 8-13.

27. Upon discovering Baskins attempting to hurt himself, Petitioner "called Sergeant Vanhorn and told him that the inmate is going to try and hang himself[,]" to which the Sergeant and several other officers quickly responded and cuffed Baskins. *Id.* at lines 16-25, p. 30, lines 1-13.

28. Inmate Baskins was not injured during the ordeal, and; afterward, Petitioner was placed back at his post to watch Baskins.

29. At PCI, Correctional Captain Jeffery Baker "oversee[s] special operations" (*Id.* at p. 106, lines 20-22), does investigations, oversees investigations, reviews investigations, and "do[es] a lot of the video footage for the facility…." *Id.* at p. 107, lines 8-14. He testified he "had no involvement of [sic] the actual incident. The only thing [he] did was provid[e] a statement [to the warden] from [after watching] video resource." T. Vol. 1, p. 116, lines 18-20. The incident occurred over a weekend, during which time he was off. Upon his return, the warden requested he obtain footage from one of the prison's cameras and "burn [a] video…look at it, and…write a statement concerning the video. And basically that's what [he] did." *Id.* at lines 14-17.

30. Although Capt. Baker repeatedly testified that he "recorded" the incident with Baskins and Stockli in restrictive housing, *see* T. Vol. 1, p. 107, lines 23-25, p. 109, lines 22-24, p. 110, lines 2-15, upon further questioning, it became clear that Capt. Baker simply obtains video from the various PCI cameras and burns copies at the direction of the warden, to make sure it is "memorialized and [does]n't get overwritten." *Id.* at p. 111, lines 12-25, p. 112, lines 1-11, 24-25, p. 113, lines 7-11.

31. In response to whether the videos could be altered or tampered with, Capt. Baker stated, "Not to my knowledge, no." *Id.* at p. 115, lines 13-16. However, he thereafter admitted, "there's three of us or four of us that actually can burn video footage…[and] I can't account for what everybody else does." *Id.* at line 25, p. 116, lines 1-6.

32. As "the admin captain" at PCI, Capt. Dillard is often charged with being the Officer in Charge ("OIC") and with conducting internal investigations. *Id.* at p. 127, lines 3-4, p. 128-130, lines 1-19. She testified it was her responsibility to determine whether a specific DPS policy or PCI policy or procedure had been violated. *Id.* at p. 132, lines 13-16. Thus, although not present during the March 8, 2020 incident and having no personal knowledge thereof, Capt. Dillard was charged with doing the internal investigation of it. *Id.* at p. 132, lines 17-21. The first thing she did was to read the statement Capt. Baker prepared for the warden. *Id.* at p. 140, lines 10-19.

33. Capt. Dillard's investigation consisted of interviewing nine (9) employees of PCI, including Petitioner; however, only three (3) of those interviewed were called by Respondent to testify at hearing, specifically: Correctional Captain III Jeffrey Baker, Correctional Lieutenant III Jerry Byrum and Petitioner. T. Vol. 1, p. 134-135. *See also DPS Internal Investigation Report by Tana Hill-Dillard, Petitioner's Exh. 4,* p. 1, 4 and 6 of 8 *(hereinafter, "Dillard IIR")*.

34. Neither Capt. Baker nor Lt. Byrum were present during the March 8, 2020 incident and, neither had any responsibility regarding the incident or Petitioner's assignment that day. *See Dillard IIR*, pp. 4 and 6 of 8. (It is noted that Respondent called Capt. Baker to testify regarding *only* the March 8, 2020 incident and called Lt. Byrum to testify regarding *only* the June 30, 2020 incident.)

35. Lt. Byrum was asked to write, date, and sign a statement about the March 8, 2020 incident in which he wrote: "I have no knowledge about offender Antonio Baskins…trying to hang himself… until I was asked to write this statement. The only thing I recall about this offender being on SIB watch is the emails I received which are attached which was passdown [sic] from Captain Johnson, Mrs. Jamie Byas M.A. & my monthly report which are collected from emails and passdowns." *Byrum IRR,* Resp. Exh. 5, Bates stamped p. 000197.

36. During her interview of Petitioner, Petitioner admitted that while he was posted to watch Baskins, he walked around to stay alert and watched Baskins at irregular intervals—recording every 15 minutes, as required by level 2 monitoring. *See Dillard* IIR, p. 5 of 8. At hearing, Petitioner maintained that position asserting that he was never told Baskins required line-of-sight, level 1 monitoring. Petitioner also told Capt. Dillard that "the sarge" didn't tell him what his duties were regarding Baskins. T. Vol. 1, p. 146, lines 1-4. Petitioner "didn't know what his post consist [sic] of…." *Id.* at p. 148, line 16.

37. When recalled to the stand, Capt. Baker further testified that he himself had at some point been assigned to the SIB unit "to observe an offender…who had been placed on self-injurious behavior precautions…" and he confirmed what line-of-sight (level 1) monitoring required. T. Vol. 2, p. 294, lines 18-23, p. 295, lines 1-13. However, he had no personal knowledge of the incident at issue.

38. Respondent could not authenticate the video or establish the chain of custody for the video offered. Neither was there any evidence offered to support that the video offered was *actually* that of Baskins in the SIB cell on March 8, 2020 at the time Petitioner was posted to monitor him. Thus, although offered into evidence, the video was excluded from the evidence.

39. At hearing, Capt. Dillard acknowledged that there are times when PCI may use the SIB cell for inmates who have not been designated self-injurious. *Id.* at p. 154, lines 5-8. She admitted that she had never personally done a suicide watch of an inmate. *Id.* at lines 20-23.

40. PCI's Standard Operating Procedures, in pertinent part, require:

> "b. Any cell used for an offender on Self-Injury Watch/Precautions shall be inspected by a Correctional Sergeant prior to placement of the offender in that cell. **The Correctional Sergeant shall ensure that the cell is free of protrusions that would facilitate hanging, or any potentially dangerous objects or devices that could be used for self-harm purposes. The Correctional Sergeant shall search the room to ensure that it is free of contraband or objects** other than standard issued items not denied by written order. …The offender shall be searched, his clothing and personal property shall be removed, and he shall be provided with standard issued apparel for Self-Injury Watch/Precautions that are specifically ordered by the attending clinician.
>
> c. When placed on Self-Injury Watch/Precautions[,] the following conditions shall be maintained:
>
> > *i.* The offender shall be placed on continuous observation, either line-of-sight or through video camera. The correctional staff assigned shall have the sole purpose to observe the offender and shall be given no other duties, no matter how slight or brief.
> >
> > . . .
> >
> > *ii.* Documentation of observations of the offender on Self-Injury Watch/Precautions shall be made every fifteen (15) minutes on the Electronic Rounds Pad by a Correctional Officer."

Standard Operating Procedures ("SOP"), Chapter III, Mental Health, .0511 Self Injurious Behavior, issue date 3/11/20, *Respondent's Exh. 2*, p. 10 of 19 (emphasis added).

41. Although Capt. Dillard's IRR reflects that she *interviewed no one with actual, first-hand knowledge* that Petitioner was told or knew Baskins was a danger to himself or that Petitioner was directed to utilize level 1 line-of-sight monitoring during his watch of Baskins, Capt. Dillard still concluded in her IRR that Petitioner "…abandoned his assigned post… [d]uring [which] time…Baskins attempted to commit suicide by trying to hang himself." *Id.* at p. 7 of 8. *See also* T. Vol. 1, p. 149, lines 3-11. Based upon this conclusion, Capt. Dillard sent the matter on up the chain of command for him to be disciplined. *Id.* at lines 21-23.

42. As relating to the Baskins incident, Assistant Commissioner of Prisons, Brandeshawn Harris ("AC Harris") testified that Petitioner's failure to keep level 1 line-of-sight monitoring of Baskins amounted to grossly inefficient job performance because: a) Baskins had already displayed self-injurious behavior while in a regular restrictive housing unit cell; and, b) because of that and the psychologist's recommendation, Baskins had been moved to an SIB cell where he could be under constant line-of-sight observation because they were "aware that he need[ed] to be constant[ly] watch[ed]." T. Vol. 2, p. 329, lines 12-25, p. 330, lines 1-15.

43. While AC Harris was certain Baskins "required a constant watch" (*Id.* at p. 330, lines 8-15) and, in reviewing Petitioner's statement made to Capt. Dillard, AC Harris could also be sure that Petitioner had not done line-of-sight monitoring of Baskins (*Id.* at p. 334-35), she could not confirm that Petitioner was *actually told or was aware* that Baskins was in a mental health crisis.

Petitioner's Relevant Work History—the Second Incident—June 30, 2020

44. On June 30, 2020, Petitioner and another Correctional Officer, Nathaniel Harper, were teamed together and assigned "hospital duty" to guard a PCI inmate (Darajay Speed). T. Vol. 1, p. 30, lines 15-19, p. 169 lines 13-15, p. 175, lines 19-25, p. 176, lines 1-3. *See also DPS Internal Investigation Report by Jerry Byrum ("Byrum IIR"), Petitioner's Exh. 5 (John Kishbaugh's interview)*, p. 5 of 8.

45. At the time, Speed was a patient at Vidant Hospital in Greenville, North Carolina and had been hospitalized there for about a week prior to June 30th due to his having been stabbed in the spinal cord by another inmate at PCI. T. Vol. 1, p. 31, lines 7-19, p. 32, lines 5-8, p. 164, lines 9-12, p. 180, lines 11-16.

46. Petitioner Stockli testified that inmate Speed was paralyzed on his left side. Petitioner overheard "[t]he doctors, the physical therapists all [sic], as they came and went, sa[ying] that…if he moved his head wrong, he would be paralyzed from the neck down. And earlier that day it took him five minutes to go four feet with Officer Harper's help just to get to the bathroom because he couldn't put any weight on that side of his body." T. Vol. 1, p. 44, lines 14-20, p. 31, lines 9-10, p. 33, lines 2-4, p. 207, lines 12-14, p. 46, lines 23-25, p. 47, line 1. "According to the[doctors] and the tests they ran in front of me, pricking him with a needle and things like that, he didn't feel anything on his left side." *Id.* at p. 48, lines 6-8.

47. When Petitioner and Officer Harper arrived, Speed was restrained by his right wrist being handcuffed to the hospital bed—which was his only restraint as he received medical care "throughout the day". *Id.* at p. 31, lines 3-19, p. 37, lines 7-11, p. 40, lines 11-15.

48. Petitioner credibly testified, without contradiction, that "because [Speed] was paralyzed on his left side, somebody made the decision before [he and Harper] got there that [restraining Speed by anything other than his right wrist] was not necessary." T. Vol. 1, p. 39, lines 6-16. Moreover, he and Officer Harper "were never told [Speed] was close custody. He could

have been minimum custody. …We're supposed to get a jacket with all that information in it, but we never received one." *Id.* at p. 45, lines 1-2, 9-10.

49. The custody level of inmate Speed matters because it determines whether full restraints were required for transport. *See Paragraph 18* above.

50. At some point later in the day, hospital staff notified the officers that Speed was being discharged and was to be transported to Central Prison where his medical care would continue. *Id.* at p. 37, lines 12-20, p. 163, lines 4-8, p. 164, lines 1-8.

51. Since neither he nor Officer Harper had ever transported an inmate before, Petitioner did not know what to do. *Id.* at p. 48, lines 12-18. In Petitioner's previous hospital duty, if an inmate needed transporting, PCI sent "transporting officers" to the hospital to get the inmate and transport him. Petitioner called PCI to speak to the Officer in Charge ("OIC"). *Id.* at lines 18-25.

52. When Petitioner stepped out of Speed's room and called PCI for guidance, he learned the OIC (at the time) was Capt. Dillard[2] and that she was already on the phone with Officer Harper. *Id.* at p. 38, lines 1-4. "As soon as [he] walked [back] in[to Speed's] room, [Harper] handed [Petitioner] the phone[] and Petitioner asked her, "Do we use full restraints[3] or not[?]" *Id.* at p. 46, line 4. Petitioner further went on to inquire of Capt. Dillard, in light of Speed's "condition, being paralyzed on his left side, how should we proceed[]" in transporting him. *Id.* at p. 38, lines 6-8. Petitioner also wanted to be assured that he would not be held liable if he transported Speed and Speed sustained additional injury. Petitioner testified that the OIC Dillard "said she would call back[but t]hat never happened. *Id.* at lines 6-12, p. 45, lines 23-25, p. 46, lines 1-7, p. 40, lines 21-22, p. 48, lines 19-24.

53. Contrarily, Capt. Dillard testified that she spoke to Petitioner but:

> "[H]e didn't ask me nothing. …I did talk to him, but it wasn't as far [sic] as restraints. …[T]he only thing we mainly kept talking back and forth over as far as to transporting the other offender. He didn't ask about no restraints or none of that. It was just the back and forth of he – he needed a – I need to fax him a waiver for you [sic] won't be held responsible for the inmate if that offender…if something happened to him when he put him in that secure vehicle. He felt like…the offender needed to be transported in another type of like [sic] ambulance or different things….
>
> …I'm not medical, so I can't really say [whether Speed was a paraplegic or paralyzed on one side] – the only thing I can know is when they telling me to move him, move him. When we get orders from Raleigh, different things saying, 'Oh, he could be transport [sic] in a secured vehicle,' that's our job[.]"

---

[2] Capt. Dillard testified that the prior OIC for the day had to leave for a doctor's appointment and she had just gotten a call to take over the shift for them as OIC in the middle of learning Speed needed to be transported. T. Vol. 1, p. 164, lines 9-22.

[3] "Full restraints" consist of handcuffs, waist chain, block box, padlock, and leg restraints. *Id.* at p. 200, lines 22-25.

. . .

> Wind up I…when I called back, [I] talked to Officer Harper, I called Sergeant Gregory. I said, 'Get me Officer Harper on the line' cause that's the last one I talked to. And I said, 'Harper, what's going on with discharge?' That's when Harper – I don't know about what's on the speaker, talked to Stock – Stockli at that time, and I said…'Stockli, they discharging him. We're going to have to move him to CP.' First the conversation was. …
>
> Then he was like, 'Oh, I need a –I don't feel comfortable to move this offender. I don't feel like he's – …I need a waiver cause something happen, I'm not gonna be responsible.'
>
> . . .
>
> [After going back and forth,] …Sergeant [Nassoma] Powell assigned Kishbaugh and Aydlette out [sic] to the hospital.[4]

T. Vol. 1, p. 161, lines 21-25, p. 162, lines 1-11, 16-22, p. 165, lines 17-25, p. 166, line 1, p. 166, lines 19-22. Ultimately, because Petitioner kept pressing about Speed's health and wellbeing, Capt. Dillard felt Petitioner was being insubordinate.

54. In her interview with the internal investigator (Jerry Byrum), Capt. Dillard said,

> "…Mrs. Alice Cameron contacted her…and advised her that offender Speede…would be discharged…and has lieu [sic] accepted for transfer to Central prison Hospital for continued medical care. She stated the offender…would be transported by a secured state vehicle. She stated Officer Harper had contacted her and advise…that the nurse had told them they were going to discharge…Speed and that he would be transported to Central Prison. She…advised Officer Harper to contact her when the nurse got the discharge paperwork ready.
>
> Officer Stockli stated to her that *in the condition of the offender[,] they may need another type of vehicle*. She…advised Officer Stockli that he was not medical staff and if medical approved for this offender to be transported by secure vehicle than [sic] that's what he would have to do. …Officer Stockli stated to her that he needed her to fax him paperwork stating that he would not be accountable or liable if something happened to offender Speede in his condition. She…told [him] that he was refusing her order to transport that offender. …She stated at that time she felt uneasy that something was wrong or something was going to happen because *there were two officers in the hospital with a closed custody offender with guns that were clueless.* She…contacted Sergeant Power and told her to put two transport officers on the road to Pitt Vidant Medical Center to take over transporting offender Speede

[4] Officer Kishbaugh testified that Capt. Dillard directed him to go to Vidant Hospital. T. Vol.1, p. 209, lines 14-17.

to Central Prison…[and] told Officer Stockli to stay still and staff was coming to relieve them."

Byrum IRR, Resp. Exh. 5, page 4 of 8 (emphasis added).

55. In the process of preparing for discharge, hospital staff put a neck brace on Speed and placed him in a wheelchair after which Petitioner and Harper secured him by handcuffing both wrists in his lap. *Id.* at p. 41, lines 1-9, p. 46, line 21.

56. In his interview with Lt. Byrum on July 25, 2020, Petitioner stated he was shocked when he learned Speed was being discharged because

"…6 days earlier[,] the doctor told…Speed in front of [Petitioner] that if he didn't wear the neck brace, that any wrong turn he made could paralyze him from the neck down and they were constantly adjusting [the neck brace]. [Petitioner] stated he called…the OIC…[at approximately 2:51pm and raised the concern about transporting the [Speed] by car in his condition (a spinal cord injury that left the offenders [sic] left side, arm, leg, and foot mostly paralyzed). [Petitioner]…asked if he would be held liable if [Speed's] injuries worsened. …[T]he OIC said it was the doctors [sic] call. [Petitioner] stated he had more questions but was informed that the OIC would call back. …[Petitioner] stated the use of full restraints in light of all this was a big question and the second question was how to get the offender in the car in an upright position when he had been lying on his back for the last 6 days. …[Petitioner] called PCI…at approximately [4]:37[pm] and was informed Officer Kishbaugh was going to relieve them…. [Petitioner] stat5ed [sic] that the call dropped a second time and they never got a call back from the OIC, and he never got an answer of whether to use full Restraints on the offender with a spinal cord injury who's left side was left paralyzed six days earlier. …Petitioner then stated that he never refused to take offender Speed to Central Prison. …[H]is concern [was] with transporting…Speed…. …[T]here was never any way, shape, or form of reason why the OIC should have thought he wasn't going to follow the order he was given to transport [Speed] to Central Prison."

Byrum IRR, Resp. Exh. 5, page 6 of 8.

57. Petitioner testified that, after Speed was discharged,

"I walked behind Officer Harper and hospital staff as they pushed him in the wheelchair…[t]o the lobby…[and] straight outside…and I went to get the car. …Officer Harper and [hospital] staff attempted to get [Speed] in the car but were unable. …It would be speculation for me to say why they couldn't[get him in but]…after the attempt was made to unsuccessfully put him in the vehicle, …I called the prison and talked to Captain Dillard who was shocked that we were in the parking lot trying to get him in the car to go to Central [Prison]. …[I just wanted to know] What do we do? …[T]hey can't get him in the car. …What's next?" …[T]his [was] the second time[I talked to Dillard but I] did [not] ask [again about]

> the restraint[.] She told me to go back inside the hospital because it was too hot outside.
>
> . . .
>
> And she said, 'Wait for Kishbaugh. He's on his way to relieve you. He'll transport [Speed].'"

T. Vol. 1, p. 49, lines 22-25, p. 50, lines 1-25, p. 51, lines 1-20, p. 53, lines 7-12.

58. Sometime thereafter, having been dispatched to transport inmate Speed, Correctional Officers III, John Kishbaugh and Georgia Aydlette, arrived at Vidant Hospital. Upon their arrival, Officer Aydlette remained in the car while Officer Kishbaugh went inside to obtain Speed. T. Vol. 1, p. 198, lines 11-13, p. 227, lines 1-6, p. 228, lines 6-9.

59. When Kishbaugh entered the waiting room of the hospital, he was alarmed to find Speed "sitting in a wheelchair with a pair of handcuffs on[]" but neither Petitioner nor Officer Harper next to him. Kishbaugh looked around and found Officer Harper "off to the left[]" (*Id.* at lines 16-22), about seven yards away. *Id.* at p. 206, lines 6-23.

60. Although there was uncontested evidence that upon Petitioner's and Harper's arrival to the hospital, Speed was restrained by nothing but his right arm to the bed, and; knowing that deviations from policy regarding restraints must be approved by the OIC (T. Vol. 1, p. 179, lines 18-25), Capt. Dillard did not investigate whether the prior OIC had, in fact, reduced the restraint requirements for Speed.

61. Officer Kishbaugh testified that when two officers arrive at the hospital for hospital duty, "[t]heir obligation is to get a pass down from the two officers that [they are relieving regarding] what's going on with the [inmate-patient] throughout the day. …So if the two officers leaving say [regarding the then-current state of the inmate's restraints], '[The inmate] is like that because that's what the doctor asked for and so, you know, that – he stays like that,' then the two officers coming on [duty] would leave him that way." T. Vol. 1, p. 219, line 25, p. 220, lines 1-8.

62. Officer Aydlette, a twenty-year veteran of PCI, having transported hundreds of inmates and knowing well the policies and procedures of transporting close custody inmates, testified that there are always two (2) officers transporting an inmate and "both officers share responsibilities equally[.] …[I]t is the expectation for both officers to ensure that the inmate is properly secured[.]" *Id.* at p. 223, lines 10-25, p. 224, lines 1-5, p. 237, lines 4-9.

63. Officer Aydlette testified that after she waited in the car for a length of time, she went inside to find out why Kishbaugh had not come out with Speed. Inside she observed Kishbaugh on the phone, Petitioner standing behind Speed in the wheelchair and, Harper standing off to the side with his arms folded which concerned her because Speed was not properly restrained, having only handcuffs on. *Id.* at p. 227, lines 5-11, p. 234, lines 3-13.

64. Petitioner stated he went to his car to retrieve the full restraints for Kishbaugh. *Id.* at p. 55, lines 1-5, p. 200, lines 17-21, *see also Byrum IRR,* Resp. Exh. 5, page 4 of 8.

65. After Kishbaugh wheeled Speed out to the car, he lifted him and put his bottom on the back seat with his legs out the door of the car and then proceeded to put Speed in full restraints, after which Kishbaugh offered to go around the other side of the car and pull Speed in but Speed declined saying he would do it himself. *Id.* at p. 231, lines 14-22. Speed complained of pain but Kishbaugh opined he was not paralyzed. *Id.* at 201, lines 6-8. When they arrived at Central Prison, officers there brought a wheelchair and put Speed in it. *Id.* at p. 204, lines 23-25, p. 205, line 1.

66. Officer Aydlette testified Speed used his good leg to "scooch" over. When asked if she could tell whether Speed's left arm and left leg were working, she replied "[h]e just wasn't moving them at all…." *Id.* at p. 236, lines 12-17.

67. Capt. Dillard did not know if anyone other than Stockli was investigated in the matter. T. Vol. 1, p. 177, lines 19-23. However, no one was terminated for this incident except the Petitioner.

68. Correctional Lieutenant Jerry Byrum testified he was tasked with doing the internal investigation of this June 30, 2020 incident. *DPS Internal Investigation Report by Jerry Byrum ("Byrum IIR"), Petitioner's Exh. 5*. He admitted he did not interview the two officers that Petitioner and Harper relieved that day at the hospital. T. Vol. 2, p. 261, lines 22-25, p. 262, line 1.

69. Lt. Byrum further testified that **custody staff no longer has access to an inmate's "medical jacket" which was used to tell the officers who the inmate is and what level of custody they are.** "…[N]ow everything is on HERO, so it's on the computer system now for them to log in. …So instead of a paper jacket[, they would need to access HERO, but…i]t's basically for medical purposes…not for custody staff. …I can't even get on HERO…at my level. …[Nevertheless, all our inmates] are still considered close custody [even the medium custody inmates] until they're transferred out." *Id.* at p. 262, lines 7-25, p. 263, lines 1-14 (emphasis added).

70. Lt. Byrum concluded his investigation finding that Petitioner violated Policy and Procedure Chapter F Section .1100-.1102 by "having a closed custody offender out in the general public with only handcuffs on in front of the offender, with no leg cuff, black box or waist chains. Policy states that no offender in close custody status will be transported without leg cuffs, handcuffs with a black box and a security chain." Byrum IRR, Resp. Exh 5, Bates stamped p. 000121.

Discipline

71. In describing DPS's disciplinary process, Asst. Com. Harris testified that:

> "As the commissioner of prisons, I review all the suspensions, as well as the dismissals. …[T]hey are all my responsibility. …So if an employee is recommended for suspension…what I get is the summary, the investigation that

was completed, and some of the employee's records as part of it as well, usually including their start date, any previous discipline…[and] whatever led up to that recommendation of suspension…prior to the suspension or dismissal actually happening.

…[T]he – [State] HR policy…drives the disciplinary process as a foundation…to what discipline we can recommend. …There's three categories [of] performance-based [discipline]: unacceptable personal conduct and grossly inefficient performance, [and unacceptable] job performance. …[Unacceptable] job performance is usually an issue where we can address through training…[it] is not a fatal error, but it is something that we feel we can provide some counseling, training, a training plan, [and] be able to utilize the evaluation system to move the employee further. The grossly inefficient job performance is – typically…tied to an incident that could lead to serious injury, serious death, may lead to serious bodily harm to an employee, the community, or an offender that we're…tasked to supervise [or protect]. And then…the unacceptable personal conduct is a…serious conduct that an employee displays where they may have intentionally disregarded rules, regulations, policies that could lead to a serious violation, as well as bring discredit overall to the Agency or just not displaying themself in a…manner that is acceptable for DPS employees.

…[D]ifferent levels of disciplinary actions based on these three categories[]…can go from…a documented counseling, written warning[o]r, …you can start off with progressive discipline as well, looking at a three-day suspension, …five-day or ten-day suspension. …Some, based off of the type of violation or type of behavior, it accelerates it straight to dismissal…especially in those two categories of unacceptable personal [conduct] and grossly inefficient job performance. …[In such cases, the] policy [does not] require a written warning prior to…any other disciplinary action[.]

…[O]ne of our biggest goals is to make sure we're even-handed across the state and that…people are being treated the same...or…very similar [sic] based off the rules that was [sic] violated. …[E]very case is different, so you have to review them all individually. But at the same time, when we see the violations, we have to make sure the level of discipline is consistent. …[W]e're familiar with the different cases, and we try to maintain consistency with the discipline that we know have [sic] been applied. So sometimes we may have to look at a same or similar case and the disciplinary [sic] that was applied to that case, even though that case is not related…to the actual discipline because we need to be consistent.

…We are looking at the facts in the case[…] what actually happened and what the investigator was actually able to prove, and does [sic] those two elements support a violation of…the various categories as identified. …[W]e also identify if there's [sic] any deficiencies…and we may need some additional information. …We look at…the facts…, the incident that occurred, and what did happen and what could have happened based off of that particular incident or activity…. …And based off

> …the potential of risk or serious injury…. We consider their prior work history, length of time they've been with our department…[whether] they're in probationary status[.] …[T]he probationary period [is]…one year."

T. Vol. 2, pp. 315-26.

72. Com. Harris testified that she treated the two (2) incidents "as two completely different disciplinary actions…each…standing on their [sic] own…." *Id.* at p. 361, lines 9-13.

73. Turning her attention to Petitioner's March 8, 2020 incident—which was within his one-year probationary period, Com. Harris stated that "[t]he regional recommended a suspension [of Petitioner], and it came up for [me] to review[.]" *Id.* at p. 326, lines 13-25. (Com. Harris believed it was "June or July" when her office received the regional recommendation in this March 8, 2020 incident.) *Id.* at p. 341, lines 19-21.

74. However, based on "the seriousness of the incident and…the outcome, it could have been extremely bad. And so it was very serious, and in that incident in the past when we had probationary employees who…did not follow…the direction and the policy as they were directed to, they were probationary separated [terminated]." *Id.* at p. 327, lines 22-25, p. 328, lines 1-5.

75. From there, Com. Harris went on to compare the March 8, 2020 Baskins incident to one in which an inmate succeeded in hanging himself and another probationary employee failed to do her routine check by looking into a cell when completing rounds. "She walked past the cells and did not actually visually check the offenders inside the cell, as she is supposed to." *Id.* at p. 329, lines 3-11. It was unclear whether the employee's failure occurred at a time that the inmate was still alive or if she was terminated for failing to find the inmate after death. However, Com. Harris advised the employee was terminated for the failure.

76. Com. Harris determined that Petitioner's conduct in the March 8, 2020 incident was grossly inefficient job performance because: a) Baskins had already displayed self-injurious behavior while in a regular restrictive housing unit cell, and; b) Baskins was moved to an SIB cell because the psychologist recommended it because he was in a mental health crisis and he required the constant observation, line-of-sight. *Id.* at pp. 329-330.

77. Com. Harris acknowledged the two (2) different kinds of monitoring—observation watch being within every 15 minutes, and; constant watch being non-stop. Petitioner's watch of Baskins met the requirements of irregular interval monitoring.

78. On cross, Com. Harris stated that the uncontroverted fact that monitoring Baskins was only Petitioner's second time working in RHU did not matter but his short tenure did. "We have certain things that we consider fatal errors. Like, for example, **if** someone tells you to constantly watch someone, you don't need a warning or additional training to constantly watch an individual who is suffering a mental crisis[]" *Id.* at p. 366, lines 19-23, and; "**if** you're told to stand right here and watch somebody and you walk away, that's a major violation[and i]t's post abandonment." *Id.* at p. 367, lines 6-9 (emphasis added).

79. Yet, like every other one of Respondent's witnesses, she could not provide evidence: a) that Petitioner had any knowledge of Baskins' prior self-injurious behavior, or; b) that Petitioner had any knowledge that Baskins was in a mental crisis or that he had been assigned to SIB by the facility's psychologist, or; c) that Petitioner had been directed by a superior officer to do line-of-sight monitoring of Baskins. *Id.* at p. 385, lines 12-24.

80. There is no evidence in the record to support that Baskins was placed in an SIB cell because of a psychologist's recommendation. *See* T. Vol. 2, p. 382-84.

81. Com. Harris acknowledged that PCI has inmates assigned to SIB for reasons other than a mental health crisis. *Id.* at p. 384, lines 11-20.

82. Nevertheless, she concluded that Petitioner had abandoned his post by only doing observation watching of Baskins and it was gross neglect for him to have done so. Based on this and the fact that Baskins *could have* been successful in taking his own life, Com. Harris recommended Petitioner be terminated and she sent her recommendation back to the facility for the warden to carry it out.

83. Com. Harris acknowledged that policy and procedure requires a sergeant to search the SIB cells prior to an inmate being placed therein and, that clotheslines show up in prisons a lot and that the search was either not done or not conducted appropriately. Yet, the sergeant (presumably Sgt. Vanhorn) who was dutybound to check the SIB cell in which Baskins attempted to hang himself was not terminated but received a short suspension as discipline for his part in the incident.

84. Turning her attention to the June 30, 2020 incident, Com. Harris testified that "…Officer Kishbaugh…indicate[d] that when he arrived…he called the nurse and spoke with the nurse, and the nurse talked to the doctor, and then nurse got back on the phone with Kisbaugh and said that there were no restrictions[for Baskins' transport]." T. Vol. 2, p. 346, lines 4-9.

85. Com. Harris stated she recommended Petitioner be terminated for this incident because: a) Speed was a close security offender who required full restraints; b) OIC had not approved modified restraints be used for him; and c) he was serving a significant amount of time and was sitting in the public lobby of the hospital with only handcuffs on.

86. Pursuant to Petitioner's testimony (supported by Lt. Byrum's testimony), there was no medical jacket from which Petitioner and Officer Harper could know what custody level Speed was or how much time he was serving. Moreover, Petitioner testified credibly that: a) Speed's restraints had been slackened prior to his and Officer Harper's arrival at the hospital; b) he believed Speed was paralyzed; c) this was both his first time being ordered to transport an inmate; and, d) although he spoke to Capt. Dillard (the OIC), she did not answer his questions regarding restraints as relating to Speed's paralysis.

87. Although working together in tandem, Petitioner's partner, Officer Harper, was suspended without pay for three (3) days but Petitioner was terminated. T. Vol. 1, p. 175, 19-25, p. 176, lines 1-3, T. Vol. 2, p. 371, lines 4-8, p. 372, lines 1-25.

88. When asked why Petitioner and Officer Harper received such disparate disciplinary treatment, Com. Harris stated:

> "…[T]here seemed to be some confusion as to if the inmate needed to be in full restraints or not. That seemed to be the confusion. And so from my understanding, the clarification was…communicated by Stockli through the captain [Dillard]. …[T]hat's the way I understood it is that the communication, the question about him being in full restraints, everything came through Stockli. And he was the one that got the direction. …[T]hat's the difference between the two. …They both are responsible, and that's why Harper ended up with a suspension…they both are responsible for the transport.
>
> . . .
>
> …[T]he direction was given to Stockli. …[t]he captain talked to him specifically. She gave him the…direction concerning the different transport. And then the…other part that was significant, too, was that the other two officers arrived and did not have any issue with transporting this offender. …[The fact that it was the first transport for both Stockli and Harper[…was] probably why the captain sent somebody out to assist. But I think the biggest issue that we run into is the offender, he was not restrained, and he wasn't restrained appropriately. And it appears that the captain spoke directly to Stockli. And I don't know what direction or what conversation Stockli had with Harper. …I don't know if he communicated that, that this is what the captain said…is left in a gray area. So from what I can read in the report, everything was actually spoken to with Stockli. [T]he issues that were raised, the communication that went back and forth with the captain came through Stockli and did not come through Harper.
>
> …[T]here's a difference between a hospital patient and a…patient in transport. If he was a patient…he would not have been in full restrains in a hospital bed…[, b]ut when it goes to transporting an offender…then you require full restraints. So at the time the[officers] were required to remove [Speed] from the room…he should have been put in…full restraints[.] …[T]he concern is raised if…he should be in full restraints. So a call is made to the captain, the OIC, for guidance and I'm guessing permission to modify. The captain does not provide that. The captain does not modify the restraints. The communication is to Stockli. …I don't know what was communicated to Harper. …They are both responsible for him. That's why Harper ended up with a suspension as well, but…I don't think it was clear if Harper was aware that the OIC did not modify those restraints[a]nd that question was not asked to the investigator to find out[.]"

T. Vol. 2, p. 372, lines 22-25, p. 373, lines 1-12, pp. 375-380.

89. By the time Com. Harris recommended Petitioner's dismissal for the June 30, 2020, incident, DPS had not yet gone through the pre-disciplinary hearing with Petitioner so DPS

combined the two (2) incidents for the purposes of completing the administrative process prior to Petitioner's filing with OAH.

90. The attorneys stipulated that procedurally everything was done properly and Petitioner exhausted his administrative remedies as to both incidents. *Id.* at p. 358, lines 22-23.

91. Respondent hand-delivered the Notification of Pre-Disciplinary Conference to Petitioner on November 9, 2021. The Pre-Disciplinary Conference was held on November 10, 2020, and; Respondent issued its formal letter of dismissal to Petitioner on November 13, 2020 for grossly inefficient job performance (in the matter of inmate Baskins) and unacceptable personal conduct (in the matter of inmate Speed). *See Resp. Exh. 8,* Bates stamped pp. 000067-68.

ANALYSIS

92. As a career State employee, Petitioner is entitled to the protections of the North Carolina State Human Resources Act, pursuant to N.C. Gen. Stat. § 126-1.1.

93. The Act outlines the procedures the State must follow in separating an employee such as the Petitioner from employment for cause due to unacceptable personal conduct and unsatisfactory job performance, specifically:

> "No career State employee subject to the North Carolina Human Resources Act shall be discharged, suspended, or demoted for disciplinary reasons, except for just cause. In cases of such disciplinary action, the employee shall, before the action is taken, be furnished with a statement in writing setting forth the specific acts or omissions that are the reasons for the disciplinary action and the employee's appeal rights. The employee shall be permitted 15 days from the date the statement is delivered to appeal to the head of the agency through the agency grievance procedure for a final agency decision. However, an employee may be suspended without warning for causes relating to personal conduct detrimental to State service, pending the giving of written reasons, in order to avoid undue disruption of work or to protect the safety of persons or property or for other serious reasons. If the employee is not satisfied with the final agency decision or is unable, within a reasonable period of time, to obtain a final agency decision, the employee may appeal to the Office of Administrative Hearings. Such appeal shall be filed not later than 30 days after receipt of notice of the final agency decision. The State Human Resources Commission may adopt, subject to the approval of the Governor, rules that define just cause.

N.C. Gen. Stat. § 126-35(a).

94. Likewise,

> (a) Any employee, regardless of occupation, position or profession may be warned, demoted, suspended or dismissed by the appointing authority. Such actions may be taken against career employees as defined by the State Human Resources Act, only

> for just cause. The provisions of this section apply only to employees who have attained career status. The degree and type of action taken shall be based upon the sound and considered judgment of the appointing authority in accordance with the provisions of this Rule. When just cause exists the only disciplinary actions provided for under this Section are:
>
> > (1) Written warning;
> > (2) Disciplinary suspension without pay;
> > (3) Demotion; and
> > (4) Dismissal.
>
> (b) There are two bases for the discipline or dismissal of employees under the statutory standard for "just cause" as set out in G.S. 126-35. These two bases are:
>
> > (1) Discipline or dismissal imposed on the basis of unsatisfactory job performance, including grossly inefficient job performance.
> > (2) Discipline or dismissal imposed on the basis of unacceptable personal conduct.
>
> (c) Either unsatisfactory or grossly inefficient job performance or unacceptable personal conduct as defined in 25 NCAC 1J. 614 of this Section constitute just cause for discipline or dismissal. The categories are not mutually exclusive, as certain actions by employees may fall into both categories, depending upon the facts of each case. No disciplinary action shall be invalid solely because the disciplinary action is labeled incorrectly.

25 N.C. Admin. Code 1J.0604

95. Moreover, "[i]n contested cases conducted pursuant to this section, the burden of showing that a career State employee was discharged, demoted, or suspended for just cause rests with the employer." N.C. Gen. Stat. § 126-34.02(d).

96. Whether a public employer's decision to discipline its employee is supported by just cause "requires two separate inquiries: first, whether the employee engaged in the conduct the employer alleges, and second, whether that conduct constitutes just cause for the disciplinary action taken." *N.C. Dep't of Env't & Natural Res. v. Carroll*, 358 N.C. 649, 665, 599 S.E.2d 888, 898 (2004). "[T]he first of these inquiries is a question of fact…[and]…the latter inquiry is a question of law…." *Id.* at 665-66, 599 S.E.2d at 898.

97. Pursuant to Com. Harris' testimony, Respondent judged each incident on its own merit. Therefore, this Tribunal shall do the same.

RE: March 8, 2020 Incident—Grossly Inefficient Job Performance

98. There is no dispute that PCI utilizes two different ways of monitoring inmates in RHU/SIB cells and, the evidence reveals that those cells are often utilized for inmates who do not

have mental health issues. Moreover, as outlined in FOF paragraph 17 above, when PCI's medical staff determines that constant line-of-sight monitoring is necessary for a particular inmate due to him having self-harm tendencies, that determination is emailed to the higher-ups—to which emails Petitioner was not privy. Therefore, in order for Petitioner to be held accountable for inmate Baskins' attempted suicide by reason of a failure to utilize line-of-sight monitoring and thereby be found liable for grossly inefficient job performance, Respondent must have been able to show that Petitioner was either told/directed to constantly watch Baskins or Petitioner knew Baskins was a self-injurious inmate or had shown some sort of self-injurious behavior prior.

99. The sergeant who posted Petitioner to watch Baskins, Sgt. Vanhorn, did not testify at hearing, and; ***no one else*** having first-hand knowledge testified at hearing to confirm either: a) that *Petitioner knew* of Baskins' prior self-injurious behavior, or; b) that Petitioner knew of the psychologist's recommendation that Baskins be constantly watched through level 1 monitoring, or; c) that Sgt. Vanhorn (or anyone else up the chain of command) had *actually directed* Petitioner to utilize level 1, line-of-sight monitoring with Baskins. Instead, testimony from Respondent's various witnesses was based on what Petitioner *should have* been told or what they *believed* Petitioner was told.

100. There is **no evidence of record** revealing that Petitioner had such foreknowledge. Moreover, it is uncontradicted that this was only Petitioner's second time in RHU/SIB and the first time he was instructed to intermittently watch that inmate.

101. Com. Harris even touched on the fact that Petitioner had been trained for SIB watch. Yet, none of his training would assist him in knowing which inmates needed which type of monitoring without a superior telling him. Moreover, the onus is on the supervisor to make certain his/her subordinate has all the information necessary to do the requested job.

102. Clotheslines are not unexpected contraband in prison but are found rather often. The sergeant who searched the cell, if in fact the cell was searched, failed to properly search the cell prior to Baskins being placed therein. Had he searched—or properly searched the cell, he would have found the clothesline with which Baskins attempted to hang himself and averted the danger altogether. This failure was a major violation of policy and carried the same potential risk and liability as the act for which Petitioner was accused.

103. The sergeant was Petitioner's superior but received much less discipline than Petitioner which is completely inconsistent with Respondent's averred practice and intent.

RE: June 30, 2020 Incident—Unacceptable Personal Conduct

104. Petitioner had never transported an inmate before this incident.

105. In transporting inmates, knowing the level of custody for the inmate is key to knowing how they must be restrained. *See Paragraph 18* above.

106. At the time of this incident, PCI housed close custody inmates, medium custody inmates (waiting to transfer out) and minimum custody inmates.

107. Officer Harper and Petitioner arrived for hospital duty to find inmate Speed with only one handcuff restraining an arm to his bed. Because of that, it was not unreasonable for the officers to believe that the OIC had modified Speed's restraint protocol before they arrived *and/or* that Speed was a minimum-security inmate for which handcuffs would suffice in transport. There is no evidence of record to explain why Speed was not better restrained in his hospital bed and the internal investigation did not include interviews of the relieved officers or of the OIC for whom Capt. Dillard took over.

108. Com. Harris testified that with Speed being restrained by nothing more than handcuffs, Petitioner and Officer Harper placed the public at a severe risk of potential harm had Speed "decided to run." T. Vol. 2, p.348, lines 10-22. However, Respondent did not produce any policy or procedure that would be violated had Speed been a minimum custody level inmate.

109. Petitioner testified that there was no information on Speed awaiting him and Officer Harper when they arrived for hospital duty, and; Lt. Byrum's testimony corroborated Petitioner's testimony in stating "custody staff no longer has access to an inmate's 'medical jacket' which was used to tell the officers who the inmate is and what level of custody they are." T. Vol. 2 at p. 262, lines 7-25. Since Petitioner and Officer Harper did not have access to the medical jacket, someone would have had to tell them what was Speed's custody level; however, Respondent put on no evidence of that information being passed on to Petitioner and Officer Harper until Officer Kishbaugh arrived to transport Speed—which was *after* Petitioner and Officer Harper had wheeled Speed into the lobby of the hospital.

110. The undisputed evidence of record and at hearing reveal that Petitioner consistently asserted he was concerned for the health and wellbeing of Speed and that he asked the OIC, Capt. Dillard, about restraints as relating to inmate Speed's medical condition (whether paralysis or other) and transporting him. Petitioner further asserted that Capt. Dillard never answered his question but said she would call back.

111. At hearing, Capt. Dillard testified that Petitioner *never* inquired about restraints, even though her written statement in Byrum's IRR states that Petitioner told her that "in the condition of [Speed]…they may need another type of vehicle[to transport him]." *Byrum's IRR*, page 4 of 8. Com. Harris testified that Capt. Dillard's having given direct instructions to Petitioner about Speed's restraints and transport was the main reason Com. Harris determined Petitioner should be terminated (for unacceptable personal conduct).

Disparate Treatment

112. "Article I, Section 19 of the North Carolina Constitution guarantees both due process rights and equal protection under the law by providing that no person shall be 'deprived of his life, liberty, or property, but by the law of the land' and that '[n]o person shall be denied the equal protection of the laws.'" *Rhyne v. K-Mart Corp.*, 358 N.C. 160, 180, 594 S.E.2d 1, 15 (2004) (quoting N.C. Const. art. I, § 19); *Sanders v. State Pers. Comm'n,* 197 N.C. App. 314, 324, 677 S.E.2d 182, 189 (2009).

113. In both the March 8, 2020 incident and the June 30, 2020 incident, there were other officers who bore the same responsibilities as Petitioner but they were not terminated.

114. Sgt. Vanhorn, who had the obligation of searching Baskins' SIB cell but did not and, whose actions created the same risk of serious liability and Baskins' death, was not terminated but received a few days' suspension.

115. Likewise, Officer Harper who was working in tandem with Petitioner to transport Speed was not terminated but received only a three-day suspension.

116. Despite the due diligence of all parties and the several week delay in receiving the transcript, the time needed for completion of this matter exceeded the usual, regular, and customary time for completion and has presented a situation of a kind other than what ordinary experience or prudence would foresee.

CONCLUSIONS OF LAW

1. This Tribunal has subject matter and personal jurisdiction and the parties received proper notice of the hearing. Moreover, extraordinary cause exists for the issuance of this Final Decision beyond 180 days from the commencement of this contested case, pursuant to N.C. Gen. Stat. § 126-34.02(a).

2. To the extent that the Findings of Fact contain Conclusions of Law, or that the Conclusions of Law are Findings of Fact, they should be so considered without regard to the given labels. *Charlotte v. Heath*, 226 N.C. 750, 755, 40 S.E.2d 600, 604 (1946); *Peters v. Pennington*, 210 N.C. App. 1, 15, 707 S.E.2d 724, 735 (2011); *Warren v. Dep't of Crime Control*, 221 N.C. App. 376, 377, 726 S.E.2d 920, 923, *disc. review denied*, 366 N.C. 408, 735 S.E.2d 175 (2012).

3. The burden of proof is on Respondent to show by a preponderance of the evidence that it had just cause to terminate Petitioner's employment for grossly inefficient job performance and unacceptable personal conduct.

4. "Dismissal on the basis of grossly inefficient job performance is administered in the same manner as for unacceptable personal conduct. Employees may be dismissed on the basis of a current incident of grossly inefficient job performance without any prior disciplinary action." 25 NCAC 1J .0606. "In order to discharge…a career state employee for disciplinary reasons based on unacceptable personal conduct, the specific misconduct must constitute just cause for the specific disciplinary sanction imposed." *Warren v. N. Carolina Dep't of Crime Control & Pub. Safety, N. Carolina Highway Patrol,* 221 N.C. App. 376, 377, 726 S.E.2d 920, 922 (2012).

5. Our appellate courts have long held that:

> "The proper analytical approach is to first determine whether the employee engaged in the conduct the employer alleges. The second inquiry is whether the employee's conduct falls within one of the categories of unacceptable personal conduct provided by the Administrative Code. Unacceptable personal conduct does not

> necessarily establish just cause for all types of discipline. If the employee's act qualifies as a type of unacceptable conduct, the tribunal proceeds to the third inquiry: whether that misconduct amounted to just cause for the disciplinary action taken. Just cause must be determined based "upon an examination of the facts and circumstances of each individual case."

Warren v. N. Carolina Dep't of Crime Control & Pub. Safety, N. Carolina Highway Patrol, 221 N.C. App. 376, 383, 726 S.E.2d 920, 925 (2012).

6. As discussed in the Analysis above, regarding the March 8, 2020 RHU/SIB incident, knowledge is key. Com. Harris testified: "**If** someone tells you to constantly watch…[or] **if** you're told to stand right there…" and you fail to do so, **then** it's post abandonment (*see Paragraph 79 above*); but without the *if* there is no *then.*

7. Petitioner had been working for PCI less than a year and had only monitored one other inmate and that by way of irregular interval monitoring. He utilized the same irregular interval monitoring for Baskins as he had during the only other time he monitored an inmate in a RHU/SIB cell. Thus, with two different types of monitoring utilized by PCI, no evidence that Petitioner was ever directed to do line-of-sight constant monitoring of inmate Baskins, and no evidence that Petitioner had any knowledge that Baskins was an SIB risk, Respondent failed to prove by the greater weight of the evidence that Petitioner abandoned his post by utilizing the same irregular interval monitoring to watch Baskins as he had used before.

8. In the present case (as related to the 3.8.20 incident), without being able to show that Petitioner knew or should have known that Baskins required constant line-of-sight monitoring and, with Petitioner having utilized irregular interval monitoring (including recording his observations every 15 minutes), Respondent has failed to demonstrate that Petitioner was either inefficient in his job performance or that his actions constitute misconduct.

9. As such, Respondent has failed to establish that Petitioner engaged in the alleged conduct and, therefore, Respondent has failed satisfy the first prong of *Warren, supra.* Thus, Respondent did not have just cause to terminate Petitioner's employment based on grossly inefficient job performance in his duties with inmate Baskins. *See Carroll*, 358 N.C. at 665, 599 S.E.2d at 898.

10. Regarding the June 30, 2020 incident, it is more likely than not that, in their first conversation, Petitioner did question Capt. Dillard about how to restrain Speed (not due to his custody level but due to his injuries) and she did not have an answer.

11. It is undisputed that in a later conversation, Capt. Dillard told Petitioner to transport Speed in the secure vehicle Petitioner and Officer Harper had with them, but Respondent failed to produce any evidence that Petitioner was ever told what was Speed's custody level prior to Officer Kishbaugh's arrival at the hospital.

12. In his dismissal letter, the warden asserted that "Offender Speed is a close custody offender and is therefore required to be place [sic] in leg cuffs, hand cuffs, and secured by a waist

chain. In general, close custody offenders are more violent, and have committed more dangerous or egregious crimes, than medium and minimum custody offenders." *Resp. Exh. 8,* p. 6 of 7. However, there is no evidence of record that Petitioner was made to know Speed was a close custody or violent offender.

13. Without Petitioner having that key information, and in light of Policy & Procedure *Chapter F .1100 03/18/20 Transporting Offenders*, which specifically allows minimum security inmates to be transported without full restraints, Respondent has failed to show that Petitioner violated any "security policies and procedures concerning the[] transportation [of an inmate]" or that Petitioner's conduct related to Speed's restraints was unacceptable. *See Resp. Exh. 8,* page 6 of 7.

14. As such, Respondent has failed to establish that Petitioner engaged in the alleged conduct and, therefore, Respondent has failed to satisfy the first prong of *Warren, supra.* Thus, Respondent did not have just cause to terminate Petitioner's employment based on unacceptable personal conduct in his duties with inmate Speed. *See Carroll*, 358 N.C. at 665, 599 S.E.2d at 898.

15. Finally, even if Petitioner's actions (in either incident) had met the first prong of *Warren*, they would not reach the level of being just cause for dismissal, specifically because Respondent violated Petitioner's right to equal protection under the law. In both incidents, there were other officers equally responsible with Petitioner, but Petitioner was subjected to disparate treatment due to Respondent's doling out inconsistent discipline by terminating Petitioner but only suspending the others. The Equal Protection Clause of the Fourteenth Amendment "keeps governmental decisionmakers from treating differently persons who are in all relevant respects alike." *Nordlinger v. Hahn,* 505 U.S. 1, 10, 112 S. Ct. 2326, 2331, 120 L. Ed. 2d 1, 12 (1992). All the same this Tribunal, lacking jurisdiction over Constitutional issues, need not consider whether Petitioner's right to equal protection was violated since our appellate courts have long held that: "A disciplinary action **is without just cause** if evidence of disparate treatment is present in the discipline. *Poarch v. N.C. Dep't of Crime Control & Pub. Safety*, 223 N.C. App. 125, 131–32, 741 S.E.2d 315, 319–20 (2012)." *Warren* at 508, 833 S.E.2d at 637. It is without doubt that Respondent's discipline of Petitioner was inconsistent with its discipline of the other officers involved in the two incidents, without reason.

FINAL DECISION

BASED UPON the foregoing Findings of Fact and Conclusions of Law, the Respondent's decision to discipline the Petitioner by termination is hereby **REVERSED**.

IT IS THEREFORE ORDERED, **ADJUDGED**, **AND DECREED** that Petitioner's termination be overturned and removed from his personnel record. Petitioner shall be reinstated to his position as a Correctional Officer III and shall receive back pay, including two days of mandatory overtime for each month he has missed since being terminated. Moreover, Respondent shall pay Petitioner's attorney's fees and costs pursuant to this Tribunal's future Order. Petitioner's counsel shall file a Petition for attorney's fees, in accordance with N.C. Gen. Stat. § 150B-33 and N.C. Gen. Stat. § 126-34.02, on or before November 17, 2021.

NOTICE OF APPEAL

This Final Decision is issued under the authority of N.C.G.S. § 150B-34. Pursuant to N.C.G.S. § 126-34.02, any party wishing to appeal the Final Decision of the Administrative Law Judge may commence such appeal by filing a Notice of Appeal with the North Carolina Court of Appeals as provided in N.C.G.S. § 7A-29(a). The appeal shall be taken within 30 days of receipt of the written notice of final decision. A notice of appeal shall be filed with the Office of Administrative Hearings and served on all parties to the contested case hearing.

SO ORDERED, this the 18th day of October, 2021.

Karlene S Turrentine
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center who subsequently will place the foregoing document into an official depository of the United States Postal Service.

Jennifer J Knox
The Law Office of Jennifer Knox
jenknox74@gmail.com
Attorney For Petitioner

James B Trachtman
North Carolina Department of Justice
jtrachtman@ncdoj.gov
Attorney For Respondent

Adrina G. Bass
North Carolina Department of Justice/Public Safety Section
abass@ncdoj.gov
Attorney For Respondent

This the 18th day of October, 2021.

Jerrod Godwin
Administrative Law Judge Assistant
N.C. Office of Administrative Hearings
1711 New Hope Church Road
Raleigh, NC 27609-6285
Phone: 984-236-1850