10-21-2008

DEPARTMENT OF CORRECTION vs. PAUL VAUGHN, Grievant

BEFORE THE CIVIL SERVICE COMMISSION
FOR THE STATE OF TENNESSEE

DEPARTMENT OF CORRECTION **v.** **PAUL VAUGHN** **Grievant**	**DOCKET NO: 26.05-097948J**

INITIAL ORDER

This matter was heard on October 21, 2008 before Leonard Pogue, Administrative Judge, sitting for the Tennessee Civil Service Commission at the Morgan County Regional Correctional Facility in Wartburg, Tennessee. Mr. Bryce Coatney, Assistant General Counsel for the Department of Correction, represented the State. Grievant Paul Vaughn was present and represented by counsel, Ms. Maha Ayesh and Ms. Jennifer Morton. This matter became ready for consideration on January 14, 2009 upon the parties submission of proposed findings of fact and conclusions of law.

The subject of the hearing was Grievant's appeal of his demotion of rank from Corporal to Correctional Officer. After consideration of the record in this matter, it is determined that the demotion should be **UPHELD.** This decision is based upon the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. Grievant has worked as a correctional officer at the Brushy Mountain Correctional Complex since 1993. Mr. Vaughn was promoted to Correctional Corporal in January 1995 and served in that job title until he was reduced in rank as of July 1, 2006, as a result of the controversy underlying this proceeding. He continues to work at the Morgan County Regional Correctional Facility.

2. In May, 2006, the Department initiated an Internal Affairs investigation relative to the death of inmate Freddie Alvis. Grievant was the supervisor of the unit in which Mr. Alvis was housed immediately before his death. As a result of the findings of this investigation, the Department, through Warden David Mills, issued Grievant a one-day suspension and demotion from Corporal to Correctional Officer. The reasons given for the disciplinary action were negligence in the performance of duties and violation of post orders and procedures. The one day suspension was later overturned following the Level IV hearing.

3. Mr. Alvis had certain chronic health problems for which he received treatment through the medical clinic at Morgan, but he was not known to have any acute or urgent healthcare needs. In the course of his experience in prison, Mr. Alvis reportedly developed a habit of using passive resistance as a means to avoid circumstances or responsibilities in daily prison life that were not to his liking. He may have used complaints of illness in this way, from time to time.

4. On May 18, 2006, while being escorted back to his housing unit, Mr. Alvis sat down in the prison yard at Morgan and claimed that he could not move. As a result of this behavior, Mr. Alvis was taken to the prison clinic and examined, and then transferred to Housing Unit 1, the prison's segregation unit.

5. Housing Unit 1 is used to house inmates who are assigned to protective custody, inmates who are under investigation for disciplinary matters, and inmates who are serving time in punitive segregation, following conviction of disciplinary infractions. It is a highly restrictive environment. Inmates in segregation are confined to their cells for the majority of the day; they have little freedom of movement; they do not interact with other inmates and have a minimum of interaction with staff.

6. Grievant was assigned to work as the Corporal for Unit 1, beginning at 2:00 p.m. on May 19, 2006. As the Corporal for the Unit, Mr. Vaughn was responsible for immediate oversight of the area

and its security, and for supervision of one Correctional Officer also assigned to work on the Unit for that shift. When Mr. Vaughn began his shift, the outgoing Corporal for the previous shift advised him that Mr. Alvis had been shaking/trembling in bed, had not eaten, and that the clinic had been notified of those circumstances. Given this information, Mr. Vaughn went to Mr. Alvis' cell and then contacted the clinic to reiterate that Mr. Alvis had not eaten all day and was shaking. It was 5:15 p.m., however, before a nurse came to the unit to check on Mr. Alvis. The nurse, Mary Evans, LPN, checked his vital signs, tried to get him to sit up, and fed him some of his dinner.

7. Grievant notified his Sergeant that Mr. Alvis was not moving from his bed. The Sergeant and his Captain came to Unit 1 to discuss the situation, in particular, whether Mr. Alvis could be transferred to the prison clinic at Brushy Mountain, where a bed might be available. The Sergeant and the Captain came to the unit at approximately 6:00 p.m. on May 19 and observed that Mr. Alvis had urinated and defecated on himself. As the officers discussed Mr. Alvis, another nurse, Christine Morrison, RN, entered Unit 1 to administer evening medications to the inmates there. Mr. Vaughn and his colleagues spoke to her and expressed their concerns about Mr. Alvis. Ms. Morrison advised them that unless Mr. Alvis' condition changed, there was nothing more to be done for him medically than was currently being done for him.

8. Around 7:00 p.m., Mr. Vaughn received notice from the prison's Central Control office that another inmate was returning to the facility and was en route to Unit 1. Mr. Vaughn contacted the prison clinic to let the medical staff know about the returning inmate and then got busy making preparations. Mr. Vaughn's correctional officer reported to Mr. Vaughn that he had found Mr. Alvis lying on the floor of his cell. The two went to Mr. Alvis' cell and urged him to get up from the floor, but Mr. Alvis indicated that he could not. Grievant observed Mr. Alvis and noted that Mr. Alvis did not appear injured or to have fallen and Grievant did not think Mr. Alvis was seriously ill. Mr. Vaughn

could not recall contacting his superiors about this development, and there is no evidence that he did. However, Grievant testified that minutes before he had called the clinic to request that a nurse be sent to his unit to administer medications to another inmate. According to Grievant, he did not contact the clinic to report that Mr. Alvis was lying on the floor because he knew a nurse would be on her way to the unit for other reasons.

9. Documentation of events on Unit 1 in the unit log book stops at 7:00 p.m. on May 19th with the notation that inmate Kirby is "back from court." Nothing further is recorded regarding Mr. Alvis until after 9:00 p.m. when a notation is made that Mr. Alvis was to be sent to an outside hospital. Grievant testified that he did not record in the unit log book that Mr. Alvis was lying on the floor or Nurse Morrison's visit to the unit because he was busy with inmate Kirby and with the nurse's arrival to the unit.

10. Nurse Morrison returned to the unit at 8:05 p.m. (per Morrison's entry in the log book) to attend to inmate Kirby (although Grievant suggested she may have arrived earlier). Mr. Vaughn called her attention to the fact that Mr. Alvis was now lying in the floor of his cell. Ms. Morrison went to check on him, tried to persuade him to get up, but was unsuccessful. When she left the unit to return to the clinic, she advised Mr. Vaughn that she would have Nurse Evans contact the attending physician.

11. The nurses consulted with a doctor, and the decision was made to transport Alvis to the hospital. Nurse Evans called for an ambulance but stated that it was not an emergency situation necessitating "lights and sirens." An ambulance did not arrive until 9:47 p.m., at which time Mr. Alvis was transported to Roane Medical Center. Mr. Alvis went into cardiac arrest twice en route to the hospital, and he was pronounced dead shortly after his arrival there.

12. The Internal Affairs investigator, Jerry Lester, concluded that Mr. Alvis' death likely would not have been prevented by any different actions of staff, including Grievant. However, Mr.

Lester testified that Grievant's actions were substandard in the time frame following when Grievant learned that Mr. Alvis was on the floor.

13. David Mills, Warden of the Morgan County Correctional Complex, determined that there were omissions in Mr. Vaughn's job performance relative to phone calls that should have been made and documentation that should have been made regarding Mr. Alvis' condition. It was also his opinion that Mr. Vaughn had failed, in that regard, to exercise the good judgment that is expected of a supervisor in matters of inmate management. Warden Mills was concerned that these omissions amounted to the supervisor's modeling of a very poor standard of performance for a subordinate officer working with his supervisor. Ultimately, Warden Mills concluded that Mr. Vaughn, because of his experience and good work record, could be a valuable worker and could function effectively in his former rank, as a Correctional Officer. Warden Mills had considered that Grievant's actions/inactions might be serious enough to warrant dismissal but ultimately concluded that a demotion and a brief suspension were the lowest appropriate disciplinary measures for the conduct, the performance, and the employee in question. He acquiesced, however, in his Commissioner's determination that a demotion, alone, was the more appropriate response.

14. Before and after his demotion, Grievant received ratings of "excellent" in his work evaluations, including evaluations of his performance as a corporal. Grievant had never been disciplined over failure to record logbook entries or over his abilities to perform his duties as corporal. Prior to this incident, Warden Mills never had cause to question Grievant's abilities as a corporal.

CONCLUSIONS OF LAW

1. Tennessee Department of Personnel Rule 1120-10-.06, EXAMPLES OF DISCIPLINARY OFFENSES, lists the following as examples of disciplinary offenses:

> (2) Negligence in the performance of duties.

2. Tennessee Department of Personnel Rule 1120-10-.07, PROGRESSIVE DISCIPLINARY ACTION, states, in relevant part:

> (1) The supervisor is responsible for maintaining the proper performance level, conduct and discipline of the employees under his supervision. When corrective action is necessary, the supervisor must administer disciplinary action beginning at the appropriate step as described.
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> (2) Oral Warning….
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> (3) Written Warning….
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> (4) Suspension Without Pay….
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> (5) Dismissal….
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> (6) Transfer or Demotion. If it is determined by the appointing authority that an employee's ability to satisfactorily perform his duties is beyond the capabilities of the employee or the employee has been compromised by notorious conduct to the extent that he is ineffective in his position, the employee may be demoted or transferred to a position that is more appropriate after minimum due process has been provided.

3. Tennessee Department of Personnel Rule 1120-2-.13, TRANSFER, LATERAL RECLASSIFICATION, DEMOTION AND REDUCTION IN RANK, states, in relevant part:

> (3) Demotion. A career service employee may be demoted…. A demotion may be made when the employee is unwilling or unable to render satisfactory service in the position held but is considered worthy of employment in a position of lower rank….

4. Tennessee Department of Personnel Rule 1120-10-.02, POLICY, states:

> A career employee may be warned, suspended, demoted, or dismissed by his appointed authority whenever just or legal cause exists. The degree and kind of action is at the discretion of the appointing authority, but must be in compliance with the intent of the provisions of this rule and the Act. . . .

5. T.C.A. § 8-30-330, PROGRESSIVE DISCIPLINE, states in relevant part:

> (a) The supervisor is responsible for maintaining the proper performance level, conduct, and discipline of the employees under the supervisor's supervision. When corrective action is necessary, the supervisor must administer disciplinary action beginning at the lowest appropriate step for each area of misconduct.
>
> ….
>
> (c) When corrective action is necessary, the supervisor must administer disciplinary action beginning at the step appropriate to the infraction or performance. Subsequent infractions or poor performance may result in more severe discipline in accordance with subsection (a).

6. At the time his shift began at 2:15 p.m. on May 19, 2006 Grievant was aware that Mr. Alvis had been in bed all day, had not eaten, and that the clinic had been apprised of Mr. Alvis condition. On several occasions following this, Grievant observed Mr. Alvis' unusual condition. Near 7:00 p.m., Grievant learned that Mr. Alvis was lying on the floor and went to check on him. Grievant found Mr. Alvis on the floor and was unsuccessful in urging Mr. Alvis to get up from the floor. However, Grievant failed to inform a superior or contact the clinic to advise that Mr. Alvis was on the floor and not responding to requests to move from the floor until a nurse returned at approximately 8:05 p.m. Based upon the evidence presented, Grievant's actions, or lack thereof, were negligent. Although much less egregious, the proof also established that Grievant neglected to properly maintain the log book.

7. Having concluded that Grievant's conduct was negligent, the remaining issue is a determination of the appropriate discipline. The Department itself decided demotion was appropriate for

Grievant's actions. Department of Personnel Rule 1120-10-.07 establishes a progressive hierarchy of discipline that includes demotion. T.C.A. § 8-30 330(a) and Department of Personnel Rule 1120-10-.02 indicate supervisory discretion in implementing corrective action at the lowest appropriate step. Grievant had no prior disciplinary history and by all accounts had been a good employee for the Department. Nonetheless, Mr. Vaughn's negligence in this matter, and the example he set for his subordinate, could reasonably lead to an appointing official's loss of confidence in Grievant's professional judgment and his ability to lead as a Corporal. Grievant's demotion is appropriate discipline for the negligent performance of his duties.

Therefore, it is **ORDERED** that the decision by the Commissioner to demote the Grievant be **UPHELD**.

This Initial Order entered this 13th day of March, 2009.

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Thomas G. Stovall, Director
Administrative Procedures Division