BEFORE GERALD R. BURKE, ESQ.

ARBITRATOR

IN THE MATTER OF THE ARBITRATION BETWEEN AFGE LOCAL 4397 COUNSEL OF PRISON LOCALS #33 FCC LOMPOC And U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS	FMCS # 210510-06573 INVOLVING THE REMOVAL OF [redacted] **ARBITRATOR'S FINDINGS**

REPRESENTING THE UNION:	Josh Klinger TITLE XXXXXX
REPRESENTING THE EMPLOYER:	Ted Booth TITLE XXXXXX
HEARING HELD ON: AT:	October 14, 2021 Via Remote Proceedings
DATE OF AWARD:	December 31, 2021

INTRODUCTION

The hearing was held on Thursday, October 14, 2021 remotely. The matter was before Arbitrator Gerald Burke and appearing for the Union was Josh Klinger. Appearing for the Bureau of Prisons was Ted Booth.

The parties Stipulated and Agreed that there was no issue of arbitrability and the matter was properly before the arbitrator.

The issue is: whether the Grievant [redacted] was discharged just cause, if not, what is the appropriate remedy?

The following joint exhibits were marked and introduced into the record:

Joint Exhibits:

1. Bureau of Prisons Master Agreement.
2. Proposal.
3. Reply oral and written.
4. Decision.
5. Informal resolution.
6. Grievance
7. Grievance response.
8. Invoke.
9. Special Housing Unit post orders.
10. Acknowledgment of post orders.
11. Memo from Scott Brown to Ops Lieutenant.
12. Affidavits from Scott Brown.
13. Acknowledgment of receipt of SOEC.
14. Standards of Employee Conduct.

Union exhibits were marked and introduced into the record as follows:

1. September 15, 2004 memorandum from Harley Lappen, Director of Bureau Prisons.
2. October 31, 2006 memorandum for all chief executive officers.
3. Daily assignments for September 25, 2019.
4. August 4, 2017 letter from Gordon Amalla along with additional memos dated September 28, 2017, August 4, 2017, and November 22, 2017.
5. August 4, 2017 memorandum from the warden (74 pages) which includes multiple disciplinary actions.
6. May 6, 2020 proposal (86 pages) of various proposals.
7. April 8, 2021 from Theo Santoro regarding grievances and six disciplinary actions.
8. August 22, 2021 memo from Mr. Santoro regarding the six grievances.
9. January 6, 2021 (29 pages) various proposals.

Agency introduced two exhibits:

1. January 13, 2021, memorandum from the warden including the December 9, 2020 memorandum. Before there was any testimony, the parties had nine stipulations which are:
   (1) The SQ1 Officer was the officer in charge of the Special Housings Unit.
   (2) The SQ Officer is required to open security grills in order for the SHU 2 officer to conduct irregular security rounds.
   (3) [redacted] has read the post orders for SHU 1 and 2. He acknowledged receipt of both.
   (4) On February 10, 2019, at 12:15am [redacted] conducted rounds with [redacted] on range 6. [redacted] was aware that only one staff member was to be down range and because [redacted] was downrange with [redacted], the range grill was

left unsecured.

(5) There was a check by Officer [redacted] with [redacted] at 3:10 on Range 6. [redacted] was aware that only one staff member was to be downrange and because [redacted] was downrange with [redacted], the range grill was unsecured.

(6) There was no check of the cells on range 6 between 12:47 and 2:03 a.m.

(7) There was no check of the cells on Range 6 between 2:04 a.m. and 3:10 a.m.

(8) There was no check of the cells on Range 6 between 3:10 a.m. to 4:27 a.m.

(9) There was a medical emergency at 4:22 a.m on February 10, 2019 on Range6 in SHU. [redacted] responded to the emergency and inmate [redacted] was seen hanging from his bunk.

The agency argues that on February 10th [redacted] was working in the secured area of the prison with [redacted] Together they had a joint responsibility to serve certain functions in the roles that night and also to complete their roles in a timely manner. During their watch an inmate was able to commit suicide. Warden Bradley had to make a difficult decision in removing [redacted] from his position for this misconduct. Warden Bradley articulated the reasons and her findings and believed that the misconduct was so serious that the only penalty was removal.

The Union takes the position that the testimony will show that the incident happened on February of 2019 but discipline and investigations have been a problem for the agency especially on a timely basis. The Union argues that the agency does not issue timely discipline or timely investigations based on the Lappin and Kinney Memos. Those memos indicate that discipline will be consistently applied. The Union points out that the agency failed to timely discipline employees and timely investigate the discipline in this matter. The Union points out that the exhibits will show that there are reprimands up to removals for the same offense and in this

situation they failed to issue timely discipline, investigation and a consistent penalty. Under the memos, the agency is supposed to complete investigatory reports and complete investigations within 120 days and issue discipline within the next 120 days. This is consistent with the Collective Bargaining Agreement 30§D which indicates that "the parties endorse the concept of timely disposition of investigations and timely disciplinary adverse actions."

In this situation [redacted] was not investigated until six months after the incident and then a year later for a second interview which violates the Collective Bargaining Agreement and the investigation once it was completed took the Deputy Captain until December of 2020 to issue a proposal and after February 2021 Warden Bradley to issue a decision which is two years after the incident. The Union points out this lacks sufficient and just cause because it violates the agency's own memos and the Collective Bargaining Agreement. The Union points out there were employees in other institutions that were removed and there were also employees who only received letters of reprimand.

The Union called Steven Martinez who was a Deputy Captain. In his position he was a Complex Captain for the medium and low security prison. He would supervise the partnership with the Complex Captain all the Lieutenants all the Officers and Correctional Staff. He has had 12 years experience in the prisons system having previously been at Illinois, Tucson Arizona and Colorado. The prison has the Special Housing Unit (SHU). Prisoners are usually placed in the SHU for administrative detention reasons or disciplinarian. You also have protective custody cases in the SHU. Inmates are in the cell an overwhelming majority of the time but are allowed out for recreational and all library privileges which are typically an hour. It is considered the most secure unit inside the prison.

The day shift is typically the most busy with the inmates being fed early in the morning on a rotational basis. They typically have four officers and a recreation officer (SHU 1, 2, 3 &

4). There are two shifts on the day watch and then you have the third watch shift which is Midnight to 8 a.m. in the morning with a SHU 1 and a SHU 2 officer. The officers have post orders and training to complete their duties. The officers in the SHU go into a range which is a big hallway with up to 20-24 cells. The officer's duty are to make sure that the inmates are secure and they perform welfare checks to make sure inmates are alive and they are not doing any harm to themselves. The rounds are to be conducted approximately every 30 minutes. Typically, officers on the Midnight shift are to switch every other round. When an officer would do the round and the other person would be at the main gate with the keys. The keys are to be maintained at the head of the range to control the prison and prevent any inmate from escaping. Even though Officer [redacted] was working overtime and doing a second shift his duties did not change.

Officer Martinez has the special investigation over security, supervises the department and conducts inmate investigations. He would collect affidavits from the staff members and would collect evidence. He indicated that he would try to finish his investigation within 120 days. He admitted that the investigations would typically not be completed within 120 days and indicated that there was no mandatory time limit. In this situation even though it was not done in 120 days it does not change the evidence or the validity of the interviews and he would issue a proposal letter for discipline. He would also review the post orders to familiarize himself with the situation because different facilities have different post orders. Officer Martinez issued the proposal and he felt that the charges were serious considering an inmate had died in the process along with Officers [redacted] and [redacted] missing a round and a shift. In this situation they did not make the rounds timely other than the mandatory count. Interestingly after this event it went from two officers to three officers since rounds were not being timely performed and this was a repetitive problem with the prison. He also admitted that Officer [redacted] working overtime in the

SHU might not have had the SHU training. More recently, the process has been changed where there are two SHU officers doing the checks and this has been in place since the suicide. Often overtime would be mandatory if there were not enough officers. In our situation there are six ranges and the officer in charge and found the inmate in range six had hung himself.

Officer Martinez admitted that the first investigation [affidavit] was not conducted within 120 days but took 180 days approximately. Officer Martinez indicated that Officer [redacted] and Officer [redacted] were making checks together and not maintaining the key at the gate to ensure that the prison was secure, and he was uncertain as to who actually had possession of the keys.

Former Warden Patricia Bradley was the warden at Lompoc from June of 2020 to February of 2021. When she became the warden, the situation was very hectic at the prison. She was previously a warden at Alabama for over three years and has been in the Federal Bureau of Prisons for 21 years. She confirmed that the SHU officers were to do rounds every 30 minutes. Staggering the rounds would not allow the inmates to know when they were coming. She indicated that the staggered rounds would prevent the inmates from passing things from cell to cell, trying to harm each other or harm themselves. She acknowledged that the typical work week were eight hour five days a week shifts but the prison was definitely understaffed, and they ended up having 12-hour shifts. She indicated that the expectation of the officer did not change even though they were working overtime.

She acknowledged that there was guidance from the previous Assistant Director who indicated that the investigation should be completed within 120 days. She indicated it was not a requirement but a goal. In reviewing exhibit No. 9, she noted that there were post orders for the SHU officers and it indicated what there major roles and responsibilities were. She indicated that every quarter they had SHU training for the staff officers that worked in the Special

Housing. She also acknowledged that before anyone worked in the SHU they had to acknowledge that they had read and fully understood the requirements of the post. She also confirmed that Mr. [redacted] had an opportunity to read and understand his responsibilities while working his SHU post. She also confirmed that Mr. [redacted] had received a copy of the Standards of Employee Conduct which has set out his duties. She confirmed that the charges against Mr. [redacted] followed post orders and that the 30-minute front meant that there were a few 30 minute rounds that were skipped. This matters because the officers are there for safety and security. When the officers fail to follow the rules, she was of the opinion that people get hurt and there is the possibility of escape. A missing round gives inmates more opportunity, more time and opportunity to do things that should not be done, including self-harm. When officers fail to do their rounds properly it sends a bad message the staff is not doing its job and they are vulnerable.

Warden Bradley looked at Mr. [redacted] years of service and went through all the Douglas factors. She acknowledged that he took full responsibility but the fact remained that they failed to make the rounds and it was actually the supervisor who found the inmate which is totally unacceptable. This was a very serious situation which she lost confidence in Mr. [redacted] ability to perform his duties. She indicated this incident was a Bureau wide effect. However it is not uncommon for an inmate to hang himself. She indicated that she was uncertain that there was something that could have been done to prevent the incident but the job of the officers was to check the inmates to ensure their safety. She indicated that the post orders are posted for a specific reason. It did not matter if you worked the shift for 30 minutes or double shift the responsibilities do not change and the accountability does not change. The warden came to the conclusion that she did not have any confidence in Officer [redacted]. The reason for the discharge was Officer [redacted] failing to conduct Special Housing Unit rounds and failing to follow post orders.

On cross-examination Warden Bradley did acknowledge that there was an incident with Mr. [redacted] who had failed to make rounds and his discipline only resulted in suspension which is the Union exhibit 9. Further there is also a decision in Mr. [redacted] case where he failed to make rounds and his removal was reduced to a 21-day suspension. The same is also true for Mr. [redacted] who was issued only a 45-day suspension. The same is also true for Mr. [redacted] and his failure to make rounds only resulted in a 40-day suspension and Mr. [redacted] situation was on the same night as Mr. [redacted]

Warden Bradley acknowledged that in the prior Director's memo (Lapping) indicated that investigations should be completed within 120 days. 180 days for OIA onsite investigations and failure to do so barring unforeseen circumstances will be dealt with as a performance issue. She indicated that the difference with Mr. [redacted] removal versus those of Mr. [redacted] and Mr. [redacted] was that there was a inmate suicide.

Maria Aceves is the Human Resource Manager at the Lompoc Facility. She was involved in the disciplinary process and she would draft up a proposed disciplinary action. The proposal is sent out to supervisors and officials and it comes back to her to make any corrections or any edits. It is her responsibility after the proposal is finalized to set up an oral meeting with the warden. Ms. Aceves also reviewed the proposed discipline and checks it for consistency.

Theodore Cintora was a correctional officer since 1998. He has held a number of positions up through a Senior Officer. He was also a Union Steward and then a Vice President of the Union for four years. In his 22 years with the Bureau of Prisons he was aware of probably four or five suicides at Lompac and he was unaware of any officer being disciplined when there was a suicide. He acknowledged that there were six grievances which involved Officer [redacted] At that time Warden White was there and they had gone over memos from Kinney and former Director Harley Lappin. The memos talked about

discipline and timeliness under the internal guidelines of the Bureau of Prisons. There were procedures to ensure that discipline is imposed consistently.

[redacted] indicated that he initiated his employment with the Bureau of Prisons in May of 2016 primarily working at Lompoc. He was previously a Medium and then went to a Senior Officer and he worked all over the institution and started working the critical post such as the lobby, arm patrol, towers and SHU. Occasionally he would work the housing unit from 4p.m. to Midnight shift if someone called in sick or is taking annual leave. When he would do relief work in the SHU he would get relieved by the last officer and do an equipment trade off. Of particular note he did not attend any official SHU quarterly training. The in person training was very specific as to the Lompoc SHU whereas any internet training was a broad spectrum of Powerpoints. He indicated he had trouble accessing parts of the SHU program from the website. The night in question he was having trouble getting into the training and he had to call a couple of Senior Officer specialists to see if they could teach him or give him access into the programs.

He indicated typically there were two officers where one officer would stand at the head of the SHU and lock the gate whereas the other officer would do the rounds and check the inmates. There were five "counts" which were Midnight, 3 a.m., 5 a.m., 4p.m. and then 10 p.m. He did the counts at Midnight or 12:01 a.m. and also 3 a.m. and there were no incidents or problems. After the 3 a.m. count he went back to the computer to work on paperwork and around 3:30 a.m. the Lieutenant showed up. They verified the number of inmates and there were 76. He did remember that the last inmate on range six was asleep since there is a single cell. That was the inmate that committed suicide later that morning. It was at 4:22 a.m. that the Lieutenant found the inmate in his cell and called for medical assistance. Shortly after that he made the rounds to make sure every other inmate was okay. He was very upset and Officer Martinez came into the Lieutenant's office and helped him calm down. He had to write some

notes since apparently the FBI was anticipated to show up and asking questions of what happened. After this incident he did work in the SHU one more time on September 14, 2019 as the third officer from 4 p.m. to Midnight.

His affidavit or interview was not done until August 20, 2019 and then the second affidavit was done slightly a year later around September 13, 2020. At the September 9, 2020 interview he got the proposal for removal. He subsequently contacted the Union and he also indicated that the Lieutenant was with him talking to him between 3:30 and about 4:20 a.m. or 4:22 a.m. with him getting notice at 4:22 a.m. that there was a medical issue from the Lieutenant. In his testimony he indicated that the purpose of doing the SHU rounds is to ensure that the inmates are in their cells had not escaped and that was their number one responsibility.

ARBITRATORS FINDINGS

The grievant on February 10, 2019 was assigned as SHU #1 officer in the Special Housing Unit. He had already worked an eight hour shift and had been called to work overtime without any time off. Thus, he was going to be working a 16 hour day at the time of the offense. The shift included insuring that SHU rounds were to be completed on irregular intervals of anywhere between 30 minutes to 40 minutes. A round would consist of walking through and checking cells and chekcing if inmates were okay. The agency clearly points out that it must prove by a preponderance of the evidence that the employee committed the conduct charged, there was an nexus between the conduct proven in the deficiency of the service and the penalty imposed is reasonable. In situations with agency charges are sustained or the employee acknowledges misconduct resulting in adverse action being challenged, the agency imposed penalty should only review if the agency considered all the relevant factors and exercised management discretion within tolerable limits of reasonableness. Consequently, penalty should be modified only when it is the found that the agency failed to weigh the relevant factors and that

it clearly exceeded the bounds of reasonableness in determining the penalty which is the situation in this case.

The agency argues that the Federal Bureau of Prisons as a result of its responsibility relating to the care and custody of inmates is to be afforded wide discretion as it related to work related conduct.

The grievant was charged with two offenses which was the failure to conduct SHU rounds and failure to follow post orders. Clearly, the evidence shows that the grievant did not conduct required duties with respect to SHU rounds on three occasions and when he was working his overtime shift. Additionally, the parties acknowledged that the two officers were conducting the inspections while one of them should have been left at the grill range with the keys to insure no one was going to escape. In this case the grievant had worked the SHU previously and he was aware of the SHU orders but had never gone through any formal training. The agency is arguing that it had shown that there was a nexus between the charged conduct and the efficiency as a service and it pointed out that law enforcement officers are to be held to a higher standard of conduct. The agency argues that the SHU rounds are to be conducted at 30 minute intervals to insure the inmates are properly observed and accounted for and its the officer's responsibility to maintain the safety and security of the institution especially when you are dealing with potentially volatile areas such as the Special Housing Unit. The agency argues that the warden's decision is entitled to deference for numerous reasons and significant discretion should be made to the decision makers in disciplinary matters unless the penalty exceeds the range of allowable punishment or the penalty is so harsh and unconscionably misappropriate to the offense and amounts to an abuse of discretion. Typically, it has been held that the nature and seriousness of the grievant's offense is the most significant factor in a penalty determination.

FACTOR #1 NATURE AND SERIOUSNESS OF THE OFFENSE

It is a standard that the first and foremost penalty consideration is the nature and seriousness of the conduct in relation to the employee's duties, position and responsibilities. If the warden had cited the seriousness of the failure to conduct the SHU rounds when she noted that an inmate under enhanced supervision had an extended period of unsupervised time that provided him with the opportunity to injure himself. The warden claimed that the seriousness of this misconduct resulted in the inmate [redacted] committing suicide. The warden had indicated that the seriousness of failing to conduct these rounds was a failure in the prison's mission. They were supposed to protect the inmates and when people die or escape we fail in our mission. The warden also indicated that the grievant did not even find the body. It was a supervisor that made the discovery.

THE ISSUE FOR THE ARBITRATOR

The evidence shows that there was no intention by the grievant to intend that the inmate committed suicide during the missed round. It appears that the suicide was unintentional and accidental in nature. The grievant prepared a memorandum immediately stating that he missed the rounds and that there was no attempt to hide his violation. The grievant was not a supervisor. He had only worked the SHU on two occasions and there was no notoriety of the offense or impact on the reputation of the agency other than the FBI did come and investigate. It was interesting that there was never an introduction of the investigation and thus it would appear that it was not adverse to Mr. [redacted] grievance performance.

Additionally, there was no showing that the suicide could have been prevented even if the rounds had been done every 30 or 40 minutes. Particular note is that a death by suicide/hanging oneself occurs either immediately or within a three to four minute time period. The inmate was housed by himself and if he wanted to kill himself which apparently he did he could have done it

at any time. There was no indication how long he had been dead when they found him and thus there is no showing that a timely round of every 30 or 40 minutes would have prevented the suicide.

The agency indicates that it was tragic that an inmate lost his life it is more important to note that he is the one who took it and apparently wanted to take it for some unknown reason. More importantly, it should be remembered that the applicant was working in the K Unit for eight hours on the prior day from approximately afternoon to midnight and then had to work an additional eight hours which was basically working consecutive 16 hours. It also should be noted (page 162 of the transcript) that he did not have official SHU quarterly training. The in-person training was very specific at the Lompoc SHU and he only had training over the Internet which was a very broad spectrum of power points although he did admit that he had post orders but he did not know as to what was discussed at the in-person training. Additionally, he had trouble accessing parts of the SHU program through a website. He was having issues in getting a hold of and using certain parts that night in question and he had to call some senior officers specialist to assist him in accessing the programs.

After the 3:00 a.m., count which was 11 hours of straight employment and without any sleep. He was contacting other officers trying to get help with the SHU program. At that point he was on the computer to do his paperwork and the lieutenant showed up around 3:30 a.m. They had already made the check that all the inmates were in their cell and they were not wandering around or escaping. They had also done their official count with the control room officer. The grievant specifically remembered that the inmate [redacted] had been asleep at the count. Between 3:30 a.m. and 4:22 a.m. the lieutenant and the grievant conversed inside the SHU office and talked about past experiences working at the facility. Later the lieutenant left and he made the call for assistance at 4:27 a.m. There was almost approximately one hour and a half

when the lieutenant was with the grievant and no one was doing the 30 or 40 minute checks. It would seem that there was some complacency even through the lieutenant should have realized that the checks were not being made. It was clear that there was nothing intentional by the grievant since he did become extremely upset when he found out that the inmate had died. Subsequently, on two occasions he did work in the Special Housing Unit before he was terminated some two years later. Thus, there is an issue for this arbitrator as to the nature and seriousness of the grievant's conduct not rising to a level warranting termination. He never had in-person training, he had only worked the SHU on a couple of occasions previously and he was working a 16 hour shift in which he was having problems with accessing the SHU training on line Again, there is no evidence that even if the rounds were done every 30 or 40 minutes it would have prevented the inmate's suicide. Why did the lieutenant that was with the grievant from 3:00 a.m., until approximately 4:27 a.m. not remind him that he should be going out and doing the 30 or 40 minute checks? It would seem that maybe even the lieutenant did not think that the 30 or 40 minute checks were warranted or mandatory.

FACTOR #2 JOB LEVEL RESPONSIBILITIES

The second Douglas Factor is the employee's job level and type of employment. The warden indicated that officers at the prison hold the position of public trust and the public trust that we do our job properly. She indicated that the grievant was responsible for insuring the completion of these rounds and that he was negligent. She did not explain why he never had any in-person training and why the lieutenant was sitting with him from 3:00 a.m., to 4:22 a.m., that morning and never told him that he should be making rounds every 30 or 40 minutes. Even though he was aware of the post orders, he was working overtime and had no rest between approximately 4:00 p.m., and approximately around 5:00 a.m. when he was relieved of his duties. Although he did fail to do the rounds the arbitrator questions why that would be

tantamount to justification for removal.

FACTOR #3 DISCIPLINARY RECORD

There is no disciplinary record to consider in this matter.

FACTOR #4 PAST WORK HISTORY

There is no issue with his past work history, performance on the job and ability to get along with fellow workers and especially dependability since he was willing to work overtime which would require 16 hour shifts over a four year period.

FACTOR #5 EFFECT ON PERFORMANCE AND SUPERVISOR'S CONFIDENCE

The fifth factor is the employee's ability to perform at a satisfactory level and its effect upon the supervisor's confidence in the employee's ability to perform assigned duties. The warden indicated if she had been the warden at that time she would not have allowed the grievant to continue to work another SHU but, in fact, he did on at least two occasions. She came in after the incident happened and there is an issue as to what was going on in February 2019 since even the lieutenant that found the body was with the grievant for almost an hour and a half that morning talking about work procedures and things that went on at the prison.

The warden indicated that in her decision to terminate the grievant she completely lost any confidence in his ability to successfully fulfill his duties yet he continued to do those duties for approximately two years after the incident without any issues or problems and one would wonder whether the warden's statement that she lost confidence is true for the working supervisors in the prison. Of more importance is Gordon Felipe Martinez came into the lieutenant's office after they found the body and told the grievant that things would be alright and that it was a learning moment for everybody at the institution about doing the rounds and, in fact,

Gordon Martinez told the FBI that they were working 16 hours shift and they were tired. There was no time to do a question and that he needed to reschedule a meeting at some point in the future. It should also be noted that when the second occasion that he worked the SHU it was again mandatory overtime. So he was working from midnight to 8:00 a.m. One has to realize that when you have no break over a 16 hour time period one loses some efficiency. In this occasion he had been working since 4:00 p.m., and the incident happened at 4:22 a.m. He was working 12 consecutive hours without any type of break. For the warden to come in later and say that she lost complete confidence in him is definitely an overreach in that it is unfair to apply a new standard to the grievant when he was trying to be helpful, trying to learn, and trying to be a good officer.

FACTORS #6 AND #7 CONSISTENCY OF THE PENALTY

The warden claimed that the employee who was on the prior shift to the grievant had been suspended by her. She had suspended three other employees in cases involving missed SHU rounds and they were only suspended since it did not involve an inmate suicide. Clearly, the reason for the termination is because the inmate committed suicide. The warden also indicated that there were two other decisions in 2020 and 2021 where rounds were not completed and the employees were ultimately removed. The warden indicated that the grievant's actions and/or inactions completely destroyed her confidence in the ability to successfully fulfill the duties and responsibilities. Yet she does not explain why he continued to work there two years. He did not have any type of disciplinary problem and even had worked in the SHU on two additional occasions without any problems even though he had no in-person training. He was working mandatory overtime at 16 hour shifts. In reviewing the table of penalties the warden clearly could have issued a reprimand as compared to the removal she issued in this case. Again, there was no showing or any indication that the lack of a round was the causal factor in the

inmate committing suicide. As indicated above the death would have been either instantaneous or would have occurred within three or four minute time period. Clearly the inmate if he wanted to kill himself could have seen someone come and do the round and as soon as that person left he knew that no one would be back for another 30-40 minutes and the suicide could have been accomplished without any difficulty.

FACTOR #8 IMPACT ON THE AGENCY'S REPUTATION

The notoriety of the events or its impact upon the reputation of the agency is a factor to be considered. The warden indicated that the effect of the inmate's suicide on the agency's reputation played on her mind. Additionally, there was an investigation by the FBI. The whole incident did not reflect well on the agency's reputation.

The arbitrator is wondering why there were so many issues of a variety of different people coming through over a three or four year time period being the warden and why there was so much overtime. Clearly, there must have been some personnel issues and they needed to get a better handle on the internal operations of the prison.

FACTOR #9 CLARITY OF THE NOTICE

This factor is dealing with the employee being on notice of any rules that were being violated and whether he had been warned about the conduct in question. The agency argued that there were orders posted and that the grievant had signed a document indicating he was aware of the duties. The agency further argues that he knew how to conduct a SHU round and he was aware of the purpose of conducting these rounds at irregular intervals. Clearly, the primary purpose is to prevent any type of escape and/or harm to the inmates amongst themselves. There is a question as to whether you can really stop an inmate inflicting harm on himself when they are not being watched over a 30 to 40 minute time period.

FACTOR #11 MITIGATING CIRCUMSTANCES

The grievant had four years of service at a very acceptable level and accepted responsibility for his actions. Clearly, the applicant was working an overtime shift and some 12 hours after he had started his original shift when the missed round had occurred.

FACTOR #12 ADEQUACY OF THE ALTERNATE SANCTIONS

The adequacy and effectiveness of alternate sanctions is to defer such conduct in the future by other employees. The warden indicated that she had considered a suspension and a demotion but the seriousness of the case where the inmate lost his life due to the grievant's negligence did not make any of these sanctions sufficient. There is an issue as to whether the lack of a round was the cause for the inmate to lose his life. It was a self-inflicted decision by the inmate and as indicated several times before there has been no showing that the suicide would have been prevented had the rounds been conducted on 30 or 40 minute intervals.

THE AGENCY'S DISCIPLINE AS TO BEING UNTIMELY

The agency indicates that there was a subsequent FBI investigation and there was a lack of adequate staff and the fact that they admitted there were staffing shortages due to the pandemic and other issues. The agency was of the position that even in the absence of a specific contractual time requirement and even a significant delay of two years it did not automatically void the discipline or cause it to be without sufficient or just cause. The agency took the position that the delay did not prejudice the grievant or cause any harmful procedural error and was not an alleged violation of the collective bargaining agreement. Joint Exhibit 1 was the master agreement at page 69 it indicated that an employee against whom an action is proposed is entitled to at least 30 days of advance written notice. The notice must state the specific reasons for the proposed action. In the 2004 investigative report due to the Department of Justice OIG determined that the Bureau of Prisons did not process employee misconduct cases in a timely

manner (Union Exhibit 1). The report indicated that the agency had been on notice for least 14 years to speed up both investigative and adjudicatory processes to effectuate discipline and risk violating the parties master labor agreement. There was a Kenny Memorandum which indicated that local investigation should be completed and the package should have been forwarded to OIA within 120 calendar days of report. It put the agency on notice that it had obligations under those master agreements as to the notion of just and sufficient cause and timely effectuated discipline under Article 30 of the master labor agreement.

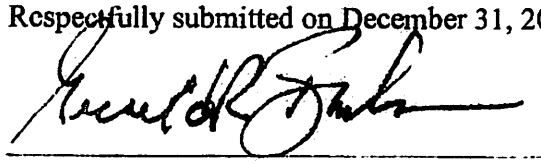
The agency did not really start an investigation into the incident until approximately six months later which would be around August 2019. At page 175 of the transcription (Joint Exhibit 12) between the incident and the discipline the grievant demonstrated a long-term commitment to a good employee in completing the tasks given to him. It would appear that the discipline instituted against the grievant was punitive for past offenses and would appear to have been corrected.

The mitigating factors in the grievance case do appear to be substantial in the arbitrator's opinion. Clearly, the grievant did not intend for the inmate to commit suicide during the missed SHU round and it was unintentional or an accidental incident that clearly weighs heavily in favor of mitigating the removal penalty. The grievant was not a supervisor and, in fact, sat with a lieutenant for almost an hour and a half that morning discussing the prison and various factors. It seems that there was more of a complacency at that period of time back in February of 2019 which the warden who came in later was not happy with but was not the warden at that time and seems to penalize the grievant unfairly for something that happened in the past especially an individual with no prior discipline. There was no progressive discipline and there was no evidence that the grievant intended to violate agency policies. A lessor penalty clearly would defer the grievant and others from committing similar alleged conduct in the future.

Additionally, the grievant continued to work for almost two years after the incident without any discipline or incident which clearly indicates that there was confidence in his ability to perform the job. Thus, removal is inconsistent with other disciplinary similarly situated employees engaged in similar offenses. In the arbitrator's opinion the discharge or removal of the grievant clearly exceeded the tolerable bounds of reasonableness based on the consideration of the Douglas Factors and the failure to follow timely investigation. The arbitrator determines that the removal penalty was excessive and believes that a 10-day suspension is a reasonable disciplinary action that should have been taken.

The arbitrator is removing and cancelling the discharge or removal. The grievant should have been assessed a 10-day suspension and is entitled to back pay and all benefits if he had been working after the 10-day suspension up until the time he is placed back in his position as an officer in the prison less any earnings or benefits received from outside sources during this time period.

Respectfully submitted on December 31, 2021.



Gerald R. Burke, Esq., Arbitrator