

COMMONWEALTH OF PENNSYLVANIA

Charles Brennan : State Civil Service Commission
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 v. :
 :
 State Correctional Institution at :
 Mahanoy, Department of Corrections : Appeal No. 30432

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ADJUDICATION

This is an appeal by Charles Brennan challenging his removal from regular Corrections Officer 3 employment with the State Correctional Institution at Mahanoy, Department of Corrections. Hearings were held February 7 and 8, 2022 at the Strawberry Square Complex in Harrisburg, Pennsylvania before Commissioner Bryan R. Lentz.

The Commissioners have reviewed the Notes of Testimony and Exhibits introduced at the hearing as well as the Briefs submitted by the parties. The issue before the Commission is whether the appointing authority had good cause to issue appellant a suspension pending investigation and just cause to remove him from his Corrections Officer 3 (hereinafter “Lieutenant”) position.¹

¹ When an appointing authority suspends an employee pending investigation and subsequently removes the employee, the period of suspension will be deemed part of the removal action. *Woods v. State Civil Service Commission (New Castle Youth Development Center, Department of Public Welfare)*, 865 A.2d 272, 274 n. 3 (Pa. Commw. 2004); 4 Pa. Code § 101.21(b)(2). Appellant having been suspended, effective November 15, 2019, pending investigation, and having remained on suspension until his removal effective April 24, 2020, we consider appellant’s removal, effective as of the date of suspension to be the sole personnel action to be reviewed through this appeal.

FINDINGS OF FACT

1. By letter dated November 19, 2019, appellant was suspended pending investigation from his position as a Corrections Officer 3, regular status, effective November 15, 2019. Comm. Ex. A.

2. By letter dated April 24, 2020 appellant was removed from his Corrections Officer 3 (hereafter “Lieutenant”) position. The appointing authority charged appellant with violations of Sections B-1, B-10, B-22, and B-29² of the Code of Ethics (hereinafter “COE”) and provided the following explanation of the charges:

² The Code of Ethics (hereinafter “COE”) Section B-1 provides:

Each employee in the correctional system is expected to subscribe to the principle that something positive can be done for each inmate. This principle is to be applied without exception. This involves an intelligent, humane, and impartial treatment of inmates. Profanity directed to inmates, or vengeful, brutal, or discriminatory treatment of inmates will not be tolerated. Corporal punishment shall not be utilized under any circumstances.

COE Section B-10 provides: “Employees are expected to treat their peers, supervisors, and the general public with respect and conduct themselves properly and professionally at all times; unacceptable conduct or insolence will not be tolerated.”

COE Section B-22 provides:

An employee shall submit any necessary and/or requested work related reports in a timely manner and in accordance with existing regulations. Reports submitted by employees shall be truthful and no employee shall knowingly enter or cause to be entered any inaccurate, false, or improper information or data, or misrepresent the facts in any Department record or reports.

COE Section B-29 provides: “All employees shall comply and cooperate with internal investigations conducted under the authority of the Department of Corrections and respond to questions completely and truthfully. Procedure in cases that may result in criminal prosecution will include those rights accorded to all citizens of the Commonwealth.”

Comm. Ex. C; AA Ex. 1.

Specifically, on November 11, 2020, as the officer in charge of the Restricted Housing Unit (RHU) and responsible for Inmate Briggs' (HS0959) care and custody you failed to provide for his intelligent, humane, and impartial treatment, and you acted unprofessionally.

You were responsible to act or direct action when encountering a person with obvious signs of medical distress and who was carried into the RHU, and to call for medical assistance. You assumed responsibility for Briggs but took no action to verify his condition, to reassess the inmate's needs, or to ensure additional medical assessment/treatment was provided. Instead, you had Briggs laid face down while handcuffed behind his back, counter to policy. At your direction, Inmate Briggs remained face down on the concrete floor, and for over forty minutes no further action was taken, until there were no signs of life. When you saw Briggs, unresponsive and not breathing, you failed to immediately initiate or direct CPR.

Your reports as well as your statements to the investigators are incomplete, misleading, and self-serving. You do not accurately reflect time lapses nor properly detail the inmate's behavior or condition. You attempt to justify your inaction under the pretense of continuing inmate misconduct. However, you knew the inmate was in

distress and not intentionally uncooperative, but was instead unable to walk or stand due to his medical condition. Yet this was omitted from your reports.

It was your professional responsibility to do the right thing for those under your care, custody and control. This included continually assessing his condition, evaluating his situation, rendering necessary aid, and contacting medical for the inmate who later died. Despite signs of distress and need, and repeated opportunities, you did not act appropriately. Your inaction, delays, waiting, and poor judgement are unacceptable.

Comm. Ex. C.

3. The appeal was properly raised before this Commission and was heard under Section 3003(7)(i) of Act 71 of 2018. Comm. Ex. D.
4. Before beginning employment with the appointing authority, appellant served eight years in the United States Air Force. He also served twelve years in the active reserves while employed by DOC. N.T. pp. 440-441.

5. Appellant began employment with the appointing authority in 1994. He has been employed as a Lieutenant since 2014. He has been a Lieutenant in the Restricted Housing Unit (hereinafter “RHU”) from 2015 to 2019. N.T. pp. 441, 452, 460, 474.
6. During his employment with the appointing authority, appellant has received accolades for intervening on behalf of inmates in distress. N.T. pp. 456-459.
7. On February 16, 1996, appellant signed the appointing authority’s Code of Ethics, agreeing to abide by its rules and guidelines. N.T. pp. 39, 41; AA Ex. 41.
8. Appellant has no prior disciplinary action and has received “Commendable” ratings on his Employee Performance Reviews. N.T. pp. 50, 464.
9. Appellant has received accolades for saving the lives of two inmates. N.T. pp. 457-460.
10. November 11, 2019 was the Veteran’s Day holiday. Because of the holiday, the staff levels at the facility were reduced in comparison to a non-holiday shift. N.T. pp. 486, 529-530.

11. On November 11, 2019, appellant was covering for the scheduled RHU Lieutenant on the 2:00 p.m. to 10:00 p.m. shift. N.T. p. 484.
12. As the RHU Lieutenant, appellant's duties included responsibility for the care, custody, and control of inmates. He was also responsible for the safety and management of all staff members and vested with the authority to issue them orders. N.T. pp. 285, 365; AA Ex. 3.
13. The RHU holds 120 inmates. N.T. pp. 478-479.
14. Appellant had a staff that consisted of four Corrections Officers and one Sergeant. N.T. pp. 487-488.
15. During appellant's shift, he heard Corrections Officers contacting Control asking for a response team for a fight between two inmates. N.T. pp. 493-509; AA Ex. 11; Ap. Ex. 1.
16. Appellant realized he needed to assist since there was only one other Lieutenant on duty, James Hawk. N.T. p. 494.

17. Appellant left the RHU and went to medical, where he saw an escort team bringing Inmate Smith into the medical area. N.T. pp. 495-496.
18. Because Inmate Smith's escort did not have a Lieutenant, he undertook the escort himself. N.T. p. 496.
19. While assisting with Inmate Smith's escort, appellant saw Lieutenant Hawk and some Corrections Officers escorting Inmate Briggs to medical. N.T. pp. 496-498.
20. Appellant was familiar with Inmate Briggs from having seen him playing basketball and running in the yard. N.T. pp. 506-507.
21. In medical, appellant obtained information from Inmate Smith regarding the fight. N.T. pp. 502-503.
22. Also while in medical, appellant went to obtain information from Inmate Briggs regarding the fight. N.T. p. 504.
23. Appellant observed Inmate Briggs was on a gurney, handcuffed, and had dark red and orange stains on his cloths. N.T. p. 505.

24. Inmate Briggs appeared tired and out of breath, but no more than any other inmate who had been in a fight. N.T. p. 507.
25. Appellant did not know Inmate Briggs had asthma and did not know he was treated with an inhaler. Appellant had previously seen Inmate Briggs as a young man who was physically active. N.T. pp. 506, 549, 590.
26. When appellant asked Inmate Briggs questions, he did not cooperate in answering them. N.T. p. 505.
27. Appellant observed Inmate Briggs appearance as similar to other inmates who had been involved in a violent altercation, spent a lot of energy in a short period of time, and who had been pepper sprayed. N.T. pp. 504-507.
28. After seeing Inmate Briggs for approximately one minute, appellant returned to Inmate Smith, called the RHU control to begin the process of preparing two cells, and then remained in medical to continue escorting Inmate Smith to the RHU. N.T. pp. 507-508.

29. After medical cleared Inmate Smith, appellant assisted with his escort from medical to the RHU strip cage. N.T. pp. 509-510.
30. Once Inmate Smith was secured in the RHU strip cage, appellant conducted the strip search and suicide checklist. N.T. pp. 512-513, 515.
31. Appellant then heard over the radio that Inmate Briggs was on the way to the RHU. Appellant knew Inmate Briggs had been cleared by medical to be escorted to the RHU area. N.T. pp. 515, 555; Ap. Ex. 1.
32. Inmate Smith told appellant he would not share a cell with another inmate. N.T. pp. 516, 531.
33. After asking the RHU Sergeant, appellant knew there was no single cell available for Inmate Smith. N.T. p. 517.
34. There is only one strip cage in the RHU so appellant moved Inmate Smith out of the strip cage and placed him into a shower cell. This ensured that the RHU strip cage would be available when Inmate Briggs arrived. N.T. pp. 517-518.

35. When Inmate Briggs arrived in the RHU, appellant met the escort team with a restraint chair, but saw they were carrying Inmate Briggs and moving quickly. N.T. pp. 78, 519-521; AA Ex. 12.
36. On the video “RHU strip cage handheld,” the escort team is heard telling appellant Inmate Briggs was breathing and conscious, refusing to walk on his own, not cooperating, “playing,” “being noncompliant” and that, “medical said he was fine.” N.T. pp. 100, 521, 527-527; AA Ex. 12.
37. Appellant determined the restraint chair was not necessary and directed Inmate Briggs be placed in the strip cage in the recovery position. N.T. pp. 524, 525; AA. Ex 12.
38. The escort team put Inmate Briggs into the strip cage and placed him in a recovery position. N.T. pp. 525-526; AA Ex. 12.
39. Appellant spoke to Inmate Briggs but did not get a reply. Inmate Briggs appeared to be in the same physical condition as he had been while in medical. N.T. p. 524; AA Ex. 12.

40. Appellant did not complete the suicide checklist for Inmate Briggs. N.T. pp. 577-579, 622.
41. Appellant released Inmate Briggs' escort team with the exception of Corrections Officer Courtney Vance, who was operating the handheld camera. N.T. pp. 528-529; AA Ex. 12.
42. Appellant directed Vance to aim the handheld camera on Inmate Briggs. She did so. N.T. pp. 535-536; AA Ex. 12.
43. Appellant directed Corrections Officer Gage Cara to remain at the strip cage, then telephoned Captain John Mushalko to explain the housing availability concerns. N.T. pp. 529-530, 535; AA Ex. 12.
44. On the video "RHU strip cage handheld," appellant is heard telling Mushalko that Inmate Briggs was not complying and did not cooperate with the escort to the RHU. He also stated Inmate Smith was currently in the shower cell and refusing a cellmate. N.T. p. 530; AA Ex, 12.

45. Mushalko instructed appellant to return to the main area of the RHU to complete the cell arrangements and then return to the RHU strip cage area to process Inmate Briggs. N.T. p. 533.
46. Approximately 04:50 minutes into the “RHU strip cage handheld” video, appellant hung up the telephone, then directed Cara and Vance to continue watching Inmate Briggs. Appellant stated that as soon as Inmate Smith was in a cell, they would find a cell for Inmate Briggs and “address his issue.” N.T. pp. 535-536; AA Ex. 12.
47. Appellant observed Inmate Briggs breathing, saw him move his leg, and believed he was asleep. Appellant did not observe any signs of medical distress. N.T. p. 548.
48. In compliance with Mushalko’s directive, appellant left the RHU strip cage area and went to the main area of the RHU to find two cells for the inmates. N.T. pp. 533, 537-538; AA Ex. 12.
49. In the main RHU, appellant directed his subordinates to assist him with making cell moves. N.T. p. 534.

50. Appellant found a cell for Inmate Smith and began to find one for Inmate Briggs. N.T. pp. 544-545.
51. Appellant returned to the main area of the RHU to continue the process of finding two cells. AA Ex. 12.
52. At approximately 15:28 minutes on the “RHU strip cage handheld” video, there is a radio transmission indicating Inmate Smith is being moved from the shower cage to a cell. AA Ex. 12.
53. At approximately 17:23 minutes, just over two minutes later, the “RHU strip cage handheld” video, shows appellant returning to the RHU strip cage. Appellant called Security Team Officer Jeffrey Trait and asked him to turn on the CCTV camera. N.T. pp. 87-89, 103-104, 552-553, 544-546, 614-615; AA Ex. 12.
54. After the CCTV camera was on and aimed at Inmate Briggs, appellant directed Vance to stop filming. N.T. pp. 547-548; AA Ex. 12.
55. Appellant returned to the main area of the RHU and continued following his orders to find a cell for Inmate Smith. N.T. pp. 549-550.

56. The “Briggs RHU strip search cage, dxa video” shows appellant entering the RHU strip cage camera view. He is on the phone to the medical unit. Appellant did not use the radio to contact medical. N.T. pp. 78, 553, 560, 583-584; AA Ex. 12.
57. Nurse Kimmel answered the telephone; appellant asked to speak with Nurse Susan Klinger, who had cleared Inmate Briggs to be housed in the RHU, and was advised she was not currently in the medical unit. N.T. pp. 554, 615-616.
58. Appellant asked to have Klinger call him back as soon as she returned to the medical unit. N.T. pp. 259, 554, 615-616.
59. Appellant did not tell Nurse Kimmel they needed medical personnel in the RHU or that there was an emergency. He did not direct anybody to come to the RHU. N.T. pp. 232, 293, 295, 304, 554.
60. Appellant telephoned Mushalko to inform him Inmate Briggs was having a medical problem. N.T. p. 568; AA Ex. 12

61. Klinger returned appellant's call and stated she had cleared Inmate Briggs, who was "playing" while in medical and stated Inmate Briggs had been cleared to be housed in the RHU. N.T. pp. 554-555, 562; AA Ex. 12.
62. Appellant informed Klinger it appeared Inmate Briggs was having "a medical condition" and asked her to get to the strip cage right away. He did not tell Klinger it appeared to be a medical emergency. N.T. pp. 232, 323, 562-563, 585.
63. While waiting for medical to arrive, appellant knew he had to get Inmate Briggs out of the strip cage. N.T. pp. 564-656.
64. Appellant called for the keys to the strip cage, retrieved a transport chair, and made sure cameras were filming Inmate Briggs. N.T. pp. 568, 593, 616.
65. Less than one minute after returning to the RHU strip cage and while waiting for medical, appellant directed the RHU strip cage door to be opened. N.T. pp. 89, 593-594, 616; AA Ex. 12.

66. When the strip cage was opened, appellant did not assess Inmate Briggs, perform CPR, check for a pulse, or provide rescue breaths. The “RHU to medical handheld” video shows appellant getting Inmate Briggs onto a restraint chair and out of the RHU strip cage. N.T. pp. 89, 323, 564-565, 593-594, 616; AA Ex. 12.
67. At approximately thirty-three seconds into the “RHU to medical handheld video,” as the Corrections Officers were wheeling Inmate Briggs out of the RHU, Kimmel entered the RHU area. N.T. pp. 106, 564, 616; AA Ex. 12.
68. Kimmel questioned Inmate Briggs and, after getting no response, began performing CPR. Kimmel appeared to be startled and surprised by Inmate Briggs’ medical condition. AA Ex. 12.
69. Inmate Briggs was wheeled out of the RHU to the medical area. AA Ex. 12.
70. In the medical area, appellant assisted in performing CPR on Inmate Briggs. N.T. p. 112; AA Ex. 12.
71. On November 11, 2019, appellant filled out an Extraordinary Occurrence Report. AA Ex. 13.

72. On November 15, 2019, appellant attended a Pre-Disciplinary Conference. N.T. pp. 36, 278-280.
73. On January 23, 2020 appellant completed a Staff Written Statement. AA Ex. 16.
74. On March 9, 2020, Chief of Investigations Harold Kertes completed his investigative report. N.T. p. 61; AA Ex. 11.
75. On March 24, 2020, appellant attended a Pre-Disciplinary Conference. N.T. pp. 278-280; Comm. Ex. C.

DISCUSSION

At issue before the Commission is whether the appointing authority has established just cause for appellant's removal. The appointing authority charged appellant with multiple violations of the Code of Ethics (hereinafter "COE") asserting appellant failed to provide intelligent, humane, and impartial treatment of Inmate Briggs and subsequently submitted incomplete, misleading, and self-serving reports and statements to investigators. The appointing authority did not charge appellant with any other COE or policy violations.

The appointing authority bears the burden of proving just cause for removal of an employee and also must prove the substance of the charges underlying the removal. *Long v. Commonwealth of Pennsylvania Liquor Control Board*, 112 Pa. Commw. 572, 535 A.2d 1233 (Pa. Commw. 1988). Factors supporting the just cause removal of a civil service employee must be related to the employee's job performance and touch in some logical manner upon the employee's competency and ability to perform his job duties. *Woods v. State Civil Service Commission*, 590 Pa. Commw. 337, 912 A.2d 803 (2006).

The appointing authority presented the testimony of Human Resource Officer Ann Somers, Chief of Investigations Harold Kertes, and Superintendents Eric Tice and Barry Smith. Appellant testified on his own behalf.

As background, appellant served eight years in the United States Air Force and twelve years in the active reserves before beginning employment with the appointing authority in 1994. N.T. pp. 440-441. On November 11, 2019, appellant was filling in as the Restricted Housing Unit (hereinafter "RHU") Lieutenant on the 2:00 p.m. to 10:00 p.m. shift. N.T. p. 484. November 11, 2019 was the Veteran's Day holiday. Because of the holiday, the staff levels at the facility were reduced in comparison to a non-holiday shift. N.T. pp. 486, 529-530.

When appellant heard there was a fight between two inmates, Inmate Briggs and Smith, he knew he needed to provide assistance and went to the medical unit to speak with both inmates. N.T. pp. 493-509; AA Exs. 11, 12; Ap. Ex. 1.

Appellant obtained information from Inmate Smith, but Inmate Briggs did not respond to questions. N.T. pp. 502-505; AA Ex. 12. After about a minute with Inmate Briggs, appellant returned to Inmate Smith to act as the Officer for his escort from medical to the RHU. N.T. pp. 507-508.

In the RHU, while Inmate Smith was in the strip cage, appellant heard over the radio that the escort for Inmate Briggs from medical to the RHU was starting. N.T. pp. 515, 555; Ap. Ex. 1. Because there is only one strip cage in the RHU, appellant had Inmate Smith relocated to the shower cell in order to avoid further conflict between the inmates. N.T. pp. 517-518. Inmate Smith refused to share a cell with any inmate and, as a result, appellant needed to move inmates to make cells available for both Inmate Smith and Inmate Briggs. N.T. pp. 175, 517. Appellant was not present and did not participate in Inmate Briggs escort from medical to the RHU. Thus, he did not observe Inmate Briggs condition or behavior during that escort. AA Ex. 12.

Based upon the video evidence, the parties do not dispute the following facts: The escort team carried Inmate Briggs to the RHU strip cage and placed him in the RHU strip cage. N.T. pp. 78, 519-521, 524-525; AA Ex. 12. Several Corrections Officers informed appellant, “medical said he was fine,” breathing and conscious, refusing to walk on his own, not cooperating, “playing,” and “being noncompliant.” N.T. pp. 100, 521, 527; AA Ex. 12. This was consistent with appellant’s brief encounter with Inmate Briggs in the medical unit. On the video, appellant is heard talking to Inmate Briggs and receiving no response. N.T. p. 524; AA Ex. 12. Appellant contacted his supervisor, Captain Mushalko, and stated that

Inmate Briggs was not compliant, had not cooperated with the escort team, and Inmate Smith was currently in the shower cell, refusing a cell mate. N.T. p. 530; AA Ex. 12. Appellant released the escort team with the exception of Corrections Officer Vance and directed her to continue filming Inmate Briggs; he also directed Corrections Officer Cara to watch over the inmate. N.T. pp. 535-536, 529-530, 535; AA Ex. 12.

In compliance with Mushalko's directive, appellant returned to the main area of the RHU and found a cell for Inmate Smith. N.T. pp. 533-538, 544-545; AA Ex. 12. Appellant returned to the RHU strip cage approximately seventeen minutes later, directed Security Team Officer Trait to turn on the CCTV, and directed Vance to turn off the handheld camera. N.T. pp. 103-104, 544-548; AA Ex. 12. Appellant left the strip cage area and returned to the main RHU where he continued following his orders to find a cell for Inmate Smith. N.T. pp. 549-550.

The video evidence also shows appellant returned to the RHU and almost immediately placed a phone call to medical regarding Inmate Briggs' condition. N.T. pp. 78, 553, 560, 583-585; AA Ex. 12. Although appellant wanted to speak with Nurse Klinger, because she had cleared Inmate Briggs to go to the RHU, she was unavailable and appellant did not tell the nurse to whom he spoke that the issue was potentially emergent. Instead, he asked that Klinger call him back. N.T. pp. 232, 259, 293, 304, 554, 615-616. When Klinger returned his phone call, she confirmed her opinion that Inmate Briggs had been "playing" and she stated she had medically cleared him to be housed in the RHU. N.T. pp. 554-555, 562. Appellant told Klinger Inmate Briggs was having "a medical condition" and asked

her to get to the RHU strip cage “right away.” N.T. p. 232, 323, 562-563, 585. Appellant also phoned Mushalko and advised him Inmate Briggs was having a medical problem. N.T. p. 568; AA Ex. 12. Further undisputed video shows appellant opened the RHU strip cage, put Inmate Briggs into a restraint chair, and began to wheel him out of the RHU toward the medical unit. AA Ex. 12. Appellant eventually assisted in the performance of CPR in the medical unit. AA Ex. 12.

To support its just cause argument, the appointing authority asserts appellant’s lack of leadership and failure to respond to Inmate Briggs’ medical distress for forty-four minutes constituted a failure to do anything positive or provide intelligent, humane, and impartial treatment of Inmate Briggs in violation of Section B-1 of the COE.

On behalf of the appointing authority, Chief of Investigations Kertes explained his investigation led to the conclusion that appellant failed to get Inmate Briggs needed medical attention and, instead, appellant left the inmate in the RHU strip cage while handcuffed and nearly on his stomach. N.T. p. 126. According to Kertes, this constituted mistreatment of the inmate. N.T. p. 126. Kertes opined appellant’s decision to call medical did not constitute doing anything “positive” for the inmate because he did not indicate there was an emergency or state they needed assistance immediately. N.T. p. 153.

Kertes also stated appellant’s decision to leave Inmate Briggs unattended for forty-four minutes constituted inhumane treatment and “could” be considered brutal treatment. N.T. pp. 179-180. According to Kertes, appellant

should have been aware Inmate Briggs' condition had deteriorated between medical and the RHU strip cage. N.T. pp. 247-248. He stated the primary violation of COE Section B-1 is the "inactions to have Inmate Briggs taken care of when he should have [been cared for] immediately and not forty-four minutes later." N.T. p. 199. Kertes also opined appellant's failure to perform CPR or direct any other staff member to do so from the time the RHU strip cage opened and Nurse Kimmel arrived constituted a violation of the COE Section B-1. N.T. pp. 184, 234.

Superintendent Tice testified appellant violated Section B-1 of the COE because he failed to ensure the safety of the inmate, which ultimately led to the inmate's death. N.T. pp. 280-281. Tice opined appellant had "many opportunities" to provide care and aid. N.T. p. 281. To expand upon his assertion, Tice testified appellant should have contacted medical when Inmate Briggs arrived even if he felt Inmate Briggs was feigning a medical condition. N.T. p. 287. Tice testified appellant should have conducted a suicide risk assessment, which may have alerted him to a medical issue. N.T. p. 288. Tice testified appellant did not have Inmate Briggs assessed immediately, did not direct any Corrections Officer to open the strip cage, and take Inmate Briggs to the RHU triage or call medical in a timely manner. N.T. pp. 286-287, 289. To clarify, Tice testified that appellant was the sole supervisor on duty when Inmate Briggs arrived in the RHU and should have contacted medical immediately. N.T. p. 323. Instead, Tice testified, appellant allowed Inmate Briggs to lie on the ground handcuffed for forty-four minutes, then, after opening the RHU strip cage, did not perform CPR, check for a pulse, or provide either rescue breaths or chest compressions. N.T. p. 323.

Superintendent Smith testified appellant's violation of COE Section B-1, even without the additional charges, provides sufficient just cause for removal. N.T. p. 379. He opined nothing positive was done for Inmate Briggs, who was incapable of stating he was in medical distress. N.T. p. 379. Upon Inmate Brigg's arrival, appellant should have been aware the inmate may have been in medical distress. N.T. p. 424. Later, when the RHU strip cage was opened, Inmate Briggs appeared to already be deceased. N.T. p. 428. Despite the fact that Inmate Briggs was already deceased, Smith opined appellant should have rendered immediate medical aid, but failed to do so. N.T. pp. 381, 428-429. According to Smith, appellant's inaction was "extremely dangerous" because it could lead to a volatile situation with inmates and jeopardize staff safety. N.T. pp. 381-382. Furthermore, Smith testified appellant's decision to call medical would only constitute doing something positive for the inmate if it had resulted in a successful, timely outcome. N.T. pp. 399-400. He further opined appellant's decisions to keep cameras on the strip cage did not constitute a positive action because he did not properly act when the inmate arrived at the RHU. N.T. p. 403. In this instance, Smith testified, calling medical at the appropriate time, when Inmate Briggs arrived at the RHU, would have constituted a positive act. N.T. p. 403. According to Smith, appellant's inaction jeopardized the safety and welfare of staff and inmates. N.T. pp. 408-409.³

In response to the charge, appellant stated he had no knowledge Inmate Briggs had asthma or had been treated in the medical unit with an inhaler; he knew Inmate Briggs to be a healthy young man, participating in sports and running in the

³ In it's Brief, the appointing authority argues appellant violated Policy 6.3.1. However, the appointing authority did not include a violation of Policy 6.3.1 in the April 24, 2020 removal letter. Comm. Ex. C. Therefore, this issue is not before the Commission.

yard. N.T. pp. 506, 549. When Inmate Briggs arrived at the RHU strip cage, appellant relied upon the information from the escort team that he was “playing,” acting up, not cooperating. N.T. pp. 527-528. When Inmate Briggs was in the RHU strip cage, he called his supervisor, Captain Mushalko and was then ordered to proceed to get a cell ready for Smith, then return to process Inmate Briggs. N.T. p. 533; AA Ex. 12. Appellant directed Corrections Officers Cara and Vance to remain on the scene observing and filming Inmate Briggs. N.T. p. 535. Appellant relied upon Corrections Officer Cara to report any necessary information and let him know if he needed to return to the RHU strip cage. N.T. p. 535.

Subsequently, appellant returned to the RHU strip cage, saw Inmate Briggs moving, believed he was “sleeping,” and saw no indication of medical distress. N.T. p. 548. Appellant directed the handheld camera to be turned off and the CCTV camera be turned on. N.T. p. 522. After the CCTV camera was on, appellant continued following Mushalko’s orders to find a cell for Inmate Smith. N.T. p. 522. Later, when appellant was called back to the scene, he immediately phoned the medical department. N.T. pp. 78, 553, 560, 583-584; AA Ex. 12. While waiting for the medical personnel to arrive, appellant directed staff to open the RHU strip cage door and began removing Inmate Briggs. N.T. pp. 89. 593-594; AA Ex. 12. The strip cage is small and there was no room for appellant or any Corrections Officer to enter in an effort to perform life saving measures. N.T. pp. 564-565, 616; AA Ex. 12.

Upon review of the testimony and evidence, the Commission finds the appointing authority has presented sufficient evidence to support the charge of violating Section B-1 of the COE only. Based upon events depicted in the video,

the credible testimony of the appointing authority's witnesses, and appellant's own testimony, it is clear appellant could have acted with a greater sense of urgency in assessing Inmate Briggs' condition and seeking medical intervention. Appellant did not complete a suicide checklist which may have alerted him to a medical crisis. Appellant also should have used the radio to communicate the fact that Inmate Briggs' may have been in medical distress. In addition, during his first call to medical, appellant should have conveyed there was a potential medical emergency. There is no evidence to support the appointing authority's claim that appellant's conduct "led to the inmate's ultimate passing." N.T. p. 281. The appointing authority did not present any medical evidence or testimony pertaining to the timing or cause of Inmate Briggs' death. Nonetheless, we conclude that appellant's efforts fell short of the COE standard.

While appellant made multiple errors, his behavior does not rise to the level of either brutal or inhumane treatment of Inmate Briggs. Contrary to Kertes' and Tice's testimony, there was no logical reason appellant should have known Inmate Briggs' medical condition could deteriorate to such a dramatic degree between the time he left the medical unit and his arrival at the RHU strip cage. Appellant was not part of the escort team from medical to the RHU strip cage. When Inmate Briggs' escort team arrived at the RHU strip cage, they reported to the appellant Inmate Briggs was "playing," had been cleared by medical, and was being noncompliant. The appointing authority provided no evidence appellant should have doubted the reliability of his coworkers.

Appellant relied upon his prior knowledge of seeing Inmate Briggs as a healthy inmate in the yard, and the statements of the escort team stating he was uncooperative, playing, and cleared by medical. He had no prior knowledge of

Inmate Briggs' asthmatic condition or treatment in medical with an inhaler. Moreover, appellant was not constantly observing Inmate Briggs because he was following Captain Mushalko's orders to prepare a cell for Inmate Smith. He did, however, ensure that the inmate was under constant observation and being filmed.

Contrary to the appointing authority's timeline, appellant did not leave Inmate Briggs unattended for "forty-four minutes." N.T. p. 323. While appellant was not physically on site, he directed Corrections Officer Cara to observe, Corrections Officer Vance to continue filming, and later directed the use of the CCTV cameras. When appellant was notified of a potential medical issue, he returned to the RHU strip cage and immediately contacted medical. Within minutes of appellant returning to the RHU strip cage, Inmate Briggs was removed from the cell. The videotaped reaction of Nurse Klinger to Inmate Briggs' rapid deterioration is instructive. Nurse Klinger was the medical professional who had cleared Inmate Briggs to be housed in the RHU; she was aware of his asthmatic condition and yet she appears startled and surprised by his rapid deterioration. AA Ex. 12.

The record is clear that appellant did perform some positive acts for the inmate. Although not thorough or indicative of an emergency, given the information he had available to him at the time, the appellant's behavior does not constitute brutal or inhumane treatment of Inmate Briggs. Such conduct is also contrary to his employment history, which includes no prior discipline and multiple accolades for intervening to assist inmates in distress. N.T. pp. 456-460. Thus, while appellant's decisions do constitute a violation of COE Section B-1, his errors do not rise to the level of either brutality or inhumane treatment.

The appointing authority also asserts appellant failed to treat peers, supervisors, and the public with respect in violation of Section B-10 of the COE. Kertes testified appellant's conduct was unprofessional because he failed to get medical attention for nearly forty-four minutes. N.T. p. 127. According to Kertes, when appellant realized Inmate Briggs was in medial distress, he acted unprofessionally by failing to initiate CPR. N.T. p. 127.

Superintendent Tice testified appellant's conduct violated Section B-10 of the COE because his "failure" resulted in discipline for other staff. N.T. p. 282. Specifically, he did not provide clear direction to his subordinates, resulting in many of them being suspended and put in harm's way. N.T. p. 343. Tice did not provide an example of any unclear directions.

Superintendent Smith testified appellant should have used the radio because doing so immediately notifies control, medical, and all staff of an emergency situation. N.T. p. 640. As a result, it increases the response time because all necessary personnel are advised simultaneously and there is no need for a multitude of individual phone calls. N.T. pp. 640, 643.

In response, appellant testified he provided directions to the staff and remained professional at all times. N.T. p. 570. At all times he acted in what he believed to be the best interests of both Inmate Briggs and Inmate Smith and followed Mushalko's orders. N.T. p. 571. However, appellant acknowledges he did not complete a suicide checklist for Inmate Briggs. N.T. pp. 577, 594, 622. Appellant also acknowledges he did not use the radio to call for a medical

emergency. N.T. pp. 583-584. According to appellant, he did not want to use the radio because it poses a security risk when inmates know of staff movements within the facility. N.T. p. 624.

The Commission finds the appointing authority has not presented sufficient evidence to support the charge of violating Section B-10 of the COE by acting in a manner that disrespected his peers, supervisors, or the public. The appointing authority has not presented any evidence to show any person in the public, inmate's family, or any employee complained about appellant's conduct. In addition, the Commission has already discounted the forty-four-minute timeline Kertes put forward. The Commission already determined appellant's rationale regarding his decision to get Inmate Briggs out of the cell without initiating CPR is credible and supported by the video evidence.

We next turn to the appointing authority's charge that appellant submitted incomplete, misleading, and self-serving reports in violation of Section B-22 of the COE. Specifically, Kertes and Tice assert appellant's report misrepresented the facts because he indicated Inmate Briggs was noncompliant, when, in fact, he was in medical distress. N.T. pp. 210, 283.

Kertes testified appellant's Extraordinary Incident Report inaccurately reported the inmate was moaning and moving, in contradiction to the video footage. N.T. pp. 131, 210; AA Ex. 13. Kertes also asserted appellant should have told Mushalko that Inmate Briggs was in medical distress, thus his report is inaccurate. N.T. pp. 217-218, 226.

In response, appellant testified he provided information that was truthful and accurate to the best of his knowledge. N.T. p. 574. He did not enter facts he believed to be false or misrepresent facts. N.T. p. 574. The appointing authority argues the report omits completing a suicide checklist for Inmate Smith, rendering the report incomplete. N.T. p. 603. Appellant replies by acknowledging he did not specifically state he completed a suicide checklist; however, he does indicate Inmate Smith cooperated with the strip search. N.T. p. 603. The suicide checklist is part of the strip search process (N.T. pp. 288, 622, 639) and, therefore, appellant's report is broad, but not inaccurate.

The Commission finds the appointing authority has not presented sufficient evidence to support a charge that appellant submitted incomplete, misleading, and self-serving reports in violation of Section B-22 of the COE. As previously stated, appellant relied upon and conveyed information from the escort team that Inmate Briggs was noncompliant. Additionally, a review of the video tape shows Inmate Briggs does make movements while being placed in the RHU strip cage. AA Ex. 12. While the amount of noise on the video tape makes it unclear whether any of the sounds are from Inmate Briggs, the appointing authority presents no reason why appellant would lie on his report when he knows there is a handheld camera filming the entire incident. Furthermore, as also indicated above, appellant had no reason to doubt the reliability of the escort team's assessment, the release by medical, and his own prior knowledge of Inmate Briggs' health. The appointing authority implicitly argues appellant actually did know Inmate Briggs was in acute medical distress, maliciously ignored his condition, and subsequently lied about his knowledge. There is no evidence in the record to support this claim. The Commission finds appellant credible that he provided accurate and truthful information to the best of his knowledge. He was fully aware of both a handheld

camera and, at a later time, the CCTV camera because he directed their continued use. The appointing authority has not presented any evidence or testimony to indicate appellant tried to cover up any of his conduct.

Finally, the appointing authority asserts appellant violated Section B-29 of the COE because he provided answers that were self-serving and omitted facts. To support this argument, Tice asserts appellant's statements did not match the video of the incident. N.T. pp. 283-284. Tice also asserts appellant's report did not align with the reports provided by other staff members. N.T. pp. 283-284.

In response, appellant testified he cooperated with the investigation and provided responses that were complete and truthful. N.T. p. 575.

Upon review of the record, the appointing authority has not presented sufficient evidence to support a charge that appellant provided answers during the investigation that were self-serving and omitted facts in violation of Section B-29 of the COE. As noted above, the issue of whether or not appellant lied during the investigation turns on whether he held a sincere belief that Inmate Briggs was being intentionally uncooperative and feigning distress. Based on the evidence presented appellant clearly relied upon the information provided by the escort team and his own knowledge of Inmate Briggs' apparent youth and health.

In summation, the Commission finds the appointing authority presented sufficient evidence to support the charge of failing to provide intelligent treatment to Inmate Briggs in violation of COE Section B-1 of the COE. The Commission finds the appointing authority has not presented sufficient evidence to support any

of the remaining charges. Because the appointing authority has presented sufficient evidence to support only one of the four charges, the Commission modifies the removal to a sixty (60) day suspension.⁴ Accordingly, we enter the following:

CONCLUSIONS OF LAW

1. The appointing authority has presented evidence establishing good cause for suspension under Section 2603 of Act 71 of 2018.
2. The appointing authority has failed to present evidence establishing just cause for removal under Section 2607 of Act 71 of 2018.

ORDER

AND NOW, the State Civil Service Commission, by agreement of its members, orders that the removal action imposed by the State Correctional Institution at Mahanoy, Department of Corrections be set aside and a sixty (60) day

⁴ *Department of Corrections v. State Civil Service Commission (Clapper)*, 842 A.2d 526, 533 (Pa. Commw. 2004) (The Commission has the authority to modify the penalty to make it consistent with such charges as have been established by the credible evidence of record). Section 3003(8)(iii) of Act 71, as amended, provides:

If an employee is removed, furloughed, suspended or demoted, the Commission may modify or set aside the action of the appointing authority. If appropriate, the Commission may order reinstatement, with the payment of the salary or wages lost, including employee benefits, as the Commission may in its discretion award.

suspension be imposed. The Commission further directs that the appointing authority amend its records to reflect a suspension of sixty (60) workdays, effective November 15, 2019, and orders the return of appellant to regular Corrections Officer 3 employment within thirty (30) calendar days. We further award appellant reimbursement of such wages and emoluments as he would have earned had he worked as a Corrections Officer 3 from November 15, 2019, less wages earned and benefits received under the Public Laws of Pennsylvania as established by a sworn statement to be submitted by appellant to the appointing authority. We further order that within thirty (30) calendar days of the mailed date of this opinion, the appointing authority shall submit written notice of compliance with this Order to the Executive Director of the State Civil Service Commission.

State Civil Service Commission

Maria P. Donatucci
Chairwoman

Gregory M. Lane
Commissioner

Bryan R. Lentz
Commissioner

Mailed: September 27, 2022