

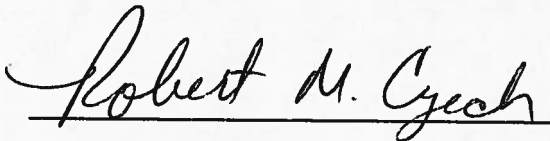
ORDER

The Civil Service Commission finds that the action of the appointing authority in removing the appellant was not justified. The Commission therefore reverses that action and grants the appeal of Robert Lacaillade. The Commission further orders that appellant be granted back pay, benefits, and seniority for the period of separation to the actual date of reinstatement. The amount of back pay awarded is to be reduced and mitigated as provided for in *N.J.A.C. 4A:2-2.10*. Proof of income earned shall be submitted by or on behalf of the appellant to the appointing authority within 30 days of issuance of this decision.

The Commission further orders that counsel fees be awarded to the attorney for appellant pursuant to *N.J.A.C. 4A:2-2.12*. An affidavit of services in support of reasonable counsel fees shall be submitted by or on behalf of the appellant to the appointing authority within 30 days of issuance of this decision. Pursuant to *N.J.A.C. 4A:2-2.10* and *N.J.A.C. 4A:2.12*, the parties shall make a good faith effort to resolve any dispute as to the amount of back pay and counsel fees. However, under no circumstances should the appellant's reinstatement be delayed pending resolution of any potential back pay or counsel fee dispute.

The parties must inform the Commission, in writing, if there is any dispute as to back pay and counsel fees within 60 days of issuance of this decision. In the absence of such notice, the Commission will assume that all outstanding issues have been amicably resolved by the parties and this decision shall become a final administrative determination pursuant to *R. 2:2-3(a)(2)*. After such time, any further review of this matter shall be pursued in the Superior Court of New Jersey, Appellate Division.

DECISION RENDERED BY THE
CIVIL SERVICE COMMISSION ON
APRIL 1, 2015



Robert M. Czech
Chairperson
Civil Service Commission

**Inquiries
and
Correspondence**

**Henry Maurer
Director
Division of Appeals
and Regulatory Affairs
Civil Service Commission
Unit H
P. O. Box 312
Trenton, New Jersey 08625-0312**

attachment



State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NO. CSR 10240-14

AGENCY DKT. NO. NA

CSC DKT # 2015-405

**IN THE MATTER OF ROBERT LACAILLADE,
BAYSIDE STATE PRISON.**

Frank Crivelli, Esq., for appellant (Pellettieri, Rabstein & Altman, attorneys)

**Christopher Kurek, Deputy Attorney General, for respondent (John J. Hoffman,
Acting Attorney General of New Jersey, attorney)**

Record Closed: February 3, 2015

Decided: February 19, 2015

BEFORE W. TODD MILLER, ALJ:

STATEMENT OF THE CASE

Appellant, Sergeant Robert Lacaillade (Lacaillade or appellant) appeals his removal effective August 1, 2014, from his employment as corrections officer with the New Jersey Department of Corrections – Bayside State Prison (DOC or BSP). Appellant was charged with a violation of N.J.A.C. 4A:2-2.3(a)6 (Conduct Unbecoming a Public Employee); N.J.A.C. 4A:2-2.3(a)7 (Neglect of Duty); N.J.A.C. 4A:2-2.3(a)12 (Other Sufficient Causes) to wit: HRB 84-17 (as amended), B-2, Neglect of Duty, loafing, idleness or willful failure to devote attention to tasks which could result in danger to persons and property; C-11 Conduct unbecoming an employee; D-7 Violation of an

Administrative Procedures and/or regulations involving safety and security; E-1 Violation of a rule, regulation, policy, procedure or administrative order.

The DOC asserts that on March 4, 2014, appellant allowed a constant watch inmate to be placed naked without a foam mattress, suicide gown or blanket contrary to the language found in BSP Policy BSP.CUS.001.000.191.

For the reasons stated below all charges against appellant are **DISMISSED**.

PROCEDURAL HISTORY

On May 30, 2014, appellant was served with a Preliminary Notice of Disciplinary Action (PNDA) (R-1). A departmental hearing was held on July 7, 2014. On or about August 1, 2014, a Final Notice of Disciplinary Action (FNDA) was served on appellant (R-2). Appellant was scheduled to be removed from his position effective August 1, 2014, the date of the FNDA. However, appellant was suspended on May 30, 2014, without pay. Appellant requested a fair hearing. The parties stipulated that appellant's salary would be reinstated on December 2, 2014 (see letter from appellant's counsel dated November 24, 2014).

This matter was filed at the Office of Administrative Law on August 8, 2014, for determination as a contested case, pursuant to N.J.S.A. 40A:14-202; N.J.S.A. 52:14B-1 to -15 and N.J.S.A. 52:14F-1 to -13. The first hearing date was scheduled for November 28, 2014. It was adjourned at the request of respondent's counsel due to prepaid vacation. A hearing was held on December 30, 2014 and January 20, 2015. The record remained open for closing submissions at the request of the parties. Submissions were received through February 3, 2015, and the record closed.

SUMMARY OF RELEVANT TESTIMONY

Sergeant Lacaillade was employed with the New Jersey Department of Corrections for approximately thirteen years. It's alleged that on March 4, 2014, Lacaillade allowed a constant (suicide) watch inmate to be "placed" in a constant watch cell without a foam mattress, suicide gown, or blanket (hereinafter clothing or wares). He is alleged to have violated BSP Policy BSP.CUS.001.000.191, entitled "Psychiatric Observation."

Lacaillade does not dispute that the inmate was left naked in the cell without his wares. The dispute herein centers on when and which specific officer was responsible for providing the inmate with his wares under the policy as it had been interpreted, practiced, and implemented by officers and management over numerous years. Bayside Internal Management Procedure (IMP) BSP.CUS.001.000.191, entitled "Psychiatric Observation," is the standing order that governs the placement of inmates in a constant watch status. Witnesses for appellant contend that the BSP medical staff makes the decision, if and when, the inmate will be issued a suicide smock/gown, a suicide mattress, and/or a suicide blanket. The DOC contends that inmates must receive a bare minimum allotment of wares immediately when placed in a protective cell. No medical order is necessary for receipt of the minimum wares.

On the date of the subject placement, the relevant portion of IMP BSP.CUS.001.000.191, Psychiatric Observation, read as follows:

IV. PROCEDURES

CONSTANT WATCH

This procedure is used for suicidal inmates. It is also used for inmates who decompensate, or are experiencing florid psychotic symptoms, or who pose an unacceptable level of risk of violence or self-harm.

Inmates shall be interviewed outside of their cells under the supervision of custody staff unless otherwise indicated.

Suicidal watch inmates are not granted any privileges (radio, TV, store orders and recreation). **A foam mattress, suicide gown and blanket will be the only items issued to inmates on this level unless ordered in writing by the psychologist or psychiatrist.**

An officer is assigned to monitor this inmate constantly. He is stationed outside of the inmates' cell/area. The officer will remain in visual observation of the inmate at all times except when properly relieved.

The officer performing the Suicide watch will complete a Constant Watch Observation Report as directed in 10A:16-12.6 showing the inmate's activity at random times. Use random times within each "15 minute block" ie. 7:12. 7:38 etc.

Copies of these forms will be forwarded to the Administrator, UMDNJ and the Major's Office.

The Constant Watch Inmate will be issued a Humane Safety Smock by the medical department. Upon removal from watch status, the Humane Safety Smock will be collected by the officer, placed in a laundry bag, for delivery to the laundry.

[R-16; emphasis added]

On March 4, 2014, Sergeant Lacaillade was assigned as staffing sergeant from 1:30 p.m. to 9:30 p.m. His duties and responsibilities were to run line-up, take attendance of general assignment and extra officers, perform uniform inspections, disseminate pertinent information and assign officers certain posts (break relief, emergency response, trips, special details etc.). Additionally, he was responsible for monitoring and running mass movements, coordinating with intake for "special" or unscheduled trips, such as detention transfers, medical transfers and medical trips. And when needed, Lacaillade was to assist with the institutional count, respond to emergency situations, and perform various other duties as assigned by the shift commander. The duties and responsibilities of a staffing sergeant are articulated in the Internal Management Procedure (R-15). Lacaillade testified he was familiar with this policy and followed same in carrying out his tasks and duties.

The staffing sergeant operates out of the command center or center control. Lacaillade described center control as the "nerve center" for custody operations and it is where the shift commander is located. On March 4, 2014, at approximately 1:35 p.m., center control received information that an inmate needed to be "placed" on "constant watch status". Lieutenant Pinder was the center commander on duty.

"Constant watch" is a term that delineates when a potentially suicidal inmate is removed from the general population and segregated in an individual cell. An officer is assigned to take the inmate from general population and place the inmate in a padded cell. "Placement" of the inmate is a distinct and separate task from watching the inmate. Once the placement of the inmate is made, the inmate is handed over to the constant watch officer. The constant watch officer stands guard and observes the inmate "one-on-one" to ensure that the inmate does not cause any harm to himself or, if he attempts to do so, the officer can respond promptly so the inmate can be stopped. The constant watch cells are located in the infirmary at BSP. The infirmary has its own staff and supervision.

On March 4, 2014, Lieutenant Pinder requested that Lacaillade "make the placement" of the inmate from his present location and "place" him in the padded cell at the infirmary. Lacaillade had never supervised the placement of an inmate. But, as a line officer, he participated in placing dozens of inmates into constant watch status.

The "placement procedure" began with Lacaillade taking compound patrol officers Romano and Byrd with him to retrieve and escort the inmate. All the officers left center control and walked to the west arcade where the inmate was located. Upon arriving at the west arcade Byrd and Romano entered the room and handcuffed the inmate. The inmate was pat-searched by Byrd and Romano. Lacaillade, Byrd, and Romano escorted the inmate to the infirmary. The nurse on duty gave the inmate a pre-placement exam, wherein his vital signs were checked and his arms, legs, knuckles, and face were checked for any injuries. The inmate was escorted from the exam room to the constant watch cell for placement, once the nurse's exam was completed.

When Lacaillade, Byrd, Romano and the inmate arrived at the constant watch cell, and the cell was searched to make sure nothing was present that the inmate could use to harm himself. All items were removed from the cell including the mattress and toilet paper as these present tripping hazards in the event of an altercation. The inmate was escorted to the far wall where the officers helped him to his knees. The handcuffs were removed and the inmate was instructed to remove his clothing for a body cavity/contraband search. As the inmate's clothing was removed, the clothing was searched by hand and tossed from the cell into the hallway. When the search was completed, the inmate was then ordered back to his knees with his hands on his head facing the wall. The officers backed out of the cell and the door was closed and locked. At this point in time, the "placement procedure" was complete. Management and supervision of the inmate was now with the officers and supervisors in charge of the infirmary. Most of the placement was depicted on the video evidence (R-22).

Lieutenant David Smith (Smith) testified. Smith retired from the DOC on December 1, 2014. He served his entire twenty-five year career at Bayside. Lieutenant Smith served as a center commander at Bayside for approximately five years. Smith confirmed that it was the commander's duty and responsibility to ensure that a constant watch inmate received the items he was entitled to as outlined in the doctor's orders. Indeed, he also testified that the practice and procedure followed at Bayside was that the inmates were always placed naked in the padded cell and would not receive any wares until the doctor's order was completed and distributed throughout the prison.

Senior Correction Officers Peter Ballurio (Ballurio), Tom Togno (Togno), and Sergeant Nathan Canion (Canion) testified with respect to the procedures that are followed for placement of constant watch inmates. Ballurio and Togno work at Bayside, while Canion worked at Bayside prior to being promoted to the rank of correction sergeant in 2014. All three of these officers testified that they have placed hundreds of inmates in constant watch status at Bayside. All three officers were consistent in stating that the inmates are left in the constant watch cell naked with nothing at the time of placement unless the doctor's order contained in the suicide watch notice is finalized, issued, and disseminated to custody staff. All three understood the policy and practice

to be, based upon their training and experience developed over time, that only the medical staff that had the power and authority to issue wares to inmates on constant watch. This practice was developed for the safety and protection of the inmate and officers due to the complex nature of mental health matters.

Lacaillade testified regarding the placement protocol he used on the subject date was consistent with the DOC procedures/policy and consistent as delineated by Smith, Ballurio, Togno and Canon. When Lacaillade, Byrd, and Romano placed the inmate into the constant watch cell, no one was in possession of the written suicide watch notice which authorized the items the inmate was entitled to receive. Therefore, for his own safety and the safety of the officers, the inmate was left with nothing in the cell as had been practiced for years at BSP.

Lacaillade also testified that this procedure was followed due to the fact that custody personnel do not have the power and/or authority to make medical decisions regarding what a constant watch inmate can or cannot receive. If inmates were issued items by custody staff that they were not entitled to possess, and the inmate was injured as a result of the same, members of the custody staff would be disciplined for their unauthorized actions.

If the constant watch inmates were issued items they were not authorized to receive, custody staff would have the responsibility of retrieving the items at a later time. Retrieving unauthorized items from the constant watch cell is/can be a dangerous and complicated task. It requires reentry into the padded cell by a fully protected special team, if the inmate was not compliant with returning the items. Inmates are reluctant to surrender items already in their possession. Custody staff would have to enter the cell and forcibly retrieve the same, thereby placing the inmate and/or custody staff at risk of injury. Thus, the practice and procedure at BSP has, for many years, been to place the inmate in his cell naked with no suicide smock, blanket, and/or bedding until authorized by medical personnel.

Here the suicide watch notice was prepared and executed by Dr. Judith McGhie (R-9). Dr. McGhie authorized the inmate to have a "suicide gown," a "suicide mattress,"

and "finger foods" while on constant watch. The inmate was not authorized to have a suicide blanket by McGhie. Had the placement and custody officers followed the policy as interpreted by the DOC, the inmate would have been provided with a suicide blanket, contrary to the Dr. McGhie's order.

A Preliminary Incident Report ("PIR or Report) is required to be completed, when the placement is finished. The report details the inmate's movement from general population to the infirmary for constant watch. Lacaillade needed to attach a copy of the suicide watch notice from Dr. McGhie to the report as evidence that the inmate was ordered on constant watch. When Lacaillade returned to center control after completing some of his other staffing sergeant duties, he turned to completing his report for the constant watch placement. Notably, center control still had not received the suicide watch notice from Dr. McGhie delineating what wares the inmate was entitled to receive.

Lacaillade placed two calls to the mental health staff. An earlier notice was apparently misplaced, lost or not sent. Dr. McGhie testified that she provided officer Mills with verbal notice followed by the official written suicide watch notice. The suicide watch notice was finally faxed to central control at 3:32 p.m., approximately two hours after the placement was made (R-9). Lacaillade fact-checked the doctor's order to ensure he placed the correct inmate on constant watch status. He then attached the doctor's order to his report and handed the full report to Center Commander, Lieutenant Mikus. Lacaillade's responsibilities to the inmate were concluded at this point.

Lieutenant Mikus (Mikus) testified. Mikus took over center control for Lieutenant Pinder at about 2:00 p.m. Mikus explained that it was his responsibility to distribute the PIR and doctor's order in the suicide watch notice and follow-up to ensure the inmate received the wares authorized by Dr. McGhie. Lieutenant Mikus confirmed that Lacaillade's responsibility to the inmate ended once he was placed in the constant watch cell and the door was closed. Lacaillade's responsibility shifted back to his normal assignment and responsibilities as the staffing sergeant. Lacaillade had no duty to follow-up and see if the inmate received his wares because Lacaillade was the

staffing sergeant assigned to center control. Those duties were left to the constant watch officer or infirmary supervisor and ultimately the center commander.

Associate Administrator Willie Bonds (Bonds) testified on behalf of DOC. Bonds was involved in the investigation. Bonds reviewed the video surveillance depicting the inmate placement in the constant watch cell, which shows the existing suicide mattress in the cell being removed (R-22). Bonds noted that the inmate was in the constant watch cell for approximately twenty-four hours, naked, without a suicide gown or mattress.

Major David Redman (Redman) testified on behalf of DOC. Redman explained that the inmate should have been provided with a suicide mattress, suicide gown, and suicide blanket at the time he was placed in constant watch pursuant to the Psychiatric Observation Internal Management Procedure (IMP), BSP.CUS.001-000.191 (R-16). The sergeant who supervised the placement (appellant) should have been familiar with the policy and ensured the inmate received the wares for which he was entitled. Appellant should have followed up in some fashion to ensure that once the suicide watch notice was received; the inmate received the items provided by in the notice. Redman acknowledged that the infirmary (trailer) sergeant was responsible for the infirmary area where the inmate was on constant watch. Redman also acknowledged that the psychiatric observation policy was amended after this incident and that the revised policy now specifies that the custody supervisor making the placement is responsible for ensuring that the inmate receives the items listed in the suicide watch notice, i.e., the doctor orders (A-3).

During cross-examination, Major Redman testified that IMP BSP.CUS.001.000.191 - Psychiatric Observation was unclear in regard to who had the responsibility or authority to issue items to inmates placed on constant watch and which items the inmates were to receive. Major Redman was asked if he was aware of the practice that was in place at BSP as described by Lieutenant David Smith, Sergeants Canion and Lacaille as well as Senior Correction Officers Ballurio and Togno. Major Redman was not aware of the particular procedure, as described by these officers, was

being utilized, but indicated that he had not placed an inmate on constant watch status for many years.

In April 2014, Psychiatric Observation policy was substantially amended because of this incident. The relevant portion of the amended IMP now reads as follows:

IV. PROCEDURES

CONSTANT WATCH

This procedure is used for suicidal inmates. It is also used for inmates who decompensate, or are experiencing florid psychotic symptoms, or who pose an unacceptable level of risk of violence or self-harm. Inmates shall be interviewed outside of their cells under the supervision of custody staff unless otherwise indicated.

Inmates placed on suicide watch shall always be given a suicide gown, suicide mattress and a suicide blanket immediately upon placement. The custody supervisor making the placement of the inmate on constant watch shall ensure each of these items is provided. These items are not to be removed, nor additional items given unless directed in writing by the psychiatrist/nurse practitioner, a psychologist or Licensed Clinical Social Worker or a Registered Nurse (either of which would be in consultation with a psychologist or psychiatrist/nurse practitioner).

Once a written copy of the order is submitted by the psychiatrist, the constant watch officer shall maintain a copy of this order on post until the inmate is released from watch.

[A-3; emphasis added in bold Italicized to indicate changes and additions that were made when the IMP was revised in April, 2014.]

The amended IMP now clearly places the responsibility on the supervising officer making the placement to ensure the inmate is provided with a suicide gown, blanket, and mattress upon placement.

FINDINGS OF FACT

1. Appellant Lacaillade was employed with the DOC for approximately thirteen (13) years and was assigned to Bayside State Prison.
2. Lacaillade held the rank of sergeant.
3. Lacaillade was assigned as a staffing sergeant. 1:30 p.m. to 9:30 p.m. on the date of the incident. His duties are clearly described in the BSP policy (R-15). There is no mention of specific duties associated with the placement of a constant watch inmate.
4. Lacaillade was based out of center control. At 1:35 p.m. on March 4, 2014, center control received information that an inmate needed to be placed on constant watch status. Lacaillade was requested by the Commander Lieutenant Pinder to make a protective placement of a possible suicidal inmate.
5. Lacaillade, along with Officers Byrd and Romano, left center control and walked to the west arcade to complete the placement. Pursuant to protocol, the cell was searched to make sure nothing was present in the cell that the inmate can and/or could use to harm himself. A mattress and a roll of toilet paper were removed from the cell for the inmate's protection and to avoid tripping hazards during the placement.
6. The inmate was left in the cell naked with no other items or possessions in the cell.
7. Pursuant to policy, the only items ever authorized to be left in a Constant Watch cell are a suicide smock/gown, a suicide mattress, and/or a suicide blanket.
8. Bayside Internal Management Procedure ("IMP") BSP.CUS.001.000.191, entitled "Psychiatric Observation," is the standing order that governs the placement of

inmates in a constant watch status. The mental health staff plays a vital role in the placements process and in this issuance of wares, according to the policy.

9. The "Psychiatric Observation" policy was substantially amended in April 2014.
10. Dr. Judith McGhie only authorized the inmate to have a "suicide gown," a "suicide mattress," and "finger foods" while on constant watch. The inmate was not authorized to have a "suicide blanket".
11. When Lacaillade, Byrd, and Romano placed the inmate into the constant watch cell, neither they, nor any other member of the custody staff, were in possession of the written suicide watch notice from the medical staff.
12. In an attempt to obtain the suicide watch notice, Lacaillade placed two calls to the mental health staff. The suicide watch notice was faxed to center control at 3:32 p.m. (R-9).
13. Lacaillade attached the medical authorization (suicide watch notice) to his report and handed the report to the Commander Lieutenant Mikus.
14. Once the report was turned over to center commander, it was his responsibility to distribute the report and the suicide watch notice containing the doctor's order to the appropriate staff to follow-up to ensure that the inmate received his medically approved wares.

CREDIBILITY

Lieutenant David Smith was employed by the DOC for twenty-five years, serving twenty of those years at BSP. He was a shift commander for five years when he retired on December 14, 2014. Smith credibly testified that it was his practice and procedure while at BSP that suicidal inmates were placed naked and did not receive any wares until the doctor's order was completed by, and distributed to, the custody officers. This was how he interpreted and applied the constant watch policy in place on March 2014,

at BSP before it was amended in April 2014. Officers Peter Ballurio, Tom Togno, and Sergeant Nathan Canion also credibly testified that inmates are left in the constant watch cell naked with nothing at the time of placement unless the suicide watch notice containing the doctor's order is finalized, issued, and disseminated to custody staff before the placement is completed.

None of the above-mentioned officer's testimony was impeached, undermined by cross-examination or by rebuttal testimony. Indeed, one could read the policy in place on March 4, 2014, as requiring some form of prior medical approval before issuing a suicidal inmate his wares. The policy was unclear and internally inconsistent. For example, one section reads "a foam mattress, suicide gown and blanket will be the only items issued to inmates on this level unless ordered in writing by the psychologist or psychiatrist" and the same section farther down reads "the constant watch inmate will be issued a humane safety smock by the medical department". Indeed, the policy never mentions the duties or responsibilities of the "placement" supervisor anywhere (R-16). Thus, the duties of the placement officer developed from practice and not from the written words in the policy. The ambiguity in the policy lends credibility to the testimony of Smith, Ballurio, Togno, and Canion that in practice, some at BSP prison simply waited for the medical staff to act before risking a possible grievous mistake with a suicidal or mentally ill inmate. The policy language that a "constant watch inmate will be issued a humane safety smock by the medical department" contains no ambiguity. It places the burden on the medical department not the placement supervisor.

Appellant was also credible. His testimony was not impeached, undermined or rebutted. His experience at BSP was consistent with that which was described by Smith, Ballurio, Togno, and Canion. Appellant understood his role was to move the inmate from point A to point B, safely, humanely and without incident. This was accomplished well before 3:32 p.m., which is when the doctor's order was completed and delivered to center control. Appellant did not simply ignore the situation either. He made two calls to the medical office looking for the doctor's order so he could attach it to his incident report and hand it to the center commander. Center commander Mikus confirmed that appellant completed his report and handed him (Mikus) the report.

Appellant was thereafter assigned back to his duties as staffing sergeant, which are extensive (R-15). Center Commander Mikus admitted that he assumed responsibility for ensuring the inmate was allocated his wares in accordance with the policy, practice and doctor's directive. Appellant completed everything he was ordered to complete according to Mikus. Since appellant's testimony of events was amply confirmed by his commanding officer, and because the constant watch policy in fact contained ambiguities, I found his testimony to be believable and credible as to how the policy was interpreted and applied at BSP.

Major Redman candidly admitted, to his credit, that IMP BSP.CUS.001.000.191 entitled Psychiatric Observation was unclear, which is why it was substantially amended. Major Redman was not aware of the particular procedure being used by many officers at BSP by as described by Smith, Ballurio, Togno, Canion and Lacaille. He indicated that he had not placed an inmate on constant watch status for many years. Therefore, he was unable to refute the suicide inmate placement practice and procedures described by the commanders, supervisors and officers that are involved in day-to-day operations at BSP.

Finally Assistant Administrator Bond interviewed numerous officers and medical staff, which did not testify. When asked the specific question relevant to this case as to who makes the ultimate decision as to what wares the suicide inmate will receive, most officers stated that the medical staff makes this decision (A-1). (Sgt. Lugo, Ofc. Sooy, Sgt. Slimmer, and Dr. Brown). Bond consistently stated in his report that the medical staff did not alter the wares allotted the inmate as set forth in the policy (A-1). This assertion is incorrect. The medical staff did not authorize the inmate to have a blanket (R-9 compared to R-16:5). The medical order therefore directly contravened the DOC policy, at least as to providing the inmate with a blanket (R-16:5). Had appellant provided the inmate with a blanket, he could have been disciplined for failing to obey the medical order. Had the inmate injured himself with the blanket, appellant could have been subject to major discipline. Therefore, the report submitted by Assistant Administrator Brown, in many respects, corroborated the testimony supporting appellant.

CONCLUSIONS

The burden of persuasion rests with the agency in enforcement proceedings to prove violations of administrative regulations. Cumberland Farms, Inc. v. Moffett, 218 N.J. Super. 331, 341 (App. Div. 1987). The agency must prove its case by a preponderance of the credible evidence, which is the standard in proceedings before an administrative agency. Atkinson v. Parsekian, 37 N.J. 143 (1962). An appeal requires the Office of Administrative Law to conduct a de novo hearing and to determine the appellant's guilt or innocence, as well as the appropriate penalty. In re Morrison, 216 N.J. Super. 143 (App. Div. 1987); Cliff v. Morris County Bd. of Social Serv., 197 N.J. Super. 307 (App. Div. 1984).

Having heard this case de novo, I was sufficiently persuaded, based upon the credible and believable testimony, that the practice and procedure employed by appellant on March 4, 2014, did not violate Bayside Internal Management Procedure ("IMP") BSP.CUS.001.000.191 (R-16). I **CONCLUDE** that the aforementioned policy does not identify or mention the nature, extent or scope of the placement supervisor's duties and responsibilities in connection with the placement of a suicidal inmate. The policy does not even mention the placement supervisor. Therefore, the policy was up for interpretation by the specific supervisor or commander that employed it during their tour of duty. Therefore, I **CONCLUDE** that the DOC/BSP did not meet its burden of proof by the preponderance of credible evidence.

A constant watch inmate is entitled to his wares (smock, blanket and mattress), but when and from who was not clear in the DOC policy. Present and past practice defined appellant's duties, as the placement supervisor, was to take the inmate from point A (general population) to point B (infirmary-padded cell) without incident or injury. The inmate is immediately handed over to the infirmary staff and placed on constant watch, once placed in the padded cell.

Appellant was required to return to his duty as staffing sergeant in the command center. Appellant had no order from the doctor providing the inmate with any wares, at the time of the placement. Nor did the existing policy clearly require appellant to

provide the inmate with his wares due to the noted ambiguities. When appellant received the doctor's order hours later, he completed his report and handed it to the center commander. There was no enumerated policy or procedure violated by appellant. The center commander clearly took responsibility implementing the doctor's order that was handed directly to him by appellant.

Constant watch means that an officer is assigned and positioned to watch the inmate 24/7. An infirmary sergeant supervises the constant watch officer and medical staff present in the infirmary. These officers and medical personnel were in the best position to oversee the inmate, who went without his wares for twenty-four hours. Appellant was not overtly aware that the inmate remained without his wares for twenty-four hours since he returned to the center control as required.

The fact that the constant watch policy was poorly drafted; the fact that center commander lost track of the report handed to him by appellant; the fact that the custodial and medical staff in the infirmary did nothing for twenty-four hours while the inmate remained naked; and the fact the appellant followed standard practices that evolved over time at BSP; necessitates that all charges be dismissed. Discipline cannot be imposed upon appellant in the face of so many deficiencies and ambiguities. This would undermine the principal of notice and due process. I so **CONCLUDE**.

ORDER

Based upon the foregoing, the charges against appellant are **DISMISSED**. I **ORDER** that appellant receive back pay, service credit and all other emoluments for any suspension which may have been served as a result of the charges from this incident. The amount of back pay awarded is to be reduced and mitigated to the extent of any income earned or that could have been earned by appellant during this period. Proof of income shall be submitted by or on behalf of appellant to the appointing authority within thirty days of issuance of this decision. Pursuant to N.J.A.C. 4A:2-2.10, the parties shall make a good faith effort to resolve any dispute as to the amount of back pay. However, under no circumstances should the appellant's reinstatement be delayed pending

resolution of any potential back pay. I further recommend that the Civil Service Commission award counsel fees.

I hereby **FILE** my initial decision with the **CIVIL SERVICE COMMISSION** for consideration.

This recommended decision may be adopted, modified or rejected by the **CIVIL SERVICE COMMISSION**, which by law is authorized to make a final decision in this matter. If the Civil Service Commission does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 40A:14-204.

Within thirteen days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **DIRECTOR, DIVISION OF APPEALS AND REGULATORY AFFAIRS, UNIT H, CIVIL SERVICE COMMISSION, 44 South Clinton Avenue, PO Box 312, Trenton, New Jersey 08625-0312**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

2/19/15

DATE

W. Todd Miller

W. TODD MILLER, ALJ

Date Received at Agency:

2/19/15

Date Mailed to Parties:

2-24-15

/jb/lam

WITNESSES AND DOCUMENTS IN EVIDENCE

WITNESSES

For Appellant:

Sergeant Nathan Canion
Lieutenant David Smith
Senior Corrections Officer Tom Togno
Senior Corrections Officer Pete Ballurio
Lieutenant Brian Mikus

For Respondent:

Dr. Judith McGhie
Assistant Administrator Willie Bond
Major David Redman

EXHIBITS

For Appellant:

- A-1 Investigation Report, May 14, 2014
- A-2 Psychiatric Observation Policy (BSP.CUS.001.000.191)
- A-3 Amended Psychiatric Observation Policy (BSP.CUS.001.000.191)
- A-4 Preliminary Incident Report – Constant Watch Placement
- A-5 Staffing Sergeant Policy (BSP.CUS.001.000.620)

For Respondent:

- R-1 Preliminary Notice of Disciplinary Action
- R-2 Final Notice of Disciplinary Action
- R-3 Appellant's Work History
- R-4 Intentionally Omitted
- R-5 Interview of Appellant
- R-6 Intentionally Omitted
- R-7 Intentionally Omitted
- R-8 Appellant's Preliminary Incident Report
- R-9 Suicide Watch Notice
- R-10 Interview of Dr. Judith McGhie
- R-11 Intentionally Omitted
- R-12 Intentionally Omitted
- R-13 DOC Personnel Rules – Receipt from Appellant
- R-14 Appellant's Orientation Check List
- R-15 Staffing Sergeant Policy (BSP.CUS.001.000.620)
- R-16 Psychiatric Observation Policy (BSP.CUS.001.000.191)
- R-17 DOC Law Enforcement Rules and Regulations
- R-18 Intentionally Omitted
- R-19 DOC Handbook
- R-20 DOC Mission Statement and Goals
- R-21 Intentionally Omitted
- R-22 Video/CD of Inmate Placement