## CERTIFICATION OF PERSONNEL BOARD RECORDS

I certify that the attached is a true and correct copy of the Findings of Fact, Conclusions of Law, Recommended Order and Final Order in the case of **SCHERRY GRIFFIN vs. CABINET FOR HEALTH AND FAMILY SERVICES (APPEAL NO. 2011-227)** as the same appears of record in the office of the Kentucky Personnel Board.

Witness my hand this 17th day of April, 2013.

**MARK A. SIPEK, SECRETARY**
**KENTUCKY PERSONNEL BOARD**

Copy to Secretary, Personnel Cabinet

COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2011-227

SCHERRY GRIFFIN — APPELLANT

VS.

FINAL ORDER
ALTERING THE HEARING OFFICER'S
FINDINGS OF FACT, CONCLUSIONS OF LAW
AND RECOMMENDED ORDER

CABINET FOR HEALTH AND FAMILY SERVICES,
J. P. HAMM, APPOINTING AUTHORITY — APPELLEE

** ** ** ** **

The Board at its regular April 2013 meeting having considered the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer dated January 3, 2013, Appellant's Exceptions, Appellee's Exceptions, Appellant's Response to Appellee's Exceptions, Appellee's Response to Appellant's Exceptions, oral arguments, and being duly advised,

**IT IS HEREBY ORDERED** that the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer be altered as follows:

A. **Rename** **II. STATEMENT OF FACTS** to read **II. SUMMARY OF TESTIMONY**.

B. **Delete** Summary of Testimony paragraph 19 and substitute the following:

19. Lt. McCollum interviewed and took a statement from William Devine, who was the officer who supervised the shaving by Chadwick Gilbert. Devine told McCollum that he checked the razor used by Gilbert before he put it in the dirty cup. He said that Cpt. Griffin was busy when he returned the razors and took no count of the razors nor inspected them before he put four of the used razors in the Sharp's container, and placed the six unused razors on the Captain's desk. He also examined the visitor logs and learned that Gilbert had no visitors that could have slipped him a razor. McCollum testified that Gilbert underwent 15 shift changes between all three shifts from the time he was allowed to shave to the time he was found to have cut himself. Lt. McCollum said that Gilbert told him he had laid the blade on the sink in his room. Lt. McCollum said that although the patient's room is stripped and an observation of the room is made every 15 minutes, the chances of a small razor blade being noticed are only about 50 percent, and that housekeeping employees are generally in a room to sweep and mop and do not know that what to look for in the way on contraband that

would allow a patient to harm himself. He added that when you go in the room of a patient that is prone to agitation, the focus is on the patient at all times.

C. **Add** **III. FINDINGS OF FACT**.

D. **Add** Findings of Fact paragraphs 1 through 4:

1. The Board finds that during the relevant times, the Appellant was a classified employee serving in the position of Captain at the Kentucky Correctional Psychiatric Center (KCPC).

2. The Board finds that the Appellant, as Shift Supervisor for the second shift on the day in question, did not properly ensure the count was cleared and that patients who were outside of the facility were not properly cleared back into the facility nor counted correctly. The Board finds this led to an incorrect count. The Board finds this was unsatisfactory performance of duties.

3. The Board finds the Appellant did engage in an improper conversation with Officer Chadwell regarding the confidential investigation ongoing at that time, when ordered not to discuss the investigation with anyone. This was a lack of good behavior.

4. The Board finds that the Appellant did not comply with Agency policy to ensure the razors were correctly counted in regards to the patient who had injured himself with a razor blade in June 2011. The Board finds that the Appellant did not inspect the razor blades before Officer Devine had deposited them into the sharps container. The Board finds that the Appellant's failure to count the used razors before they were placed into the sharps container was poor work performance and did not follow policy.

E. **Delete** the Hearing Officer's Conclusions of Law and substitute the following:

## IV. CONCLUSIONS OF LAW

1. The Board concludes that the decision of the Appellee to demote the Appellant was excessive, and that a lesser punishment would be more appropriate given the Appellant's work record.

2. The Board concludes that a more just punishment for the misconduct found would be a 30-day suspension without pay instead of a three (3) pay grade demotion.

F. **Delete** the Recommended Order and substitute the following:

> **IT IS FURTHER ORDERED** that the Hearing Officer's Recommended Order be altered and that the appeal of **SCHERRY GRIFFIN VS. CABINET FOR HEALTH AND FAMILY SERVICES (APPEAL NO. 2011-227)** be **SUSTAINED to the extent** that the three pay grade demotion with concomitant 15 percent loss in pay be reduced to a 30-day suspension without pay. The Appellant should be restored to her pay as a Captain effective October 1, 2011, and receive appropriate back pay and benefits. In addition, the Appellee is ordered to reimburse the Appellant for any leave time she used attending the hearing and any pre-hearing conferences at the Board, and to otherwise make the Appellant whole. **KRS 18A.105, KRS 18A.095(25) and 200 KAR 12:030.**

**IT IS FURTHER ORDERED** that the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer, as altered, be and they hereby are approved, adopted and incorporated herein by reference as a part of this Order and that the Appellant's appeal be **SUSTAINED to the extent** herein.

The parties shall take notice that is Order may be appealed to the Franklin Circuit Court in accordance with KRS 13B.140 and KRS 18A.100.

**SO ORDERED** this 17th day of April, 2013.

**KENTUCKY PERSONNEL BOARD**

**MARK A. SIPEK, SECRETARY**

A copy hereof this day mailed to:

Hon. Mary S. Tansey
Hon. Ruth Baxter
J.P. Hamm

**COMMONWEALTH OF KENTUCKY**
**KENTUCKY PERSONNEL BOARD**
**APPEAL NO. 2011-227**

**SCHERRY GRIFFIN** **APPELLANT**

**vs.** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDED ORDER**

**CABINET FOR HEALTH AND FAMILY SERVICES** **APPELLEE**
**J. P. HAMM, APPOINTING AUTHORITY**

**********

This matter came for an evidentiary hearing on August 7 and 8, and September 5, 6 and 28, 2012, at the Kentucky Personnel Board, Frankfort, Kentucky. The proceedings were recorded by audio-video equipment pursuant to the authority found at KRS Chapter 18A.

The Appellant, Scherry Griffin, was present and represented by Hon. Ruth H. Baxter, of Carrollton, Kentucky. The Appellee was represented by the Hon. Mary S. Tansey, Staff Attorney for the Kentucky Cabinet for Health and Family Services, Frankfort, Kentucky.

## I. STATEMENT OF THE CASE

1. Scherry Griffin appeals her employer's decision on September 27, 2011, to demote her from her position as a Correctional Captain with the Department for Behavioral Health, Development and Intellectual Disabilities at the Kentucky Correctional Psychiatric Center in LaGrange, Kentucky (hereinafter referred to as the "KCPC"), three grades to the position of Correctional Officer. The Demotion included a 15% reduction in pay from Pay Grade 12 to Pay Grade 09, and was to be effective October 1, 2011. Her pay was reduced from $3,443.22 to $2,994.14 monthly.

2. The demotion and reduction in pay was based on alleged multiple instances of misconduct, pursuant to KRS 18A.095, and 101 KAR 2:034, Section 3(2), for the reasons of (1) Unsatisfactory Performance of Duties (two separate alleged instances); and (2) Lack of Good Behavior.

3. The Appellant, Scherry Griffin, was sent written notice from Howard J. Klein, Appointing Authority for the Cabinet's Office of Human Resource Management, that she was being demoted as a result of findings from an investigation (1) into her conduct on March 31, 2011, when she failed to take custody of two patients being returned to the facility, and made an improper count concerning the patients in the facility, in violation of KCPC Standard Practice #17(II)(B) "Count Procedures"; (2) her failing to follow proper procedure concerning a pending investigation, following a discussion she had with a fellow KCPC officer in a Wal-Mart parking lot about the investigation pending against her and later falsely told an investigator that she had not

discussed the investigation with anyone; and (3) failed to follow proper count and inspection procedure under KCPC Security Policy #37 "Patient Shaving and Razor Control," that placed a patient at risk by allowing him to secrete a razor blade and subsequently use it to inflict self-injurious wounds. The reduction notice also informed Ms. Griffin that her actions also violated Cabinet Personnel Procedure 2.1 "Employee Conduct," which provides that violation of policies and procedures, unsatisfactory performance of duties, and /or failure to exhibit good behavior may lead to corrective disciplinary action, up to and including dismissal.

4. A Pre-Hearing Conference was conducted before the Personnel Board's Executive Director on November 21, 2011, followed by a series of motions, discovery requests and objections, and a deposition, that caused the evidentiary hearing to be rescheduled three times. Although the counsel for the parties represented to the Board that the hearing would last only two days, the evidentiary hearing began on August 7, 2012, and covered five days spread over a month and a half. The issue presented was whether the disciplinary action taken by the Cabinet against Ms. Griffin was neither excessive nor erroneous and was taken with just cause. The Appellee Cabinet had the burden of proof.

## II. STATEMENT OF FACTS

1. The Cabinet's first witness, **Laura Hall**, was the former Human Resources Director at KCPC. She was called for the sole purpose of authenticating the Cabinet's documents, which the Appellant stipulated, thereby making the need for further testimony from Ms. Hall to establish the authenticity of that evidence not be required.

2. The second witness for the Cabinet was **Merv Haddix**, a Correctional Security Supervisor at KCPC, who stated he was responsible for the security staff on all shifts, and that he investigates incidents concerning violations of KCPC policies. He acknowledged knowing Scherry Griffin as a shift captain at KCPC. He was called upon to investigate the first charge against Cpt. Griffin, which involved an incident that occurred on March 31, 2011, during which two patients were returned to the Transportation Admissions and Discharge (TAD) area of the Luther Luckett Correctional Complex facility at the time Ms. Griffin was coming on duty on the second shift at 1500 hours, and the two patients were not returned to the KCPC's custody and supervision until approximately 1529 hours. The Luther Luckett Correctional Complex (LLCC) of the Kentucky State Prison system in LaGrange, Kentucky, is under the jurisdiction of the Department of Corrections, and it shares facilities of the prison complex with KCPC, which is responsible for the provision of professional objective and thorough forensic pretrial psychiatric evaluations for the judicial system and quality inpatient psychiatric services of persons charged with or convicted of felony offenses. However, the KCPC is under the jurisdiction of the Cabinet for Health and Family Services. The Sally Port entrance to the complex is shared by the two facilities, which includes the Transportation Admissions and Discharge (TAD) area, which is an inmate movement hub to and from the facilities.

3. Haddix testified that the most important function all day in the complex is maintaining a proper count of the patient inmates, which is a vital function of protecting the public and the inmates. It is the responsibility of the Shift Supervisor to clear the count at the beginning, during and end of each shift. He introduced KCPC Standard Practice 17: "Count Procedures," which describes the second shift that is on duty from 1500 to 2300 hours and has count responsibilities at 1500, 1830, 2100 and 2230 hours. Haddix testified that the inmate count logs are maintained in the Captain's Office and are the primary tracking and accountability records of the patients. He testified that it came to his attention on March 31, 2011, that there

was a mistake in the count when he received a phone call from Cpt. Griffin, the second shift supervisor, expressing concern that she had been led to believe that only one patient had returned to KCPC and that custody of that inmate had been secured in the KCPC facility, when in fact there were two inmates back and that neither had been returned from the TAD to custody in the KCPC. She told him that as a result of this mistake, the inmate count was incorrect.

4. Haddix was directed to investigate the circumstances and determine why the two returned patients were allowed to remain in the TAD, yet accounted as present on the log. He said he interviewed everyone having involvement in the events comprising the incident, and that he reviewed all the logs. It was determined that at the end of the first shift, at approximately 1450 hours, a patient identified as Crenshaw was returned to the TAD, and the KCPC was notified. Sgt. Blankenship was the shift sergeant on the first shift which was winding down its day's involvement. The next shift to come on duty conducts roll call in the training room 15 minutes before the end of the previous shift, during which the reporting staff is told where to work and receives any special instructions. Immediately after roll call, each person is to report directly to their assignment. The Second Shift supervisor, Cpt. Griffin, had just reported to the Captain's Office following roll call, and Blankenship said he overheard Lt. Greer inform Cpt. Griffin that a patient had been returned, and that one was still out.

5. Haddix testified that the count at the start of each shift is critical, and only the shift supervisor can clear the count, which for the start of the second shift was Cpt. Griffin. When she made a notation on the log as to the count of the inmate patients in the facility, she mistakenly was accounting for the return of a patient still in the TAD, and not returned to their custody. Haddix testified that the inmate patient identified as Crenshaw was left in TAD 36 minutes, and shortly thereafter an inmate patient identified as Maple was returned to the TAD where he remained for 24 minutes before he was returned to the custody of the KCPC. Haddix stated that this delay in clearing the custody of the inmates was unacceptable, and that a security officer in TAD reported that he had called the Captain's office on three occasions to advise that the patients were still in TAD. At that time, the logs had an incorrect count, and Haddix testified that they have to account for all patients at all times. He added the change of supervision occurs when the next shift supervisor signs in to duty, and that once information concerning inmates and the count is delivered to the next shift captain, that supervisor takes responsibility for the shift duties, including preparing the count logs. The count log at the start of the shift is the most appropriate count; however, at the time of the change to the second shift, custody of patient Crenshaw had not been transferred to KCPC, although he was logged in on the Second Shift count log as having been cleared and in the KCPC facility.

6. Haddix testified that it became apparent that upon reporting for duty at the start of the second shift, Cpt. Griffin's attention was diverted to a meeting with Kim Fisher, an administrative assistant. Fisher had received an email from Griffin concerning an apparent incorrect accounting on her available leave time and had requested Fisher to meet with her, "at your convenience," to train her on the computer records. Fisher determined to do this at the end of her shift, which coincided with the start of Griffin's supervision over the second shift. As a result, Griffin requested Sgt. Kerry Pierce to take the count, and later told Haddix that he had cleared the count. Haddix testified that it was appropriate for the shift sergeant to take the count, but the responsibility to "clear the count" rested solely with the shift supervisor. He testified that the count is a security function, on which the responsibility for the accuracy falls on the supervising officer of the shift. The importance of KCPC promptly assuming custody of returning inmates is the fact that they are patients with mental and emotional issues, and that they have to go through a search process and be logged back into the facility, as part of the security procedure. Haddix testified that the staff undergoes training about retrieving

inmates being returned to KCPC custody, adding they are trained to account for all patients at all times, and that once word is received of a returned patient inmate, it is the responsibility of the shift supervisor to pick them up immediately from the TAD and return them to the custody of KCPC.

7. A key exhibit introduced by the Cabinet through Haddix was **KCPC Standard Policy 15** [Appellee Exhibit 14: "Shift Supervisors' Responsibilities and Duties"]. The Policy provides, in pertinent part: "that the Shift Supervisor has the mandatory duty of maintaining all count sheets and clearing the count, and is responsible for all security functions." [¶¶ II.A.3 and II.B.1.]

8. As a result of the confusion generated in the taking and clearing of the count at the start of the second shift on March 31, a discrepancy was created in the logs, not only in the accounting of the inmates in the KCPC facility, but also as to the times the two inmates that had left the facility earlier that day for court appearances were returned to the facility and cleared back to the custody of the KCPC. Haddix testified that although the first call from the TAD that an inmate of the KCPC had been returned from a court appearance was received near the end of the first shift, as long as that information had been given to the second shift supervisor, the responsibility for taking custody of the returned inmate had been turned over to the second shift supervisor, together with the responsibility for the accuracy of the count logs. The reason for the transfer of responsibility to the second shift where an inmate is returned at the end of the first shift is that the second shift was already reporting on duty, and to prevent overtime. Haddix acknowledged that the LLCC guards who run the TAD had supervisory control of the two KCPC inmates, Crenshaw and Maples, at all times. However, that did not excuse Griffin as the second shift supervisor from immediately taking custody of the returning inmates and assuring that the count was accurate, as the first count of the shift is the most important. The fact was clear that at the start of the second shift, patient Crenshaw had not been transferred to the custody of KCPC, while the second shift starting count, incorrectly cleared by Sgt. Pierce, reflected that he had. Haddix testified that the determining factor from his investigation was Griffin's confusion from her inattention to the details concerning the inmates upon her taking control of the KCPC at the start of her shift, as to who had returned, when, where they were, and who was still out.

9. Haddix also investigated the second charge against Cpt. Griffin, concerning her failing to follow proper procedure during a pending investigation, regarding a discussion she had with a fellow KCPC officer in a Wal-Mart parking lot, about the investigation pending against her and that she later falsely told an investigator that she had not discussed the investigation with anyone. Haddix testified that his investigation into this event was made necessary under KCPC policy that while an investigation is being conducted, all staff personnel have received training that they are to not discuss the investigation with anyone. During an ongoing investigation, all persons contacted are reminded by the investigator that they are to maintain confidentiality. Haddix testified that it was brought to his attention that Griffin had subsequently run into an Officer Casey Chadwell in the parking lot of a Wal-Mart and informed him that she was under investigation concerning the incident of the patients being left in the TAD. Griffin was confronted about the conversation with Chadwell, which she initially denied, then later admitted. Haddix interviewed Chadwell, who told him that Griffin had told him she was under investigation, although she had not revealed the names of the inmates involved. Regardless, it was Haddix' conclusion that Griffin violated the KCPC Code of Conduct and Code of Ethics.

10. **Lt. Joshua Greer** testified that on the date in question concerning the return of KCPC inmates, he was the supervisor of the first shift and that when Griffin reported to the Captain's Office, he informed her there was one patient that had just been returned to the TAD at 1453, and that one patient was still out in court. He said he gave Griffin the paperwork concerning the count logs and that she relieved him as the

supervising officer around 1455 p.m., stating that she would take care of it. Greer testified that at the moment Griffin said she would take care of the return of the inmates, he was relieved of any further duties concerning the custody and logs of the inmate patients at KCPC.

11. **Sonny Mays** was a property room officer at the LLCC located adjacent to the TAD, at the event of the custody issue concerning the returning KCPC inmates. He testified concerning the different log documentation kept to record the movements of anyone entering and leaving the facility. He said he was the person that first called the KCPC Captain's Office to inform them that an inmate of theirs had been returned, although he could not recall who he talked to at KCPC. He also called a second time when another KCPC inmate was returned. He said he ultimately had to call three times to the Captain's Office, before someone from KCPC responded to pick them up. He acknowledged that although the inmate patients were left in the TAD, they were under observation at all times.

12. **Michael Doss**, a corrections officer at KCPC, testified that on the date in issue he was instructed to go pick up patients Crenshaw and Maples at the TAD, although he could not recall if he received the instructions from Cpt. Griffin or Sgt. Pierce, as both were in the Captain's Office at the time. He said he was given two chain of custody packets and that he went immediately to retrieve custody of both inmate patients. He said he spent approximately five minutes apiece searching each inmate before returning them to KCPC.

13. **Casey Chadwell,** a former employee at KCPC, testified concerning the conversation he had with Griffin about the investigation, although he could not remember the date. He said that he ran into Griffin in the Wal-Mart parking lot and that she started the conversation about how stressed she was, because she was being investigated by the Cabinet for patient neglect. Chadwell testified that Griffin advised him Sgt. Blankenship and Lt. Greer has reported that she had been told about a KCPC inmate patient being at the TAD, but that she alleged that they did not tell her. Chadwell testified that although he generally had assumed an investigation was going on, he felt it was important that he report the conversation and that he was later asked by Officer Haddix to give a statement about his encounter with Griffin. He said the encounter with Griffin was merely coincidental, and that Griffin did not tell him the names of the patients involved.

14. **William Bradley Devine** was a corrections officer at KCPC from November 2010 until August 2011, and was called by the Cabinet to testify concerning the razor incident, which formed the third charge against Griffin for failing to follow proper count and inspection procedure under KCPC Security Policy #37, "Patient Shaving and Razor Control," that placed a patient at risk by allowing him to secrete a razor blade and subsequently use it to inflict self-injurious wounds. He testified that he was the officer that was called upon to conduct the shaving operations of those patients that wanted to shave. He stated that early in the second shift they would ask the patients if any of them wanted to shave. He then went to the Captain's Office and got 10 razors that were kept under lock and key, and placed them in a cup. He also retrieved a second cup in which to place any of the used razors. Devine testified that he initially had five inmates inform him that they wanted to shave, but one later decided not to shave. He would then go to each inmate on a one-by-one basis and supervise their shaves.

15. Devine testified that when everybody finished shaving, he took the dirty razors in one cup back to the Captain's Office and returned the six unused razors to the Captain's desk. He testified that Cpt. Griffin appeared to be working on the computer, so he dumped the dirty razors in the "Sharp's Container." He said that all the razors were intact and that none were broken.

16. **Lt. Donald E. McCollum** testified that he is now a shift supervisor which requires him to report 15 minutes prior to the start of his shift to appear at roll call, following which he reports to his assigned station and assumes the duties of a supervisor. He testified that he was not aware of any set written policy on retrieving patients in the TAD as to how soon they are to be picked up, adding that he was always taught that once he became aware a patient was brought into the TAD, it was his responsibility to go get them.

17. McCollum testified concerning his investigation into the incident of the patient that cut himself shaving. He introduced the KCPC shaving and razor control policy, that describes the shaving by the inmate patients is only supposed to occur during the second shift, and that the supervising officer is to allow only one patient at a time to conduct a shave. He was instructed to investigate the incident in which an inmate patient cut himself, because he was the supervisor on duty when the incident occurred. The inmate involved was named Chadwick Gilbert, who had been to the KCPC facility several times and was a known risk to the staff. McCollum testified that he learned that Officer Devine was supervising the shaving of the inmate patients wanting to shave, obtaining the razors from the Captain's Office, where they are kept under lock and key, and the keys to the cabinet containing the razors are maintained in another locked cabinet. The razors are required to be dispensed by the Captain or supervisor and not by a corrections officer. Gilbert shaved on June 11, and on June 13 he was found sitting on the edge of his bed with blood over him and blood all over the floor and wall of his room. It was determined that he had cut himself with a razor blade, which he alleged he brought into the facility with him in his mouth. He had lacerations on his right wrist, upper forearm and neck.

18. Lt. McCollum examined the razor log which showed that four razors had been used and that six razors were returned unused. The log was signed by Cpt. Griffin. He also checked the security round logs and noted the logs showed that Chadwick Gilbert was observed every 15 minutes. The physician's orders showed that the patient had been admitted on June 6, 2011, as a Suicide Level 2, indicating the patient was to be kept under close observation and treated with precaution, as he was considered to be a danger to himself. McCollum testified that when the patients are brought into the Center, they undergo a full and thorough strip search, including the mouth. McCollum described his job as "living in a fish tank" where the inmate patients are virtually under visual observation 100% of the time, from both the panel control room officer and the floor officers that monitor the wards. He testified that the patients are placed in a restricted room, where the doors remain open 90% of the time, and the patients are checked every 15 minutes and charted every hour. An SL2 room is stripped of all items that can be used by a patient to harm himself, restricting the patient to his clothes he is wearing, the bed, pillow, mattress and two blankets. A patient is "patted down" and frisked on each shift change. Gilbert was later lowered to a SL3 status on June 12, which eased the restrictions on the patient, although his room is still observed and he still underwent a pat down on each shift change. The incident of his cutting himself took place on June 13 at approximately 8:00 am.

19. Lt. McCollum interviewed and took a statement from William Devine, who was the officer who supervised the shaving by Chadwick Gilbert. Devine told McCollum that he checked the razor used by Gilbert before he put it in the dirty cup. He said that Cpt. Griffin was busy when he returned the razors and took no count of the razors nor inspected them before he put four of the used razors in the Sharp's Container, and placed the six unused razors on the Captain's desk. He also examined the visitor logs and learned that Gilbert had no visitors that could have slipped him a razor. McCollum testified that Gilbert underwent 15 shift changes between all three shifts from the time he was allowed to shave to the time he was found to have cut himself. Lt. McCollum said that Gilbert told him had laid the blame on the sink in his room. McCollum said that although the patient's room is stripped and an observation of the room is made every 15 minutes, the chances of a small razor blade being noticed are only about 50 percent, and that housekeeping employees are

generally in a room to sweep and mop and don't know what to look for in the way of contraband that would allow a patient to harm himself. He added that when you go in the room of a patient who is prone to agitation, the focus is on the patient at all times.

20. McCollum took custody of the razor blade taken from Gilbert after he cut himself, compared it with the razors used by KCPC and found them to be an identical match, even in the notches where the razor blade attaches to the body of the razor. He further compared it to the razor and blades utilized by LLCC, and found no matching characteristics in the razors and blades. Lastly, he compared the recovered blade to a razor he obtained from the McCracken County Jail, where Chadwick was before he was transferred to the KCPC, and where he alleged he got the blade, and McCollum found no match. He and Lt. Greer also examined all the razors held in the Sharp's Container and found no broken razors or missing blades. McCollum testified that he did not consider that it was a legitimate possibility that Chadwick Gilbert could have brought the razor blade into the facility hidden in his mouth.

21. McCollum concluded from his investigation that Gilbert was cut by a razor blade that matched the razor blades utilized by KCPC, and that he had no available means to obtain the razor that he cut himself with other than from the razor used when he shaved. He stated that the inmate patients live behind locks and doors, and that there are no keys to the doors, which are opened and locked by an automatic switch controlled by the panel unit officer that has monitoring and observation capability of all activity in the facility. As a suicide watch patient, Chadwick Gilbert was unable to go anywhere without a security escort. McCollum stated that he believed that both Devine and Griffin did not tell the truth about their counting the razors returned. Devine reported that he put four dirty razors in the Sharp's Container, and reported that Griffin was occupied on another matter at her computer and did not see him put the razors in the container, indicating to McCollum that Devine placed the razors in the sharp's container without clearing them with Cpt. Griffin. McCollum testified that had Cpt. Griffin properly inspected and counted the razors, the missing blade would have been noted, which would have resulted in a complete shakedown inspection of the inmates' rooms until the blade was found. McCollum testified that the important issue concerning Gilbert cutting himself was that the incident occurred as a breach of security.

22. **Horace Klinglesmith**, a corrections officer with KCPC since November 2007, testified that when he reported for duty on March 31, 2011, at the conclusion of roll call, he went ahead of Cpt. Griffin and Sgt. Pierce into the Captain's Office to get the equipment he needed, where he said he overheard Lt. Greer tell Cpt. Griffin that all the patient's were back, but added that the next day he overheard a couple of officers talking about a patient left in TAD.

23. **Kerry Joseph Pierce**, currently an "acting" lieutenant, served as a sergeant under Cpt. Griffin on the second shift on March 31, 2011. He testified that when they reported to the Captain's Office following roll call, at no time did he overhear anyone mention a patient in the TAD. He said that if that had been reported, he would have immediately put his stuff down and gone to bring the patient back under KCPC custody. He acknowledged that he took the count at 1500, at the start of the second shift, and it was 70-2, indicating 70 inmates were actually present, and two patients, Crenshaw and Maples, were still out for court appearances. He testified that a call was received at 1529 informing them that "you have two back." He said that within two minutes two officers were dispatched to TAD to get the patients and return them to KCPC custody. At that time, the count was changed to 72 on facility.

24. Pierce said the count 70-2 was correct by KCPC policy, as the patients don't come back onto their count until they have the patient in their custody and control. He said that Cpt. Griffin did not take the count nor did she clear the count, although he did tell her all here." Pierce said there is no official policy that they retrieve patients from the TAD within a prescribed amount of time, and that until the KCPC signs for them; they are not in KCPC custody and control. However, while in the TAD the patients are never unattended. Pierce argued that if the count is going on at the start of their shift, they sometimes can't "drop everything" and go do what is needed to be done to bring the patients into KCPC custody. Pierce said he received a written reprimand over this incident, and that only he and Griffin received discipline, but he stated that others were involved who went undisciplined. He added that he believed this incident cost him a promotion.

25. **Larry Wayne Blankenship** is currently employed by the LLCC under the Department of Corrections; however, in March 2011 he served as a sergeant at the KCPC. He stated that the count time at the start of each shift is the most critical period of their duties, in order to make sure everyone is where they are supposed to be. He said that as a sergeant he could take a count but he could not clear the count, as that responsibility fell on the most senior supervisor in charge of the shift. On the date in question, he was working on the first shift with Lt. Greer. He testified that they took counts of the patient inmates at specified times, the last being at 1430 which showed that 70 were present and two, Crenshaw and Maples, were still out. He testified that he was in the Captain's Office and took a call at 1453 informing him that a KCPC inmate had been returned from the Jefferson County Court and was in the TAD, which is the only place that inmates can be returned. He said that he relayed that information to Lt. Greer and that Cpt. Griffin reported for duty to the Captain's Office less than five minutes later. He testified he overheard Lt. Greer inform Cpt. Griffin that one patient had been returned; Lt. Greer told Sgt. Pierce and, as they were at a shift change, it then became the second shift's responsibility to retrieve patients in the Transportation facility. Blankenship testified that the count is always specific about who was present and who was out, and at the start of the second shift the count should have been 71 plus 1, once the patient was retrieved.

26. Blankenship testified that he was approached by Officer Casey Chadwell, telling him that he had encountered Cpt. Griffin at a Wal-Mart parking lot, who informed him that she was being investigated. He reported this information to Merv Haddix.

27. Blankenship testified that he was familiar with Chadwick Gilbert, who was a known risk of injury and that it was always important to know under what security level a patient was admitted, as higher security levels require more observation. He recalled that Gilbert was admitted as a SL 2, but was later changed to a Level 3. He said that Gilbert was searched by a pat and frisk search at the beginning and end of each shift, and his room would be searched as well, because they allowed no items in his room that would allow him to harm himself. He testified that Gilbert later told him how he got the razor blade, saying he received it during the second shift when he was allowed to shave, and that he popped the blade out.

28. The testimony of **Allen Brookshire** was introduced into the record by deposition. He is employed at KCPC to monitor the patients and schedule their recreation activities. Previously he had been employed as a corrections officer and a TAD officer, during which he was trained in the procedure and involvement of processing individuals entering and leaving the facility. He testified that he was involved in the processing of Chadwick Gilbert into the KCPC facility on June 6, 2011. He testified about the KCPC policy for searches and shakedowns and described his conducting a full strip search of Gilbert, that included all areas of his body and body cavities, ears, eyes and mouth, and marking on a body chart all scars, defects and tattoos.

The incoming patient's clothes and possessions are removed and sent to the warehouse to be cleaned and stored, and he is issued a jumpsuit, socks and flip-flops to wear. He testified that the search of Gilbert on his intake would have found any attempt by the patient to smuggle in a razor blade in his mouth. Brookshire also testified about the process of room checks of each patient and the observation of the patients when they are in the day room and outside in a recreation area, to monitor and prevent any passing of contraband.

29. The Appellant, **Scherry Griffin**, has been employed by KCPC for almost 17 years. Her first job was with Murray Guard security firm as a supervisor at the Louisville Gas & Electric power plant in Trimble County. She then served as a deputy jailer at the Carroll County Detention Center. She served in the U.S. Army Reserve Hospital Medi-Vac unit in Louisville and served on active duty during Operation Desert Storm. She started at KCPC as a corrections officer and in 2002 was promoted to the position of Lieutenant, and to the position of Captain in 2005. Prior to this incident, she had never been disciplined.

30. On March 31, 2011, she reported to the Captain's Office following the completion of roll call. Lt. Greer informed her "only one out, one back." She testified that she assumed this to mean that one patient was already back in the facility. She testified that among her duties, she was responsible for the time sheets, and that she was having problems utilizing the computer program's database, because she had no training on the program, and that she had sent a memo to Kim Fisher requesting some training. When she reported to take over the second shift at the Captain's Office, Ms. Fisher came into the office to provide her the computer training. Griffin testified she instructed Sgt. Pierce to take over under the KCPC policy, take and clear the count, and to handle all phone calls, and she spent the next 30 minutes in training with Fisher. During that time, Sgt. Pierce took a call from TAD about a new patient being returned during which he learned there were two patients of KCPC in TAD. Sgt. Pierce immediately dispatched two officers to retrieve the patients, and when they returned with the patients and the custody forms, Griffin realized that the paperwork didn't match up with the returning patients. She testified that she then called Lt. Greer to ask him why he didn't tell her there was a patient still in TAD. When he explained he had told her, Griffin then called Haddix to explain there was an error in the count. Griffin then set about to gather information on what happened, making many inquiries, and explaining she was under the impression that Maples had been returned first and was in the facility. She testified that she was not aware of any KCPC policy rules she had violated about retrieving the two patients.

31. Griffin acknowledged that she had a coincidental meeting with Officer Chadwell in the parking lot of Wal-Mart, during which he asked how she was doing and she responded that she was "stressed out" about being investigated concerning a patient left in the TAD. She stated that she did not mention any patient's name, but Chadwell responded "so you're the one," indicating that he already knew a supervisor was under investigation. Griffin said the conversation only lasted 3-4 minutes. Later she was called into the office to meet with Haddix, and her supervisor, Cpt. Darlene Brown, was present. Haddix asked her if she had discussed the investigation with anyone, and she responded she had made inquiries to Sgt. Pierce and discussed the incident with Cpt. Brown. On May 11, she was called back again to meet with Haddix, when she was asked about a conversation with Chadwell, whereupon she gave him the details of her conversation with him. She said she did not discuss the investigation with Chadwell, nor the name of the patient involved, but merely said she was under investigation.

32. Concerning the incident of the missing razor blade that was used by a patient to cut himself, Griffin testified that Sgt. Pierce was responsible for checking out the razors. She said that Officer Devine was given the duty to conduct the shaves of those patients that wanted to shave. He was given 10 razors and two cups, one for the clean razors, and the other in which to put the dirty used razors. When the shaving was

completed, Devine returned the razors to the Captain's Office, whereupon the clean, unused blades were returned to the cabinet, and the dirty used razors were inspected and put into the Sharp's Container which was located an arm's length from her desk seat. She said she accounted for all razors on June 11, and none of the razors had blades removed.

33. **Gregory Taylor** is the Facility Director and Supervisor of KCPC, with overall operations control of the security facility, 170 employees, and the 80-90 security staff that monitors the patients. Taylor testified that when Ms. Fisher came to the Captain's Office to provide computer training to Cpt. Griffin, she inappropriately transferred the count responsibility to Sgt. Pierce. Under KCPC Standard Policy 15 [Appellee Exhibit 14], Taylor testified that the Shift Supervisor has the mandatory duty of maintaining all count sheets and clearing the count, and is responsible for all security functions. Taylor testified that he has communicated to the staff that it is unacceptable to transfer this responsibility, and that it is inappropriate for a sergeant to clear the count. Taylor said he did not seek discipline against Lt. Greer, because the information concerning the patient being returned to the TAD had already been transmitted to Cpt. Griffin and with the second shift taking on the responsibility of supervising the facility, it was not appropriate to send a day shift officer to retrieve the patient from TAD. Taylor said he considered the incident to be a serious infraction of KCPC policy, as they have the responsibility for the well-being of the patient, and they needed to transfer the patient ASAP, as leaving the patient sitting in the TAD is not conducive to appropriate oversight. Taylor said for this reason he considered the discipline given to Griffin was appropriate.

34. **Howard J. Klein** is the acting Division Director and appointing authority for the Cabinet's Office of Human Resource Management. He testified that he thought his decision of the demotion of Cpt. Griffin was appropriate, even with no previous disciplinary actions against her, because of the seriousness of the actions that arose from her conduct in performing her duties. Klein testified that he recalled receiving an extensive file of written statements and evaluations, as the department's typical process in reviewing and determining the level of discipline to be handed down requires consideration of all available information and any prior disciplinary acts. He expressed the opinion that if Griffin was only demoted to a lieutenant or sergeant she would still be in a supervisory position, and he felt she needed to be removed from any supervisory level. He further transferred her to the third shift so she wouldn't be working with people she previously supervised. He stated that looking at the level of her poor performance and because of the egregiousness of the incidents; he believed the disciplinary decision was consistent and not excessive.

35. Klein noted that the matter of Griffin's discipline involved a very complex case, which involved some gray area that could have resulted in the decision going either way. He felt the fact that the call of the returning patient to the TAD occurred during the first shift didn't require someone from the first shift to immediately go retrieve the patient. What Klein described as the more relevant and important issue was that Griffin had been told the patient was back in TAD awaiting transport back to KCPC. She was there in the Captain's Office, having already reported for duty, and was told by Lt. Greer that a patient had been returned. For Klein, the fact that this knowledge had been passed to her shifted the responsibility of that patient's well-being to her as the supervisor of the second shift. Although Griffin claimed that she interpreted Greer's statement to mean that there was one returned to the KCPC facility, Klein believed this confusion could be remedied and they wouldn't have to deal with this issue if she had performed her responsibility of taking and clearing the count.

36. Klein acknowledged that had there only been the one patient that was not retrieved; the matter would not have been so serious as to warrant the demotion, although she would probably have still received a

suspension. The issue was compounded by the fact that a second patient was left sitting in the TAD, until another call was made 20 minutes later. He said that LLCC, which operated the TAD, should not be watching over KCPC patients, as LLCC don't have the training for working with that type of patient and the different methods of handling them.

37. Klein stated that Griffin's discussion of the investigation with another KCPC employee outside the facility created not only the problem that she violated policy, but that her denial of this discussion raised an element of dishonesty by someone in a supervisory position. He stated that the position held by Griffin carried an expectancy of someone with her rank and position of trust to tell the truth.

38. For Klein, the most egregious issue was the breach of security that occurred under Griffin's duty of supervision which resulted in the incident of the patient cutting himself on June 13, 2011. Even though Klein acknowledged he was not aware that a broken razor was never found that would show where the patient got the blade, and even though almost two days and numerous shift change inspections had occurred from the occurrence of the patient's shaving on the start of the second shift on June 11, and the cutting himself during the start of the first shift on June 13, Klein described these facts as "red herrings," as a razor blade is so small it can easily be hidden. The most important issue for Klein was "how" the patient obtained the blade. This is what represented to him a critical breach of security, and that a proper count and inspection of the razors on their return to the officer and to the Captain's Office by the supervisor on duty (Cpt. Griffin) would have revealed the problem. Considering all the acts charged against Griffin, this was the key event in her position overseeing the patient's care that led Klein to believe that Griffin was irresponsible in performing her duties in her supervisory position, and that the demotion relieving her from a supervisory position was appropriate.

## III. CONCLUSIONS OF LAW

1. The Hearing Officer concludes that the decision of the Appellee to demote the Appellant, Scherry Griffin, for violating 101 KAR 1:345, Section 1, with conduct raising two counts of unsatisfactory performance of duties and one count of lack of good behavior, is well founded and supported by the evidence.

2. The evidence presented concerns the supervisory conduct and errors of judgment of an Officer and Shift Supervisor of the Kentucky Correctional Psychiatric Center (KCPC) located in the Luther Luckett prison facility in LaGrange, Kentucky. KCPC is operated by the Department for Behavioral Health, Developmental and Intellectual Disabilities within the Cabinet for Health and Family Services. The purpose of the institution is described in the facility's Mission Statement as follows: "As part of the Mental Health and Criminal Justice Systems of the Commonwealth of Kentucky, the Kentucky Correctional Psychiatric Center is responsible for the provision of professional objective and thorough forensic pretrial evaluations for the judicial system and quality inpatient psychiatric services of persons charged with or convicted of felony offenses."

3. The Cabinet's authority to impose the disciplinary action against Griffin is based on KRS 18A.095 and 101 KAR 1:345, Section 1. Pursuant to KRS 18A.095(1), a classified employee with status shall not be dismissed, demoted, or otherwise penalized except for cause. The burden of proof establishing "just cause" rests on the government agency. A person in the service of the government, who derives his position from a duly and legally authorized election or appointment, whose duties are continuous in their nature and defined by rules prescribed by government, and not by contract, consisting of the exercise of important public powers, trusts, or duties, as a part of the legal administration of the government, is an officer and holds a "public

office" in the constitutional meaning of the term. *Alvey v. Brigham*, 150 S.W.2d 935, 286 Ky. 610 (Ky. App. 1940). However, the services offered by the Commonwealth of Kentucky in the present matter involves providing for the "special needs" of persons accused of criminal activity and incarcerated at KCPC as mental healthcare patients being evaluated for fitness to undergo the criminal justice process. This service carries several important duties and responsibilities that cannot be delegated.

4. As noted in the evidence summarized above, Cpt. Griffin was appointed by the Cabinet of Health and Family Services to serve at KCPC as a shift supervisor. She was employed at a facility which involves providing a special needs service to the people of the Commonwealth of Kentucky, in addition to those residents of the KCPC. In this position of trust to which she was appointed, Cpt. Griffin had conferred upon her certain responsibilities, which cannot be trifled with. The function of the services provided at the KCPC facility is very serious, not only to the residents in the facility and their families, but also to the people of the Commonwealth of Kentucky who provide for the position and pay for its implementation. KCPC Standard Policy 15 sets the specific duties and responsibilities that are mandatory, and not transferable. Primary among these are the mandatory duties of maintaining all count sheets and clearing the count, and being responsible for all security functions. The process of taking and clearing the count are clearly the key functional responsibility of the shift supervisor. As a shift supervisor at the KCPC, it was incumbent upon her to attend to her duties first.

5. On March 31, 2011, the evidence establishes that the Appellant, Cpt. Griffin, began the second shift at the close of roll call at 1450, and reported to her duty station at the Captain's Office. Unfortunately, the evidence shows she was more focused at the start of her shift on some computer training she felt she needed than she was in attending to her most critical requirement, maintaining all count sheets and clearing the count. There is sufficient evidence that she transferred her responsibilities to Sgt. Pierce, who proceeded to take and clear the count. The problem created by Cpt. Griffin transferring her responsibility was compounded by the second call received from the TAD that another KCPC patient had returned from a court appearance that was allowed to remain in TAD until another call was received approximately 20 minutes later.

6. An argument was made that the two patients went out of the facility on the first shift and that one of them returned while the first shift was still on duty. Lt. McCollum had testified that he had been trained "you get the call, you go," implying that you dropped what you were doing and went to retrieve the patient to KCPC custody, raising an implication that since the first shift was still on duty when the call came of the patients arrival at TAD, it was the first shift's responsibility. The reason for an immediate response in taking custody is that the KCPC patient inmates require special needs handling and are not to be left waiting in a facility they are unfamiliar with and being overseen by security personnel not trained in handling these patients. However, neither the appointing authority, Howard J. Klein, nor the Facility Director, Gregory Taylor, considered that the responsibility rested on the first shift supervisors, as Cpt. Griffin had already reported for duty and she had been informed of the return of the patient. For Klein, there would have been no issue of confusion if she had performed her responsibility taking and clearing the count. The evidence was clear that at the beginning of the second shift, which is the most important time to take the count, Cpt. Griffin was working with her computer under some training by Kim Fisher, instead of attending to her immediate job responsibilities.

7. Cpt. Griffin added another issue to the complex circumstances when she had a chance encounter with Officer Chadwell outside the facility and disclosed to him that she was under investigation for the situation involving the patients left in the TAD. At first she denied the encounter, stating she had only

discussed it with her supervisor and her sergeant involved in the issue with her. However, she subsequently admitted the conversation with Chadwell, even though she denied stating the patients involved, however, the conversation was inappropriate and a violation of policy. Unfortunately, as Mr. Klein noted, this raised an issue of dishonesty with one in such a position of trust.

8. The razor incident was considered by Klein as the most egregious breach of security. It involved a patient cutting himself on June 13, 2011, with a blade that the evidence indicates was confiscated by the patient while he was shaving, and the razor was not accounted for when the officer returned them to the Captain's Office that was under the supervision of Cpt. Griffin. The only known, viable opportunity that the patient had to obtain the razor blade was when he requested a shave on June 11. The patient was a known risk to harm himself, and had been placed on a suicide watch when he was admitted on June 6. Such circumstances obviously commanded a higher attention to detail, and the shaving policy required an accountability of the razors. Officer Devine testified that when he returned the razors to the Captain's Office, Griffin was occupied on a matter on her computer and did not inspect the razors before he disposed of them in the Sharp's Container. The key issue for Klein was "how" the patient obtained the blade. This is what represented to him a critical breach of security, and it was his position that a proper count and inspection of the razors on their return to the officer overseeing the shaving, and to the Captain's Office by the supervisor on duty (Cpt. Griffin) would have revealed the problem.

9. The Kentucky Courts have held that the position of one appointed by a government agency providing security must maintain that position of trust as the individual's primary occupation. Even under normal circumstances, this duty imposes certain limitations upon them. *Puckett v. Miller*, 821 S.W.2d 791 (Ky. 1991). Cpt. Griffin's primary duty as a shift supervisor at KCPC was to attend to the security responsibilities she held in that position. This was a position of trust that she had received from the Commonwealth, and it may not be delegated. The clear implication from all the evidence presented in five days of witness testimony is that the safety of the patients was uppermost on everything done in and around the facility, which required constant accountability of where everyone was and if they were being observed and monitored. To accomplish this purpose of accountability, certain scheduled counts and clearing the count were required under KCPC policy. It was without question the responsibility of the supervising officer to meet this requirement and it was not something that could be delegated.

10. Having reviewed all the evidence of witness testimony and documentation in the exhibits, it is the conclusion of the Hearing Officer that the Cabinet met its burden of proof by an overwhelming preponderance of the evidence. The Appointing Authority has the authority, and responsibility, to determine appropriate discipline under the circumstances, so long as the burden of proof of just cause is shown, the punishment is not unreasonable or arbitrary. A valid case has been presented by the Cabinet justifying the Appointing Authority's decision that Griffin had to be removed from her supervisory position, which required she be demoted three levels, with the resultant loss of pay. Accordingly, the demotion should be affirmed and the appeal of Ms. Griffin dismissed.

## IV. RECOMMENDED ORDER

The Hearing Officer recommends to the Personnel Board that the appeal of **SCHERRY GRIFFIN V. CABINET FOR HEALTH AND FAMILY SERVICES (APPEAL NO. 2011-227)** be **DISMISSED.**

## NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13.B.110(4), each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file exceptions to the Recommended Order with the Personnel Board. In addition, the Kentucky Personnel Board allows each party to file a response to any exceptions that are filed by the other party within five (5) days of the date on which the exceptions are filed with the Kentucky Personnel Board. 101 KAR 1:365, Section 8(1). Failure to file exceptions will result in preclusion of judicial review of those issues not specifically excepted to. On appeal, a circuit court will consider only the issues a party raised in written exceptions. See *Rapier v. Philpot*, 130 S.W.3d 560 (Ky. 2004).

The Personnel Board also provides that each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file a Request for Oral Argument with the Personnel Board. 101 KAR 1:365, Section 8(2).

Each Party has thirty (30) days after the date the Personnel Board issues a Final Order in which to appeal to the Franklin Circuit Court pursuant to KRS 13B.140 and KRS 18A.100.

ISSUED at the direction of **Hearing Officer E. Patrick Moores**, this 3rd day of January, 2013.

KENTUCKY PERSONNEL BOARD

Mark A. Sipek
Executive Director

A copy hereof this day mailed to:

Hon. Ruth H. Baxter, Counsel for Appellant

Hon. Mary S. Tansey, Counsel for Appellee