This is the final decision of the Montgomery County Merit System Protection Board (MSPB or Board) on the appeal of [redacted] (Appellant). On October 9, 2017, Appellant filed this appeal with the Board challenging his dismissal from a Correctional Supervisor - Sergeant position with the Montgomery County Department of Correction and Rehabilitation (DOCR or Department).

BACKGROUND

The discipline in this matter relates to an April 27, 2017, incident involving the use of force against an inmate at the Montgomery County Correctional Facility (MCCF). On October 3, 2017, DOCR issued a Notice of Disciplinary Action (NODA) dismissing Appellant. County Exhibit (CX) 16. The NODA found that Appellant violated the following provisions of the Montgomery County Personnel Regulations (MCPR): § 33-5(c) (violates any established policy or procedure); § 33-5(e) (fails to perform duties in a competent or acceptable manner); § 33-5(h) (negligent or careless in performing duties). CX 8.

In addition, Appellant was found to have violated multiple DOCR policies, as follows. DOCR Policy Number 1300-10: § III(F) (use of force shall be reported, documented); § V(A) (Except in cases of extreme emergency, only the Shift Administrator/Shift Manager/Assistant Shift Administrator shall authorize the use of physical force); § V(D) (staff involved in a use of force incident must submit a written report); § VIII(E) (any inmate placed in restraints must be seen by
medical personnel as soon as reasonably possible). CX 4. Appellant was also found to have violated the following DOCR policies; namely, Policy Number 3000-7: § VII(E)(3) (use of force); § VII(E)(4) (integrity of the reporting system); § VII(E)(9) (conduct unbecoming, false report); § VII(E)(10) (Neglect of Duty/Unsatisfactory Performance). CX 5. Finally, Appellant was found to have violated MCCF Post Order No. 3(C) (Correctional Supervisor Sergeant duties) and MCCF Post Order No. 4(C) (Senior Floor Officer duties). CX 6.

On December 14, 2017, the County filed a prehearing submission and exhibits pursuant to the Board’s procedural rules. On January 2, 2018, Appellant filed his prehearing submission and exhibits. Included in Appellant’s prehearing submission was a Motion to Dismiss the charges against him as untimely. Appellant Prehearing Submission, pp. 3-4. The County moved to consolidate this matter with MSPB Case No. 18-07, which involves the discipline of another correctional officer, (Corporal RS), in connection with the same April 27, 2017, use of force incident. County Motion to Consolidate, January 16, 2018. Appellant filed a response opposing consolidation on January 23, 2018. On January 25, 2018, Appellant filed an Amended Prehearing Submission. On February 27, 2018, the Board issued an order denying Appellant’s motion to dismiss the charges against him.

On March 6, 2018, the parties appeared before the Board for a prehearing conference. Because the prehearing conference in Case No. 18-07 was scheduled to immediately follow the prehearing conference in this case, the Board asked Appellant if he was willing remain in the conference room so that the Board could discuss the consolidation issue with all parties at the same time. Appellant agreed to this approach, as did the appellant in Case No. 18-07 (RS) and his attorney.

The Board discussed with the parties in both cases whether there was an acceptable approach that would obviate the need for the Board to hear the same testimony from the same witnesses in two separate hearings. After discussion, the Board and the parties in both cases agreed to jointly hear the testimony of witnesses and produce a joint hearing transcript. Except for the taking of testimony the cases were not consolidated. On March 14, 2018, the Board issued a Prehearing Order.

The joint hearing was held over the course of three days, July 16, 17, and 18, 2018. During the hearing the Board heard testimony from ten witnesses, including the appellants in both MSPB Case Nos. 18-06 and 18-07.¹ County Exhibits 1 through 18 and 20 through 21 were admitted into

¹ The following witnesses testified and are identified by their initials, or as “Appellant,” elsewhere in this decision:

1. Corporal KM
2. Corporal JB
3. Lieutenant AM
4. Lieutenant DL
5. Deputy Warden Captain CSG
6. Captain DW
7. Director RG
8. Sergeant GS
Subsequent to the hearing the parties submitted post-hearing briefs, including proposed findings of fact and conclusions of law, and rebuttals. See Post-Hearing Brief of Montgomery County, September 17, 2018 (County Brief); Appellant Closing Statement Brief, September 17, 2018 (Appellant’s Brief); Appellant Post Hearing Rebuttal Brief, October 15, 2018 (Appellant’s Rebuttal); Employer’s Response to Appellant Closing Statement Brief, October 18, 2018 (County Response).

After hearing the testimony and reviewing the exhibits and briefs of the parties the appeal was considered and decided by the Board. The Board separately decided the cases and issued separate decisions and orders.

FACTUAL POSITIONS OF THE PARTIES

The Board carefully considered the factual positions of the parties, which we set out below.

Appellant’s Factual Position

The following reflects Appellant’s position on the facts in this case:

1. Appellant was hired as a Correctional Officer with DOCR on July 12, 2004, after having retired as a sergeant with the State Division of Corrections. CX 15; Tr. 850.
2. On April 27, 2017, Appellant was acting as the Cluster Sergeant in charge of supervising the Crisis Intervention Unit (CIU). Tr. 856-57.
3. As the Cluster Sergeant, Appellant was the highest-ranking officer in the CIU and all other correctional officers were required to obey his commands. Tr. 857.
4. Inmate SG was escorted by Appellant and other officers from the North 1 housing unit to the medical department after SG claimed to have ingested deodorant. Tr. 833, 898, 921.
5. The nursing staff in medical told Appellant that Inmate SG had not drunk enough deodorant to be a health concern, but that he was to be placed on a suicide watch. Tr. 833.
6. While being escorted back to the CIU, Inmate SG made statements suggesting that he would do anything he could to get out of MCCF and to an outside medical facility. Tr. 837, 921.

9. Sergeant (CR or Appellant)
10. Corporal (RS)
7. Inmate SG was well-known for being difficult to manage and a disciplinary problem. Tr. 920.

8. After being placed in CIU cell B1, Inmate SG became upset because being placed on suicide watch meant that he would be stripped naked, put into a suicide gown, and have to sleep on a mattress on the floor. Tr. 834.

9. After Inmate SG reluctantly agreed to change into the suicide gown, Appellant and the other correctional officers left the cell. Tr. 835.

10. Shortly after leaving cell B1, Appellant heard loud banging noises coming from B section. Tr. 835, 837, 860-61, 921.

11. Corporal RS informed Appellant that Inmate SG was “banging his head.” Tr. 835, 849, 867, 918, 921.

12. Appellant had worked with Corporal RS for years and had no reason to doubt him. Tr. 922.

13. Corporal JB testified that he too heard banging coming from SG’s cell. Tr. 194.

14. County witness Lieutenant AM conceded that if an inmate is banging his head and his life may be in imminent danger, it would be appropriate to enter the cell to restrain him from further self harm. Tr. 223-24.

15. County witness Lieutenant DL also testified that if the inmate is causing imminent harm to himself the correctional officers on the scene need not wait for a shift commander to enter the cell, but that the shift commander should be notified at the earliest opportunity. Tr. 343.

16. Based on the totality of the circumstances and what Appellant knew about Inmate SG, Appellant believed that SG was causing serious injury to himself in cell B1. Tr. 837, 867.

17. Corporal JB also testified that the only reason he entered SG’s cell was to make sure that the inmate was not hurting himself. Tr. 194-95.

18. Accordingly, Appellant gave Corporal KM, the officer assigned to the B section control panel, an order to open the door to SG’s cell. Tr. 835-36.

19. After Corporal KM opened the door to cell B1 Officers JB, JG, and RS entered the cell. Tr. 836.

20. Inmate SG was standing in the back of the cell when they entered. Tr. 836.

21. Appellant was standing in the doorway. Tr. 836.

23. At some point, Inmate SG became a little resistant, so Appellant ordered the officers to lay him down on the mattress on the floor. Tr. 836.
25. Appellant did not see any sign of injury. Tr. 837.
26. Appellant then walked out of the cell and turned around to observe what was happening in the cell. Tr. 837.
27. Inmate SG then quickly flipped himself up and jumped off the mattress and went towards Corporal RS. Tr. 837-38, 875, 880.
28. Corporal RS then grabbed SG by his jumpsuit or suicide smock, put his right arm over the inmate, and took him face first toward the wall by the sink. Tr. 838-39, 875, 879, 881.
29. Corporal RS then used his knuckles to apply force to the hypoglossal nerve under Inmate SG’s jaw. Tr. 838-41.
30. The hold Corporal RS used lasted 2-3 seconds and there was not enough time for Appellant to intervene. Appellant’s Brief, p. 5.
31. The maneuver did not seem to work too well so Corporal RS turned Inmate SG around and positioned the inmate against the wall to the rear and reapplied the maneuver. Tr. 839-40.
32. When Corporal RS reapplied the maneuver more successfully Inmate SG said “it hurts, it hurts.” TR. 841.
33. Although the inmate also said that he could not breathe, his airway was not cut off, as evidenced by his ability to speak. Tr. 755, 948.
34. After application of the pressure point by Corporal RS Inmate SG calmed down and he and Corporal RS began arguing. Tr. 841.
35. Appellant intervened, telling Corporal RS to be quiet. Appellant’s Brief, p. 5; Tr. 841.
36. Corporal RS ceased arguing with the inmate and Appellant was able to calm the inmate and defuse the situation. Appellant’s Brief, p. 5; Tr. 842.
37. Inmate SG’s handcuffs were then removed, and all officers exited the cell. Appellant’s Brief, p. 5; TR. 843.
38. Sergeant GS testified that it is the policy in DOCR “that we use whatever means necessary to guard against attack where serious death or bodily injury could occur.” Tr. 750.
39. Sergeant GS also stated that “You can do whatever you deem necessary so long as it appears what a reasonable person would do at the scene rather than hindsight 20/20,” and that DOCR trainers do not wish to “incorporate hesitation into the trainees.” Tr. 751-52.

40. DOCR Use of Force Policy 1300-10 grants correctional officers the authority to act when an officer reasonably believes force is necessary to protect others from harm and to prevent self-injury. Appellant’s Brief, p. 1.

41. Lieutenant DL testified that in a use of force restraint situation that does not involve use of a restraint chair there is no obligation to call medical “unless the inmate has a visible injury or is complaining about pain somewhere.” Appellant’s Brief, p. 11; Tr. 363.

42. Appellant testified that after the incident there was no visible sign of injury on Inmate SG. Tr. 837, 867.

43. Appellant testified that there was no visible injury or other evidence that the inmate’s head had been struck. Tr. 837.

44. Appellant concedes that he “should have reported to my shift supervisor and documented the incident.” Appellant’s Brief, p. 3; Tr. 849.

45. The entry into Inmate SG’s cell was not planned, it “was spontaneous and fluid.” Appellant’s Brief, p. 5.

46. Because Appellant believed Inmate SG was causing serious injury to his head and immediate response was necessary, this was not a planned use of force that would have required a call to the shift lieutenant before entering the cell. Appellant’s Brief, p. 7; Tr. 867.

47. Corporal KM was outside of Inmate SG’s cell and not in a position to observe the incident. Tr. 176, 182, 314, 843, 915-16, 952, 998.

48. Corporal KM’s testimony was not credible because he told investigators that he had reported the April 27 incident to Human Resources and then changed his story to say that he had reported it to the Office of the Inspector General (OIG). AX 2; Tr. 81, 84.

49. KM’s hearing testimony was fabricated and not credible because he has resentment against Appellant for correcting him on the way he performed his job. Tr. 916-17, 998.

50. There are other cases involving similar infractions where DOCR imposed less severe discipline than that imposed on Appellant. AX 12, 13, and 14.
The County’s Factual Position

The County’s position on the facts is as follows:

1. The CIU is a housing unit for inmates who have mental health issues or who need to be monitored for suicidal ideations. Tr. 52.
2. Within the CIU is the B unit where individuals who have serious mental health issues are placed. Tr. 223.
4. Cell Bl has a mattress but no bed frame. Tr. 153.
5. The cell has a sink and toilet but is otherwise empty. CX 20.
6. The door to cell Bl has windows at the top and bottom of the door, and there is a food slot in between the two windows. Tr. 154, 268; CX 20.
7. An individual standing outside the door to cell Bl and looking through the window can see the entirety of the cell. Tr. 62, 99, 165.
8. On April 27, 2017, Corporal KM and Corporal RS were assigned as correctional officers to the CIU. Tr. 52.
9. Appellant was their supervisor for that shift. Tr. 52.
10. Corporal KM was assigned to the control panel from which he could open and close doors within CIU. Tr. 56-57.
11. The control panel is located in the center of the unit and there are windows at the control unit that look into the B unit. Tr. 56.
12. The proper protocol when entering into an occupied cell on the B unit is to handcuff the inmate through the food slot prior to entry and uncuff the inmate through the food slot after exiting the cell. Tr. 230.
13. Inmate SG was brought to the CIU on April 27, 2017 after a report that he had tried to drink deodorant and had been deemed to have suicidal ideations. Tr. 53-54, 153.
14. After Inmate SG was brought to CIU, he was placed in cell Bl. Tr. 55, 153.
15. Inmate SG changed into a suicide gown without incident and the cell door was closed. Tr. 57.
16. Approximately 10:00 p.m., after Inmate SG had changed into the suicide gown and the door was closed, a banging noise was heard coming from that cell. Tr. 58.

17. After the banging began, Corporal RS asked Corporal KM to open the door to Inmate SG’s cell. Tr. 58, 157.

18. Upon hearing the request from Corporal RS, Appellant ordered Corporal KM to open the cell door. Tr. 835.

19. Corporal KM opened the door to cell B1 and then ran into the B unit to observe what was happening inside the cell. Tr. 58.

20. Corporal RS entered the cell, followed by Corporal JB and Corporal JG, while Appellant remained outside in the doorway of the cell. Tr. 158.

21. At no time prior to entry into the cell did Corporal RS visually confirm that Inmate SG was banging his head or otherwise harming himself. Tr. 973-74, 977-78.

22. At no time prior to entry into the cell did Appellant visually confirm that Inmate SG was banging his head. Tr. 861.

23. No officer visually confirmed that Inmate SG was actively harming himself before they entered the cell. Tr. 58, 157, 195, 268, 861, 864, 973-74, 977-78.

24. When Corporal RS entered the cell, Inmate SG was not actively banging his head. Tr. 268.

25. At the time officers entered the cell, there was no confirmed on-going emergency that justified entry into the cell. Tr. 274.

26. Prior to entering the cell, there was nothing preventing Appellant from calling a Lieutenant. Tr. 863.

27. Likewise, nothing prevented Appellant from calling a Lieutenant either while the incident was occurring or after the incident concluded.

28. Each officer is equipped with a radio which they carry on their person. The component used to speak into the radio is located on the shoulder of each officer. To place a call on the radio, one needs to press a button on the side of the device located on the shoulder and speak. That transmission would be heard throughout the facility on each officer’s radio, including the Lieutenant’s. Additionally, there is a phone at the control station that can be used to call a Lieutenant. Tr. 220-22, 419-20.
29. Once inside the cell, Corporal RS, Corporal JB, and Corporal JG handcuffed Inmate SG pursuant to Appellant’s order. Tr. 59.

30. Corporal JB and Corporal JG then assisted Inmate SG to stand up and faced him towards the wall by the sink. Tr. 65, 296; See CX 20 for visual reference.

31. At the time that Inmate SG was handcuffed and standing by the wall, he was under control. Tr. 69-70, 121, 167.

32. Corporal RS came behind Inmate SG as he was facing the wall and choked him by placing his right hand and arm around Inmate SG’s neck. Tr. 66, 70, 100, 166.

33. The move was also described as a headlock. Tr. 165.

34. This action caused Inmate SG to say, “I can’t breathe.” Tr. 66, 256-57, 891, 948.

35. Inmate SG also said that the action caused him pain. Tr. 256-57, 882, 889, 948.

36. Inmate SG also said that Corporal RS was choking him. Tr. 259.

37. After Inmate SG made those statements, Corporal RS released his grip on Inmate SG and then choked him again. Tr. 67, 259.

38. The second time Corporal RS placed his hands on Inmate SG, he did it “really hard, hard and fast so it would hurt very much.” Tr. 281-82.

39. After releasing the hold Corporal RS asked Inmate SG if he was going to behave. Tr. 67.

40. Inmate SG was still handcuffed behind his back. Tr. 168, 296, 302.

41. At the time that Corporal RS put his arm around Inmate SG’s neck, Inmate SG was compliant and there was no need for any force to be used. Tr. 103-04, 167, 201-02, 205-06, 229.

42. Inmate SG had not made any aggressive or assertive act towards Corporal RS or any other officer prior to Corporal RS placing his hands on Inmate SG. Tr. 71-72, 166.

43. Inmate SG had not made any threats or engaged in spitting, kicking, or biting. Tr. 121-122, 166.

44. Corporal RS did not apply an approved or taught pressure point on Inmate SG when he placed his hand and arm around Inmate SG’s neck. Tr. 106.

45. After Corporal RS choked Inmate SG, Appellant ordered the officers to place SG down on the mattress inside the cell and remove his handcuffs. The officers did so and then exited the cell and the door was closed. Tr. 168-69.
46. Once the incident was over, the other officers involved specifically asked Appellant whether they needed to document the incident and Appellant told them they did not have to write reports. Tr. 73-74, 169, 893.

47. Appellant told Corporal JB that he was willing to take responsibility if there was an issue regarding the failure to report. Tr. 171.

48. Appellant was asked multiple times by multiple officers whether they needed to write a report, and each time Appellant told them not to write a report. Tr. 73-74, 170.

49. Appellant admitted that when he told Corporal JB, “we are good,” it could be construed as a directive not to write a report. Tr. 893.

50. At no time prior to, during, or after the incident did Appellant contact the Lieutenant on duty to report the incident. Tr. 223, 893.

51. Appellant was required to report the incident. Tr. 204, 206; CX 4.

52. Appellant, as shift supervisor, was required to ensure that use of force reports were written. Tr. 295.

53. When there is a use of force outside of normal or routine procedures, the medical unit must be called to evaluate the inmate. Tr. 401-02; CX 4, § (VII)(E).

54. At no time during or after the incident did Appellant contact the medical unit to have Inmate SG evaluated for injuries. Tr. 894.

55. Appellant is neither a doctor, nor a paramedic. Tr. 853.

56. Inmate SG should have been seen by medical after the incident. Tr. 291.

57. After the choking incident, Appellant completed a report regarding Inmate SG’s visit to the medical unit prior to coming to CIU. Tr. 847; CX 17.

58. Appellant did not complete a Use of Force report (DCA 36) to document the incident in CIU, cell B1. Tr. 849, 892.

59. Later during the shift on April 27, 2017, Appellant called the CIU to check on Inmate SG. Tr. 109-10, 847, 957-58.

60. Appellant told Corporal RS and other Correctional Officers not to report the use of force. Tr. 73, 86, 170-71.

61. According to Corporal KM, after the use of force against inmate SG, Corporal RS asked Appellant “do we have to write anything?” Tr. 73.
62. Appellant’s response was, “Don’t worry about it. I did not see anything.” Tr. 73-74; 86.
63. Corporal JB asked Appellant whether he should file a report on the incident and was told that it was a “minimal incident” that did not require a report. Tr. 170.
64. When JB asked again the next week, Appellant said that “he had gone back and spoken with the inmate and he was fine,” so no report was necessary. Tr. 171.
65. Appellant assured JB “that if something were to come over, that he would take responsibility for us not writing a report.” Tr. 171.
66. Notwithstanding Appellant’s order not to write a report, Correctional Officers KM and JB eventually reported the use of force to the OIG. CX 1; Tr. 79, 137, 171-72.
67. The OIG conducted an investigation of the incident and submitted a written report to Director on June 5, 2017. CX 1; Tr. 574-75.
68. Upon receipt of the report, Director ordered an internal investigation of the incident, which was completed by Captain MW. CX 2; Tr. 576.
69. When a Use of Force report (DCA 36) is written by an officer, it is submitted to the Sergeant and then to the Lieutenant. Tr. 133.
70. The Lieutenant conducts an investigation including a use of force checklist, gathers all reports, reviews video surveillance, and then forwards the information to the Deputy Warden with a recommendation on whether the use of force was justified. Tr. 219, 421; CX 4, §§ (V)(D) and (V)(E). That process did not happen because no DCA 36 was filed.
71. The Use of Force Policy of the DOCR is available, at all times, on a shared drive accessible to all correctional officers. Tr. 120-21, 521, 587.
72. Officers are told to review the policy. Tr. 120-21.
73. Additionally, officers receive use of force training during pre-shift training. Tr. 525.
74. Use of force training does not include training on the use of pressure points or defensive tactics techniques. Tr. 332.
77. Corporal RS has never taken a Defensive Tactics training while employed by DOCR. Tr. 316, 344.
78. Corporal RS was not interested in and never requested to take a Defensive Tactics course while employed by DOCR. Tr. 284, 286-87.
79. Appellant took a Defensive Tactics course while employed by DOCR, in 2010. Tr. 854.
80. The Defensive Tactics training did not cover headlocks or choke holds. Tr. 854.
81. The Defensive Tactics course is offered monthly by DOCR. Tr. 523.
82. It is not a State law requirement to take the Defensive Tactics class every year. Rather, it is a departmental goal for all officers to take yearly defensive tactics training. Tr. 522.
83. The Defensive Tactics course is taught by Lieutenant DL, who is also the instructor for the Emergency Response Team (ERT). Tr. 324.
84. Defensive Tactics is a hands-on class. Tr. 332.
85. Only five pressure point techniques are taught in the Defensive Tactics course, to include the mandibular angle, infraorbital, C-clamp, femoral, and common peroneal. Tr. 333.
86. The Defensive Tactics course does not teach officers to place inmates in headlocks or chokeholds. Tr. 336, 340.
87. The pressure point known as the mandibular angle is effectuated by applying pressure to the soft spot behind the earlobe with a part of the thumb while having counter pressure against the head. Tr. 333.
88. This pressure point does not require the head to be secured by a hand. Tr. 333.
89. At the time of the incident, there were no surveillance cameras filming inside the cell or inside the B unit. Tr. 493.
90. At the time of the incident, there was a surveillance camera filming the central part of the CIU unit. Tr. 493.
91. By the time DOCR had notice that the incident occurred the video footage was no longer available due to the system recording over video more than two to four weeks old, depending on movement in the area being recorded. Tr. 492, 632.
92. Appellant learned within a week to 10 days after the incident that the OIG was investigating the incident. Tr. 894.
93. Even after learning about the OIG investigation Appellant at no time requested that the surveillance video be preserved. Tr. 894.
94. Prior to this incident, Corporal KM did not hold any resentment towards Appellant. Tr. 88.
95. At the conclusion of the incident, Inmate SG asked Corporal RS why he was doing this to him, and Corporal RS told him that’s what you get for not listening. Tr. 67.

96. Corporal RS admitted that he told SG that he wanted him to stop and behave. Tr. 999.

97. As a result of the incident, Director [redacted], with guidance from Warden [redacted] and Deputy Warden CSG, decided to dismiss Appellant. Tr. 580.


100. Appellant, Corporal RS, and Sergeant GS are personal friends. Tr. 903.

101. Appellant was hired by the [redacted] County Jail on November 2, 2017 and was still employed there at the time of the hearing. Tr. 903-04.

**FINDINGS OF FACT**

After hearing testimony, reviewing exhibits, and weighing the proposed findings of fact of both parties, the Board has made the following factual findings.

On April 27, 2017, Appellant was the Sergeant in charge of supervising the CIU, and the other correctional officers were under his command. On that day, Inmate SG claimed to have ingested deodorant and expressed suicidal ideations. After examination by the medical unit at MCCF it was determined that he had not consumed enough deodorant to cause him harm. The medical staff ordered that SG be placed on a suicide watch, so Inmate SG was taken to the CIU and placed in cell B1, a suicide watch cell. Cell B1 had a mattress with no bed frame, a sink and toilet, but was otherwise empty.

Inmate SG was less than pleased with the conditions he would face in the suicide watch cell. Tr. 834. However, after SG and Appellant discussed the situation, SG complied with Appellant’s instructions that he change into a suicide gown. Tr. 57. After he did so without incident Appellant and other correctional officers left cell B1. Tr. 835. The cell door was then closed. Tr. 57.

A short time later, around 10:00 p.m., officers heard “loud banging” coming from Inmate SG’s cell. Tr. 58, 194, 835, 837, 860-61, 921. Corporal RS testified that he went to the cell door and he and Inmate SG began yelling at each other. Tr. 936, 973. Appellant acknowledged that in addition to the banging noise he also heard “arguing going on in the B pod area,” and that he “couldn’t see what was going on in there.” Tr. 835.

Corporal RS attempted to handcuff Inmate SG through the food slot of the closed cell door, but SG refused to cooperate and retreated to the back of the cell. Tr. 936-38. It was at that point
that Corporal RS said that SG was “banging his head.” Tr. 835, 849, 867, 918, 921. Corporal RS asked that the cell door be opened, and Appellant ordered Corporal KM, the officer at the control panel, to open the door to SG’s cell. Tr. 58, 157, 835-36.

Appellant testified that he could not see what was happening in cell B1 and relied on the statement of Corporal RS that Inmate SG was banging his head. Tr. 835, 921-22. Neither Appellant, Corporal RS, nor any of the other correctional officers actually saw Inmate SG banging his head. Tr. 58, 157, 195, 268, 861, 864, 973-74, 977-78. Once Corporal RS went to Inmate SG’s cell door the banging ceased. Tr. 268-69.

Appellant and officers JB and JG responded to cell B1. Tr. 835, 849, 867, 918, 921. Appellant states that he ran to the cell, which was about 30 to 35 feet away, and arrived in about three (3) seconds. Tr. 866. Appellant stated that he did not begin moving towards cell B1 until after he had ordered that the cell door be opened. Tr. 865.

Entering the cell was no small matter. To reduce the risk of assault on correctional officers the appropriate protocol is to handcuff the inmate through the food slot prior to entry. Tr. 230. Presumably, that is why Corporal RS attempted to handcuff Inmate SG through the food slot prior to asking for the cell door to be opened. Tr. 936.

When SG argued with Corporal RS, refused to be handcuffed, and instead went to the back of his cell, the banging had ceased. Tr. 268-69, 936-37. Corporal RS nevertheless asked for the door to be opened. Tr. 938. Appellant was a few steps away from the cell and admits that he heard the loud banging followed by the verbal exchange between Corporal RS and Inmate SG, Tr. 835, yet he made no attempt to verify that an emergency existed that would require immediate entry into cell B1.

Appellant’s witness, Sergeant GS, and County witnesses Lieutenant AM and Lieutenant DL all testified that if an inmate is violently banging his head or otherwise causing imminent harm or danger to himself it would be appropriate to immediately enter a cell to prevent self harm. The testimony of Lieutenant AM and Lieutenant DL was based on hypotheticals, while the testimony of Sergeant GS was based on his review of the investigative report and conversations with Appellant and Corporal RS.

The record evidence, however, does not support Appellant’s claim that such a situation existed prior to his order that Inmate SG’s cell door be opened. Upon hearing the loud noise coming from SG’s cell Appellant had an ample opportunity to accurately assess the situation by quickly taking a few steps and looking into the cell. Tr. 866. Instead, Appellant says that he chose to trust Corporal RS because they have known each other for years. Tr. 922. Appellant’s decision was likely influenced by his personal friendship with Corporal RS, as were the opinions expressed in the testimony of Sergeant GS. Tr. 903. Appellant’s reliance on the word of a friend, his failure to verify whether an emergency existed before authorizing entry into Inmate SG’s cell, and the

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3 Corporal RS provided inconsistent testimony concerning Inmate SG’s behavior. At one point Corporal RS seemed to suggest that he may have seen Inmate SG banging his head from the corner of his eye (Tr. 935, 971-72), but later conceded that he never saw Inmate SG banging his head or otherwise harming himself and had made an assumption because he saw the inmate’s face in cell door window while the noise was being made. Tr. 972-74, 977-78.
subsequent use of force were not reasonable under the circumstances. That is especially so because by the time Appellant’s order to open the cell was given the banging had ceased. In the absence of a true emergency, Appellant was instead obligated under DOCR Policy 1300-10.V.A to contact the Lieutenant supervising the shift in order to obtain authorization for “the use of physical force to either move or restrain an unruly or uncooperative inmate.”

Corporal KM was on the unit and operating the control panel, which is in the center of the unit. Tr. 56. After Corporal KM opened the door to cell B1, Appellant watched Officers JB, JG, and RS enter the cell. Tr. 836. Appellant remained in the doorway and ordered the other officers to handcuff Inmate SG, who was standing in the back of the cell. Tr. 836. Corporal KM testified that the control panel was about 10-15 steps away from cell B1, and that after he opened the cell door he too went to the cell to see what was happening. Tr. 58.

Corporal KM further testified that when he got to cell B1 he saw officers JB and JG handcuff Inmate SG and order him to lay on the ground. Tr. 59, 63-64. Corporal KM said that Inmate SG was not resisting, and that Corporal RS kicked Inmate SG in the “facial area.” Tr. 64. No other witness testified to observing Corporal RS kicking the inmate. Tr. 184, 200, 845, 954.

Appellant challenges Corporal KM’s testimony and seeks to discredit him by suggesting that it was not possible for KM to observe what happened in the cell because Appellant did not see KM by the cell door. Appellant’s Brief, p. 14. However, Appellant admitted that he was facing the cell and that his focus was on what was happening inside the cell. Tr. 846. Corporal JB also stated that his field of view did not include where Corporal KM said he was standing outside the cell. Tr. 182-83. Corporal RS also testified that his focus was on his dealings with the inmate and not on who was standing in the cell doorway. Tr. 952, 981. We find it more likely than not that Corporal KM did go to the cell to observe events and that the other officers, including Appellant, were occupied with the inmate and did not notice where KM was standing. We conclude that KM had the opportunity and capacity to observe what took place after the other officers entered cell B1.

Appellant also suggests that Corporal KM harbored personal resentment against him and therefore gave false testimony at the hearing and to the investigator, Captain MW. Appellant’s Brief, p. 14. Appellant speculates that KM resented him “for making corrections to his units, the way he runs his pod.” Tr. 916. Corporal KM denied ill will or resentment toward Appellant and testified that he had not been disciplined or written up by Appellant. Tr. 88. Other than Appellant’s unsupported allegation there is no evidence in the record that KM had a motivation to be untruthful. We find no evidence in the record of any discipline of KM by Appellant, or that there was any reason for KM to harbor resentment against Appellant. We find that the allegations of KM’s personal bias against Appellant are unsubstantiated and unconvincing.

Appellant also argues that KM is not to be believed because KM allegedly told the investigator that he first reported the April 27 incident to OHR, and in a subsequent interview said that he had first spoken to the OIG. Corporal KM testified at the hearing that there may have been miscommunication during the first interview. Tr. 84. Corporal KM said that he never told the investigator that he went to OHR. Tr. 83. In any event, the issue was clarified in a subsequent interview when KM explained to the investigator that he had discussed the incident with the OIG. CX 2. This misunderstanding over a minor and immaterial fact hardly suggests dishonesty.
Whether KM misspoke or the investigator misheard is unimportant and certainly does not suggest a motivation for KM to testify untruthfully under oath.

KM’s decision to report the incident despite instructions to the contrary, and his frank acknowledgement of his regrets about previously failing to report certain unspecified incidents while serving in military detention facilities overseas, add credence to his testimony. Tr. 136-37. For the reasons discussed above, because his version of events was plausible, and based on his straightforward, consistent, and believable demeanor while testifying, we find Corporal KM to be a credible witness and give weight to his testimony.

With specific regard to KM’s testimony that he saw Corporal RS kick Inmate SG in the “facial area,” neither direct nor cross examination elicited additional useful detail as to the circumstances. Thus, while we credit KM’s testimony generally, we are unable to adequately assess the likelihood that KM may, in the confusion of the moment, have seen a kick to the face or merely a movement that he erroneously interpreted as a kick. Moreover, because of the failure to refer Inmate SG for medical examination, we have no medical evidence concerning the presence or absence of an injury to SG’s face, head, or neck. In any event, we need not reach a conclusion as to whether or not RS actually did kick SG to conclude, as we do below, that Appellant improperly allowed an unnecessary use of force and failed to prevent the excessive use of force.

Appellant testified that after Inmate SG was handcuffed and the other officers had placed him face down on the mattress, he checked SG’s head for injuries and found none. Tr. 837, 880. Appellant then walked out of the cell and turned to observe what was happening in the cell. Tr. 837.

According to Appellant, Inmate SG then suddenly rises from a face down position to his knees, “flips himself up,” and jumps off the mattress towards Corporal RS. Tr. 837-38, 875, 880. When asked how SG could quickly rise to his knees without rolling over, jump to his feet, and lunge at Corporal RS from a position face down on the mattress with his arms handcuffed behind his back, Appellant responded that SG was “young” and “pretty flexible.” Tr. 880. Corporal RS told investigators that Inmate SG “stood up quickly (from a laying-down position while handcuffed in the back) and approached him and the other officers.” CX 2, p. 13; Tr. 315.

The Board finds this version of events espoused by Appellant and Corporal RS implausible. We find more credible the testimony of KM that, because it is so difficult for a person to stand up after being handcuffed behind the back and face down on the floor, Corporals JB and JG helped Inmate SG to stand up. Tr. 65. Corporal JB also testified that Inmate SG “was stood up.” Tr. 162-63. If Inmate SG had gotten to his feet from such an awkward position it could not have been as quickly as Appellant suggests. We conclude that Inmate SG was not in a position to and did not attempt to lunge at or assault Corporal RS.

4 “I served in the U.S. Army. I served overseas, five tours. So I work in different detention facility. And I saw stuff that I never reported. But later on, it come back and I feel guilty about it because I thought I must say something. So I wasn’t allowed to be pretty much proud of me later on in my life. Because it can happen to me. It can happen to my son. It can happen to anyone. I mean, we are trusted with this inmate (inaudible) making sure they are safe, they are secure in the facility. And to be honest with you, the other thing I was thinking the inmate can later on go back and report it, so I better come forward and do the right thing.” Tr. 136-37.
We find that after Inmate SG was under control, handcuffed behind his back and face down on the mattress, officers JB and JG helped him to his feet. Tr. 65. They then had him stand facing the wall of the cell, next to the sink. Tr. 66, 296; CX 20. We credit the testimony of Corporals KM and JB that while Inmate SG was handcuffed and facing the wall he was under control and not resisting. Tr. 69-70, 121-22, 163, 166-67.

Although Inmate SG was compliant, he was continuing to talk in an agitated manner. Tr. 163, 167. Corporal JB testified that while Appellant was talking to Inmate SG, Corporal RS came up behind Inmate SG, put his right arm around SG’s neck in a headlock, and moved him face first towards the wall by the sink. Tr. 165-67. Corporal KM gave similar testimony. Tr. 66, 70, 100. The headlock or chokehold Corporal RS applied to Inmate SG caused him to exclaim, “I can’t breathe.” Tr. 66, 256-57, 259, 891, 948, 987.

After Inmate SG claimed that he was choking, Corporal RS released his grip, and then immediately endeavored to apply the maneuver more effectively. Tr. 67, 259, 987. Corporal RS admits that the second time he applied the pressure point to Inmate SG he did so “really hard, hard and fast so it would hurt very much.” Tr. 282, 987. Corporal RS was successful in his second attempt and Inmate SG exclaimed that he was in pain. Tr. 256-58, 841, 882, 889, 948. Corporal RS testified that the application of the hold and use of the pressure point on Inmate SG, who was handcuffed behind his back and did not represent a threat to Corporal RS or the other officers, was for “pain compliance.” Tr. 296, 302.

Corporal RS acknowledged that after he finished successfully applying the “pain compliance” maneuver the second time, he told Inmate SG to behave. Tr. 999. Although not remembering the exact words, Corporal KM recalled Corporal RS telling Inmate SG “that’s what you get” for not behaving. Tr. 67.

Corporal RS and Inmate SG continued to talk and Appellant intervened, telling Corporal RS to be quiet. Tr. 841, 956. Appellant spoke to Inmate SG and then ordered the other officers to place SG down on the mattress inside the cell and remove his handcuffs. The officers then exited the cell and the door was closed. Tr. 168-69, 842-43.

DOCR policy mandates that each correctional officer involved in a use of physical force incident must file a report using form DCA 36 before the end of their shift. CX 4, DOCR Policy 1300-10, § (V)(D); Tr. 204, 206. The policy also requires that supervisory personnel ensure that the incident is documented, including photos of the inmate. Id.

It is undisputed that, contrary to DOCR policy, the use of force incident was not reported in writing by Appellant by way of a DCA 36 or otherwise. Tr. 849, 892. Nor did Appellant report the incident to the Lieutenant who was the shift commander on duty. Tr. 223, 893.

As a supervisor, Appellant was also required to ensure that use of force reports were submitted by subordinates who were involved in the use of force. Tr. 295. Appellant failed to carry out that responsibility and instead instructed the officers under his command not to file reports on the use of force. Tr. 73-74, 86, 169-71, 893. Appellant told Corporal JB that he would take responsibility if there was an issue regarding the failure to report, Tr. 171, and admitted that when he told Corporal JB, “we are good,” it could be construed as a directive not to write a report. Tr. 893. When other officers asked Appellant whether they should write reports Appellant told them not to
file reports. Corporal KM testified that when Corporal RS asked Appellant “do we have to write anything?” Appellant’s response was, “Don’t worry about it. I did not see anything.” Tr. 73-74; 86. In response to Corporal JB asking, Appellant told him that it was a “minimal incident” that did not require a report. Tr. 170. When Corporal JB asked again the next week, Appellant said that “he had gone back and spoken with the inmate and he was fine,” so no report was necessary. Tr. 171. Appellant further assured JB, “that if something were to come over, that he would take responsibility for us not writing a report.” Tr. 171.

Eventually Officers KM and JB reported the use of force to the OIG. CX 1; Tr. 79, 137, 171-72. The OIG investigated the incident and provided a report to Director RG on June 5, 2017. CX 1; Tr. 574-75. Director [redacted] then ordered an internal investigation of the incident, which was completed by Captain MW. CX 2; Tr. 576.

DOCR policies also mandate that when there is a use of force outside of routine procedures, the medical unit must be notified so that the inmate may be evaluated. Tr. 291, 401-02; CX 4, DOCR Policy 1300-10, § (VII)(E). However, contrary to DOCR policy, after the use of force Appellant did not refer Inmate SG to the medical unit so that he could be evaluated for injuries. Tr. 894.

After the incident, Appellant submitted a report concerning Inmate SG’s visit to the medical unit, which occurred prior to his being taken to the CIU, but made no mention of the subsequent use of force. Tr. 847; CX 17.

APPLICABLE LAW

Montgomery County Personnel Regulations (MCPR), 2001 (as amended December 11, 2007, October 21, 2008, November 3, 2009, and June 30, 2015), § 33, Disciplinary Actions, which provides, in pertinent part:

§ 33-1. Definition.

Disciplinary action: One of the following adverse personnel actions taken by a supervisor against an employee:

(a) oral admonishment;
(b) written reprimand;
(c) forfeiture of annual leave or compensatory time;
(d) within-grade salary reduction;
(e) suspension;
(f) demotion; or
(g) dismissal.
§ 33-2. Policy on disciplinary actions.

(a) Purpose of disciplinary actions. A department director may take a disciplinary action against an employee to maintain order, productivity, or safety in the workplace.

(c) Progressive discipline.

(1) A department director must apply discipline progressively by increasing the severity of the disciplinary action proposed against the employee in response to:

(A) the severity of the employee’s misconduct and its actual or possible consequences; or

(B) the employee’s continuing misconduct or attendance violations over time.

(2) Progressive discipline does not require a department director to apply discipline in a particular order or to always begin with the least severe penalty. In some cases involving serious misconduct or a serious violation of policy or procedure, a department director may bypass progressive discipline and dismiss the employee or take another more severe disciplinary action.

(d) Consideration of other factors. A department director should also consider the following factors when deciding if discipline is appropriate or how severe the disciplinary action should be:

(1) the relationship of the misconduct to the employee's assigned duties and responsibilities;
(2) the employee's work record;
(3) the discipline given to other employees in comparable positions in the department for similar behavior;
(4) if the employee was aware or should have been aware of the rule, procedure, or regulation that the employee is charged with violating; and
(5) any other relevant factors.

§ 33-3. Types of disciplinary actions.

(h) Dismissal. Dismissal is the removal of an employee from County employment for cause.
§ 33-5. Causes for disciplinary action. The following, while not all-inclusive, may be cause for a disciplinary action by a department director against an employee who: . . .

(c) violates any established policy or procedure; . . .

(e) fails to perform duties in a competent or acceptable manner; . . .

(h) is negligent or careless in performing duties. . .

Montgomery County Department of Correction and Rehabilitation, Policy Number: 3000-7, Standards of Conduct/Code of Ethics, effective December 30, 2016, (replacing policy of November 5, 2012), which states in applicable part:

VII. DEPARTMENT RULES FOR EMPLOYEES

E. Specific Departmental Rules:

3. Use of Force:

Employees shall use force only in accordance with the law and departmental policy and procedures and shall not use more force than is necessary to control the situation or protect themselves and/or others from harm. No employee shall use force in a discriminatory manner.

4. Integrity of the Reporting System:

Employees shall submit all necessary reports in accordance with established departmental policy and procedures. These reports shall be accurate, complete, and timely and shall be submitted before the end of the employee’s tour of duty whenever possible. Unless an operational emergency on injury precludes this, employees will be compensated for working beyond their scheduled shift to complete reports, before leaving the facility.

9. Conduct Unbecoming:

a. No employee shall commit any act which constitutes conduct unbecoming a department employee occurring either within or outside of his/her place of employment. Conduct unbecoming includes, but is not limited to any breach of the peace, neglect of duty, misconduct or any conduct on the part of any employee of the Department which tends to undermine the good order, efficiency, or discipline of the Department, or which reflects
discredit upon the Department or any employee thereof, or which is prejudicial to the efficiency and discipline of the Department, even though these offenses may not be specifically enumerated or stated in other Departmental policies, shall be considered conduct unbecoming an employee of this Department, and will subject the employee to disciplinary action by the Department.

b. Examples of conduct unbecoming include but are not limited to falsifying a written or verbal report, excessive absenteeism, assault on a fellow employee, sexual harassment, retaliation, misuse of a county owned radio, and the failure to cooperate with an internal investigation.

10. Neglect of Duty/Unsatisfactory Performance:

Employees shall maintain sufficient competency to properly perform their duties and assume the responsibilities of their positions. Unsatisfactory performance is demonstrated by an inability or unwillingness to perform assigned tasks, or the failure to take appropriate action in a situation deserving attention, or failure to conform to work standards established for the employee's rank, grade, or position.

Montgomery County Department of Correction and Rehabilitation, Policy Number: 1300-10, Use of Force, Chemical Agents & Restraints, effective December 30, 2016, (replacing policy of April 15, 2015), which provides, in relevant part:

III. POLICY

It is the policy of the MCDOCR that:

A. Use of force against an inmate is authorized when the acting staff member reasonably believes such force is necessary to accomplish any of the following objectives:

1. protection of self or others;
2. protection of property from damage or destruction;
3. prevention of an escape;
4. recapture of an escapee;
5. prevention of a criminal act;
6. effect compliance with the rules and regulations when other methods of control are ineffective or insufficient; and/or

7. the prevention of the individual from self-inflicted harm.

B. When force is used, the least amount of force reasonably necessary to achieve the authorized purpose is to be used and the use of force will stop once control is achieved.

C. Use of force shall be applied in accordance with the force continuum, as defined in Section II of this policy, unless the acting staff member reasonably believes the situation requires immediate escalation to a greater degree of force to accomplish any of the objectives identified in this policy.

D. Force is not authorized as a means of punishment.

F. All incidents of use of force shall be reported, documented, and reviewed by the Deputy Warden of Custody and Security or designee.

V. USE OF PHYSICAL FORCE - GUIDELINES

The following guidelines must be strictly followed whenever it becomes necessary to use physical force on an inmate:

A. Except in cases of extreme emergency, ONLY the Shift Administrator/Shift Manager/Assistant Unit Manager shall authorize the use of physical force to either move or restrain an unruly or uncooperative inmate. Whenever an officer believes that the use of physical force may be necessary, he/she must immediately contact the Shift Administrator/Shift Manager/Assistant Unit Manager.

D. In any situation where physical force is used, the Shift Administrator/Shift Manager/Assistant Unit Manager ensures that the incident is properly documented. Each staff member who is involved in the incident must submit a written report (DCA-36) detailing both why the use of force was necessary and the amount of force that was used to accomplish the assigned task. The officer’s written report must be submitted before the
end of his/her tour of duty. The Shift Administrator/Shift Manager/Assistant Unit Manager ensures that two (2) photos of all inmates involved in the incidents are taken.

**VIII. INSTRUMENTS OF RESTRAINT**

E. Any inmate placed in restraints or placed in the restraint chair must be seen by Medical personnel as soon as reasonably possible to determine if the inmate has suffered any injury while he/she was being subdued and to check the application of restraints.

*Montgomery County Correctional Facility (MCCF) Post Order No. 3, Correctional Supervisor Sergeant (2015)*, provides, in part:

**C. Duties:**

1. The Sergeant provides oversight and facilitates the work performance of the correctional staff assigned to the unit and ensures that Policies and Procedures and directives are appropriately carried out and seeks Lieutenant's input on a regular basis.

2. The Sergeant provides leadership, direction, and instruction to subordinate officers on institutional rules, regulations and procedures in their assigned subsection. Resolves informal complaints of officers assigned to their assigned work area.

5. The Sergeant is responsible for the basic security of the subsection. He/she must provide oversight for all security operations to prevent escapes, disorders, destruction of property, suicide, fire or other actions affecting the safety and security of the facility staff and inmates.

*Montgomery County Correctional Facility (MCCF) Post Order No. 4, Senior Floor Officer (2015)*, provides, in part:

**C. Duties:**

1. Due to MCCF staffing patterns, the Senior Floor Officers (SFO’s) assume the duties of all post positions.

2. The SFO is responsible for the supervision of all officers assigned to the subsection. He/she observes the conduct and activities of these officers and initiates corrective measures to remedy inappropriate behavior by staff.

16. The SFO is responsible for making certain that all unusual incidents are documented and he/she alerts the Shift Manager/Assistant Unit Manager/Sergeant to those
problems, which need further attention. When the Shift Manager/Assistant Unit Manager/Sergeant is not immediately available, the SFO may order the temporary lock-in of problem inmates until he/she has the opportunity to confer with supervisors.

**ISSUE**

Was Appellant’s dismissal consistent with law and regulation and otherwise appropriate?

**ANALYSIS AND CONCLUSIONS**

*Timeliness of Discipline*

As previously noted, Appellant moved to dismiss the charges against him, asserting that they were brought too late. On February 27, 2018, the Board issued an order denying Appellant’s motion to dismiss. Under Montgomery County Personnel Regulations (MCPR), § 33-2(b)(1), “[a] department director should start the disciplinary process promptly and issue a statement of charges within 30 calendar days of the date on which the supervisor became aware of the employee’s conduct, performance, or attendance problem.” The Board concluded that it is well settled that use of the term “should” or “may,” rather than “shall” or “must,” suggests that the 30-day requirement is not absolute. Moreover, MCPR § 33-2(b)(2), provides that “[a] department director may wait for more than 30 calendar days to issue a statement of charges if an investigation of the employee’s conduct or other circumstances justify a delay.” Thus, the County Personnel Regulations are readily distinguishable from the mandatory State statute construed by the Court of Appeals in *Western Correctional Institution v. Geiger*, 371 Md. 125 (2002).

Appellant also referenced MSPB Case No. 11-02 (2011), where the Board found that the County had not taken prompt discipline when the department director waited over one year after he became aware of the alleged misconduct to issue a statement of charges. In this case the statement of charges was issued 43 days after the investigative report on the incident had been finalized. Thus, we decline to hold that an alleged delay of less than two weeks violated the prompt discipline requirements of MCPR, § 33-2(b).

*Burden of Proof*

In a disciplinary matter, the County bears the burden of proving its case by a preponderance of the evidence. Montgomery County Code, Administrative Procedures Act (APA), § 2A-10. The Board has explained that preponderance of the evidence exists when evidence presented has more convincing force than the opposing evidence, and thus results in a belief that such evidence is more likely true than not. MSPB Case No. 17-13 (2017); MSPB Case No. 13-03 (2013). See, *Metropolitan Stevedore Co. v. Rambo*, 521 U.S. 121, 137 n. 9 (1997); *Commodities Reserve Corp. v. Belt’s Wharf Warehouses, Inc.*, 310 Md. 365, 370 (1987); *Muti v. University of Maryland Medical System*, 197 Md. App. 561, 583 n.13 (2011), vacated on other grounds 426 Md. 358.
(2012) (“the preponderance of evidence standard generally translates to a greater-than-fifty-percent probability”).

**Appellant’s Testimony Lacked Credibility**

Appellant’s testimony and that of other witnesses differ on certain key points. Accordingly, the Board is obligated to consider and resolve the issue of credibility. As the Board has discussed in previous decisions, credibility is the quality that makes a witness or evidence worthy of belief. MSPB Case No. 17-13 (2017); MSPB Case No. 13-03 (2013), citing *Haebe v. Department of Justice*, 288 F.3d 1288, 1300 n. 27 (Fed. Cir. 2002).

It was Appellant’s testimony that, after being handcuffed behind his back and placed face down on a mattress on the floor, Inmate SG was able to quickly leap to his feet and lunge at Corporal RS. Tr. 837-38, 875, 880. Critically, this purported maneuver was what Corporal RS testified impelled his use of force against Inmate SG. As noted above, however, no other witnesses besides Appellant and Corporal RS testified to seeing any such maneuver or threatening behavior from Inmate SG. Rather, they testified that they “stood up” Inmate SG and that he was compliant and under control when Corporal RS thrust him against the wall and began using physical force against him. Moreover, no matter how “young” or “flexible” Inmate SG may have been, the act of springing to one’s feet from a mattress on the floor with one’s hands cuffed behind the back seems implausible, if not impossible. Because we find Appellant’s description of events on this critical point contradicted by the testimony of disinterested witnesses and implausible, we conclude that Appellant’s testimony is not worthy of credence. For that reason, we also view his testimony on other points with skepticism.

Appellant’s acknowledgement that he used poor judgment in failing to report or document the use of force incident, and his expression of regret, may express genuine remorse but they certainly cannot excuse his misconduct. His stated explanations for his failure to report included: it was late in the shift; he did not want to write up officers in another unit for lying to Inmate SG about conditions on the CIU; there were no injuries to SG; and, the incident was not that serious. Tr. 922-23. Appellant maintained his effort to avoid documentation and reporting of the use of force incident even after repeated questions from subordinate officers about the need to submit the required reports. Appellant did not reconsider his failure to report until other officers had gone to the OIG and investigations were launched. We thus view Appellant’s failure to report, and his orders to his subordinates to neglect their reporting obligations, as a conscious effort to deceive DOCR leadership and protect himself and Corporal RS from the potential consequences of their actions. Had the other officers similarly lacked the integrity to step forward and subject their actions to review it is quite likely that the April 27 incident would never have become known to the DOCR leadership ultimately responsible for the security and safety of inmates and staff at MCCF.

Appellant’s explanations for his failure to report the April 27 incident come across as *post hoc* rationalizations, and his scheme to conceal a serious use of force incident from appropriate review by ordering his subordinates to do the same, strongly suggest that his testimony was
unreliable. We conclude that on certain key points Appellant’s testimony was self-serving and ultimately not credible. See MSPB Case Nos. 15-12 & 15-13 (2016); MSPB Case No. 14-19 (2014); MSPB Case No. 10-15 (2010). 5

Appellant Improperly Allowed Officers to Enter Inmate SG’s Cell

It is undisputed that Inmate SG was unhappy when he realized that being placed on suicide watch meant that he would be stripped naked, put into a suicide gown, and have to sleep on a mattress on the floor of CIU cell B1. Tr. 834. It is also undisputed that Inmate SG soon agreed to cooperate, after which Appellant and the other correctional officers left the cell. Tr. 57, 835.

Some time after Appellant and the other officers left cell B1 they heard a loud banging coming from the cell. While Appellant heard the banging, he could not see into the cell from his position and did not know how the inmate was creating the noise. Even though he was only a few steps away from the cell door, Appellant admitted that he took the word of Corporal RS that Inmate SG was banging his head. Appellant made no attempt to confirm that SG was indeed engaged in such troubling behavior despite his proximity to cell B1.

Appellant admitted that he was relatively close to the cell and that it only took him about three seconds to get from the control station to the cell door. Tr. 786. It is appropriate and reasonable for DOCR to expect a front-line supervisor to take three seconds to visually confirm the existence of an emergency justifying the opening of a cell door and sending in three officers. As Lieutenant AM testified, if a correctional officer is concerned that an inmate with mental health issues may be banging his head in a cell and causing himself harm, the officer should “look at what’s exactly happening.” Tr. 223.

Appellant argues that DOCR Policy 1300-10 on use of force states that “it is the policy of MCDOCR that: A. Use of force against an inmate is authorized when the acting staff member reasonably believes such force is necessary to accomplish any of the following objectives: 1. Protection of self or others . . . 7. The prevention of the individual from self-harm.” Appellant asserts that by allowing Corporal RS and the other officers to enter cell B1 he was trying to protect Inmate SG from himself and to prevent self-harm. The reasonableness of the decision to enter the cell was evident, in his view, due to the loudness of the banging, the fact that Corporal RS said that SG was banging his head, the prior statements of Inmate SG that he would do anything to be

5 Unlike the circumstances in MSPB Case No. 08-09 (2008), where Appellant’s dismissal for allegedly leaving an inmate in handcuffs for eight hours as punishment was reduced to a 30-day suspension based on Appellant’s testimony that his behavior was unintentional, Appellant here is not claiming that his actions during and after the April 27 incident were inadvertent or simply negligent. Instead, Appellant admits that he made a conscious decision not to report the use of force incident. Tr. 849, 922-23. We hasten to add that we do not consider MSPB Case No. 08-09 in determining the appropriate level of discipline in this case. Rather, we distinguish the facts in that case to explain any possible perceived differences in our reasoning. Because the DOCR Director did not consider MSPB Case No. 08-09 for purposes of making his decision regarding the severity of discipline in this case, we sustained Appellant’s objection to cross examination questions concerning the Last Chance Agreement in MSPB Case No. 08-09. Tr. 907-09.
sent to an outside medical provider, and Inmate SG’s claim to have consumed deodorant. Appellant Brief, p. 5.

Citing the testimony of Lieutenants AM and DL, the County concedes that were Inmate SG in actual imminent danger of bodily harm, it may have been appropriate to enter the cell. Tr. 223-24, 343. However, the record evidence does not support Appellant’s position that an emergency situation involving the imminent risk of harm to Inmate SG had been established prior to Appellant ordering the cell door opened. No officer looked into the cell to verify that SG was harming himself.

Appellant argues that he reasonably believed that the banging noise from the cell indicated that Inmate SG was harming himself. However, at the time Appellant ordered the cell door opened Appellant could not see inside the cell to confirm that Inmate SG was harming himself and the banging had ceased. Tr. 268-69, 780, 787, 835, 936-37.

Appellant notes that Corporal JB also testified that he believed Inmate SG was injuring himself in the cell. Appellant Rebuttal, p. 5. However, Corporal JB’s testimony in response to a question from the attorney for Corporal RS was that he “couldn’t see the cell . . . [and] just went on the noise and what was being said.” Tr. 194 (emphasis added). To the next question, “prior to entering the cell did you know whether or not the inmate was hurting himself,” he responded “No, I didn’t know.” Tr. 195.

This testimony suggests to us that Corporal JB was responding not just to the noise, but also to the declaration by Corporal RS that the inmate was “banging his head,” the argument between Corporal RS and Inmate SG, and to Appellant’s order that the cell door be opened. Corporal JB was not acting in a supervisory or decision-making capacity. He was following the lead of the more senior officers at the scene. In our view, his testimony does not provide support for Appellant’s suggestion that his actions were reasonable. Appellant, the supervisor on the scene, ordered the cell door opened without attempting to ascertain whether Inmate SG was indeed harming himself and in need of assistance.

While both Appellant and Corporal RS asked for the cell door to be opened, Appellant was the supervisor in charge, and it was his order that was obeyed. We discern no valid reason for Appellant’s failure to verify that an emergency existed or comply with the mandate in DOCR Policy 1300-10 (V)(A) that he contact the Lieutenant supervising the shift in order to obtain authorization for “the use of physical force to either move or restrain an unruly or uncooperative inmate.” And, as the County correctly notes, even Corporal RS conceded that he never should have entered the cell “in the first place.” Tr. 1000.

We conclude that Appellant’s actions therefore constituted violations of MCPR § 33-5(c), (e), and (h); DOCR Policy 1300-10(V)(A); DOCR Policy 3000-7(VII)(E)(3) & (10); and MCCF Post Order Nos. 3(C) and 4(C).
**Failure to Prevent or Mitigate the Excessive Use of Force**

Once officers entered Inmate SG’s cell the use of force was significantly more likely because of DOCR protocols designed to protect the safety of the officers. Thus, even though Inmate SG was standing in the back of his cell, was not exhibiting any threatening or aggressive behavior, and the banging had ceased, Appellant ordered Corporals RS, JB, and JG to handcuff Inmate SG and lay him down on the mattress. Tr. 268-69, 836, 936-37.\(^6\)

The record evidence suggests that Inmate SG was under control once the three officers handcuffed him behind his back and placed him face down on the mattress on the floor. Tr. 64-65, 163. Then Corporal JB and Corporal JG assisted Inmate SG to stand up and faced him towards the wall by the sink. Tr. 65, 296. As discussed above, we do not find the testimony of Appellant and Corporal RS credible when they claim that Inmate SG somehow leapt up and behaved in an aggressive manner. For that reason, we conclude that the subsequent use of force actions by Corporal RS were unnecessary and unauthorized.

Appellant goes to extensive effort to persuade the Board that Corporal RS did not perform a chokehold on Inmate SG but instead executed a headlock while using his thumb on a pressure point to inflict pain. The Board need not delve into the distinctions between a chokehold and a headlock or determine which specific maneuver was employed.\(^7\) The record evidence indicates that Inmate SG was not a threat to the safety of the officers or himself when Corporal RS applied the hold to him. SG was still handcuffed behind his back and facing the wall. While he may have been agitated and argumentative, he was not behaving in an aggressive, combative, or even non-compliant manner.

Appellant observed Corporal RS come up behind Inmate SG and wrap his right arm around SG in what appeared to be a chokehold or headlock and attempt to apply a pressure point to him. It is undisputed that Inmate SG pleaded that he was being choked and could not breathe. He further said that the hold applied by Corporal RS hurt. Tr. 66, 256-57, 259, 891, 948. Yet Appellant did nothing, and Corporal RS immediately put SG in the hold for a second time, rotated his thumb into SG’s jaw “really hard, hard and fast so that it would hurt very much,” Tr. 281-82, 987, and only released SG after asking if he was ready to behave. Tr. 67, 999. We find that Appellant, as the

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\(^6\) Director \[redacted\] and the DOCR training manager testified concerning DOCR’s efforts to convey its use of force policies to correctional officers. The Board is nevertheless concerned that DOCR may not have an adequate amount of mandatory training on the use of force and may not have administrative procedures in place to ensure that every front-line correctional officer has received all necessary training. Tr. 526-36. We urge that use of force policies receive greater emphasis in DOCR’s training efforts, including stress on the requirement that inmates receive adequate medical care immediately following a use of force.

\(^7\) With regard to Appellant’s credibility, we also note that although Appellant’s post-hearing brief suggested that Corporal RS’ hold was the mandibular pressure point, which is taught by DOCR, at the hearing he specifically testified that the hold was instead the hypoglossal pressure point, a technique that apparently is not taught in DOCR’s Defensive Tactics class. Compare Appellant’s Brief, p. 14 with Tr. 838; see Tr. 283, 333, 948.
supervising officer, did not take any steps to ameliorate the situation despite having adequate time to react.

Appellant cites Graham v. Conner, 490 U.S. 386 (1989), a Fourth Amendment search and seizure case, for the proposition that the reasonableness of the use of force against inmate SG “must be judged from the perspective of a reasonable officer on the scene rather than with 20/20 vision of hindsight.” Appellant’s Brief, p. 4. He further argues that:

[I]t was after I examined Inmate [SG’s] head for visible signs of injury and found none that I determined that he must have used his shower shoes to band [sic] the cell door. My reasons for going into the cell in the first place are sound and the fact that I determined that he must have banged the cell door with his shower shoes does not alter that fact.

Id.

Appellant’s failure to verify the alleged emergency, as discussed above, led us to conclude that there was no reasonable basis for entry into the cell in the first place. Had Appellant behaved as a reasonable officer there most likely would have been no reason for any use of force. Further, once the cell was opened and officers verified that Inmate SG was not, in fact, seriously hurting himself there was no justification for the use of any physical force, let alone that which was applied. It appears that Corporal RS was motivated by a desire to discipline SG for being loud and difficult, and perhaps to physically impress upon him that future transgressions were intolerable to and would be punished by Corporal RS. The actions of Corporal RS were not justified by the need for him to protect himself from an assault or to protect the inmate or another officer from serious bodily injury. Correctional officers have no right or authority to impose their personal attitudes concerning proper behavior on inmates through physical intimidation and harm. And Appellant, as the supervisor of Corporal RS, had a duty to prevent his unjustified behavior if at all possible.

Even were there a justification for using force against Inmate SG, which we do not agree existed, Corporal RS applied a headlock or similar maneuver and a pressure point after the risk that he claims justified the use of force had passed. A correctional officer may not use retaliatory physical force against an inmate for making noise and complaining. DOCR policies permit the use of force and restraints only to protect an inmate or others from harm and to maintain order within the facility. The use of force or restraints to punish inmates is prohibited. The use of a headlock or similar hold and application of a pressure point to obtain “pain compliance” did not constitute a good faith effort to maintain or restore discipline, but instead involved the use of force to maliciously and sadistically cause unnecessary pain to an inmate. Hudson v. McMillian, 503 U.S. 1, 9 (1992) (“When prison officials maliciously and sadistically use force to cause harm, contemporary standards of decency always are violated . . . whether or not significant injury is evident.”).
The evidence unequivocally demonstrates that the inmate was not assaulting or threatening officers. Tr. 71-72, 121-22, 166. There was thus no need to use force to get Inmate SG under control, restrain, or subdue him. He was not a threat to himself or another. The actions of Corporal RS amount to an unjustified and seemingly emotionally-driven assault against an inmate.

Appellant’s duty as the immediate supervisor of Corporal RS was to prevent, if at all possible, his subordinate’s ill-advised conduct. Appellant was on the scene and in a position to intervene to prevent the unnecessary use of force. Indeed, at one point Appellant did appear to intervene when he ordered Corporal RS to “be quiet” and disengage with the inmate. But this was too little, too late. Instead, Appellant stood by and watched Corporal RS unnecessarily use excessive force against Inmate SG. We find that Appellant stood by and allowed Corporal RS to gratuitously inflict pain on Inmate SG in order to punish past conduct, deter future conduct, and intimidate. It is completely unacceptable and contrary to established DOCR policies for a supervisor to stand by and do nothing while a correctional officer behaves in that manner.

Appellant should have intervened once he saw Corporal RS using unnecessary force and attempting to execute a hold involving Inmate SG’s head and neck. Appellant had a realistic opportunity to prevent Corporal RS from using excessive force--he was standing in the cell or its doorway during essentially the entire duration of the critical events here-- yet he failed to do so. Instead, Appellant stood by and watched as Corporal RS twice applied a painful hold to a vulnerable inmate with his arms handcuffed behind his back. Appellant only stepped in afterwards and told Corporal RS to be quiet and stop arguing with the inmate. Appellant’s failure to make any effort to intervene and attempt to stop what we find to have been a punitive action fell far short of the standard expected of a frontline DOCR supervisor. The County need not tolerate a supervisor’s deliberate indifference and failure to intervene to prevent the unnecessary and excessive use of force against an inmate in the care and custody of the County. We therefore find that Appellant violated MCPR § 33-5(c), (e), and (h); DOCR Policy 1300-10(V)(A); DOCR Policy 3000-7(VII)(E)(3) & (10); and MCCF Post Order Nos. 3(C) and 4(C).

**Failure to Refer Inmate SG for Medical Evaluation**

In addition to Appellant’s failure to report and document the use of force, DOCR policy requires that the medical unit be called after a use of force. CX 4; Tr. 291. The policy is undoubtedly designed to determine if an individual subjected to the use of force had any injuries, including those not evident to a lay person.\(^8\)

Appellant argues that County witness Lieutenant DL testified that “unless the inmate has a visible injury or is complaining about pain somewhere” there is no obligation to call medical, Appellant’s Brief, p. 11. Appellant’s argument is completely unpersuasive, as he fails to acknowledge the very next question and answer:

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8 Presumably the policy is also intended to provide documentation necessary for the County to defend itself in tort or civil rights lawsuits concerning allegations of injury.
Q. If, in the course of interaction with an inmate, the inmate at some point said, it hurts, it hurts, or, I can’t breathe, would it have been appropriate to call medical?

A. Yes.

Tr. 363.

We find that Appellant’s failure to refer Inmate SG to the medical unit was, at least in part, due to his desire to avoid reporting that the use of force had occurred and that the failure to have Inmate SG checked by medical professionals after the use of force incident clearly violated DOCR policy. DOCR need not tolerate its supervisors disregarding policies that are essential to the health and safety of inmates. Irrespective of his motive, Appellant had a duty to refer the inmate for medical evaluation and indisputably he failed to perform that duty. Accordingly, we find that Appellant violated MCPR § 33-5(c), (e), and (h); DOCR Policy 1300-10(V)(E); DOCR Policy 3000-7(VII)(E)(10); and MCCF Post Order Nos. 3(C) and 4(C).

Failure to Report the Use of Force

Appellant concedes that his failure to document and report the use of force incident was improper and in violation of DOCR policy.

I understand that I should have documented it. That was a big mistake. I really do understand that. If I had documented it and ordered the officers to document that incident, we wouldn’t be here today. I fully get that and understand that. And I fully regret that.

Tr. 849. Thus, there is no dispute that Appellant is guilty of violating several County regulations and DOCR policies. However, it is troubling that even Appellant’s confession is carefully couched in an attempt to downplay or limit his responsibility. Even if Appellant’s remorse is genuine, he nonetheless offered no reason for his utter failure to comply with DOCR’s explicit mandates for reporting use of force. Worse, fully aware of these directives, he dissuaded his subordinates from fulfilling their reporting obligations. The conclusion is inescapable that Appellant’s failure to report the incident, and his efforts to ensure that no one else did, were born of a desire to ensure that no one was ever to be held to account for what transpired in Cell B1.

Appellant’s subsequent explanations to investigators and the Board regarding the events of April 27 lacked complete candor, and his actions that evening and the following days, as well as during the subsequent investigation, fell far short of the integrity expected of supervisory

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9 See MCPR § 33-5(c) (violates any established policy or procedure); MCPR § 33-5(e) (fails to perform duties in a competent or acceptable manner); MCPR § 33-5(h) (negligent or careless in performing duties); DOCR Policy Number 1300-10, § III(F) (use of force shall be reported, documented), § V(D) (staff involved in a use of force incident must submit a written report); DOCR Policy Number 3000-7, § VII(E)(4) (integrity of the reporting system), § VII(E)(9) (conduct unbecoming, false report), § VII(E)(10) (Neglect of Duty/Unsatisfactory Performance); MCCF Post Order Nos. 3(C) (Correctional Supervisor Sergeant duties) and 4(C) (Senior Floor Officer duties).
correctional officers charged with protecting the health and safety of inmates in County custody. To highlight but one of the charges against Appellant, we find that Appellant’s behavior is unquestionably conduct unbecoming, which includes neglect of duty, misconduct which tends to undermine the good order, efficiency, or discipline of DOCR, or which reflects discredit upon DOCR or its employees, or which is prejudicial to the efficiency and discipline of the DOCR. DOCR Policy 3000-7, § VII(E)(9), CX 5.

We therefore find that Appellant violated MCPR § 33-5(c), (e), and (h); DOCR Policy 1300-10(III)(F) and (V)(D); DOCR Policy 3000-7(VII)(E)(4), (9), and (10); and MCCF Post Order Nos. 3(C) and 4(C).

The Appropriate Level of Discipline is Dismissal

Appellant, as a supervisory correctional officer, was responsible for maintaining institutional security, properly supervising the officers under his command, and for the custody and care of inmates. As detailed above, the County has proven the charges against Appellant of improperly allowing officers to enter Inmate SG’s cell, failing to prevent the excessive use of force by Corporal RS, failing to refer Inmate SG for medical evaluation, and both failing to report the use of force and ordering his subordinates to not report the incident. The remaining question is the appropriate level of discipline.

Appellant admits that he improperly failed to report the use of force against Inmate SG but, notwithstanding the serious nature of his offense, argues that the evidence does not support his dismissal. He contends that the Director failed to properly take into account comparable DOCR cases before making the decision to dismiss him from County employment.

Appellant served as a Correctional Supervisor - Sergeant, which is a correctional supervisory position of substantial trust and responsibility. This Board has previously found that correctional supervisors must be held to a higher standard of conduct and a higher degree of trust. MSPB Case No. 15-27 (2016); MSPB Case No. 07-13 (2007). See Crawford v. Department of Justice, 45 M.S.P.R. 234, 237 (1990) (“the most important consideration” is that a correctional officer is “a position of great trust and responsibility, and must therefore conform to a higher standard of conduct”); Luongo v. Department of Justice, 95 M.S.P.R. 643 (2004), aff’d, 123 Fed.Appx. 405 (Fed.Cir. 2005) (higher standard of conduct and higher degree of trust are required of law enforcement supervisors). See also MSPB Case No. 09-11 (2009) (Employee in a public safety agency with an “impeccable” 28 year County employment record may be held to a higher standard as a supervisor in a position of trust and responsibility); MSPB Case No. 05-07 (2006) (“The County is allowed to hold a supervisor to a higher standard as a supervisor holds a position of trust and responsibility and should be a role model for the supervisor’s subordinates.”).

The officers under Appellant’s command specifically asked him about their obligation to comply with DOCR reporting protocols. Appellant repeatedly ordered them not to file the appropriate reports—indeed, he told them that any failure on their part to report would be “on him.” Appellant’s failure to immediately document and report the use of force against inmate SG,
and to order those under his command not to document and report, was a conscious and considered attempt to avoid scrutiny by DOCR leadership of the serious use of force incident. Appellant’s behavior strongly suggests that he was aware that review of the incident by his supervisors would likely result in critical findings and discipline. His apparent efforts to evade responsibility, and to protect Corporal RS from the consequences of his actions, was an egregious breach of trust.

By attempting to prevent mandatory reports from being written and filed, Appellant delayed the investigation and the preservation of evidence, such as the cell block video recordings. From these facts we infer that Appellant intended to avoid, obstruct, and hinder any investigation into the April 27, 2017 incident.\(^\text{10}\)

The Director testified that he considered Appellant’s offense serious enough that progressive discipline was not required. Rather, the egregious behavior warranted the most severe level of discipline. Tr. 582-83 (“misconduct where the level of use of force that was used in his immediate presence, his duty to protect his staff that are assigned, junior officers. His duty to protect the inmate population from abuse and punishment.); CX 16. Director \[redacted\] also considered the fact that Appellant endeavored to cover up the improper use of force by ordering his subordinates to not document and report the incident. Tr. 585, 648.

The DOCR Director testified that the incident at issue had caused him to lose confidence in the Appellant. Tr. 591-92. He also testified that it is important for supervisors to make sound decisions that are based on policies, directives, and law. Tr. 592. Appellant, as a front-line supervisor, generally oversees a less experienced workforce, and such junior employees look to their supervisors for appropriate guidance and direction. Appellant’s behavior thus set a poor example for those subordinate officers and undermined the trust and confidence management had bestowed on him. Appellant’s actions were antithetical to the agency’s mission and rightfully caused the DOCR Director to lose confidence in Appellant’s ability to protect inmates, lead other officers, and uphold the high standards expected of every Correctional Officer. Cristia v. Dep’t of Justice, 36 M.S.P.R. 75, 1988 WL 7965 (1988), aff’d, 861 F.2d 728 (Fed. Cir. 1988) (Agency is entitled to hold a supervisory correctional officer to a higher standard of conduct).

The County personnel regulations vest the DOCR Director with the discretion to eschew progressive discipline and move directly to termination given the serious nature of Appellant’s misbehavior. MCPR § 33-2(c)(2) (“In some cases involving serious misconduct or a serious violation of policy or procedure, a department director may bypass progressive discipline and dismiss the employee. . .”).

When the state takes individuals into custody it also takes on the responsibility to protect them from harm. Appellant had a fundamental responsibility to protect the health and safety of Inmate SG. He and the correctional officers under his command had no authority to impose ad hoc punishment, and Appellant had a duty to prevent such behavior by his subordinate. And Appellant

certainly did not have the authority to cover up a serious incident. Appellant abused his position as a supervisor by ordering his subordinates to not report a use of force incident. Those actions violated DOCR policies and had the potential to encourage a dangerous culture of silence within a correctional facility.

We consider whether DOCR has consistently applied this standard and dismissed other staff who have engaged in similar behavior, a factor listed in MCPR § 33-2(d)(3). Appellant must show that he and the comparison employees engaged in similar misconduct without differentiating or mitigating circumstances so as to warrant distinguishing the misconduct or the appropriate discipline for it. MSPB Case No. 10-04 (2010), citing Burton v. U.S. Postal Service, 112 M.S.P.R. 115 (2009).

Appellant referenced a case where a Correctional Officer III was suspended for improperly entering a cell and engaging in a verbal and physical confrontation with an inmate, but the use of force that followed was determined to be in self-defense. AX 12. Another case involved the five-day suspension of a Correctional Officer III for pushing a teenaged citizen out the front door of a facility, not the use of force against an inmate in custody. AX 13. In both cases reports were written and submitted and there was no attempt to cover up. We find the facts of those two cases to be readily distinguishable and, because neither officer was a first-line supervisor such as Appellant, they are not valid comparators with regard to discipline. MSPB Case No. 10-04 (2010).

In one case cited by Appellant a Correctional Sergeant received a one-day suspension for applying a hold to an inmate. AX 14. In that case, the inmate was combative and there was no allegation that the goal of the use of force was to punish the inmate. In addition, a report was filed. We thus find that case to be distinguishable on its facts from this one and do not treat it as an appropriate basis for comparison.

Moreover, the case is distinguishable for two additional reasons. First, Director testified that the suspension in that case was, in retrospect, insufficient:

The discipline in this case should have and could have been higher, but because we under disciplined in this case I do not need to make the same mistake twice and that does not set a precedent. But we did as a Department in this case under discipline the individual, in my view.

Tr. 616. An agency may legitimately contend that a penalty in a previous case was too lenient and that, as Director testified, it need not make the same mistake again. Davis v. U.S. Postal Service, 120 MSPR at 457, 465 (2013); Boucher v. U.S. Postal Service, 118 M.S.P.R. 640, 651 (2012).

Second, the level of discipline was the result of a settlement. In that circumstance, DOCR need not even explain the difference in treatment. Davis v. U.S. Postal Service, 120 MSPR at 463-

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11 We also note that the five-day penalty imposed in the case involving the non-inmate teenager (AX 13) was also the result of a settlement agreement.
64 (“The Board has held that if another employee receives a lesser penalty, despite apparent similarities in circumstances, as the result of a settlement agreement, the agency is not required to explain the difference in treatment. See Portner v. Department of Justice, 119 M.S.P.R. 365, ¶ 20 n.4 (2013)); Dick v. U.S. Postal Service, 52 M.S.P.R. 322, 325 (agency not required to explain lesser penalties imposed against other employees whose charges were resolved by settlement), aff’d, 975 F.2d 869 (Fed. Cir.1992).12

The record simply does not reflect that there have been any other cases sufficiently similar to the circumstances in this one. Director testiﬁed that he was not aware of other DOCR cases involving excessive use of force and a conscious effort to cover up the incident. Tr. 585. We are unaware of any comparators who had been charged with the full range of misconduct present here. Reid v. Department of the Navy, 118 M.S.P.R. 396 (2012) (no disparate penalty where comparison cases involved similar conduct for only one of multiple charges for which appellant was dismissed). No case brought to our attention involved excessive force, failure to report, an intentional effort to cover up the excessive use of force, and a failure to obtain a medical evaluation for an inmate subjected to the excessive use of force. There is not enough similarity between both the nature of his misconduct and the other factors to lead a reasonable person to conclude that DOCR has treated similarly situated employees differently.

Finding that the County has proven by a preponderance of the evidence that Appellant’s behavior was unacceptable and in violation of County policies and regulations, we have upheld all charges against him. We do not see how the County could tolerate a supervisory correctional officer abusing his official authority by allowing the unnecessary use of force against a vulnerable inmate, failing to report the use of force or have the inmate evaluated by medical personnel, and by ordering his subordinates to not report the use of force. MSPB Case No. 07-10 (2007) (dismissal appropriate for unnecessary confrontation and use of force on an inmate).

Appellant displayed extremely poor judgment that certainly justified the imposition of the most signiﬁcant discipline. Considering the seriousness of the Appellant’s misconduct, that he occupied a position of trust and responsibility as both a correctional officer and a supervisor, and even though there were mitigating factors such as his work record and years of service, the penalty of dismissal was well within the bounds of reasonableness.

Accordingly, we conclude that the discipline of dismissal was appropriate and consistent with law.

ORDER

For the foregoing reasons, the Board DENIES Appellant’s appeal of his dismissal.

If any party disagrees with the decision of the Merit System Protection Board, pursuant to Montgomery County Code, § 33-15, Judicial review and enforcement, and MCPR, § 35-18, Appeals to court of MSPB decisions, within 30 days of this Order an appeal may be ﬁled with the

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12 Although the settlement agreement in AX 14 was not made part of the record, such agreements typically specify that they may not be considered precedent in other cases. That may be what Director was referencing when he said it “does not set a precedent.”
Circuit Court for Montgomery County, Maryland, in the manner prescribed under Chapter 200, Title 7 of the Maryland Rules.

For the Board
June 24, 2019

Michael J. Kator
Chair