COMMONWEALTH OF MASSACHUSETTS
CIVIL SERVICE COMMISSION

SUFFOLK, SS.

One Ashburton Place - Room 503
Boston, MA 02108
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DAVID GAGNE,
Appellant
v.

CASE NO: D-05-383

DEPARTMENT OF CORRECTION,
Respondent

Appellant's Attorney:

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Commissioner:

Paul M. Stein

DECISION

The Appellant, David Gagne, acting pursuant to G.L.c.31, §43, duly appealed a decision of the Department of Correction ("DOC"), the Appointing Authority, to suspend him for twenty days after finding he had violated DOC rules and regulations concerning use of force while responding to an emergency call to restrain a patient at the Bridgewater State Hospital and in being untruthful with those assigned to investigate the incident. A full hearing was held by the Commission on July 23, 2008. The hearing was declared private as no party requested a public hearing. Witnesses were sequestered save for the Appellant and the DOC's representative Captain Martin. DOC called four witnesses. The Appellant called one witness and testified on his own behalf. Twenty-one (21) exhibits were received in evidence. The hearing was recorded on two audiocassettes.

FINDINGS OF FACT

Giving appropriate weight to the Exhibits, the testimony of DOC Deputy Superintendent James A. Ferreira, DOC Director of Security Brian D. Frye, DOC Captain Vincent Martin, DOC Sergeant Robert M. Gordon, DOC Correction Officer Linda Donnelly and the Appellant, and inferences reasonably drawn from the evidence as I find credible, I make the findings of fact set forth below.

The Appellant

1. At the time of the incident in question on January 5, 2005, the Appellant, David Gagne, was a tenured civil service employee within DOC's employ in the position of Correction Officer (CO) I. CO Gagne had been employed by DOC since September 25, 1985. (*Undisputed Facts; Gagne Testimony*)

2. In the twenty-three year period of his employment as a DOC correctional officer, Co Gagne's only discipline concerned two written warnings for tardiness, one in 1995 for being late on four occasions for roll call and one in 1998 for tardiness on nine occasions in that year. (*Gagne Testimony; Exhibits 17 & 18*)

3. On January 5, 2005, CO Gagne was working his shift at the Bridgewater State Hospital (BSH) stationed in the Max I Unit. (*Undisputed Fact; Gagne Testimony*)

4. BHS is the only psychiatric hospital in the Massachusetts correctional system, and is maintained by the Commonwealth to perform psychiatric evaluations of inmates and provide hospital care to inmates who need psychiatric treatment. (*Undisputed Facts; Ferreira Testimony*)

5. CO Gagne duties on the day in question included responsibility as an emergency responder, meaning that he was one of several corrections officers on-call to respond to emergency situations that may arise throughout the institution. (*Gagne Testimony*)

Applicable DOC Rules and Regulations

6. The DOC has promulgated "Rules and Regulations Governing All Employees of the Massachusetts Department of Correction" (DOC Rules) binding on all DOC personnel. (*Exhibit 15*).

7. The relevant portions of the DOC Rules relevant to this appeal include:

> Rule 10. INSTITUTIONAL DISCIPLINE.
> "(a) . . . Under no circumstances shall an employee use or permit the use of excessive force, or use of force as punishment (103 CMR 505 Use of Force)."
>
> Rule 19. ADMINISTRATIVE PROCEDURES.
> "(c) Since the sphere of activity within an institution or the Department of Correction may on occasion encompass incidents that require thorough investigation and inquiry, you must respond fully and promptly to any questions or interrogatories relative to the conduct of an inmate, a visitor, another employee or yourself."

(*Exhibit 15*)

8. In addition, DOC employees are required to comply with regulations concerning "Use of Force" promulgated pursuant to law and codified in 103 CMR 505 (Use of Force Regulations) (*Exhibit 16; Testimony of Ferreira*)

9. The relevant portions of the Use of Force Regulations provide:

> **505.06. Definitions**
> "Excessive Force – Force which exceeds reasonable force, or force which was reasonable at the time its use began but was used beyond the need for its application."
> "Force – The use of physical power. The use of a weapon, a chemical agent or instrument to compel, restrain, or otherwise subdue a person."
> "Reasonable Force – The force that an objective, trained and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order."

"Instruments of Restraint – Equipment authorized for use during the transportation of inmates to prevent escape, or to prevent injury to self, others or property. Instruments of restraint shall include . . . handcuffs . . . ."

505.07. Use of Force

"(1) Before the use of force upon an inmate, an employee when time and circumstances permit, should issue a verbal warning to the inmate to stop or otherwise desist and obey the order of the employee."

"(2) An employee may use reasonable force when it is necessary to . . . (c) defend himself/herself or another against a physical assault; . . . (i) preserve the overall order and security of the institution; and (j) preserve the safety of any employee, inmate, or visitor"

505.08. Prohibitions on the Use of Force

"(1) An employee shall not use or permit the use of excessive force."

505.10. Requirements Governing the Use of Instruments of Restraint

"(4) Instruments of restraint used during the routine movement of inmates from one point to another within a correctional institution shall not be considered a use of force."

"(11) The application of instruments of restraint shall be such that they provide the least amount of physical restraint necessary for the situation. This may include the use of handcuffs, waist chain or leg restraints, separately or in combination."

505.13. Reporting Requirements for the Use of Force

"(1) After an employee uses force, the superintendent, or a designee, or the special unit director, or a designee shall be notified immediately. In addition, the employee as soon as possible, and in no event later than the end of the employee's tour of duty, unless otherwise authorized by the superintendent or special unit director, shall submit a written report to the superintendent, or the special unit director. The report shall include: (a) An accounting of the events leading up to the use of force; (b)A precise description of the incident and the reasons for employing force; (c) A description of the type of force used, and how it [was] used; (d) A description of the injuries suffered, if any, and the treatment given, if known, along with attached photographs, if any; and (e) A list of all participants and witnesses to the incident."

"(2) The superintendent or special unit director shall also require a written report containing matters listed in subsection (1) above, from any employee who witnessed the use of force."

"(3) A copy of the report described in 103 CMR 505.13(1), and a completed form 505-1 shall be submitted to the director of the special operations division, by the superintendent or special unit director within ten working days from the time of the incident . . . The director of the special operations division shall review the reports and may request additional information or may recommend to the commissioner that an investigation be conducted by the department investigations unit."

"(5) All use of force incidents shall be investigated and analyzed. The investigation shall include a review by the superintendent or designee of the following: video/audio tapes, and the completed use of force package. Any inappropriate

action discovered during this investigation shall be reported to the respective assistant deputy commissioner."
"(6) The director of special operations shall conduct an analysis of all uses of force, which occur within the department of correction. Each quarter, the Director of Special Operations shall submit his/her written findings to the commissioner."

505.14. Medical Treatment
"(1) Any inmate involved in a use of force shall be examined by medical staff as soon as possible. This examination and any treatment performed shall be documented."
"(2) Any person injured during a use of force shall be examined as soon as possible by a medical staff member. Such care or treatment shall be documented."

505.15. Sanctions for Violation of 103 CMR 505.00
"Any employee who violates or permits the violation of these regulations or who failed to report any violation or suspected violation of these regulations shall be subject to disciplinary action up to and including termination."

505.15. Training in the Use of Force
"All employees charged with the care and custody of inmates shall be trained in approved methods of using physical force, instruments of restraint, chemical agents and firearms to control inmates where necessary. Such training shall be documented in the employees' permanent training file."

(*Exhibit 16*)

10. CO Gagne acknowledged his receipt of copies of the DOC Rules and the Use of Force Regulations on or about September 30, 1985. (*Exhibits 13 & 14)*

The Use of Force Incident

11. On January 5, 2005, Sergeant Doug Bower, Officer in Charge of the Max II Unit, saw Patient M[1] being disruptive and confrontational with correctional staff and other patients. As a result, Patient M was brought to the Max II Treatment Room for a clinical assessment by Treatment Team members Eileen English, a Rehabilitation Department clinician, and Helen Clancy, RN. Patient M had been housed in the Max II Unit a short time, having recently been released from the Intensive Treatment Unit (ITU) to the Max II Unit. (*Exhibits 8, 9 & 10 [Reports/Interviews with Sergeant Bower & Ms. English]*)

[1] The Commission refers to the patient by a randomly assigned letter, rather than name, to protect any patient privacy interest of the individual involved.

12. During the clinical assessment, Patient M became agitated and provocative leading the clinicians to determine that he should be transferred back to the Intensive Treatment Unit due to his mental status. (*Exhibits 8, 9 & 10 [Investigation Report/Staff Reports/Interviews with Sergeant Bower & Ms. English]*)

13. Sergeant Bower directed CO Miner to bring a set of handcuffs to the treatment room which he did. Ms. Clancy informed Patient M that he would be transported to the ITU. Sergeant Bower directed Patient M to stand and turn around so that he could be handcuffed. Patient M stood up and appeared to be ready to comply, but then suddenly spun around and assaulted CO Miner, punching him in the face with a closed fist, giving CO Miner a bloody nose. (*Exhibits 8, 9 & 10 [Investigation Report/Staff Reports/ Interviews with Sergeant Bower, CO Miner & Ms. English]*)

14. Sergeant Bower and CO Miner attempted to restrain Patient M and in the ensuing struggle all parties fell to the floor in the doorway between the Treatment Team Office and the Mental Health Workers Office. Sergeant Bower initiated a request for emergency back-up. CO Gagne (the Appellant) was one of five emergency responders to come to the aid of Sergeant Bower and CO Miner, along with Deputy Superintendent Ferreira and Director of Security Frye who happened to have been conducting supervisory "rounds" together in another area of the Max II Unit at the time and intercepted Sergeant Bower's radio transmission for emergency response. (*Exhibits 8, 9 & 10 [Investigation Report/Staff Reports/Interviews]; Testimony of Ferreira & Frye*)

15. The nine officers on scene eventually were successful in restraining Patient M with handcuffs and leg irons. Patient M was transported to ITU by CO Gagne and Demaranville under the supervision of Sector Supervisor Sergeant Michael Reddy. The

16. A medical examination of Patient M performed within 30 minutes of the incident reported no injuries or evidence of struggle other than droplets of blood on his shirt. Patient M refused any medical treatment. (*Exhibit 9 [Staff Reports of CO Demaranville & Jeanne Grant, RN]; Exhibit 12[Use of Force Report]*)

17. CO Miner was treated at the BSH infirmary and, thereafter, sought medical care from his primary care physician. (*Exhibits 9 & 10 [Staff Reports/ Interview of CO Minor, CO Demaranville & Eileen Simon, RN]; Exhibit 12 [Use of Force Report]*)

Use of Force Reporting

18. As required by DOC's Use of Force Regulations, the personnel who participated or witnessed the use of force incident involving Patient M submitted written reports as prescribed by the regulations. The differing accounts of CO Gagne's actions reflected in these reports form the basis for initiating an investigation into his alleged use of excessive force and the discipline imposed after finding that he did so and had been untruthful in his own accounts of the incident. (*Exhibits 2 through 12; Testimony of Ferreira, Frye, Martin*)

19. According to Deputy Ferreira's written report on January 5, 2005, he and Director of Security Frye were in the vicinity of the Max II Treatment Room when they heard an alarm sound, entered the Treatment Room, saw Sgt. Bower and CO Miner struggling with Patient M, cleared all patients out of the area and called the control room to activate

20. Director of Security Frye also made a written report on January 5, 2005, in which he stated that he observed CO Gagne place his hands on the shoulders of other officers who were attempting to subdue Patient M, and then saw CO Gagne put his foot on Patient M's temple while he "leaned into the doorframe to balance himself and apply pressure to Patient [M]'s head for "3-5 seconds". When CO Gagne's boot slide off Patient M's head, CO Gagne replaced it for another "1-2 seconds". At that point, Frye saw Deputy Superintendent Ferreira tap CO Gagne with his radio and saw CO Donnelly grab CO Gagne by the waist area and pull him off the patient. CO Gagne then dropped to his knees and continued to assist restraining the patient. (*Exhibit 10; Testimony of Frye*)

21. Immediately after the incident was over, Deputy Ferreira and Director of Security Frye conferred and decided that CO Gagne would be removed from his post and his alleged excessive use of force reported to Superintendent Nelson as a "Category II" (meaning "serious") complaint. Deputy Ferreira did so. (*Exhibits 9, 10 & 11; Testimony of Ferreira, Frye & Martin*)

22. In his January 5, 2005 written incident report, CO Gagne describes his actions as follows:

> "I C/O Gagne responded to an emergency on Max2. Upon arriving I observed Pt [M] on the floor of the treatment team room doorway struggling with officer's. I [assisted] by taking hold of the pt's right wrist with both of my hands. Pt [M] at this point had his right hand under his torso and was attempting to bite at this officer. I was able to bring [M]'s arm out from under him and Officer Marcotte took control of his right arm. At this time I moved to [M]'s legs and held them with both of my hand's until they were placed into leg iron's. I then held pt [M]'s right arm and escorted him to ITU [where] ITU officers took control of him. I had no further contact with this pt.[2]

23. In his January 5, 2005 incident report, Sergeant Robert Gordon stated that he responded to the emergency call and assisted by kneeling down and instructing staff on how to subdue the patient. He states that, prior to the patient being controlled and placed in restraints he saw someone (unidentifiable) who was standing place a foot to the base of the patient's neck area" and heard someone say "hey that excessive force". I note that Sergeant Gordon's report places the incident at 14:35 hours, when all the other reports and evidence place it at 13:10, which I find to be clearly the accurate time. (*Exhibit 9{Staff Reports]; Exhibit 20 {Video]; Exhibit 21 [Video Stills*])

24. None of the other officers or witnesses to the incident who submitted staff reports (Sergeant Bower, COs Demaranville, Donnelly, Marcotte, Miner, and clinicians English and Clancy) make any mention of seeing CO Gagne or any other person having placed a foot on Patient M. CO Donnelly's report describes her principal involvement to have been getting leg irons from the officers' trap and providing them to CO Demaraneville who applied them to the patient. She makes no mention of any interaction between her and CO Gagne. (*Exhibit 9*)

[2] There are actually two substantially identical reports from CO Gagne on January 5, 2005, one entered by him and another entered by Captain Steven McKenzie. (*Exhibit 9*)

25. On January 10, 2005, Sector Supervisor Sergeant Michael Reddy submitted a Memorandum and DOC Form 505-1 as required by the Use of Force Regulations to Superintendent Nelson. Sergeant Reddy's report closely tracks the information provided in the staff reports of Sergeant Bower and COs Gagne, Demaranville, Donnelly, Marcotte and Miner, and clinicians English and Clancy. I note that Sergeant Reddy did not list Sergeant Gordon on the Form 505-1 as one of the employees who applied or assisted in the application of restraint, or who witnessed the Use of Force. (*Exhibit 12*)

Use of Force Investigation

26. Prompted by the foregoing, Captain Vincent Martin, Director of Investigations, conducted a "Category II" level investigation of the incident, as part of which he interviewed CO Gagne (January 12, 2005), Sergeant Bower and Sergeant Gordon (February 21, 2005), Director of Security Frye and Deputy Superintendent Ferreira (February 23, 2005), CO Demaranville (February 23, 2005), CO Donnelly (February 24, 2005), CO Marcotte and CO Miner (March 9, 2005) and Eileen English (March 22, 2005). (*Exhibit 10; Testimony of Ferreira, Frye, Martin, Donnelly & Gagne*)

27. Capt. Martin's report of his interview with CO Gagne tracks closely with the written report made by CO Gagne on January 5, 2005. CO Gagne denied at the interview that he placed his foot on Patient M's head or on any other part of his body. (*Exhibit 10; Testimony of Martin*)

28. Capt. Martin's report of his interview with Sergeant Gordon states that Gordon was giving verbal instructions on how to remove Patient M's hands from under his body when he saw a foot on the neck area of Patient M for approximately one to two seconds and heard someone shout "that's excessive force". When asked who else was present,

29. CO Marcotte also stated to Capt. Martin that he (Marcotte) saw someone's foot on the side of Patient M's head for approximately two seconds, but did not know whose foot it was. Officer Marcotte said he had no recollection of any other staff on site other than Sergeant Bower and CO Miner. (*Exhibit 10; Testimony of Martin*)

30. Officer Minor said he could not recall who the emergency responders were, other than CO Demaranville. He said he saw no one put their foot on Patient M. (*Exhibit 10; Testimony of Martin*)

31. Sergeant Bower stated to Capt. Martin that, while there were other uniformed officers present, his focus was on Patient M, and the only staff member he could identify as present was CO Marcotte. He said he no one placed their foot on Patient M. (*Exhibit 10; Testimony of Martin*)

32. CO Donnelly told Capt. Martin essentially what she had reported in writing on January 5, 2005. She recalled the presence of emergency responders CO Gagne, CO Demaranville and CO Marcotte, as well as Director of Security Frye, Deputy Superintendent Ferreira and Sergeant Reddy. Capt. Martin reported that she stated that "there were so many officers in the area with the Patient's head being controlled by Sergeant Bower that she was not able to assist" in the restraint effort. She did not recall anyone's foot on Patient M's head and denied "pulling Correction Officer Gagne off Patient [M]". (Exhibit 10; Testimony of Martin)

33. Capt. Martin's report of his interviews with Deputy Superintendent Ferreira and Director of Security Frye track closely with their respective original reports and are

34. Capt. Martin also reviewed the available time-lapse video, a copy of which was introduced as evidence at the hearing before the Commission. As will be confirmed by the detailed findings about the video are set forth below, I note here that Capt. Martin concluded that, while the video does show the use of force incident involving Patient M, "due to the position of staff in the area there is no clear visual evidence to denote Correction Officer David Gagne placing his foot on Patient [M]'s head." (*Exhibit 8*)

35. On April 1, 2005, Capt. Martin submitted an Investigation Report which concluded:

> "Based on Deputy Superintendent James Ferreira and Director of Security Brian Frye's direct observation, and the preponderance of evidence, Correction Officer David Gagne did place his foot on Patient [M]'s head during the use of force incident on January 5, 2005, in the Max II Unit." (*Exhibit 8*)

36. On May 17, 2005, Superintendent Nelson concurred with Capt. Martin's findings and found that, by "placing his foot on the patient's head" CO Gagne used excessive force" and was "not truthful" in telling Capt. Martin he had not done so. Superintendent Nelson ordered a Commissioner's hearing to determine discipline. (*Exhibits 7, 8*)

37. After a hearing before the Commissioner's designee, Dennis Cullen, DOC Deputy Director of Employee Relations, concluded:

> ". . . C.O. Gagne had his foot on the head of the patient only for a few seconds. In the excitement of a response to an officer being assaulted, some inappropriate or incorrect actions may occur and they will be addressed. However, in this case, C.O. Gagne says that it did not happen at all. In many ways, the lying is more of a concern that the actual event."

He recommended a 20-day suspension and use of force retraining. (*Exhibits 5 & 6*).

38. On October 14, 2005, Commissioner Kathleen Dennehy adopted the recommendations of the hearings officer's report, found CO Gagne in violation of DOC Rule 10(a), regarding use of excessive force, and Rule 19(c), regarding truthfulness, and, "with particular attention paid to your untruthfulness during the investigation", ordered that CO Gagne be suspended for 20 days and attend Use of Force Retraining. The discipline was subsequently imposed and this appeal duly ensued. (*Exhibits 1, 2 & 3*)

Related Discipline of CO Donnelly

39. Simultaneously with the Commissioner's hearing to discipline CO Gagne, a Commissioner's hearing was also ordered for CO Donnelly, for being less than truthful during the investigation, e.g., for telling Capt. Martin that she did not see CO Gagne put his foot on Patient M and did not take any action to move him off the patient. (*Exhibit 6*)

40. By letter dated February 21, 2006, Commissioner Dennehy imposed a 15-day suspension on CO Donnelly for being "less than truthful". Her collective bargaining Unit grieved the discipline on her behalf, the matter proceeded to arbitration and, on December 31, 2007, the arbitrator issued an Award that stated:

> "The Department of Correction did not have just cause to issue Officer Linda Donnelly a fifteen-workday suspension for being less than truthful during the Department's investigation into another officer's use of force.

> "The Department is directed to rescind the suspension, remove the record of discipline from Officer Donnelly's file, and make her whole for lost wages and benefits for the period of her suspension."

(*Exhibit 19; Testimony of Donnelly*)

41. Although the Donnelly arbitration plowed somewhat similar ground as does this appeal, I find that the issues before the arbitrator and the Commission are sufficiently distinct that I will not treat the arbitrator's Award as preclusive of any of the issues concerning the truth of the charges against CO Gagne. My findings are based on my assessment of the credible testimony and other evidence actually presented to the Commission. I will give some weight to the Award, however, to the extent that it confirms my own independent findings that a reasonable person, i.e., an impartial single arbitrator, would fairly conclude, and did conclude, that, in some respects, the recollections and reports of Director of Security Frye and Deputy Superintendent Ferreira about the use of force incident on January 5, 2005 are not supported by the weight of the substantial evidence. (*Exhibit 19*)

The DOC's Evidence Before the Commission

42. The DOC called four supervisory officers as witnesses: Deputy Superintendent Ferreira, Director of Security Frye, Director of Investigative Services Capt. Martin, and Sergeant Gordon. Each witness described a career of many years involving command experience at BHS and other DOC facilities. They each presented as dedicated and consummate professionals. Except for the points described below, their testimony about the incident was largely consistent with their contemporaneous reports and interviews conducted by Capt. Martin, and consistent with each other. I find nothing in their testimony or demeanor to suggest specific animosity between any of them and CO Gagne

43. Both Deputy Superintendent Ferreira and Director Frye testified that there could be situations in which an officer's use of his foot to subdue an inmate might not be considered excessive force, such as if the inmate were attempting to bite, but that they saw no obvious reason to do so in this particular case. (*Testimony of Ferreira & Frye*)

44. DOC also introduced a copy of the CD containing the time-lapse video recording showing footage of the use of force incident that was captured by cameras positioned at various nearby locations in the Max II unit that are part of the BHS routine monitoring system. The video system begins recording whenever a camera's sensor detects activity in the area, and takes snap-shots at intervals from approximately one to five frames per second. A selected sequence of thirty-six still pictures (marked Articles 1 thru 36) taken from the video was also introduced. Captain Martin testified that his review of the video provided him with the corroborating evidence he was looking for to find that CO Gagne had placed his foot on Patient M's head. (*Exhibits 20 & 21; Testimony of Martin*)[3]

45. After reviewing the video and still photos, I find that, contrary to the testimony of Captain Martin, the version of the incident as told by Deputy Chief Ferreira and Director of Security Fry is not corroborated by the video, nor does it discredit the conflicting version provided by CO Gagne and others. I find:

a. CO Demaranville was the first emergency responder to arrive on scene.

[3] In the course of reviewing the evidence, the Commission discovered that the CD marked in evidence as Exhibit 20, purporting to contain the video footage of the use of force incident, in fact, contained other information wholly unrelated to the present appeal. The DOC was notified and filed a replacement CD which has been substituted for the erroneously marked Exhibit 20.

b. Director Frye and Deputy Superintendent Ferreira arrived on scene shortly thereafter, and prior to CO Gagne and other emergency responders.

c. Director Frye positioned himself in the Mental Health Workers' area several feet across the room from the doorway in which officers were struggling to subdue Patient M, and remained in this position with his attention focused on the struggle throughout the incident.

d. As CO Gagne arrived on the scene, Deputy Superintendent Ferreira passed him as he (Ferreira) was leaving the room to enter the adjoining corridor. He returned to the scene after CO Gagne had been in the room for nearly 20 to 30 seconds.

e. While Superintendent Ferreira was in the corridor, Sergeant Gordon and CO Marcotte arrived and began to support the other officers engaged in attempting to subdue Patient M.

f. CO Donnelly was the last responder to arrive on scene, She leaves the scene and returns with leg-irons as she testified .

g. The video shows CO Gagne near the doorway on the right side of the struggle that is still ensuing on the floor. CO Donnelly appears to be standing behind other officers several feet from CO Gagne. Deputy Superintendent Ferreira appears to be standing on to the left side of the struggle, with most of the other officers between them bent over Patient M.

h. The angles of the video cameras and the number of officers hovering over Patient M precluded Captain Martin from any video confirmation that CO Gagne's foot, or anyone else's foot, was placed on Patient M's head at any time.

i. I infer from the video and the testimony of Director Frye and CO Donnelly that, at the time CO Gagne is alleged to have first used excessive force by leaning at the doorway while applying a foot to Patient M, Patient M is face down on the floor, with Sergeant Bower restraining the head of Patient M, who continued to struggle with his hands still underneath his torso.

j. I find no direct evidence on the video to confirm whether or not Patient M was attempting to bite any of the officers at this point in time, as CO Gagne testified, but the video makes clear that Patient M is definitely not "under control" when CO Gagne alleged used excessive force, as Deputy Superintendent Ferreira and Director Frye testified.

k. I find that the video does not show that Deputy Superintendent Ferreira tapped CO Gagne with his radio as he told him twice to "get off" Patient M, as Deputy Superintendent Ferreira testified and Captain Martin believed.

l. I find that at the point in the video that Captain Martin testified Deputy Ferreira tapped CO Gagne, CO Donnelly was positioned behind other officers who were closer to Patient M and in a manner that would be unlikely to have permitted her to see Patient M's head or CO Gagne's feet through the crowd.

m. I find that, if anyone's foot had been placed on Patient M's head and any point in time, several other officers (Sergeant Bower, Sergeant Gordon, CO Demaranville, CO Marcotte, CO Miner and CO Gagne), would have been in a better position that CO Donnelly to have seen it and better to have known the person who did it.

n. I find that the video does not show CO Donnelly pulling CO Gagne away from the struggle at any time.

o. I find that Patient M was not under restraints until at least two to three minutes after the responders first arrived.

46. I give no weight to the testimony of Sergeant Gordon to the effect that he heard someone say “Hey that’s excessive force”. There was no other witness who recalls this statement. Even Sergeant Gordon could not be certain whether the statement was uttered by a DOC officer or Patient M. (*Exhibits 8, 9 & 10 [Investigation Report/Staff Reports/Interviews]; Exhibit 20 [Video]; Exhibit 12 [Use of Force Report]; Testimony of Gordon*)

47. I give considerable weight to the testimony of CO Donnelly, who appeared somewhat nervous as a witness but was steadfast in her clear and credible memory of her actions in the incident. I am particularly persuaded by her testimony that, as she watched the other officers subdue Patient M, she was certain that Sergeant Bower was restraining Patient M’s head with his hands because, according to Sergeant Bower she said, Patient M was still fighting, spitting and attempting to bite. (*Testimony of Donnelly*)

48. I also found CO Gagne to be a credible witness. He responded to questions in a direct and confident manner, both on direct and cross-examination. He made good eye contact while responding to questions and presented a demeanor that suggested to this commissioner that he was being truthful about the testimony he gave. I am persuaded that he was not the person whom others say they saw apply excessive force to Patient M. (*Testimony of Gagne*)

49. Thus, while I do not find no person could have placed a foot on Patient M’s head in a way that might be viewed as excessive, I do find that DOC did not met its burden to prove that CO Gagne did so by a preponderance of the credible evidence.

50. I find that the discipline imposed on CO Gagne was based both on his use of excessive force in subduing Patent M as well as untruthfulness in denying the charges, but that the alleged excessive use of force was of less concern to DOC than the alleged subsequent untruthfulness. As Hearing Officer Cullen stated in his memorandum recommending discipline: "the lying is more of a concern than the actual event" and Deputy Superintendent Ferreira testified: "If he [CO Gagne] had just admitted it we wouldn't be here". (*Testimony of Ferreira; Exhibits 3 & 4*)

CONCLUSION

Summary of Conclusion

The DOC has failed to establish by a preponderance of evidence that CO Gagne used excessive force on Patient M on January 5, 2005 and there is no just cause to impose discipline for that reason. Whether discipline is justified on the basis of untruthfulness is a separate question. While it is improbable that CO Gagne used excessive force, if such force was used, he would have been a better percipient witness than either Director Frye or Deputy Superintendent Ferreira, as would the other officers in closer proximity to Patient M. This case, however, is not one in which DOC claims CO Gagne was concealing something or covering up for someone else, and he cannot be disciplined solely for denying what DOC had failed to prove that he did.

Applicable Legal Standards

A person aggrieved by disciplinary action of an appointing authority made pursuant to G.L.c.31,§41 may appeal to the Commission under G.L.c.31,§43, which provides:

> "*If the commission by a preponderance of the evidence determines that there was just cause for an action taken against such person it shall affirm the action of the appointing authority, otherwise it shall reverse such action* and the person concerned shall be returned to his position without loss of compensation or other

> rights; provided, however, *if the employee by a preponderance of evidence, establishes that said action was based upon harmful error in the application of the appointing authority's procedure, an error of law, or upon any factor or conduct on the part of the employee not reasonably related to the fitness of the employee to perform in his position, said action shall not be sustained*, and the person shall be returned to his position without loss of compensation or other rights. The commission may also modify any penalty imposed by the appointing authority." (*emphasis added*)

Under Section 43, the Commission is required "to conduct a de novo hearing for the purpose of finding the facts anew." Town of Falmouth v. Civil Service Comm'n, 447 Mass. 814, 823, 857 N.E.2d 1053, 1059 (2006) and cases cited. The role of the Commission is to determine "whether the appointing authority has sustained its burden of proving that there was reasonable justification for the action taken by the appointing authority." City of Cambridge v. Civil Service Comm'n, 43 Mass.App.Ct. 300, 304, rev.den., 426 Mass. 1102 (1997). See also City of Leominster v. Stratton, 58 Mass. App. Ct. 726, 728, rev.den., 440 Mass. 1108 (2003); Police Dep't of Boston v. Collins, 48 Mass.App.Ct. 411, rev.den., 726 N.E.2d 417 (2000); McIsaac v. Civil Service Comm'n, 38 Mass App.Ct. 473, 477 (1995); Town of Watertown v. Arria, 16 Mass.App.Ct. 331, 451 N.E.2d 443, rev.den., 390 Mass. 1102 (1983).

An action is "justified" if it is "done upon adequate reasons sufficiently supported by credible evidence, when weighed by an unprejudiced mind; guided by common sense and by correct rules of law." Commissioners of Civil Service v. Municipal Ct. of Boston., 359 Mass. 211, 214 (1971); City of Cambridge v. Civil Service Comm'n, 43 Mass.App.Ct. 300, 304, rev.den., 426 Mass. 1102 (1997); Selectmen of Wakefield v. Judge of First Dist. Ct., 262 Mass. 477, 482 (1928). The Commission determines justification for discipline by inquiring, "whether the employee has been guilty of substantial misconduct which adversely affects the public interest by impairing the

efficiency of public service." School Comm. v. Civil Service Comm'n, 43 Mass. App. Ct. 486, 488, rev.den., 426 Mass. 1104 (1997); Murray v. Second Dist. Ct., 389 Mass. 508, 514 (1983) The Commission is guided by "the principle of uniformity and the 'equitable treatment of similarly situated individuals' [both within and across different appointing authorities]" as well as the "underlying purpose of the civil service system 'to guard against political considerations, favoritism and bias in governmental employment decisions.' " Town of Falmouth v. Civil Service Comm'n, 447 Mass. 814, 823 (2006) and cases cited.

The Appointing Authority's burden of proof by a preponderance of the evidence is satisfied "if it is made to appear more likely or probable in the sense that actual belief in its truth, derived from the evidence, exists in the mind or minds of the tribunal notwithstanding any doubts that may still linger there." Tucker v. Pearlstein, 334 Mass. 33, 35-36 (1956).

> *The greater amount of credible evidence must in the mind of the judge be to the effect that such action 'was justified,'* in order that he may make the necessary finding. If the court is unable to make such affirmative finding, that is, *if on all the evidence his mind is in an even balance or inclines to the view that such action was not justified, then the decision under review must be reversed. The review must be conducted with the underlying principle in mind that an executive action, presumably taken in the public interest, is being re-examined.* The present statute is different in phrase and in meaning and effect from [other laws] where the court was and is required on review to affirm the decision of the removing officer or board, 'unless it shall appear that it was made without proper cause or in bad faith.'

Selectmen of Wakefield v. Judge of First Dist. Ct., 262 Mass. 477, 482 (1928) (*emphasis added*) The Commission must take account of all credible evidence in the entire administrative record, including whatever would fairly detract from the weight of any particular supporting evidence. See, e.g., Massachusetts Ass'n of Minority Law

_____, 434 Mass 256, 264-65 (2001) It is the function of the hearing officer to determine the credibility of the testimony presented through the witnesses who appear before the Commission. See Covell v. Department of Social Services, 439 Mass 766, 787 (2003); Doherty v. Retirement Bd. , 425 Mass. 130, 141 (1997); Embers of Salisbury, Inc. v. Alcoholic Beverages Control Comm'n, 401 Mass. 526, 529 (1988)

"The commission's task, however, is not to be accomplished on a wholly blank slate. After making its de novo findings of fact . . . the commission does not act without regard to the previous decision of the [appointing authority], but rather decides whether 'there was reasonable justification for the action taken by the appointing authority in the circumstances found by the commission to have existed when the appointing authority made its decision'". Town of Falmouth v. Civil Service Comm'n, 447 Mass. 814, 823, 857 N.E.2d 1053, 1059 (2006). See Town of Watertown v. Arria, 16 Mass. App. Ct. 331, 334, 451 N.E.2d 443, rev.den., 390 Mass. 1102, 453 N.E.2d 1231 (1983) and cases cited.

Discipline for Use of Excessive Force

The Commission recognizes that use of excessive force in restraint of an inmate DOC's care and custody, in violation of clearly stated rules and regulations, is a significant neglect of duty that the DOC must take seriously. The Commission also recognizes that the duties of a correctional officer can place him or her in situations in which rapid response is required to confront a quickly developing inmate disturbance that calls for split-second decisions regarding the level of force required to control the situation. See generally "Patient's death under investigation – concerns raised on level of

force", BOSTON GLOBE, May 5, 2009; "Man restrained at Bridgewater dies", BOSTON HERALD, May 5, 2009.

Here, the Commission is not asked to second-guess either the DOC or a correctional official as to these judgment calls, i.e., whether the extent of force used to restrain a patient was reasonable or excessive. Rather, the Commission is presented with a more fundamental evidentiary dispute that requires a determination as to which of two conflicting versions of the restraint of Patient M is more likely to have occurred, the DOC's version, in which discipline of CO Gagne would be justified, and the Appellant's version, in which discipline would not be justified.

The Commission resolves this conflict against the DOC, which has the burden of proof, and in favor of CO Gagne. Both the witnesses for both DOC and the Appellant presented largely credible testimony, but the preponderance of evidence supports the conclusion that CO Gagne never applied excessive force to Patient M's head with his foot.

First and foremost is CO Gagne's consistent and credible denial in his reporting and testimony about the incident. His recollection is reinforced by the absence of any direct confirmation on the video tape and a failure of any other officers who would be likely percipient witnesses to come forward to corroborate the testimony of Deputy Superintendent Ferreira and Director Frye. In fact, portions of the video and reports of others raise substantial doubt about the DOC's version of events and suggest that CO Gagne's recollection is more likely true than not true.

In addition, the absence upon immediate medical examination of any physical evidence of such contact on Patient M or, indeed, any complaint of mistreatment by him

(an inmate with a history of being "disruptive and confrontational with correctional staff' who was trying to find a way to keep from being transferred back to the Intensive Treatment Unit), also infers that it is improbable that what Deputy Ferreira and Director Frye say they saw as excessive force actually occurred.

Also, CO Gagne (a 23 year correctional veteran with a largely unblemished disciplinary record) did not impress me as someone who would be inclined, even under the pressure of an emergency response situation, to blatantly commit a serious infraction of the use of force policy knowing that he was likely being videotaped and with two senior management officials in the room and one or both were allegedly looking right over his shoulder.

Finally, the arbitrator's Award involving CO Donnelly corroborates my findings that the perceptions of Director Frye and Deputy Superintendent Ferreira as to their memory of at least some of what they say they saw should be discounted. Director Frye and Deputy Ferreira may well have thought they saw a foot being applied to Patient M's head, and may well have thought it was CO Gagne's foot. In the press of rapidly developing circumstances – the relevant events taking place in a matter of seconds – and the perspective of their view, it is entirely understandable how such a mistake could be made. While neither official is to be faulted for their misperception, the preponderance of the evidence establishes that they are materially mistaken in their conclusions about CO Gagne. Indeed, the fact that CO Gagne was permitted to help escort Patient M from the Max II Unit to ITU suggests the perceptions of what took place did not completely form until well after the incident was over.

In sum, DOC has failed to meet its burden of proof to justify imposing discipline on CO Gagne for use of excessive force.

Discipline for Untruthfulness

The DOC expressed more concern with CO Gagne's "lying" about the excessive use of force and downplayed the violation of the use of force regulation itself. This is consistent with its choice of a 15-day suspension of CO Donnelly solely for allegedly trying to cover up for CO Gagne. There are problems, however, with imposing discipline on CO Gagne for being untruthful. The DOC has failed to establish that he committed the offense of use of excessive force. He cannot then be disciplined indirectly for denying an offense that DOC failed to prove directly to have been a "lie".

This is quite different from a case in which investigation revealed that CO Gagne had committed an offense or that he was covering up for another offense or another officer, or in which he concealed information of any kind. Even if CO Gagne knew more than he had told, the same could be said of several other percipient officers, but discipline was never pursued, or apparently ever considered, as to any of them, as to the mendacity of any them (save for the unsuccessful selective attempted discipline of CO Donnelly). Indeed, in the face of his professed innocence, he cannot be disciplined for failing to "respond fully and promptly" to questions about the involvement of others that he was never asked. In sum, in this case, the DOC's offense of untruthfulness lodged against CO Gagne stands simply as a proxy for the offense of excessive use of force and must fail for the same reasons as the charge against him for the predicate offense.

Accordingly, for the reasons stated above, the appeal of the Appellant, David Gagne is hereby ***allowed.***

Civil Service Commission

Paul M. Stein
Commissioner

By 3-2 vote of the Civil Service Commission (Bowman, Chairman [NO]; Henderson [YES], Marquis [NO], Stein [YES] and Taylor [YES], Commissioners) on June 4, 2009.

A True Record. Attest:

_____
Commissioner

Either party may file a motion for reconsideration within ten days of the receipt of a Commission order or decision. Under the pertinent provisions of the Code of Mass. Regulations, 801 CMR 1.01(7)(l), the motion must identify a clerical or mechanical error in the decision or a significant factor the Agency or the Presiding Officer may have overlooked in deciding the case. A motion for reconsideration shall be deemed a motion for rehearing in accordance with G.L. c. 30A, § 14(1) for the purpose of tolling the time for appeal.

Under the provisions of G.L c. 31, § 44, any party aggrieved by a final decision or order of the Commission may initiate proceedings for judicial review under G.L. c. 30A, § 14 in the superior court within thirty (30) days after receipt of such order or decision. Commencement of such proceeding shall not, unless specifically ordered by the court, operate as a stay of the Commission's order or decision.

Notice to:
Stephen C. Pfaff, Esq. (Appellant)
Earl Wilson, Esq. (Appointing Authority)
John Marra, Esq (HRD)