STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. **2009B030**

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

ANETT HARP,

Complainant,

vs.

DEPARTMENT OF HUMAN SERVICES, COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO,

Respondent.

Administrative Law Judge Denise DeForest held the hearing in this matter on February 10, March 24, March 26, April 13, and April 15, 2009, at the State Personnel Board, 633 - 17th Street, Courtroom 6, Denver, Colorado. The record was closed by the ALJ at the conclusion of the written briefing schedule on May 15, 2009, pursuant to a written Order issued April 15, 2009. Assistant Attorney General Michael D. Scott represented Respondent. Respondent's advisory witness was Irene Drewnicky, the appointing authority. Complainant appeared and was represented by Tamara Wayland, Esq.

MATTER APPEALED

Complainant, Anett Harp ("Complainant") appeals her termination by Respondent, Department of Human Services, Colorado Mental Health Institute at Pueblo ("CMHIP" or "Respondent"). Complainant seeks an order reversing her termination, an award of back pay and benefits, and an award of attorney fees and expenses.

For the reasons set forth below, Respondent's action is **rescinded.**

ISSUES

1. Whether Complainant committed the acts for which she was disciplined;

2. Whether Respondent's action was arbitrary, capricious or contrary to rule or law;

3. Whether the discipline imposed was within the reasonable range of alternatives available to the appointing authority;

4. Whether attorney fees are warranted.

FINDINGS OF FACT

General Background

1. Complainant is an African-American woman who was first employed at CMHIP in 1987. In 1993, Complainant was hired by the Colorado Department of Corrections as a Correctional Officer I. By 2003, Complainant was re-hired by CMHIP as a Health Care Technician I. Complainant promoted to Clinical Safety and Security Officer II (CSSO II) at CMHIP in November of 2006 when she transferred to the F-2 forensics unit in November of 2006. As of July of 2008, Complainant was assigned to the second shift for the F-2 unit.

2. The F-2 unit is in a maximum security building at CMHIP. The F-2 unit houses CMHIP patients who are at risk of being the most violent and dangerous of the patients at the facility.

3. Patient D.M. was housed on Unit F-2 during July of 2008.

4. As a CSSO II, Complainant's duties included handling seclusion and restraint episodes involving the patients on the F-2 unit.

5. Complainant was trained to handle seclusion and restraint episodes according to CMHIP's Continuum of Therapeutic Intervention (CTI).

6. CTI provides directions to CMHIP staff on how to handle potentially dangerous or disruptive patients. All CMHIP clinical staff are trained on the principles of CTI and are expected to use the techniques approved by CTI in their handling of CMHIP patients.

Continuum of Therapeutic Intervention –

7. CTI provides that a staff member confronting a potentially dangerous or disruptive patient should engage in several steps in order to convince the patient to comply with staff directions prior to reaching the point of applying a hands-on use of force on the patient.

8. It is CMHIP's policy that physical force be used to restrain a patient only when other interventions have failed or are not adequate to prevent imminent physical harm to the patient, other patients, or to staff. When physical force is used, only the minimum amount of force necessary to defend against physical injury is authorized.

9. CTI requires that use of force be progressive. Staff is expected to follow a progression of actions, as follows:

    a. Presence of employees as a deterrent to violence;
    b. Appropriate verbal interaction with the patient;
    c. Use of hands – minimum necessary physical force; and
    d. Use of humane restraints.

10. The appropriate verbal interaction requirement taught to CMHIP staff is known as Verbal Judo. Verbal Judo teaches that staff should use four steps of communication in order to persuade a disruptive or non-compliant patient to cooperate. The first step is to tell the patient directly not to take the disruptive action or to cooperate. The second step requires staff to provide an explanation to the patient as to why the conduct is disruptive or why the patient should cooperate. The third step is to motivate the patient by connecting a desired benefit to the desired activity, such as telling the patient that if their room is not cleaned then there will be no television. The fourth step has the staff asking the patient, "Is there anything I can say to earn your cooperation at this time?"

11. If none of these approaches produce the desired action by the patient, then staff is at the fifth step of Verbal Judo. The program teaches that, at this point, it is appropriate to remove the source of the problem. The options can include a number of reactions by staff, including sending the patient to time out, calling for additional staff, calling the police, proceeding with restraint and seclusion, and removing the person from the area.

12. In training staff on their use of hands on a patient, CMHIP does not permit the use of pain compliance or pressure point techniques as part of CTI. Pain compliance and pressure point techniques are taught to CMHIP law enforcement officers for use in their general law enforcement duties, but not to clinical staff for use on patients.

13. CTI policy includes a sub-section, CMHIP Policy 6.38, Section III (B), which defines the limited circumstances under which an employee may use a type of force not authorized under CTI. This sub-section provides:

    > When a clinical employee is required by emergency circumstances to defend a person from imminent serious bodily injury, use of additional force (force that is outside of the CTI continuum) is justified. The clinical employee should use an amount and type of force that will be effective to prevent serious bodily injury. **In this as in all instances, staff action must be limited to the minimum amount of force necessary to eliminate the threat of bodily injury.** (emphasis in original)

14. CMHIP further defines danger of imminent serious bodily injury to mean that "a person is in immediate danger of physical injury that involves a substantial risk of death, a substantial risk of serious permanent disfigurement, a substantial risk of protracted loss or impairment of the function of any part or organ of the body, or breaks, factures, or burns of the second or third degree." CMHIP Policy 6.38, Section III (B)(1).

15. CMHIP policy also requires that that three additional criteria be met "before the use of force beyond the CTI, such as striking a patient," would be authorized:

    a) Ability - The patient must have the ability to inflict serious bodily injury or loss of life upon the employee, or another (i.e., must be armed with a deadly weapon, be of physical size/strength, or demonstrate knowledge or martial arts).
    b) Opportunity – The patient must have the opportunity to inflict serious bodily injury or loss of life upon the employee, to another (i.e., must be within operational range for effective use of the deadly weapon with which he/she is armed, close proximity to engage the employee, and the employee cannot retreat to a safe area.
    c) Jeopardy – The patient must make an overt move to use his/her deadly weapon, physical size, strength, or martial arts against the employee, or another, to inflect serious bodily injury or placing the employee's life, or another's in jeopardy.

    CMHIP Policy 6.38, Section III(B)(2).

16. CMHIP policy also defines "patient abuse" as "any behavior by an employee that is anti-therapeutic, non-professional, and/or affects the patient detrimentally." CMHIP Policy 16.15, Section I(A)(2). The term is further defined to include "using unnecessary force." CMHIP is required to report incidents of neglect and patient abuse to state regulators.

17. CMHIP policy requires that any employee who suspects or learns of patient abuse must report it immediately to CMHIP's Department of Public Safety (DPS), and then to the team leader or administrator on call. DPS then directs an investigation to determine the facts surrounding the incident. CMHIP Policy 16.15, Section III (1). "Upon completion of the investigation, if indicated, an employee may be subject to corrective action and/or disciplinary action up to and including dismissal, by the Appointing Authority for that department or division." Policy 16.15, Section III (4).

Restraint of Patient D.M.

18. Patient D.M. has had a history at CMHIP of regularly resisting staff to the point of requiring physical restraint. There have been days with as many as two hands-on events with D.M.

19. Several weeks prior to the July 21, 2008, restraint of patient D.M., D.M's psychiatrist, Dr. Abel, told clinical staff that D.M.'s more recent outbursts were attention-seeking behavior and that the incidents would be better handled by not spending as much time focusing attention on D.M. Dr. Abel did not specify how this modification of staff response was to be implemented, and instead left it to staff discretion on how to decrease the amount of time spent focusing on D.M. while he was acting out. Complainant reasonably interpreted this instruction to mean that less time would be spent trying to talk D.M. into complying with staff requests.

20. D.M. is a large and strong individual with a history of kicking, biting, and self-mutilation during prior restraint episodes.

July 21, 2008 Incident -

21. On July 21, 2008, a group activity for unit patients was scheduled to begin at 3:00 P.M. The group activity was led by CMHIP staff psychologist, Dr. Sean Kelly. D.M. had the option of attending the activity. A number of unit patients attended the group activity.

22. The F-2 unit has a series of rooms for patients located around the perimeter of a common area and a nurse's station.

23. At about the time when the group activity began, D.M. began to bang on the nurses' station window. When he was told not to disrupt the nurses, D.M. moved over to a table in the day hall, which was in the common area of the ward. The table had a completed puzzle on it, and D.M. began taking the puzzle apart.

24. D.M. continued to make loud noises while he was at the table. Complainant and other patients asked D.M. to be quiet. D.M. stopped making the noises.

25. Complainant told D.M. several times that he needed to take a self time-out. D.M. did not respond to Complainant, and told her that he was not listening to her. Complainant asked D.M. if he needed medication. D.M. did not respond. Complainant made the decision to initiate a physical escort of D.M.

26. Additional staff, including Dr. Kelly, assembled around D.M. Dr. Kelly sat at the table with D.M. and spoke with him in an attempt to have D.M. agree to take the self time-out requested by Complainant.

27. When staff attention focused on D.M., F-2 unit staff members spread the word that they were likely to need assistance. A staff member went to

nearby units, and a duress alarm was sounded. Staff members from other units and other CMHIP functions came to the F-2 unit to assist. By the time that the staff began their restraint of D.M., there were close to a dozen CMHIP staff members present in the day hall.

28. Staff members directed other patients back to their rooms and locked the doors of those rooms so that the other patients would not become involved in any action to be taken with D.M.

29. Staff members gathered in a semi-circle around the portion of the room where D.M. sat with Dr. Kelly. Dr. Kelly continued to try to gain D.M.' s compliance with the self time out requested by Complainant. Other staff members encouraged D.M. to take a voluntary time-out.

30. Complainant repeatedly refused to answer any questions or to speak in response to Dr. Kelly's questions or other staff encouragement. On at least one occasion, D.M. told Dr. Kelly and the staff that he was not listening to anyone.

31. While Dr. Kelly was still speaking with D.M., Complainant signaled to another CMHIP staff member, Paul Okins, that it was time to place hands on D.M. for a physical escort to place D.M. into a time-out. Complainant and Mr. Okins stepped forward and attempted to take hold of D.M.'s arms. D.M was sitting at the time. When Complainant and Mr. Okins attempted to grasp his arms, D.M. stood up and began to resist.

32. When patient D.M. began to resist, additional staff moved toward him. D.M. had one arm free and he appeared to try to hit Gail Manchester, the nursing supervisor of the F-1 unit. D.M. did not make contact with Ms. Manchester. Staff then forced D.M. to the floor.

Initial Entry into the Seclusion Room -

33. Once D.M. was on the ground, Complainant took control of D.M.'s head. Other staff members grabbed an arm or a leg. D.M. was struggling and trying to bite and spit.

34. CMHIP Correctional Security Officer John Speier was present on the ward at the time D.M. was taken to the floor. He placed handcuffs on D.M. while staff members held D.M.'s limbs and attempted to prevent D.M. from thrashing about.

35. Staff members picked up D.M. from the floor and carried him face-down into a seclusion room. The room was not large enough to hold all of the staff that were initially assisting. Six or so staff members continued into the room with

D.M. and placed him face-down on the seclusion room bed.

36. Complainant moved to the head of the bed and controlled D.M.'s head during the placement of restraints on D.M. Other staff members controlled D.M's arms and legs. D.M. was spitting and trying to move his head to bite.

37. Gail Manchester assisted in the initial securing of D.M. arms while they were in the day hall. Ms. Manchester moved to the side of the bed to continue securing an arm while restraints were applied to D.M.

38. During the effort to secure D.M., D.M. complained of the pressure that was being applied to him. At one point, he called Complainant a "black nigger." When Ms. Manchester heard this exchange, she asked Complainant if Complainant was all right, and Complainant answered that she was fine.

39. Ms. Manchester observed Complainant press into the left side of D.M.'s face below his earlobe, and apply pressure to that spot. Complainant pressed hard enough at the spot below and behind D.M.'s earlobe that Ms. Manchester could see the pressure on Complainant's nailbed. While this pressure was being applied by Complainant, D.M. was still struggling with staff but no one in the room was in immediate danger of physical injury involving a substantial risk of death, a substantial risk of serious permanent disfigurement, a substantial risk of protracted loss or impairment of the function of any part or organ of the body, or breaks, factures, or burns of the second or third degree.

40. Once the restraints were secure on D.M.'s arms and legs, the staff exited the restraint room.

2nd Entry into the Seclusion Room –

41. Shortly after the restraints had been first applied to D.M., a staff member noticed that D.M. had slipped his left wrist cuff.

42. Staff members again entered the seclusion room. Complainant again took control of D.M.'s head, while other staff members took control of D.M.'s arm and reapplied the wrist cuff.

3rd Entry into the Seclusion Room-

43. Shortly after the second entry into the seclusion room, D.M. again slipped out of his left wrist cuff.

44. Staff entered the seclusion room a third time to administer an injection of medication to patient D.M. and to change his restraints to a wrist and waist

belt in order to prevent D.M. from slipping his cuff. D.M. continued to spit and attempt to bite. Complainant again placed her hands on D.M's head to control his head movements, and other staff members assisted by controlling D.M.'s legs and arms while the medication was administered and the restraints changed.

45. Correctional Sergeant Jeff Horn, entered the seclusion room to assist with D.M.'s handling during the administration of medication and change of restraints. Sgt. Horn assisted by placing D.M.'s left hand into the wrist cuff. As he was waiting for staff to finish securing the restraints, he observed that Complainant was using pressure point control techniques on the left side of D.M.'s face. These techniques involved applications of strong finger pressure to the sensitive area below the ear and behind the mandibular notch. Sgt. Horn has learned these techniques as part of his law enforcement training on pressure point control tactics, and he considered the name of these pressure point techniques to be a "C-Clamp" technique and a "mandibular angle" technique.

46. At the time when Sgt. Horn saw Complainant applying pressure behind the ear and under D.M.'s jaw, no one in the room was in immediate danger of physical injury involving a substantial risk of death, a substantial risk of serious permanent disfigurement, a substantial risk of protracted loss or impairment of the function of any part or organ of the body, or breaks, factures, or burns of the second or third degree.

47. Complainant reported that D.M. had assaulted her while they had been in the day hall. After Sgt. Horn had assisted with the restraint of D.M., Sgt. Horn left the unit to obtain statement forms and other reporting materials so that Complainant and the other staff could file their reports relating to Complainant's assault allegations.

Post-Incident Events

48. On July 22, 2008, Dr. Kelly reported to clinical supervisors that he believed that Complainant was stressed from other recent violent episodes with patient D.M. and another patient, and was reacting too quickly because of these other incidents. His memo included this explanation of events:

> Annett Harp, an employee on the second shift F2 treatment team, has been involved in several Seclusion & Restraint incidents recently (some resulting in injuries from patient M.M.) that may have impacted her judgment in yesterday's physical restraint with patient D.M. I observed her to be very quick in her approach to physically manage the patient when he did not respond to a request for a self time out. At the time, I was

attempting to use verbal compliance techniques as a least restrictive intervention. DM appeared to resist verbal communication but he did not appear escalated, he was not making his usual verbal threats, nor was he exhibiting any aggressive behavior. He appeared calm working on a puzzle at the day hall table...

Currently, I believe that Ms. Harp is experiencing a great deal of stress from this event and other more violent incidents that she has been involved with over the past few weeks. She appears to be operating from a "survival mode" in which her judgment may be clouded by defensive instincts rather than her usual rational mode of interacting. I further believe that she may be at risk of being a target by the two patients that have recently exhibited a great deal of behavioral dyscontrol. She may also be at risk of making poor decisions when interacting with aggressive patients in the immediate future, Therefore, I am recommending that she temporarily move to a more stable and less aggressive ward for her own and other patient safety.

49. After the incident on July 21, 2009, Ms. Manchester had spoken with Lt. Dean VanZandt of the CMHIP Department of Public Safety and told him that she was reluctant to report Complainant because she did not want to appear to be harassing Complainant, but that she had witnessed Complainant using finger pressure below D.M.'s left earlobe and leaning so as to apply pressure to that spot. On June 22, 2008, Gail Manchester filed an initial report concerning her observations of Complainant. She also reported that she heard D.M. complain about the pressure that Complainant was applying to his head. Ms. Manchester additionally reported that she heard Complainant tell D.M. that she was not going to take the pressure off until he stopped struggling. This initial report started an investigation into possible patient abuse by Complainant.

50. Once the investigation into possible patient abuse began, Captain Mark Ramirez, CMHIP Department of Public Safety, asked Sgt. Horn what had occurred during the restraint. At that point, Sgt. Horn realized that the holds he had seen Complainant use, while permissible for a law enforcement function, were unapproved holds for patient control. Sgt. Horn reported that he had seen Complainant use unauthorized control technique on D.M.

51. Complainant was placed on administrative leave as of June 24, 2008. When she returned to work, Complaint worked in other assignments other than on the F-2 unit.

CMHIP Law Enforcement Investigations

52. The CMHIP Department of Public Safety initiated two investigations into the restraint of D.M.

53. Complainant reported that D.M. had hit her lip with his elbow as he was initially resisting the physical escort. This case was investigated by CMHIP Officer Jason Mondragon as a report of assault by a patient to staff. The report, Incident Report 2008BCR0484, found probable cause for a charge of assault against D.M. based upon Complainant's report of the blow to her lip.

54. A second report, authored by CMHIP Officer Robert Montoya, investigated the allegation that Complainant had used unapproved holds of patient D.M.

55. This report, 2008CR0489, involved interviews of, or statements from, CMHIP staff members who had either been assigned to Unit F-2 or had responded to either the informal requests for assistance or the duress alarm. The employees interviewed included Gail Manchester, Paul Okins, Shari Lawson, Correctional Officer John Speier, Correctional Sgt. Jeff Horn, Mike Lovato, Noriel Mirrales, Casey Hunter, Gaylea Molinaro, Brianna Aragon, Ralph Taylor, Dr. Sean Kelly, Paul Otero, Fil Swift, Lillian Rubiadoux, Noriel Miralles, Casey Hunter, patient D.M. and Complainant.

56. Gail Manchester and Sgt, Horn filed written statements repeating their observations of Complainant's use of finger pressure on D.M.

57. Paul Taylor, a nursing assistant, reported that he had witnessed Complainant wrap his arm around D.M.'s neck while D.M. was still on the floor in the day hall, and apply pressure on D.M.'s mandible area while D.M. was initially being moved into the seclusion room.

58. As part of his statements during the investigation into possible patient abuse, Dr. Kelly reported his concerns about the Complainant's initial decision to lay hands on D.M. After he had been interviewed by Ms. Drewnicky in late September, 2008, concerning this matter, Dr. Kelly supplemented his report to include his observations of D.M. the day after the incident. Dr. Kelly reported that, on the day after the incident, D.M. had denied any injury from the restraint. He also recorded that D.M. had a swollen face with puffy eyes, bruising on the left side of his face and what appeared to be three small bruises on his neck that may have resulted from fingers or hand pressure. Dr. Kelly also noted that D.M. also frequently engaged in self-harm, and that he could not rule out that these bruises had been self-inflicted.

59. Paul Otero, Clinical Team Leader, reported in his interview that he believed that Complainant's decision to place hands on D.M. was premature and

more could have been done to de-escalate D.M. Mr. Otero said that he did not witness any inappropriate holds.

60. Other staff members interviewed as part of the investigation into the allegation of patient abuse reported that they had not observed anything unusual in the manner in which D.M. had been restrained, or were so focused on what they were doing that they had not watched or noticed Complainant's actions. Patient D.M. told Officer Montoya that nothing out of the ordinary happened and did not report any injury from the restraint.

61. During her interview by Officer Montoya, Complainant explained that, during the entry into the seclusion room to restrain Complainant's left arm after he had slipped a cuff, she had noticed D.M. grab the arm of a staff member. Complainant told Officer Montoya that she had then employed a distraction technique on D.M. so that D.M. would release the arm. Officer Montoya recognized the technique as application of pressure to an infra-orbital pressure point located on D.M.'s upper lip.

62. The infra-orbital pressure point technique is not an approved technique under CIT, but is allowed under CMHIP policy when a patient is biting another and there is a need to have the patient release his or her bite. At the time that Complainant used the technique, D.M. was not biting anyone. Complainant's use of that technique under such circumstances was not within policy.

63. Officer Montoya also had Complainant demonstrate how she controlled D.M.'s head. Complainant placed her hands on the back of Officer Ramirez's head with her wrists together and her fingers spread across the back of his head. Officer Montoya concluded that this position could produce the scratch in the shape of a half moon located on D.M.'s upper left jawbone and below his left earlobe that Officer Montoya had observed in his interview of patient D.M. in the days after the restraint incident.

64. Complainant denied that she had used a pressure point technique or any other unapproved law enforcement control technique. Complainant told Officer Montoya that she had learned pressure point techniques while she was employed at the Colorado Department of Corrections, and that her last training in the techniques was in 2003 but that she had not employed them in the restraint of D.M.

65. Officer Montoya concluded that probable cause for patient abuse was established given Complainant's admission to use of an unapproved technique during D.M.'s restraint.

Other Incidents Involving Complainant

66. Complainant testified to a series of events which have occurred during her employment with CMHIP which she believes constitute reasons to disbelieve the statements of Gail Manchester and anyone who reports to Captain Mark Ramirez of the CMHIP Department of Public Safety.

67. Complainant has a significant allergy to dogs. The Department of Public Safety began using a dog in the wards for contraband in early 2005 because of a problem with contraband in the facility. Lt. Dean VanZandt was the dog handler for the K-9 program. In March of 2005, Complainant asked for warning when the dog would be on her unit, and initially CMHIP administration instructed the K-9 program not to bring the dog onto Complainant's unit. On one occasion, however, someone from the Department of Public Safety hid the dog under Complainant's dinner table one night. Complainant left her shift early that evening because she suffered a reaction. Complainant testified that she found out years later that it had been a test to see if she really was allergic. In July of 2005, Complainant filed a grievance against Captain Ramirez and Lt. VanZandt for repeatedly bring a dog onto her unit. Complainant's grievance against Capt. Ramirez and Lt. VanZandt was resolved through an order not to bring the dog into the unit when Complainant was present.

68. After Complainant transferred to the F-2 unit in November, 2006, Lt. VanZandt brought the dog to the F-2 unit when Complainant was present. Visits by the dog to the F-2 unit while Complainant was present finally ended in 2008.

69. In July of 2005, Complainant's son was institutionalized at CMHIP. There was incident during which Complainant's son was placed into seclusion and restraint. This incident involved Captain Ramirez and Captain Ramirez's son, Officer Mark Ramirez. Complainant was told by her son that officers matching the descriptions of Captain Ramirez and Officer Ramirez had choked him, and another staff member told Complainant that there had been unnecessary force used. After an investigation, CMHIP found that there was no probable cause for patient abuse.

70. When Complainant was first assigned to the F-2 unit, Gail Manchester was the supervisor for both the F-2 and F-1 units. Gail Manchester is the sister of Michele Manchester, the Division Director in charge of the forensic units at CMHIP, including the F-2 unit.

71. Beginning in December of 2006, Complainant became involved in a conflict with Gail Manchester over the way that the second shift was to sign the narcotics log for the unit. Complainant insisted that the process used in the other CMHIP unit for which she had worked was the proper manner for the

log to be completed. Gail Manchester told her that the unit had been using another method for a long time and had insisted that Complainant comply. Complainant eventually prompted quality assurance to investigate the practice; quality assurance found that Complainant's method was correct. After that point, Complainant believed that Ms. Manchester began to refuse to approve her leave, exclude her from training, and would not consult her on security issues for the F-2 unit. Complainant and Ms. Manchester went through a mediation process in the later part of 2007, which Complainant does not believe was a success. Gail Manchester provided Complaint with a 1.2 out of 3 rating for her interim rating period ending in October of 2007. Complainant grieved the rating.

72. In January of 2008, Gail Manchester was removed as Complainant's supervisor and Ana Lewis was given responsibility for supervising Complainant. Ms. Lewis left in May of 2008, and Gail Manchester resumed authority over the F-2 unit shortly afterwards.

Board Rule 6-10 Meeting and Disciplinary Action

73. Complainant's appointing authority, Ms. Drewnicky, received a copy of Officer Montoya's completed investigation to the patient abuse allegations. Ms. Drewnicky reviewed the file in its entirety.

74. Ms. Drewnicky considered Complainant's admission during the investigation that she had used the infra-orbital distraction technique to be an admission of violation of CMHIP policy by Complainant.

75. Ms. Drewnicky also decided to interview the staff members who had alleged that they had witnessed Complaint use other unapproved techniques to determine if their version of events was credible and warranted additional inquiry of Complainant. Ms. Drewnicky interviewed Ralph Taylor, Sgt. Horn, Gail Manchester, and Dr. Kelly in one-on-one interviews. During her interview with Dr. Kelly, Ms. Drewnicky told Dr. Kelly that Complainant had violated CMHIP policy.

76. Ms. Drewnicky decided that the events warranted a Rule 6-10 meeting with Complainant.

77. By letter dated September 3, 2008, Ms. Drewnicky transmitted a copy of the patient abuse report to Complainant and scheduled a Rule 6-10 meeting for September 12, 2008.

78. Complainant attended the Rule 6-10 meeting with her representative Pam Cress. Ms. Drewnicky had Mr. Robert Tucker, Southern District Human Resources Specialist, with her as her representative.

79. During the Rule 6-10 meeting, Complainant was permitted to respond to the patient abuse investigation report. Complainant denied the use of excessive force and the use of unauthorized techniques, and she argued that the infra-orbital distraction technique was an approved "release from bites" technique.

80. Ms. Drewnicky retrieved information from Complainant's initial supervisor when she transferred to the F-2 unit, Ms. Manchester. Ms. Manchester had made notes on two instances where she counseled Complainant to use better verbal de-escalation skills. On conversation occurred on January 27, 2007; the second occurred September 23, 2007. Ms. Manchester noted the conversations in her files and provided a copy of one of the memos to Complainant. No warning was issued, no corrective action was issued, and no additional training was required of Complainant.

81. Ms. Drewnicky had no record of any corrective action or prior disciplinary action being issued to Complainant involving an inappropriate uses of force or inappropriate hands-on techniques.

82. The annual performance evaluations on Complainant's work showed that Complainant received an overall rating of 3 out of 4 (representing a level of work that is "very good, commendable, and exceeds expectations") in April of 2006 for her work as a Health Care Tech I. Complainant then promoted to CSSO II during the middle of the 2006-2007 performance year. Complainant's first full year annual rating as a CSSO II occurred in April of 2008, at which time she received an overall level of 2 out of 3 (representing work which was "accomplished and competent, or sometimes also exceptional").

83. By letter dated September 30, 2008, Ms. Drewnicky announced the conclusion of her investigation and disciplinary decision.

84. Ms. Drewnicky concluded that Complainant had demonstrated repeated willful misconduct by applying excessive force and on four separate occasions used unapproved pain control techniques on July 21, 2008.

85. Ms. Drewnicky's reference to application of excessive force stems from Ms. Drewnicky's conclusion that Complainant "had initiated hands on physical control over the patient prematurely as he was sitting, non-threatening and was not aggressive, at a table with another staff person who was attempting to gain his cooperation."

86. Ms. Drewnicky's reference to four separate occasions of use of unapproved pain control techniques stems form her finding that Mr. Taylor, Sgt. Horn. Ms. Manchester, and Complainant reported use of unapproved pressure point control techniques in four separate instances within the restraint process.

87. Ms. Drewnicky also considered the use of such techniques, and the application of

the premature hand-on control of D.M., to constitute a failure to perform competently that created the risk of patient and staff injury.

88. Ms. Drewnicky terminated Complainant's employment as of October 2, 2008.

Board Appeal

89. Complainant filed a timely appeal of the termination of her employment with the Board.

DISCUSSION

I. GENERAL

Certified state employees have a property interest in their positions and may only be disciplined for just cause. Colo. Const. Art. 12, §§ 13-15; C.R.S. §§ 24-50-101, *et seq.*; *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994). Such cause is outlined in State Personnel Board Rule 6-12, 4 CCR 801 and generally includes:

(1) failure to comply with standards of efficient service or competence;
(2) willful misconduct including either a violation of the State Personnel Board's rules or of the rules of the agency of employment;
(3) false statements of fact during the application process for a state position;
(4) willful failure or inability to perform duties assigned; and
(5) final conviction of a felony or any other offense involving moral turpitude.

In this *de novo* disciplinary proceeding, the agency has the burden to prove by preponderant evidence that the acts or omissions on which the discipline was based occurred and that just cause warranted the discipline imposed. *Department of Institutions v. Kinchen*, 886 P.2d 700, 704 (Colo. 1994). The Board may reverse Respondent's decision if the action is found to be arbitrary, capricious or contrary to rule or law. C.R.S. § 24-50-103(6).

Complainant also raises a claim of unlawful discrimination on the basis of race under the Colorado Anti-Discrimination Act, C.R.S. §§ 24-34-401, *et. seq.* (CADA). The legal standards for the determination of a CADA claim are discussed below in section II. B.3.

II. HEARING ISSUES

A. Complainant committed one of the two types of acts for which she was disciplined.

Respondent based its decision on two types of alleged violations: Complainant's

initial decision to place hands on D.M. and the allegations of inappropriate holds used during the restraint process.

The evidence supporting Respondent's first contention that Complainant placed hands on D.M. so early as to constitute a policy violation was ambiguous at best. The evidence supports that staff were told by D.M.'s psychiatrist not to direct so much time to D.M. because he was using disruption as an attention-getting device. The evidence also established that D.M. had already been non-compliant with multiple staff directions, and that Complainant was enforcing a request for D.M. to take a time-out while D.M. was refusing to respond to her or to others. CMHIP policy teaches that, once staff has failed to persuade a patient to comply voluntarily, then step 5 of Verbal Judo allows the removal of the patient from the area by placing the patient under restraint or placing the patient into seclusion. In this case, D.M. had refused to respond to Complainant and others who had repeatedly requested that he take a time-out. The staff had assembled in the day hall, and locked down the other patients, because the possibility that D.M. would require a hand-on approach was apparently obvious to them. Dr. Kelly, on the other hand, was still trying to interact with D.M. at the time that the first attempt at escorting D.M was made.

Given that CMHIP's policy allows considerable discretion to the staff member as to choice of appropriate response once a patient is non-compliant at level 5 of Verbal Judo, and given the expressed need of D.M.'s psychiatrist to try to limit attention provided to D.M. during his periods of defiance, Respondent has not provided sufficient persuasive evidence that Complainant's decision to begin a physical escort of D.M. violated the applicable standards of conduct under the circumstances of this case.

The evidence concerning Complainant's use of unapproved holds was not ambiguous. CMHIP polices are clear that pressure point control holds (or pain compliance holds, as they are sometimes called) are not within the CTI. CMHIP is also clear that, in order to go beyond what CTI allows, there must be a reason to believe that there will be imminent serious bodily injury. The circumstances justifying a use of force outside of the CTI were not present here. D.M. may be very difficult to control, but the CMHIP staff had him outnumbered and were effectively restraining him.

Complainant presented a significant amount of evidence related to problems that Complainant has previously experienced with her former supervisor, Gail Manchester, and with members of the Department of Public Safety. Complainant argues that these incidents show that Ms. Manchester and the law enforcement witnesses involved in this matter are unworthy of credence.

After having heard the evidence of prior issues between Complainant and Ms. Manchester, Captain Ramirez, and Lt. VanZandt, and having observed the demeanor of Ms. Manchester and Sgt. Horn on the stand, the undersigned concludes that Ms. Manchester and Sgt. Horn were credible witnesses in this case. The negative incidents described by Complainant were, for the most part, remote in time and often involved others not directly involved in this matter. Moreover, Officer Montoya's investigative report does

not appear to be biased; the basis of its finding against Complainant was the admission that Complainant made during the investigative process. The report also appears to be reasonably complete. The testimony at hearing did not, for the most, differ significantly from the information provided in the report. After the sufficiency, credibility and probative value of the conflicting evidence has been evaluated in light of everything in the record, there is a preponderance of the evidence establishing that Complainant used pressure point holds on the left side of D.M.'s face near the jaw line and below the earlobe at two different times during the restraint process. [1]

Complainant has also admitted to use of an infra-orbital distraction technique. This technique is authorized under CMHIP policy only as a response to a bite and D.M. did not bite anyone. Complainant argued in testimony that she used this technique to have D.M. release the hand of a staff member during the restraint process. There is no credible basis to find that D.M. grabbed someone's hand, however, and this version of events has not been adopted in the findings of fact. Complainant's use of an infra-orbital distraction technique is another example of the use of an unapproved technique.

Respondent, accordingly, has presented sufficient persuasive evidence that Complainant used unapproved holds on D.M. while in the restraint room on July 21, 2008.

B. The Appointing Authority's action was arbitrary, capricious, or contrary to rule or law.

1. Respondent's Disciplinary Action Ignored Progressive Discipline Required Under Board Rule 6-2

As the prior discussion demonstrates, there is a sufficient factual basis to conclude that Complainant violated CMHIP standards of conduct when she utilized pressure point control holds on Complainant on three occasions.

A finding that there has been a violation of the standards of conduct for CMHIP staff, however, does not end the inquiry. The Board rules also require that an appointing authority utilize progressive discipline in her determination of the appropriate action to be taken in response to a violation of the standards of conduct.

Board Rule 6-2, 4 CCR 801, incorporates the Board's requirement for progressive discipline. The rule provides:

---

1 Mr. Taylor's statements about his observations of Complainant using inappropriate holds on D.M. while in the day hall fall into a separate category. Mr. Taylor's observations were not incorporated into the findings because there was insufficient information offered at hearing as to precisely what he was describing. It was a lack of persuasive evidence, rather than a credibility determination, which resulted in Mr. Taylor's observations being treated differently than Ms. Manchester and Sgt. Horn's observations. Respondent, therefore, did not prove by a preponderance of the evidence that Complainant used an inappropriate hold on D.M. while in the day hall.

> A certified employee **shall be subject to corrective action** before discipline unless the act is so flagrant or serious that immediate discipline is proper. The nature and severity of discipline depends upon the act committed. When appropriate, the appointing authority may proceed immediately to disciplinary action, up to and including immediate termination.

Complainant's work record included no mention of any prior corrective actions or disciplinary actions relating to Complainant's choice of physical tactics, and certainly nothing suggesting that Complaint had been observed using excessive force or inappropriate holds prior to the incident in question. Under the terms of Board Rule 6-2, therefore, a disciplinary action would be warranted only in cases of acts that are "so flagrant or serious that immediate discipline is proper."

The facts of this matter do not support that the acts committed by Complainant are so flagrant or serious as to warrant immediate discipline rather than a corrective action. The evidence demonstrated that control techniques beyond the CTI are permitted in certain circumstances. While those circumstances were not present in this case, this matter does not represent a case of an employee using wholly unapproved control techniques on a patient, but an error in judgment in when such techniques could and should be utilized.

The fact that this was not a flagrant or serious violation was also made clear by Complainant's co-workers. Of the three individuals who testified that they had seen Complainant using a prohibited control technique on Patient D.M., none reported the incident right away. Complainant's use of unapproved control holds on D.M. were not so egregious that her violation of the standards of conduct should be considered to be flagrant or serious, thereby warranting termination of employment without any prior corrective actions on the subject.

Under the terms of Board Rule 6-2, Respondent was expected to subject Complainant to corrective action before concluding that discipline is necessary in this case. This is true even through Respondent categorizes Complainant's actions as acts of patient abuse. While there are many acts of patient abuse that could, and should, be classified as sufficiently flagrant or serious to warrant immediate discipline, the use of an unapproved control hold under these circumstances is not among that category.

Respondent's disciplinary action, therefore, was contrary to rule in that it failed to apply the progressive discipline requirements of Board Rule 6-2.

2. <u>The Appointing Authority's Investigation Was Not Arbitrary, Capricious, or Contrary to Rule or Law</u>:

Complainant argues that Mr. Drewnicky's investigation into this offense is flawed because she only chose to speak with the employees who alleged that Complainant had

violated policy. Additionally, Complainant argues that Ms. Drewnicky had determined that Complainant had violated policy prior to the Rule 6-10 meeting, and that such pre-judgment violated due process owed to Complainant.

Complainant's arguments are not persuasive for several reasons.

First, Ms. Drewnicky had a police investigation report, Incident Report 2008cr0489, in addition to her own interviews upon which to base her decisions. The evidence at hearing demonstrated that Ms. Drewnicky was reasonably aware of what the witnesses to these events had observed, and did not limit her consideration to only those witnesses who had alleged that Complainant had committed errors in her handling of DM.

Second, the state personnel system does not require a full evidentiary-style hearing at the Rule 6-10 level. Board Rule 6-10, 4 CCR 801, provides that an appointing authority must meet with the certified employee to present information about the reason for potential discipline, disclose the source of that information unless prohibited by law, and give the employee an opportunity to respond, before making a final decision on discipline.

In this case, Respondent performed a reasonable investigation into the allegations through the investigation performed by the Department of Public Safety. This investigation provided the appointing authority with a good understanding of what the potential witnesses had to say about the event, and it would not have been unreasonable for an appointing authority to make a decision to schedule a Rule 6-10 meeting simply on the basis of that report. The report, however, was also followed by Ms. Drewnicky's in-person interviews with witnesses whose credibility would be the basis of an adverse finding against Complainant. This supplementation of the law enforcement report increased the reliability of Respondent's investigation, and did not decrease the reliability of Respondent's efforts.

Complainant contends in a related argument that Ms. Drewnicky decided that Complainant had violated policy prior to holding the Rule 6-10 meeting. This argument is based on Ms. Drewnicky's statement to Dr. Kelly that Complainant had violated CMHIP policy in the incident. Ms. Drewnicky's actions in this case were not an unreasonable understanding of the law enforcement report; Complainant had admitted to using a technique that was not approved under the circumstances that she and the other witnesses described. Respondent then held a Rule 6-10 meeting at which Complainant was given an opportunity to review the report and to present her side of events. There was insufficient evidence presented at hearing to show that Ms. Drewnicky had made a final decision on discipline prior to hearing Complainant's explanation of her actions.

Respondent's actions, therefore, have met the requirements of Board Rule 6-10 with the investigative and decision-making process employed in this matter. Complainant's arguments that Respondent's actions in this regard are grounds for reversal of the decision are not persuasive.

3. Complainant Has Not Demonstrated That She Was Subject To Illegal Discrimination On The Basis Of Her Race:

(a) Legal Test for Discrimination On the Basis of Race:

Complainant's employment discrimination claim arises under the Colorado Anti-Discrimination Act (CADA). Section 24-34-402(1)(a), C.R.S., provides, in relevant part:

> It shall be a discriminatory or unfair employment practice . . . [f]or an employer to refuse to hire, to discharge, to promote or demote, to harass during the course of employment, or to discriminate in matters of compensation against any person otherwise qualified because of disability, race, creed, color, sex, age, national origin, or ancestry.

In most cases, a plaintiff lacks direct evidence of an employer's discriminatory motivation and must prove intent indirectly by way of inference. Colorado has adopted the following approach, modeled on the Supreme Court's analysis in *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 93 S.Ct. 1817, 36 L.Ed.2d 668 (1973), for proving an inference of discriminatory intent.

Initially, the plaintiff must establish a *prima facie* case of discrimination by showing (1) he or she belongs to a protected class; (2) he or she was qualified for the job at issue; (3) he or she suffered an adverse employment decision despite his or her qualifications; and (4) the circumstances give rise to an inference of unlawful discrimination. *Colo. Civil Rights Comm'n v. Big O Tires, Inc.,* 940 P.2d 397, 400. (Colo. 1987).

If the plaintiff establishes a *prima facie* case of discrimination, the burden of production shifts to the employer to articulate some legitimate, nondiscriminatory reason for the employment decision. If the employer produces such an explanation, the plaintiff must then be given a full and fair opportunity to demonstrate by competent evidence that the presumptively valid reasons for the employment decision were in fact a pretext for discrimination. *Id.* at 401.

Intentional discrimination is presumed if a plaintiff proves a *prima facie* case unrebutted by an employer's offer of a nondiscriminatory reason for an adverse job action. *See Tex. Dep't of Cmty. Affairs v. Burdine,* 450 U.S. 248, 101 S.Ct. 1089, 67 L.Ed.2d 207 (1981). A nondiscriminatory reason is one that is not prohibited by CADA, namely, a reason that is not based on factors such as disability, race, creed, color, sex, age, national origin, or ancestry. *See Equal Employment Opportunity Comm'n v. Flasher Co.,* 986 F.2d 1312, 1316 n. 4 (10th Cir.1992); *Bodaghi v. Dep't of Natural Res.,* 995 P.2d 288, 307 (Colo.2000).

Once such a reason is provided, however, the presumption of discrimination "drops out of the picture"; at that point, the trier of fact must decide the ultimate question of whether the employer intentionally discriminated against the plaintiff. *St. Mary's Honor Ctr.*

v. Hicks, 509 U.S. 502, 511, 113 S.Ct. 2742, 2749, 125 L.Ed.2d 407 (1993). The burden of proving intentional discrimination always remains with the plaintiff. *Lawley v. Dep't of Higher Educ.,* 36 P.3d 1239, 1248 (Colo.2001); *Bodaghi,* 995 P.2d at 298.

Plaintiffs typically demonstrate pretext in one of three ways: (1) with evidence that the defendant's stated reason for the adverse employment action was false; (2) with evidence that the defendant acted contrary to a written company policy prescribing the action to be taken by the defendant under the circumstances; or (3) with evidence that the defendant acted contrary to an unwritten policy or contrary to company practice when making the adverse employment decision affecting the plaintiff. *Kendrick v. Penske Transp. Servs.*, 220 F.3d 1220 (10th Cir. 2000).

"A plaintiff who wishes to show that the company acted contrary to an unwritten policy or to company practice often does so by providing evidence that he was treated differently from other similarly-situated employees who violated work rules of comparable seriousness." *Kendrick,* 220 F.3d at 1230. The plaintiff bears the burden of proving different treatment from that of similarly-situated employees. *Burdine, supra,* 450 U.S. at 258, 101 S.Ct. at 1096.

To carry this burden, the plaintiff must show that the employees who were treated differently were similarly situated to the plaintiff in all relevant respects. To be similarly situated, other employees must be supervised by the same person, and subject to the same standards concerning performance, evaluation, and discipline. *McGowan v. City of Eufala, 472 F.3d 736*, 745 (10th Cir.2006). In evaluating whether employees are similarly situated, a court should "compare the relevant employment circumstances, such as work history and company policies, applicable to the plaintiff and the intended comparable employees." *Aramburu v. Boeing Co.,* 112 F.3d 1298, 1404 (10th Cir.1997). In order for the disparate treatment of other employees to be relevant, they must have engaged in conduct of "comparable seriousness" to the plaintiff's conduct. *Kendrick,* 220 F.3d at 1230.

(b) Complainant's Evidence:

There is no dispute at hearing that Complainant met the first three elements for a *prima facie* showing of unlawful discrimination: 1) Complainant is an African-American; 2) Complainant was qualified for her CSSO II position; and 3) Complainant suffered an adverse employment decision in the termination of her employment.

The fourth element in a *prima facie* showing, however, is not met in this case: Complainant has not shown that the circumstances give rise to an inference of unlawful discrimination.

Complainant's race has appeared only one time in the case, and that was when D.M. issued a racially-based insult. Other than this event, Complainant has not been able to present any nexus between her race and Respondent's decision to terminate her employment. For this reason, Complainant has not been able to present a *prima facie* case of discrimination.

Assuming, however, that Complainant has made a *prima facie* showing, the next step in the analysis is for Respondent to offer its nondiscriminatory reason for terminating Complainant's employment. Respondent has asserted that it terminated Complainant's employment because she used excessive force and unapproved holds against patient D.M. This explanation suffices as a nondiscriminatory reason for taking disciplinary action.

The burden of production then shifts to Complainant to prove that this reason is merely pretext for racial discrimination. Complainant attempts to show pretext in two ways: first, by arguing that Respondent's allegations are false, and second, by arguing that she has presented evidence of similarly situated white employees who have to been disciplined in the same manner as Complainant.

As the findings of fact demonstrate, however, there was credible and persuasive evidence presented that Complaint used inappropriate control techniques on patient D.M. While some of Respondent's initial allegations have not been supported by a preponderance of the evidence, Complainant has not persuasively demonstrated that Respondent's allegations are so flawed so as to support a finding of pretext.

Complainant's argument on similarly situated white employees is also not persuasive because it was based on an incomplete presentation of evidence. Complainant did not identify any individuals or situations which could be examined to determine if similarly situated employees were treated more favorably than Complainant. In order for Complainant's argument to serve as a proper basis for a finding of pretext, Complainant must show that that there were employees who were treated differently than she was, and that thee others were similarly situated to her in all relevant respects. To be similarly situated, other employees must be supervised by the same person, and subject to the same standards concerning performance, evaluation, and discipline. *McGowan, 472 F.3d at* 745. Complainant has presented insufficient evidence from which to conclude that there were any similarly-situated employees at CMHIP.

Complainant, therefore, cannot on this record demonstrate that Respondent's explanation for why it terminated her employment is merely a pretext for unlawful discrimination. Complainant does not prevail on her claim of unlawful discrimination on the basis of race.

C. The discipline imposed was not within the range of reasonable alternatives.

In determining whether an agency's decision is arbitrary or capricious, a court must determine whether the agency has 1) neglected or refused to use reasonable diligence and care to procure such evidence as it is by law authorized to consider in exercising the discretion vested in it; 2) failed to give candid and honest consideration of the evidence before it on which it is authorized to act in exercising its discretion; 3) exercised its discretion in such manner after a consideration of evidence before it as clearly to indicate

that its action is based on conclusions from the evidence such that reasonable men fairly and honestly considering the evidence must reach contrary conclusions. *Lawley v. Department of Higher Education,* 36 P.3d 1239, 1252 (Colo. 2001).

Board Rule 6-9, 4 CCR 801, requires that an appointing authority is to weigh the facts of the incident as well as an employee's information and performance in making a decision on the level of discipline to impose. *See* Board Rule 6-9 ("The decision to take corrective or disciplinary action shall be based on the nature, extent, seriousness, and effect of the act... type and frequency of previous unsatisfactory behavior or acts, prior corrective or disciplinary actions, period of time since a prior offense, previous performance evaluations, and mitigating circumstances").

Ms. Drewnicky's decision to terminate Complainant's employment failed to give appropriate consideration to the nature of the infraction, the lack of any prior corrective or disciplinary action assessed to Complainant for similar actions, and the nature of the situation faced by Complainant in handling of patient D.M. Additionally, Ms. Drewnicky had Dr. Kelly's assessment of the stresses that Complainant had been under due to violent incidents by patients in the weeks prior to the incident. There was no persuasive indication at hearing that Ms. Drewnicky considered any of these events as mitigating circumstances. When these additional factors are included in the consideration, the appointing authority's decision that termination is the only appropriate response constitutes an unreasonable conclusion and meets the test for arbitrary and capricious action under *Lawley.*

The credible evidence demonstrates that the appointing authority did not pursue her decision thoughtfully and with due regard for the circumstances of the situation as well as Complainant's individual circumstances, as required by Board Rule 6-9. Even if some discipline was warranted in this matter, it was outside of the range of reasonable alternatives to terminate Complainant's employment for a mistake in judgment in the type of control holds that Complainant was permitted under CMHIP policy to use under the circumstances presented by D.M.'s restraint.

D. Attorney fees are not warranted in this action.

Attorney fees are warranted if an action was instituted frivolously, in bad faith, maliciously, or as a means of harassment or was otherwise groundless. § 24-50-125.5, C.R.S. and Board Rule 8-38, 4 CCR 801. The party seeking an award of attorney fees and costs shall bear the burden of proof as to whether the personnel action is frivolous, in bad faith, malicious, harassing, or otherwise groundless. Board Rule 8-38(B)(3), 4 CCR 801.

The standard for an award of attorney fees requires more than a finding that the appointing authority has acted unreasonably in her choice of level of discipline. Respondent presented rational arguments and competent evidence to support its imposition of a personnel action against Complainant, albeit not a termination action and not for all of the acts originally alleged. In addition, there was no evidence that would lead to the conclusion that Respondent imposed the personnel action against the Complainant

in order to annoy, harass, abuse, be stubbornly litigious or disrespectful of the truth. Given the above findings of fact, an award of attorney fees is not warranted in this matter.

CONCLUSIONS OF LAW

1. Complainant committed some of the acts for which she was disciplined.
2. Respondent's action was arbitrary, capricious, or contrary to rule or law.
3. The discipline imposed was not within the range of reasonable alternatives.
4. Attorney fees are not warranted.

ORDER

Respondent's action is **rescinded**. Complainant is reinstated with full back pay and benefits from the date of the termination of her employment. Respondent is permitted to issue a corrective action to Complainant related to her use of inappropriate holds during the restraint of patient D.M. Attorney fees and costs are not awarded.

Dated this 22nd day of June, 2009.

[redacted]

Denise DeForest
Administrative Law Judge
633 – 17th Street, Suite 1320
Denver, CO 80202
303-866-3300

NOTICE OF APPEAL RIGHTS

EACH PARTY HAS THE FOLLOWING RIGHTS

1. To abide by the decision of the Administrative Law Judge ("ALJ").
2. To appeal the decision of the ALJ to the State Personnel Board ("Board"). To appeal the decision of the ALJ, a party must file a designation of record with the Board within twenty (20) calendar days of the date the decision of the ALJ is mailed to the parties. Section 24-4-105(15), C.R.S. Additionally, a written notice of appeal must be filed with the State Personnel Board within thirty (30) calendar days after the decision of the ALJ is mailed to the parties. Section 24-4-105(14)(a)(II) and 24-50-125.4(4) C.R.S. and Board Rule 8-67, 4 CCR 801. The appeal must describe, in detail, the basis for the appeal, the specific findings of fact and/or conclusions of law that the party alleges to be improper and the remedy being sought. Board Rule 8-70, 4 CCR 801. Both the designation of record and the notice of appeal must be received by the Board no later than the applicable twenty (20) or thirty (30) calendar day deadline referred to above. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Colo. App. 1990); Sections 24-4-105(14) and (15), C.R.S.); Board Rule 8-68, 4 CCR 801.
3. The parties are hereby advised that this constitutes the Board's motion, pursuant to Section 24-4-105(14)(a)(II), C.R.S., to review this Initial Decision regardless of whether the parties file exceptions.

RECORD ON APPEAL

The cost to prepare the record on appeal in this case is $50.00. This amount does not include the cost of a transcript, which must be paid by the party that files the appeal. That party may pay the preparation fee either by check or, in the case of a governmental entity, documentary proof that actual payment already has been made to the Board through COFRS. A party that is financially unable to pay the preparation fee may file a motion for waiver of the fee. That motion must include information showing that the party is indigent or explaining why the party is financially unable to pay the fee.

Any party wishing to have a transcript made part of the record is responsible for having the transcript prepared. Board Rule 8-69, 4 CCR 801. To be certified as part of the record, an original transcript must be prepared by a disinterested, recognized transcriber and filed with the Board within 59 days of the date of the designation of record. For additional information contact the State Personnel Board office at (303) 866-3300.

BRIEFS ON APPEAL

When the Certificate of Record of Hearing Proceedings is mailed to the parties, signifying the Board's certification of the record, the parties will be notified of the briefing schedule and the due dates of the opening, answer and reply briefs and other details regarding the filing of the briefs, as set forth in Board Rule 8-72, 4 CCR 801.

ORAL ARGUMENT ON APPEAL

A request for oral argument must be filed with the Board on or before the date a party's brief is due. Board Rule 8-75, 4 CCR 801. Requests for oral argument are seldom granted.

PETITION FOR RECONSIDERATION

A petition for reconsideration of the decision of the ALJ must be filed within 5 calendar days after receipt of the decision of the ALJ. The petition for reconsideration must allege an oversight or misapprehension by the ALJ. The filing of a petition for reconsideration does not extend the thirty-calendar day deadline, described above, for filing a notice of appeal of the ALJ's decision. Board Rule 8-65, 4 CCR 801.

CERTIFICATE OF SERVICE

This is to certify that on the 23rd day of June, 2009, I placed true copies of the foregoing **INITIAL DECISION OF ADMINISTRATIVE LAW JUDGE and NOTICE OF APPEAL RIGHTS** in the United States mail, postage prepaid, addressed as follows:

Tamara Wayland, Esq.

[redacted]

and in the interagency mail, to:

Michael D. Scott

[redacted]

[redacted]

Andrea C. Woods

(rev'd. 5/07)