STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. **2011B017**

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

LYNN LEASE,

Complainant,

vs.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

Administrative Law Judge Mary S. McClatchey held the hearing in this matter on January 4, 2011, at the State Personnel Board, 633 17th Street, Courtroom 6, Denver, Colorado. Assistant Attorney General Micah Payton represented Respondent. Respondent's advisory witness was Doug Severinsen, former Qualified Mental Retardation Professional (QMRP) and Complainant's appointing authority. Complainant represented herself.

MATTER APPEALED

Complainant, Lynn Lease (Complainant), appeals her disciplinary pay reduction of five percent for six months by Respondent, Department of Human Services (DHS or Respondent). Complainant seeks rescission of the disciplinary action and reimbursement.

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

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; and

3. Whether the discipline imposed was within the range of reasonable alternatives.

FINDINGS OF FACT

1. Complainant is a certified Mental Health Technician (MHT) II with Wheat Ridge Regional Centers (WRRC), which houses developmentally disabled residents.

Complainant serves as a lead worker, responsible for assuring that all staff adhere to DHS and facility policies and procedures.

2. Complainant has worked for WRRC for seventeen years.

3. In 2002, Complainant received training in Colorado Approved Intervention Techniques (CAIT). When WRRC staff find it necessary to gain physical control over a resident, the only permissible means of doing so is through use of a CAIT-approved hold.

4. Since 2004, prone holds (wherein the resident is lying face down on the floor) have been prohibited at WRRC. In that year, one or more residents in a Pueblo mental health facility died after being placed in a prone hold.

5. If a staff member finds himself or herself with a resident in a prone hold at any time, the staff member is required to release the resident immediately. Then, the staff member is required to attempt to complete an appropriate and safe CAIT hold.

6. When DHS initiated the prohibition on prone holds of residents in 2004, it conducted in-service training of all staff, including Complainant. In addition, WRRC management circulated and posted a memo regarding the prohibition in all of the WRRC facilities. The policy was not placed in the WRRC policy and procedure handbook until July 2010.

7. Complainant has been aware of the prohibition on prone holds since 2004.

8. WRRC Policy PR-III-A-9, governing Abuse, Mistreatment, Neglect, and Exploitation (AMNE), defines physical abuse as:

> The infliction of physical pain, injury, or the imposition of unreasonable confinement or restraint on a person receiving services. This includes, but is not limited to: striking, pushing, pulling, twisting body parts, restricting a person's freedom of movement outside of appropriate, approved CAIT techniques.

9. The policy states that failure of WRRC staff to report any "witnessed or suspected AMNE" will be considered as serious as the act itself." Witnessed or suspected AMNA must be reported to the Quality Assurance (QA) staff of WRRC.

TM[1]

10. TM is a developmentally disabled resident of WRRC who was admitted to the facility in January of 2010. TM has a history at WRRC of physical assault on staff and of verbal confrontations with staff and residents.

11. According to TM's care plan, if he is given an order by staff and he resists complying, staff are encouraged to enforce the directive.

June 10, 2010 Incident

12. On June 10, 2010, Complainant was caring for TM, who was having a bad day. During the morning of June 10, he became involved in arguments with other residents and verbally lashed out at them.

13. Complainant brought TM to the psychologist's office, so that TM could visit with his therapist and calm down. He had a meeting with one of the therapy staff members, but when they reminded TM that he had to complete a "safety control plan" before his anticipated home visit that upcoming weekend, he became upset again.

14. Complainant then brought TM back to his residence.

15. During the afternoon on June 10, it was time for the residents to make their lunches for the next day in the kitchen. Complainant directed TM to make his lunch, and he objected. Once his lunch was made, she directed him to accompany her to the Quick Chill Room, a refrigerated room, to put his lunch away. He responded that he did not want to put his lunch away.

16. Complainant did not direct any of the other residents to put their lunch away in the Quick Chill Room.

17. TM followed Complainant into the freezer and the door automatically closed behind them. Complainant stooped down in order to put some food away. She put the other residents' lunches away, and directed TM to put his lunch away. He objected, made a fist, and attempted to punch her. She ducked down and TM hit her on the side of the head.

18. Complainant yelled out and TM left the room.

19. Jeremy Jones, an MHT I, heard Complainant yell for assistance and immediately arrived at the scene. TM began to physically attack Jones. Jones attempted to gain physical control of TM by using an approved CAIT hold on him, but was unable to do so.

[1] Initials are utilized in order to protect the identity of the resident.

20. Within seconds, TM was lying face down, prone, on the floor. Jones held TM down with his right arm across TM's back and placed his knee in the middle of TM's back.

21. Complainant left the Quick Chill Room and came over to help Jones control TM. TM was kicking his legs. Complainant lay on the floor with her arms around TM's lower legs in order to keep him from kicking. She did not place her weight on TM's body.

22. Jones and Complainant held TM in an unauthorized prone hold on the floor. Neither Complainant nor Jones immediately released TM from the prone hold. They remained there with TM for a few minutes. TM started to cry, and he yelled and screamed.

23. Complainant claimed at hearing for the first time that the reason they placed TM in the prone hold was that TM was banging his head on the floor. However, this testimony lacks credibility for the following reasons: neither she nor Jones ever stated this before; there is no corroboration in the record for this assertion; and, if TM had banged his head on the floor, Complainant and Jones would have placed TM on "head precaution," requiring monitoring of his condition for potential head injury.

24. During the time Complainant was in the prone hold, Randy Bruce, Clinical Behavioral Specialist for WRRC, left a nearby building and walked into the courtyard outside the building where Complainant, Jones, and TM were located. Bruce immediately heard TM yelling in a distressed voice. Bruce knew TM and recognized his voice.

25. Bruce quickly approached the residence, opened the door with his key, and walked over to the scene with TM, Complainant, and Jones. TM was yelling, "You're hurting me, you're breaking my arm." TM was also cursing and frantically yelling at Jones, "I'm going to kill you. Let me go."

26. Bruce observed TM in the prone hold on the floor. Jones still had TM's right arm pulled back behind TM's back, at a 90-degree angle. Jones also still had his knee in the middle of TM's back. Complainant was on the floor, holding TM's legs down.

27. Complainant immediately released TM upon seeing Bruce. Bruce had to ask Jones to release TM. As soon as TM was released, Bruce began to talk to TM, and asked him to de-escalate and self-restrain. TM responded by self-restraining, meaning to sit on the floor cross-legged, with his hands behind him.

28. Bruce's assessment of the situation was that Jones was doing his best to protect Complainant from TM, and that neither Lease nor Jones had intended to harm TM.

29. Bruce spoke to Jones, informing him that the hold on TM was not an approved one, and reviewing the proper way to contain him in a CAIT hold.

30. Neither Complainant nor Jones reported to QA at WRRC that a non-CAIT approved physical intervention had been used on TM.

31. TM sustained no injuries from the hold.

32. Complainant and Jones wrote incident reports. Jones stated that he had placed TM in a hold on the floor, had held TM's arm on his back, and had his body lying flat on the floor.

33. Complainant's incident report indicated that as she left the Quick Chill Room, she could see that Jones was attempting to get TM into a hold. She stated that TM "was flinging his legs, kicking Jeremy [Jones]. TM went down to the floor and I was able to hold his legs so that Jeremy could get a better hold on him."

QA Investigation

34. Bruce informed April Grimsley, Program Quality Manager in the Division of Developmental Disabilities, DHS, of the incident. She conducted an investigation into what occurred.

35. Complainant and Jones were placed on paid administrative leave pending the investigation.

36. Grimsley conducted a thorough investigation, interviewing Jones, Complainant, TM, Bruce, and nursing staff. Grimsley also reviewed the incident reports.

37. TM reported to Grimsley that it hurt his arm to be restrained behind his back during the hold.

38. In June 2010, Grimsley issued her QA report. Grimsley concluded that both Complainant and Jones had engaged in substantiated physical abuse of TM. Her report stated that the elements necessary to substantiate physical abuse are: 1) intentionally or knowingly or recklessly; 2) [causing] bodily injury and/or serious bodily injury; and/or 3) unreasonable confinement or restraint. Grimsley found that Jones and Complainant had placed TM in an unapproved physical restraint, which was therefore unreasonable. In addition, because Bruce heard TM scream that he was being hurt and they were breaking his arm, and because TM reported to Grimsley that his arm had hurt during the hold, physical abuse had been substantiated.

39. In her report, Grimsley noted, "Although Lynn [Lease] was only holding [TM's] feet down, she participated in holding [TM] in a face-down restraint and as the lead staff should have instructed Jeremy to get [TM] out of this unsafe restraint."

40. The QA Report was reviewed by the WRRC Management Team and referred for follow-up action to the appointing authority, Doug Severinsen, QMRP for WRRC at that time.

41. Ken Kaiser, Program Services Manager for WRCC, mentored Severinsen through the process of following up on the QA report, because Severinsen had never done so before.

42. Kaiser and Severinsen met. Kaiser informed Severinsen that cases of substantiated physical abuse of a WRRC resident had historically resulted in the dismissal of the employee. However, they both agreed that there was significant mitigation in this case.

Predisciplinary Meeting

43. On June 21, 2010, Severinsen sent Complainant a letter noticing a predisciplinary meeting on June 28, 2010, to discuss "substantiated physical abuse."

44. On June 28, 2010, Complainant attended the predisciplinary meeting with her representative, a member of the state employees' union. Severinsen attended with Grimsley as his representative.

45. Severinsen prepared a typed list of fifteen questions and issues he planned to discuss with Complainant at the meeting, to assure he was prepared. At the meeting, Complainant did not deny the QA Report's factual findings or conclusions. The meeting provided Complainant an opportunity to present clarifying and mitigating information on the events of June 10, 2010. Complainant discussed the events prior to the hold occurring, including TM's aggressive and combative conduct. She did not mention TM hitting his head on the floor.

46. After the meeting, Severinsen discussed his options with Kaiser. Because of WRRC's history of terminating employees involved in substantiated resident abuse, Kaiser and Severinsen agreed that disciplinary action was essential for both Jones and Complainant.

47. Severinsen seriously considered a demotion, due to Complainant's failure as lead worker to enforce the policy prohibiting prone holds.

48. However, Severinsen also believed that there was significant mitigation in the case of Complainant. He understood she had clearly not intended to harm TM.

In addition, her performance history was generally good, and she had been employed by WRRC for seventeen years.

49. Severinsen reviewed Complainant's personnel record and found one disciplinary action from 1998, which involved verbal abuse of a resident.

50. On July 29, 2010, Severinsen issued a disciplinary action letter to Complainant, imposing a 5% reduction in pay for six months. He required Complainant to take the CAIT training again. And, he determined that because the QA report substantiated that she did physically abuse TM by using a non-CAIT approved hold, she would not be allowed to work with him for the duration of her employment at WRRC. The letter noted that she had been trained that the "Division of Developmental Disabilities has banned all prone holds as there have been deaths attributed to prone holds."

51. The letter stated that as lead worker, it was her duty to intervene to redirect the situation, to report the unapproved CAIT hold to QA, and to report the incident to nursing staff immediately so that TM would have been immediately assessed. Lastly, the letter noted that Complainant had contributed to the situation with TM by insisting that he engage in lunch activities at a time when he was verbally combative.

52. Complainant timely appealed her disciplinary action.

DISCUSSION

I. GENERAL

A. Burden of Proof

Certified state employees have a property interest in their positions and may only be disciplined for just cause. Colo. Const. Art. 12, §§ 13-15; § 24-50-101, *et seq.*, C.R.S.; *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 perform competently;
(2) willful misconduct or violation of these or department rules or law that affect the ability to perform the job;
(3) false statements of fact during the application process for a state position;
(4) willful failure to perform, including failure to plan or evaluate performance in a timely manner, or inability to perform; and
(5) final conviction of a felony or any other offense involving moral turpitude that adversely affects the employee's ability to perform or may have an adverse effect on the department if the employment is continued.

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. *Kinchen, supra.* The Board may reverse or modify Respondent's decision if the action is found to be arbitrary, capricious or contrary to rule or law. Section 24-50-103(6), C.R.S.

II. HEARING ISSUES

A. Complainant committed the acts for which she was disciplined.

Respondent has proven by preponderant evidence that Complainant committed the acts for which she was disciplined. Complainant concedes that Jones and she placed TM in a prone hold.

As the Lead Worker, Complainant had a duty to order Jones to step away from TM so that they could implement an approved CAIT hold. When she exited the Quick Chill Room and saw that Jones was taking TM to the floor, on his stomach, she had the opportunity to do this. Instead, Complainant joined Jones and TM on the floor and assisted Jones with the prone hold by placing her arms around TM's legs. Her conduct contributed to the substantiated physical abuse of TM.

Complainant's conduct on June 10, 2010 violated the WRRC abuse policy in two ways. First, the policy prohibits inappropriate physical restraint, defined as unapproved CAIT holds such as a prone hold. Second, Complainant failed to report the unapproved physical restraint to QA staff, which, under the policy, is as serious as the restraint itself.

Complainant argued at hearing that it was unfair to mention in the disciplinary action letter that Complainant had contributed to the situation with TM by insisting that he engage in lunch activities at a time when he was verbally combative. She noted that TM's care plan states that staff should not back off of verbal directives given to TM. While Complainant is correct about TM's care plan, the evidence demonstrated that Complainant did not direct any other residents to put their lunch away. Therefore, it was not necessary for TM to do so, and it was an error in judgment for Complainant to order him to do so when he was in such an agitated state.

B. The Appointing Authority's action was not arbitrary, capricious, or contrary to rule or law.

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; or 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).

Respondent carefully and honestly considered all of the information relevant to its decision prior to imposing disciplinary action. The QA investigation was comprehensive. Severinsen's predisciplinary process was professional, methodical, and thorough. Severinsen gave a great deal of weight to the mitigating information before him. His exercise of discretion was reasonable.

C. The discipline imposed was within the range of reasonable alternatives.

This case involves a substantiated case of physical abuse of a resident by WRRC employees. In such cases, WRRC has historically imposed disciplinary termination on the employees involved. Because of Complainant's leadership position as lead worker, and because of her prior disciplinary action for verbal abuse of a resident, a demotion would have been within the range of reasonable alternatives. The lesser discipline imposed herein, a 5% pay reduction for six months, was well within the range of reasonable personnel actions available to the appointing authority.

CONCLUSIONS OF LAW

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

2. Respondent's action was not arbitrary, capricious, or contrary to rule or law.

3. The discipline imposed was within the range of reasonable alternatives.

ORDER

Respondent's action is **affirmed.** Complainant's appeal is dismissed with prejudice.

Dated this 16th day of February, 2011

[redacted]

Mary S. McClatchey
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 electronic record on appeal in this case is $5.00. 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 16th day of Feb., 2011, I electronically served 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~~ as follows:

Lynn Lease
[redacted]

~~and in the interagency mail, to:~~

Micah Payton
[redacted]

[redacted]

Andrea C. Woods