STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. **2012B123**

AMENDED INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

DANIEL WUNDERLICH,
Complainant,

vs.

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

Administrative Law Judge (ALJ) Denise DeForest held the hearing in this matter on September 28, 2012, at the State Personnel Board, 633 17th Street, Denver, Colorado. The case commenced on the record on September 28, 2012. The record was closed at the conclusion of the hearing on September 28, 2012. Assistant Attorney General Stacy L. Worthington represented Respondent. Respondent's advisory witness was Lorraine Avina, Forensic Division Chief Nurse and Complainant's appointing authority. F.J. "Rick" Dindinger II, Esq., represented Complainant.

MATTERS APPEALED

Complainant, a certified employee classified as a Registered Nurse (RN) appeals his termination of employment from the Colorado Mental Health Institute At Pueblo (CMHIP), arguing that it was arbitrary, capricious and contrary to rule or law that Complainant was terminated from employment for defending himself and another patient from an assaultive patient and while he was attempting to de-escalate the situation, and that it was contrary to rule or law that Complainant was not notified in writing of his termination for more than a month after the termination was effective. Complainant asks for reinstatement to his position, back pay, attorney fees and costs, and other relief as determined by the ALJ. Respondent argues that the termination was properly imposed after Complainant had failed to apply an authorized level of physical force to a patient, disregarded his duties to watch a highly suicidal patient, and had been disingenuous during the investigation of his actions. Respondent asks that the discipline be upheld.

For the reasons presented below, the undersigned ALJ finds that Respondent's disciplinary action is **affirmed in part** and **modified in part**. Complainant's termination is affirmed. Respondent is ordered to provide Complainant with compensation in full for the delay in providing Complainant with timely written notification of his termination under C.R.S. § 24-50-125(2).

ISSUES

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

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

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

4. Whether Complainant is entitled to an award of attorney fees.

FINDINGS OF FACT

Background:

1. The Colorado Mental Health Institute at Pueblo (CMHIP) serves the state by providing psychiatric services to patients and performing psychiatric evaluations.

2. At least two wards at the facility house patients who have been committed to the Department of Corrections but who are mentally ill. One of those wards is Ward E-2.

3. Complainant is a Registered Nurse, and a certified employee with CMHIP. Complainant has been employed by CMHIP since August of 2009. At the time of the termination of Complainant's employment, he was assigned as direct care staff for Ward E-2. Complainant's appointing authority was Lorraine Avina, Forensic Division Chief Nurse.

Limitations On The Use of Force At CMHIP:

4. Ward E-2 houses mentally ill patients. Many of the patients on the ward have a history of disturbed and violent behavior, including assaultive behavior with staff and other patients.

5. The use of force policies at CMHIP limit the use of physical force on patients to a level that is compatible with a therapeutic use of force. Complainant was trained to handle seclusion and restraint episodes according to CMHIP's Continuum of Therapeutic Intervention (CTI).

6. It is mandatory for all direct care CMHIP staff to take CTI training and to follow the CTI policy in the handling of patients.

CTI Policy Requirements –

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. In evaluating whether the use of physical force was within CMHIP standards, CMHIP utilizes a five question review:

1. Was physical force used to preclude imminent physical harm?
2. Would a reasonable person agree, after assessing the totality of the circumstances, that the patient appears to have the intent, ability, means, and opportunity to cause physical harm to self or others?

3. Were tactical verbal skills utilized in an attempt to [defuse] the situation prior to increasing the force response?
4. Were CMHIP approved CTI and RIPP restraint techniques used in addressing the situation?
5. Did the employee use the least amount of force necessary to prevent physical harm to others? In this regard, factors to be weighed include the seriousness of the likely harm to be inflicted by the patient, and the nature and severity of any injury inflicted on the patient while being contained by staff.
6. Does the evidence support a finding that the use of force was not motivated by anger or to punish the patient?

CMHIP Policy 6.38, "Employee Use of Force and Self Defense," Section III(2)(a) – (2)(f).

10. 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 that is not authorized as part of CTI. This sub-section provides:

> When an employee determines that emergency circumstances require that additional force be used (force that is above approved CMHIP containment techniques) to defend a person from imminent serious bodily injury, use of that additional force may be justified. Given the totality of the circumstances, CMHIP employees may use only the 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 serious bodily injury. As soon as the threat is eliminated, staff shall resume the use of only CMHIP approved containment techniques.**

11. 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).

12. CMHIP policy also requires that five additional criteria be met "before the use of force beyond approved CTI techniques" is authorized:

1. Intent - The patient has communicated or otherwise demonstrated the intent to immediately cause serious bodily injury.
2. 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/strength, or demonstrate knowledge or martial arts).
3. Means - The patient must possess or have ready access to the means necessary to cause serious bodily injury.
4. 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).

5. 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 inflict serious bodily injury or placing the employee's life, or another's in jeopardy.

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

13. The policy also informs employees that the use of physical force may be investigated, and that "[u]njustified use of force, i.e., force not meeting the guidelines in this policy, may be investigated for patient abuse/neglect, may result in progressive discipline, and may be referred to licensing and/or law enforcement agencies as required." CMHIP Policy 6.38, Section III(C).

14. 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.

15. 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).

Specific CTI Use of Force Procedures and Options:

16. CMHIP expects staff to be able to effectively use the two parts of CTI: verbal judo, and escapes and physical containment efforts.

17. CTI generally requires that use of force be progressive. CMHIP employees are generally expected to follow a progression of actions, as follows:

1. Presence of employees as a deterrent to violence;
2. Appropriate verbal interaction with the patient;
3. Use of hands – minimum necessary physical force; and
4. Use of humane restraints.

18. 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.

19. Under CMHIP policy, it is possible that staff may need to skip Verbal Judo and take a different action when one or more of five conditions are present (referred to by the mnemonic of SAFER):

Security – Whenever others are in imminent jeopardy;
Attack – Whenever the employee's personal danger zone is violated, take action based upon the employee's training and the situation presented;
Flight – Whenever someone flees the employee's presence;

Excessive Repetition – When no voluntary compliance is forthcoming and all verbal options have been exhausted;
Revised Priorities – Whenever a matter of higher priority required the employee's immediate attention or presence.

20. In terms of force options, CMHIP policy teaches that employees have three types of force options:

1. Professional Presence – Showing up, looking good, and looking the role necessary to establish credibility with the patients;
2. Voice – the professional use of language, with carefully chosen therapeutic words, and the ability to sound good while under pressure;
3. Empty hands – including directional moves, positioning, and grasps. Using this option requires that the option be reasonable, appropriate necessary, least restrictive and justifiable.

21. As for empty hand use of force options, CMHIP trains its employees to use only certain types of control techniques. These techniques are based upon leverage, balance, and the use of body weight combined with the element of surprise. The moves are responsive control techniques, rather than offensive moves, and the employee is not to be the aggressor.

22. Employees are taught a variety of release techniques to allow them to escape from a patient who has grabbed or bit them. Employees are also taught specific physical control techniques to allow them to physically control a patient.

23. One of the physical control techniques potentially allowable under CMHIP policy is the one-person protective restraint technique (PRT). A PRT can also be done with more than one staff member.

24. A PRT involves the employee addressing the patient from the back or side, swinging his or her arms up and over the patient's shoulders, and stepping backwards so that the patient is unbalanced, while pulling the patient's back close to the employee's chest. The patient can then be escorted backwards.

25. A PRT can also involve a takedown to the floor instead of just a backwards escort. The PRT takedown involves the employee performing a PRT, taking a deep step backwards and off to the side, then dropping down to one knee. The employee then sits the patient on the floor by dropping down on his or her other knee, while maintaining close contact of the employee's chest to the patient's back. If necessary, the patient can also be rolled chest down to the floor, with the employee maintaining the chest to back contact. A second employee can assist to control the patient's legs if the patient is kicking.

26. If a patient requires continued restraint, CMHIP allows employees to make appropriate use of various types of physical restraints that can be applied securely to the patient, such as quick cuffs, back straps, and transport belts. These restraints are called RIPP restraints.

CMHIP Suicide Watch:

27. CMHIP patients are evaluated for suicide risks.

28. A patient who poses some suicide risk but is not currently imminently at risk for suicide would be assigned to Suicide Precaution I level. Patients on Suicide Precaution I level are checked every 15 minutes. CMHIP Policy 6.56, "Clinical Precautions / Alerts," Section III(B)(2)(b).

29. A patient who is deemed to be highly suicidal is assigned to a Suicide Precaution II level. Such patients "must remain within arm's length (within 3 feet) of a staff member at all times AND the staff member must be able to visualize the patient at all times." CMHIP Policy 6.56 Section III(B)(4)(emphasis in original). A physician may order "line-of-sight monitoring" only during night time sleeping hours.

CMHIP Assault Precaution Levels:

30. CMHIP policy was to treat patients in the most appropriate environment, considering the patient's clinical needs and progress, and the physical characteristics of the unit, while optimizing the safety of the patients, staff, and the community. In carrying out this directive, CMHIP staff members were expected to evaluate patient behavior and to identify precautions to be taken for those patients who were at risk for assaultive behavior. A patient who has an Assault Precaution designation has restrictions placed upon his movement and activities, depending upon the ward, staffing, and events.

31. An Assault Precaution Level I designation is appropriate for a patient who was at risk for assaultive behavior but not imminently so, such as patients who were angry and irritable, or who are making general threats of violence. CMHIP Policy 6.56 Section III(A)(2)(a).

32. An Assault Precaution Level II is appropriate for a patient who was at imminent risk for assaultive behavior. Imminent risk, for this purpose, is defined in CMHIP policy as a "patient has been assaultive in the past seven days; and/or has assaulted someone recently during [the] current hospitalization". Patients who had been placed as Assault Precaution Level II were not allowed to leave the unit other than during an emergent situation. CMHIP Policy 6.56 Section III(A)(2)(b).

Patient M:

33. Patient M was brought to CMHIP from the San Carlos Correctional Facility where he was charged with assault and found to be not competent to stand trial. He was admitted to Ward E-2 on March 8, 2012.

34. Patient M has a psychiatric history that includes being threatening and assaultive toward staff. Patient M posed a risk for self-injury as well. Given his history, mental status and impaired judgment, Patient M posed a significant risk to harm others or himself. As of March 23, 2012, Patient M had an Assault Precaution Level II rating.

35. Patient M was also recorded as being verbally threatening, particularly toward women. He was also sexually threatening through his use of graphically sexual verbal threats and exposure of his genitals.

36. Patient M also demonstrated that he was willing to spit at staff when he spat at Complainant on March 17, 2012, while Complainant was at the door of Patient's M's room.

37. Spitting is considered to be assaultive behavior on the part of a patient. Staff members who are spat upon are placed at risk for disease transmission and should undergo testing and, if necessary, treatment.

The Containment Incident on March 23, 2012:

Ward E-2:

38. Ward E-2 has a common day hall area that includes a nurse's station desk and some tables and couches for residents to use. The tables are scattered about the room. Each table has a series of seats around the table. The room is designed to limit the ability of the potentially violent patients housed on Ward E-2 to obtain items that can be used as weapons. The seats around a table, for example, are all physically connected to the table. The nurse's station has a high partition around it so that patients cannot easily reach in and take items. When patients need to write, they are provided with small pencils that are difficult to hold as a weapon. Staff members were also instructed to limit items inside the ward, and limit access to items that are within the ward, to reduce the possibility of patients finding something to use as a weapon.

39. The nurse's station is along the main interior wall. Behind the nurse's station is a charting room that serves both Ward E-2 and Ward E-1. There is also a passageway between Wards E-1 and E-2, as well as a laundry room behind a portion of the main interior wall.

40. The day hall area has several doors along the edges of the room that open to hallways. The patients housed on Ward E-2 have rooms off these hallways.

41. Patient M was housed in a room off the hallway that was farthest to the right of someone standing at the nurse's station who is facing the day hall area. This hallway was known as the D-Wing.

Events of March 23, 2012:

42. On March 23, 2012, Complainant was assigned to a patient who was on Suicide Prevention Level II (the "one-on-one"). This assignment meant that Complainant was expected to stay within an arm's length, or approximately three feet, of the patient at all times, and to be in a position that he could visualize the patient at all times.

43. Patient M came out to the nursing station at about 8:10 AM. He was informed that he remained on Assault Precaution II level. Patient M became increasing hostile and threating, and began cursing at female staff. He exposed his genitals and was redirected by staff back to his room. Patient M spat on the floor and returned to his room. Staff administered medication to Patient M to help calm him.

44. At about 9:05 AM, Complainant was with his assigned one-on-one patient in the day hall area for Ward E-2. Patient M returned to the day hall area.

45. Patient M went to the nurse's station to ask about a phone number. He became argumentative with the staff member behind the nurse's station, Beverly White, during that discussion, and was asked by staff to go back to his room or to go to a seclusion room.

46. During the incident with Patient M at about 9:05 AM, Health Care Technician Feliz Gallegos, Heath Care Technician Nazario Duran, Charge Nurse Tiffany Lanier, and

Complainant were direct care staff present in the Ward E-2 day hall. Molly Kliewer was also direct care staff assigned to Ward E-2, but was in the chart room when the incident began. CMHIP's Department of Public Safety employee, Officer Jacob Korba, had been assigned to cover Ward E-2 that day because no ward officer was present, and was present when the incident started.

47. Mr. Duran asked Patient M to return to his room, and Patient M continued to curse. Mr. Duran indicated to others in the day hall that the room should be cleared. The other patients in the day hall moved out of the day hall and into the hallways where their rooms are located. Complainant and his one-to-one patient, however, remained where they were in the day hall.

48. Patient M continued to escalate while staff members came up to him. Patient M then spit at Mr. Gallegos' face and took off running toward his room in D-Wing. When Patient M turned to run, he did not make physical contact with any of the staff.

49. When Patient M began running, Mr. Duran, Ms. Lanier, Mr. Gallegos, and Officer Korba followed directly behind Patient M. Patient M ran toward the D-Wing, which meant that his path was along the side of the nurse's station, and then along the main interior wall toward the hallway door that led to his room.

50. When Patient M began running toward his room, Complainant was standing with his foot up on one of the seats attached to a table, and he was carrying a clipboard. Complainant's assigned one-to-one was sitting behind the table. Patient M's path toward his room was to Complainant's left. When Patient M began running, he was not running directly toward Complainant's position or toward the one-to-one patient. Complainant and the one-to-one patient were the closest individuals in front of Patient M as he ran, but they were off to Patient M's left side. The one-to-one patient was also separated from Patient M's path by a table and the attached seats.

51. As soon as Patient M spat and began running, Complainant also started to move in order to intercept Patient M. Complainant took several running steps diagonally forward and to the side, so that he came in contact with Patient M before Patient M reached the doorway to D-Wing. When Complainant ran toward Patient M, his attention was focused on Patient M and he was no longer positioned to watch his one-to-one patient.

52. When Complainant intercepted Patient M, Complainant was moving quickly. Complainant hit Patient M primarily with his arms. Complainant's collision with Patient M knocked Patient M off his feet and sideways into a trash can, and up against the main interior wall. When Patient M fell to the floor, Complainant also went to the floor.

53. The collision between Complainant and Patient M was not an approved PRT control movement. It looked like, and had the effect of, a football tackle rather than a controlled restraint procedure.

54. Complainant's actions in intercepting Patient M required that Complainant move significantly beyond the three foot radius expected of a direct care staff who is to watch a highly suicidal patient on Suicide Precaution Level II. When Complainant was in contact with Patient M, he continued to be beyond a three-foot radius of his one-to-one patient and no longer positioned to visualize his assigned patient. Complainant got back to his feet after contacting Patient M and returned to his one-to-one patient within approximately 43 seconds.

55. Staff members on the ward were directly behind Patient M as he ran. When Patient M went to the floor, staff was able to control his legs and quickly place him into RIPP restraints. At least five Department of Public Safety officers escorted Patient M to a seclusion room. Staff placed him into an eight-point restraint on the seclusion room bed. Patient M was told that the behavioral criteria for his release would be not to spit, bite, or kick staff or become verbally or sexually threatening. Staff monitored patient M for approximately three and a half hours before he was calm enough to meet the behavior criteria for release from the seclusion room.

Reporting and Investigation of the March 23, 2012 Incident:

56. Ms. Lanier wrote a patient note on March 23, 212, which eliminated any description of how Complainant had physically restrained Patient M:

> [Patient M] was instructed to either go to his room or seclusion room to calm down, he then yelled "f*** you" and began charging towards his wing hall and turned and spit in staff members face before he was physically contained for safety of others. He was escorted to seclusion room [with] physical escort and use of back strap. He was placed in 8 point restraint and monitored at arm's length for safety..."

57. On March 23, 2012, Ms. Lanier also reported the incident on an CMHIP Incident Reporting form. Ms. Lanier's report, however, described the incident as only one of Patient M spitting at Mr. Gallegos. Ms. Lanier did not report Complainant's actions in restraining Patient M. Instead, Ms. Lanier falsely reported that, after Patient M spit into Mr. Gallegos' face, "he was put into manual hold and lowered to ground and escorted to seclusion room."

58. The incident was also reported on March 23, 2012, to CMHIP's Quality Support (QSS) staff as a patient-to-staff assault. On March 29, 2012, QSS staff reviewed video recordings of the Ward E-2 day hall area and seclusion room.

59. QSS staff determined that Complainant's take down on Patient M did not comply with CTI procedures. On March 29, 2012, QSS staff notified the Forensics Division Chief Nurse, Ms. Avina, of the results of their inquiry. Ms. Avina is the appointing authority for the direct care staff on Ward E-2. QSS staff also notified CMHIP Department of Public Safety and the CMHIP Superintendant of their findings.

60. On or about April 4, 2012, QSS staff also produced a report for the Colorado Department of Public Health & Environment which found that Complainant's action in performing the takedown of Patient M was patient abuse. The report detailed the response that was taken by CMHIP as a result.

61. The Chief of the CMHIP Department of Public Safety, Louis Archuleta, assigned Officer Billy Wade to conduct an investigation into the handling of Patient M.

62. On or about May 29 and 30, 2012, Officer Wade interviewed Patient M and the Ward E-2 direct care staff members who were present during the incident:

a. Ms. Lanier reported that Complainant had rushed towards Patient M and tackled him. Ms. Lanier also reported that she believed that Complainant's actions were rough and unnecessary. Ms. Lanier additionally created a revised Incident Report Form on March 29, 2012, after being contacted by QSS staff. The

revised Incident Report noted that Complainant had left the table "and ran toward [Patient M] and rushed him pushing him into [the] laundry room wall."

b. Mr. Duran told Officer Wade that he had seen Patient M spit on Mr. Gallegos and then run toward D-Wing. Mr. Duran told Officer Wade that Complainant ran toward Patient M and shoved Patient M into the wall. Mr. Duran told Officer Wade that he had expressed his concern about Complainant's use of force to Ms. Lanier.

c. Ms. White told Officer Wade that she was behind the nurse's station at the time of the incident, and that she had seen Complainant had run toward Patient M after Patient M had spit in Mr. Gallegos' face, and that Complainant had done "a kind of tackling thing" on Patient M that was wrong and unnecessary.

d. Mr. Gallegos told Officer Wade that Complainant's take down of Patient M was "a little rough" and that he could have sworn it was a "body shot." When asked to explain what he meant by body shot, Mr. Gallegos explained that Complainant shoved Patient M.

e. Ms. Kliewer told Officer Wade that she had stepped out into the Ward E-2 day hall after she saw Patient M start running, and she observed that Complainant had Patient M pinned up against the wall, and that Complainant and Patient M were shoulder to shoulder. Ms. Kliewer also confirmed that she later heard Mr. Duran express his concerns over the incident to Ms. Lanier.

f. Officer Korba initially told Officer Ward that he had seen Complainant approach Patient M and place him in a PRT. When Officer Ward asked if it was a PRT or a takedown, Officer Korba reported that Complainant had performed a fluid takedown. When Officer Ward asked why Officer Korba had first reported that Complainant had performed a PRT, Officer Korba answered that he was trying to cover for Complainant. Officer Korba agreed that Complainant had used an unauthorized technique in his takedown.

63. Officer Ward also interviewed two staff members who were informed of the incident by Ms. Lanier.

64. Team Leader Lawrence Rodriquez reported that he had been notified of an incident with Patient M spitting on Mr. Gallegos. When he called in to speak with Ms. Lanier about the incident, she had told him that Complainant had performed an unorthodox takedown of Patient M that was perhaps not a CTI takedown.

65. Officer Wade also interviewed Andrea Dallaguardia, who had been the Registered Nurse II on the next nursing shift on Ward E-2. Ms. Dallaguardia reported that Ms. Lanier had told her that Complainant was rough in taking down Patient M, and that she had said that Complainant had gotten his revenge on Patient M for spitting on him earlier.

66. Complainant was also interviewed by Officer Wade. Complainant told Officer Wade at the beginning of his interview that "the video does look bad." Complainant explained his actions with Patient M by saying that he was trying to protect himself and his one-to-one patient, and that their collision occurred when he raised his clipboard because he thought that Patient M was going to spit at him. Complainant told Officer Wade that he did not intend to shove Patient M

into the wall, but only to slow down Patient M and de-escalate the situation. Complainant acknowledged to Officer Wade that he did not use a CTI technique in restraining Patent M.

67. Complainant completed a written statement that repeated his argument that he collided with Patient M after he approached Patient M to slow Patient M's progress toward him and his one-to-one patient, and to de-escalate the situation.

68. The CMHIP Department of Public safety report reached the conclusion that Complainant's takedown of Patient M constituted patient abuse.

Respondent's Response To the Investigation:

69. When Ms. Avina received the report from Quality Assurance that there had been an unauthorized use of force against Patient M, she reviewed the video of the incident.

70. Ms. Avina decided to place all of the direct care staff members who were present when Complainant used force against Patient M, but who had not reported the incident, on administrative leave pending further investigation. Mr. Duran was allowed to return to work when his report to Ms. Lanier was substantiated. Ms. Dallaguardia was also placed on administrative leave while her role in failing to report what Ms. Lanier had told her was investigated.

71. Complainant and five other direct care staff were placed on paid administrative leave on or about March 30, 2012 pending the outcome of Board Rule 6-10 processes. The CMHIP Department of Public Safety also placed Officer Korba on administrative leave pending the outcome of an investigation.

The Board Rule 6-10 Process:

72. By letter dated April 5, 2012, Ms. Avina schedule a Board Rule 6-10 meeting with Complainant to discuss "alleged patient abuse and failure to report." The meeting was scheduled for April 12, 2012.

73. The Board Rule 6-10 meeting was held as scheduled. Complainant brought a representative with him, Mr. Daniel Casias. Ms. Avila was present along with Nancy Schmelzer from the Department of Human Services Southern District Human Resources department.

74. Complainant presented his knowledge of Patient M's aggressive, threatening, and assaultive behavior in the weeks he had been on Ward E-2. Complainant maintained his version of events that he acted to protect himself and the one-to-one patient that he was assigned to monitor, and he wanted to de-escalate the situation. Complainant told Ms. Avina that Patient M was pushing his way through staff, and that Patient M was glaring at him while he was running at Complainant and Complainant's one-to-one patient.

The Decision To Terminate Complainant's Employment:

75. Ms. Avina considered that Complainant had received no disciplinary or corrective actions in the approximately three years he worked for CMHIP.

76. Ms. Avina concluded that Verbal Judo and CTI required that, when a situation like the one with Patient M occurs, the safest and best intervention was to allow the patient a way to retreat to his room.

77. Ms. Avina also concluded that Complainant's use of force was not within CTI, and also did not meet any exemption for use of force outside of the parameters of CTI. Ms. Avina found that Complainant was not truthful when he explained that Patient M was running toward him and his one-to-one, or that Patient M had been pushing himself through other staff members. She found that Patient M had simply gone around staff members, rather than pushing through them. She also found that Complainant had to move approximately eight feet to the side to place himself on Patient's M's path, and that Patient M was not running toward Complainant or his one-to-one patient when Complainant performed a takedown of Patient M.

78. Ms. Avina concluded that Complainant violated CMHIP Policy 6.56 by leaving his one-to-one patient beyond an arm's length distance.

79. She concluded that Complainant violated SMHIP Policy 16.15 by committing physical abuse of a patient by the manner in which Complainant performed the takedown of Patient M. She further found that Complainant had violated another section of the policy by also failing to report his conduct.

80. Ms. Avina found that Complainant violated the terms in the Nursing Employees General Expectations In Working With Patients directive that Complainant had signed on or about August 3, 2009. The document prohibits "[d]irecting physical or verbal abuse toward patients or others. (Any observed physical or verbal abuse must be reported to a supervisor.)"

81. Ms. Avina found that Complainant violated two codes of ethics. She found that Complainant had violated the CMHIP Code of Ethics, which requires that Complainant treat "patients...with courtesy and respect." Ms. Avina additionally found that Complainant had violated the Department of Human Services (DHS) Code of Ethics, which required Complainant to "[t]reat all customers fairly. Be truthful, honest, and courteous to co-workers and to customers at all times." Ms. Avina found that Complainant had been disingenuous and not forthcoming with relevant information during the Department of Public Safety investigation or the Board Rule 6-10 process.

82. Finally, Ms. Avina found that Complainant's actions were serious and flagrant, and justified the imposition of immediate discipline. Ms. Avina determined that immediate termination was warranted because of "the criticality of the policies you violated, the serious and flagrant nature of your conduct, the egregiousness of your abuse of the patient, and failure to properly report the incident."

83. Ms. Avina terminated Complainant's employment effective April 20, 2012.

84. Ms. Avina called Complainant into the office for a meeting to tell him of her determination. The letter terminating Complainant's employment, however, was sent to an incorrect home address. The fact that the letter had not been delivered was discovered approximately a month after it had been sent, and another letter was generated and sent to Complainant's correct home address.

85. Complainant did not receive the letter terminating him from employment until May 23, 2012.

86. Complainant timely appealed the termination of his employment to the Board.

87. By check dated September 17, 2012, Respondent provided Complainant with pay for the time between his termination date of April 20, 2012, and the date which he received his termination letter. The calculation of back pay paid to Complainant did not include any interest or include any attorney fees and costs.

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; 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 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*, 886 P.2d at 704. The Board may reverse or modify 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).

II. HEARING ISSUES

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

The core evidentiary issue presented at hearing concerned whether or not Respondent could prove that Complainant had failed to perform competently in addressing the actions of Patient M on March 23, 2012, and had been disingenuous in his later explanations of the relevant events. Complainant argues that he was attempting to de-escalate a patient who he believed was going to assault him or the patient that he was watching, and that under such circumstances, he should have not been found to have violated CMHIP policy.

One of the essential functions of a *de novo* hearing process is to permit the Board's administrative law judge to evaluate the credibility of witnesses. *See Charnes v. Lobato*, 743 P.2d 27, 32 (Colo. 1987)("An administrative hearing officer functions as the trier of fact, makes determinations of witness' credibility, and weighs the evidence presented at the hearing"); *Colorado Ethics Watch v. City and County of Broomfield*, 203 P.3d 623, 626 (Colo.App.

2009)(holding that "[w]here conflicting testimony is presented in an administrative hearing, the credibility of the witnesses and the weight to be given their testimony are decisions within the province of the presiding officer").

Complainant's explanation for his actions was not found to be credible. Complainant took actions that were inconsistent with an attempt to merely defend himself or to defend the one-to-one patient that he was to be watching. As the video evidence made clear, Patient M was moving toward the doorway to D-Wing and not toward either Complainant or the one-to-one patient that Complainant was watching. Complainant had to move diagonally several steps to be able to intercept Patient M, and his collision with Patient M was not the product of an accident or was otherwise unintentional. The persuasive evidence at hearing established that Complainant intended to physically stop Patient M before Patient M reached the D-Wing hallway door.

Complainant's explanation for his actions is also not consistent with CMHIP policy, even if his explanation of events were to be accepted at face value. Complainant stresses that Patient M was a mentally ill patient who was on Assault Precaution II status at the time of this incident because of a history of assault and verbal threats. Complainant points to the fact that five or more Department of Public Safety officers were used to place Patient M into seclusion on March 23, 2012, and that Patient M had to remain in the seclusion room for hours. Complainant argues that it was even possible that Patient M had armed himself with something he could wield as a weapon when he was at the nurse's station, even though such items are not to be left out as a precaution against presenting patients which such an opportunity. Complainant contends that it was reasonable to react as he did to such a volatile patient.

This argument ignores the essential nature of the performance standards for CMHIP staff. CMHIP's function is to house and treat mentally ill patients, many of whom are volatile and assaultive. Unless very specific circumstances are present, staff members are expected to handle the unpredictable, threatening behavior of such patients using only the tactics taught as part of CTI.

The exceptional circumstances that might permit Complainant to utilize a non-CTI application of force require that the force be used against a threat of serious bodily injury. To constitute such a threat, a person must be "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). Patient M did not pose such an immediate danger when Complainant performed a takedown. The question is not whether Patient M had a history of assaultive and threatening behavior, or whether Patient M demonstrated such behavior after he had been knocked to the floor by Complainant. The issue is whether, at the time he was running toward his room in D-Wing, Patient M posed a threat of serious bodily injury by creating an immediate danger of substantial physical injury. If he did not, then Complainant should have adopted the tactic used by his colleagues and allowed Patient M a clear path back to his room. Complainant's additional argument that Patient M should be considered to be sufficiently dangerous to warrant a non-CTI use of force because he might have picked up a weapon in the day hall was not based on anything more than sheer speculation. Such supposition cannot create legitimate grounds to conclude that Patient M posed an immediate danger of substantial physical injury.

Respondent, accordingly, was successful in demonstrating that Complainant used an unauthorized level of physical force against Patient M, and therefore committed patient abuse,

by performing a takedown of Patient M on March 23, 2012, in violation of CMHIP Policy 16.15. Additionally, given that Complainant did not report his use of force, Respondent has also shown that Complainant violated the notification requirement in CMHIP Policy 16.15. Complainant's actions also violate similar performance requirements found in the Nursing Employees General Expectations In Working With Patients form that Complainant signed when he began work in August of 2009.

Respondent additionally demonstrated at hearing that Complainant had stopped watching the highly suicidal patient that he had been assigned to monitor on March 23, 2012. The evidence at hearing demonstrated that Complainant spent approximately 43 seconds addressing Patient M. During this time, Complainant did not remain within an arm's length of his one-to-one patient. Additionally, once Complainant began to run toward the interception point with Patient M, he turned in such a way as to lose the ability to visualize his patient. Respondent has, therefore, demonstrated that Complainant violated his performance obligations with regard to his monitoring of a suicidal patient on March 23, 2012, pursuant to the requirements of CMHIP Policy 6.56.

Respondent has demonstrated that Complainant's actions in performing an unnecessary takedown of Patient M also constituted a failure to treat Patient M with courtesy and respect, in violation of the CMHIP Code of Ethics and the similar DHS Code of Ethics requirements.

Finally, Complainant's version of the events of March 23 2012, was found to be not credible, particularly with regard to Complainant's description of why he engaged Patient M and how his actions resulted in a takedown of Patient M. Complainant's version of events demonstrates that he was disingenuous in his response to the Department of Public Safety investigation and to his appointing authority's questions during the Board Rule 6-10 meeting. Such statements constitute a violation of Complainant's obligation to be truthful and honest under the DHS Code of Ethics requirements.

As a result, Respondent has successfully demonstrated by a preponderance of the evidence that Complainant has committed all of the acts for which he was disciplined.

B. The Appointing Authority's action was not arbitrary, capricious, or contrary to rule, although it was contrary to law in one regard.

(1) Respondent's decision to impose discipline was neither arbitrary nor capricious:

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's actions in this case were neither arbitrary nor capricious. The evidence at hearing demonstrated that Ms. Avina assembled the information she needed to evaluate

Complainant's performance, and provided Complainant with an opportunity to address that information. Ms. Avina gathered the information contained in both the QSS and the Department of Public Safety reports concerning the incident on March 23, 2012, including the video recording of the Ward E-2 day hall at the time in question. She also gathered additional information from all of the direct care staff participants from the reports and as part of her Board Rule 6-10 processes related to this incident. The collection of this information constitutes the use of reasonable diligence and care to procure the evidence which could be considered in the exercise of Respondent's discretion in imposing discipline.

Additionally, the evidence introduced at hearing demonstrated that Ms. Avina gave candid and honest consideration to all of the information she had collected, including the information that Respondent had presented to her. Moreover, the conclusion that Ms. Avina reached were reasonable conclusions based upon the evidence she had reviewed.

Accordingly, Respondent's decision to discipline Complainant was neither arbitrary nor capricious.

(2) Respondent's action was not contrary to rule but was contrary to law in one regard:

Board Rule 6-9:

Respondent's action in taking disciplinary action comports with Board Rule 6-9, 4 CCR 801, which requires that a decision to take disciplinary action "shall be based on the nature, extent, seriousness, and effect of the act, the error or omission, 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. Information presented by the employee must also be considered."

The evidence at hearing demonstrated that Ms. Avina considered the information presented by Complainant concerning Patient M, as well as Complainant's three year performance history in reaching her decision to impose discipline. Complainant's good work history and Patient M's history of assaultive and threatening behavior, however, were not sufficient to outweigh the finding that there had been physical abuse of a patient, that the supervisory duties for a highly suicidal patient had been ignored for a period of time, and that Complainant had explained his version of events in a manner which was not consistent with the video evidence and much of the eyewitness evidence. There was no violation of Board Rule 6-9 in Respondent's decision that the nature, extent, and seriousness of the violations in the case required the imposition of discipline.

Progressive Discipline:

Board Rule 6-2, 4 CCR 801, provides that "[a] certified employee shall be subject to corrective action before discipline unless the act is so flagrant or serious that immediate discipline is proper." Complainant has no prior discipline or corrective actions in his employment with Respondent. Respondent did not present any information that would demonstrate that progressive discipline was achieved in this case.

The rule, of course, does not demand progressive discipline in every case. There is an exception within the rule permitting immediate discipline, including termination, for serious or flagrant actions. Ms. Avina specifically found that Complainant's takedown of Patient M was

sufficiently serious and flagrant to warrant immediate discipline. This conclusion is well-grounded on the facts of this case. Complainant ignored the need to use only therapeutic levels of force, and he applied force in a way that delivered a physical blow sufficient to knock a patient off his feet. Complainant then failed to report the incident, and did not tell the truth when interviewed later by the Department of Public Safety, during his meeting with his Appointing Authority, or at his hearing before the Board. Finally, Complainant disregarded his duty to closely monitor a suicidal patient in order to intercept the other patient. Complainant's actions are sufficiently serious and flagrant to warrant the imposition of immediate discipline. There has been no violation of Board Rule 6-2 in this case.

Statutory notice requirements in C.R.S. § 24-50-125(2):

State statute requires that "any certified employee disciplined...shall be notified in writing by the appointing authority, by certified letter or hand delivery, no later than five days following the effective date of the action, of the action taken, the specified charges giving rise to such action, and the employee's right of appeal to the board...Upon failure of the appointing authority to notify the employee in accordance with this subsection (2), the employee shall be compensated in full for the five-day period and until proper notification is received." C.R.S. 24-50-125(2).

The requirement in C.R.S. § 24-50-125(2) was not met in this case. Complainant was not provided with a written copy of his termination letter until more than a month had passed from the effective date of his termination. Respondent has provided compensation to Complainant for the period during which Complainant had not received his termination letter, but that payment was made only in September of 2012, and did not include interest or attorney fees and costs.

Respondent's violation of C.R.S. § 24-50-125(2) does not warrant a reversal or modification of Complainant's termination from employment. The statute itself provides the proper remedy if there is a violation, and that remedy is for Complainant to be "compensated in full" from the effective date of the discipline until he has received the proper notice. The record at hearing was insufficient to determine if Respondent's payment to Complainant by check dated September 17, 2012, included the correct amount; it may be the case that Respondent has already provided that portion of the remedy to Complainant.

Accordingly, Respondent will be ordered to provide "compensation in full" to Complainant for the days between April 20, 2012, and May 23, 2012, with credit to be provided for any amount already paid to Complainant. The law is silent on how full compensation is to be determined. In the absence of guidance, the Board applies the plain meaning of the words, and implements the intent of the legislature. *See* C.R.S. § 2-4-101. C.R.S. § 24-50-125(2) is designed to be a deterrent to the state in delaying the formal notification of employees concerning disciplinary actions. Full compensation, for this purpose, therefore, should be liberally construed to effectuate the deterrent purpose of the statute. The statutory requirement that an employee is to be "compensated in full", therefore, will be interpreted to be the amount that the State would have paid to Complainant directly or on his behalf if he had remained on the payroll. This definition clearly encompasses the amount of base pay that Complainant would be entitled to receive, along with any shift differential that Complainant would have received if he had remained in his position during the period in question. If an amount would have been paid to another entity by the state, such as for PERA retirement or as the employer's contribution to health insurance, that amount should be directed to Complainant as part of his full compensation because those are amounts that are paid by the state as part of an

employee's compensation. Given, however, that the legislature considered the remedy to involve providing an employee with compensation, rather than the broader category of damages or benefits, the need to reimburse Complainant does not extend to non-monetary benefits such as accrual of annual or sick leave, even if those non-monetary benefits could be translated into monetary amounts. The amount would also not cover monetary payments for more speculative additions to base pay, such as the possibility of overtime payments.

An award of statutory interest is also an additional component for the calculation of withheld pay. When a party is deprived of funds to which he has a right, then interest accrues at the 8% per annum rate under C.R.S. § 5-12-102(1)(b) because the funds have been "wrongfully withheld." *Rodgers v. Department of Human Services, CMHIP*, 39 P.3d 1232, 1237-38 (Colo.App. 2001)(holding that CMHIP was entitled to recover statutory interest on monies which had been paid to an employee pursuant to Board order, but which the employee had to return to the agency once he lost his case on appeal). *See also Mesa Sand & Gravel Co. v. Landfill, Inc.*, 776 P.2d 362, 365 (Colo. 1989)(quoting the legislative purpose of the statutory interest requirements to be that "[a]ll plaintiffs, or defendants who counterclaim, for that matter, are entitled to interest from the time the action accrued, not from the time the suit was filed, not from the time judgment was entered, but from the time they were wronged..."). A prorated portion of the statutory interest rate will be made part of the remedy to be awarded to Complainant for violation of C.R.S. § 24-50-125(2).

Complainant's request for additional compensation in the form of an award of attorney fees and costs is handled as part of the discussion of that issue, *supra*.

Respondent's decision to discipline Complainant under the circumstances of this case is neither arbitrary nor capricious, and is not in violation of rule. Respondent's actions in providing written notice to Complainant, however, have violated the requirements of C.R.S. § 24-50-125(2). Complainant will be provided with the remedy created by that statutory requirement as part of the outcome of this hearing.

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

The final question is whether termination was within the range of reasonable alternatives available to Ms. Avina.

Ms. Avina determined that termination of employment was the appropriate response to the type of violations present in this case. This determination is a reasonable one under the circumstances of this case. Complainant exercised a level of physical force against Patient M that was sufficient to knock Patient M off his feet and into a wall, and the use of such force was contrary to the core requirement that CMHIP staff use only therapeutic levels of force on patients. Moreover, in the process of focusing on Patient M, Complainant disregarded his obligation to closely supervise the actions of a highly suicidal patient who was in Complainant's care at the time. Additionally, Complaint's explanation for why he employed the level of force that he used was not supported by the evidence, including the video evidence. Complainant's willingness to maintain his version of events, even in the face of the conflicting evidence available on video, supports the conclusion that Complainant was being disingenuous when he was interviewed by the CMHIP Department of Public Safety and by his Appointing Authority.

Under such circumstances, termination of Complainant's employment was within the range of reasonable alternatives available to Ms. Avina.

D. Complainant is not entitled to an award of attorney fees.

Attorney fees are warranted if an action was instituted frivolously, in bad faith, maliciously, or as a means of harassment or was otherwise groundless. C.R.S. § 24-50-125.5; 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).

A groundless personnel action is one in which "it is found that despite having a valid legal theory, a party fails to offer or produce any competent evidence to support such an action..." Board Rule 8-38(A)(3). Frivolous actions, on the other hand, are actions "in which is it found that no rational argument based on the evidence or law is presented." Board Rule 8-38(A)(1).

In this case, Respondent has proven that Complainant committed all of the actions for which he was disciplined, and has shown that these actions constituted violations of various important performance standards that Complainant was expected to meet. Under such circumstances, there are no grounds to find that the termination of Complainant's employment was instituted frivolously, in bad faith, maliciously, as a means of harassment, or was otherwise groundless.

Complainant has additionally argued that he should receive attorney fees and costs specifically related to Respondent's failure to send his written notice of termination in a timely fashion pursuant to the requirements of C.R.S. § 24-50-125(2). The evidence at hearing demonstrated that the reason for the delay in written notification was a clerical problem which resulted in the letter being sent to the wrong address initially. Once the mistake was caught and corrected, proper written notice was delivered to Complainant. Respondent also did not provide compensation to Complainant under the terms of C.R.S. § 24-50-125(2) for an untimely written notice until shortly before hearing in September of 2012. Complainant has not shown, however, that the handling of the written notice or the payment to Complainant was done frivolously, in bad faith, maliciously, as a means of harassment, or was otherwise groundless. Complainant, accordingly, has not carried his burden to demonstrate that he is entitled to any award of attorney fees and costs.

CONCLUSIONS OF LAW

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

2. Respondent's action was not arbitrary, capricious, or contrary to rule, although it was contrary to law in one respect.

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

4. Complainant is not entitled to attorney fees.

ORDER

Respondent's disciplinary action is **affirmed in part** and **modified in part**. The termination of Complainant's employment is affirmed. Respondent's action is modified so that Complainant is to be compensated in full, as that phrase is defined in the Initial Decision, for the period of April 20, 2012, through May 23, 2012. There is no award of attorney fees or costs.

Dated this 20th day of November, 2012 at Denver, Colorado.

[redacted]

Denise DeForest
Administrative Law Judge
State Personnel Board
633 – 17th Street, Suite 1320
Denver, CO 80202-3640
(303) 866-3300

CERTIFICATE OF MAILING

This is to certify that on the 21st day of Nov., 2012, I electronically served true copies of the foregoing **INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE**, addressed as follows:

F.J. "Rick" Dindinger II

[redacted]

Stacy L. Worthington, A.A.G.

[redacted]

[redacted]

Andrea Woods

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.