STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. **2013B129**

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

CHERYL NEUMEISTER,
Complainant,

v.

DEPARTMENT OF CORRECTIONS, SAN CARLOS CORRECTIONAL FACILITY,
Respondent.

Senior Administrative Law Judge (ALJ) Mary S. McClatchey held the hearing in this matter on September 28, 29, and 30, 2013. Complainant appeared through Andrew Newcomb, Finger & Newcomb PC. Respondent appeared through Assistant Attorneys General Sabrina Jensen and Davin Dahl. Respondent's advisory witness was Kellie Wasko, Deputy Director, Colorado Department of Corrections.

MATTER APPEALED

Complainant, a former Mental Health Clinician IV at the San Carlos Correctional Facility (SCCF), Department of Corrections (DOC), appeals her disciplinary termination of employment. Complainant seeks reinstatement, back pay, and an award of attorney fees and costs. For the reasons set forth below, the 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;

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

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

FINDINGS OF FACT

1. Complainant was hired by DOC in 1999. She has held the positions of Correctional Officer, Mental Health Clinician III, Social Worker II/Counselor III, and Social Worker/Counselor IV. Complainant became a Licensed Professional Counselor in Colorado in 2002.

2. During the years 2002 through 2007, Complainant received overall performance ratings of Level 3, Commendable, on a 4-Level scale. She was consistently rated at level 4, Outstanding, in the areas of Accountability/Organizational Commitment, and Job Knowledge. On her 2007 evaluation, it was noted that she is an example of a loyal and dedicated DOC employee, her knowledge of mental health policies and procedures is

exceptional, she consistently adheres to all ethical guidelines, and she uses sound clinical judgment in her work with clients.

Mental Health Supervisor Position

3. In 2008, Complainant was promoted to Social Worker/Counselor IV, or Mental Health Clinician IV, also known as Mental Health Supervisor. She worked at La Vista Correctional Facility in Pueblo, Colorado at the time.

4. In this position, Complainant was responsible for supervision and oversight of the mental health clinical program and work unit. According to Complainant's official position description, Complainant is "accountable for planning, directing, and maintaining delivery of mental health services, assuring compliance with mental health guidelines, and managing appropriate use of resources." She also directed the "management of psychiatric crises and or emergencies."

5. The Duty Statements for Complainant's position included:

   - Provides leadership and vision for the Mental Health Clinical program or work unit; supervises and evaluates the work of staff; recommends hiring and corrective action of staff;

   - "Responsible for maintaining the standard of care for the clinical program or work unit assigned by verifying compliance with all applicable mental health standards."

   - "Provides clinical and administrative supervision of all staff activities."

   - "Provides advanced practice mental health care to the inmate population."

   - Provides individual, group therapy and crisis intervention, including "participation in 24 hour Mental Health On-Call rotation."

   - "Responsible for maintaining the standards of the program or work unit by verifying compliance with all applicable Mental Health, departmental, organizational and unit standards; implements action to maximize the quality of patient care delivered within the assigned work unit; . . . formulates and implements policies and procedures essential to promoting quality care," and

   - Responsible and accountable for ensuring staff compliance with all Life Safety protocols and procedures.

6. Complainant's annual evaluations for the period 2008-2009 and 2009-2010 were at an overall Level 2 on a 3-Level scale. In both years, she received Level 3's in Accountability/Organizational Commitment and Interpersonal Skills. Narrative notes included the following: she consistently demonstrates the ability to go above and beyond; shows personal and professional pride and is quick to point out staff that do the same; abides by and ensures that her subordinate staff follow the DOC Staff Code of Conduct; and is an active and valued participant in the La Vista and SCCF Management Team.

7. The evaluations from 2008-2009 and 2009-2010 both documented positive feedback about Complainant received from other members of the Management Team.

Ms. Wasko

8. Kelly Wasko is a registered nurse and began her career with DOC in a nursing position. Ms. Wasko promoted through the ranks to the level of Health Services Administrator in 2003. In that position she was responsible at the facility level for clinical operations, overseeing behavioral health, nursing, dental, and medical services. In 2008, Ms. Wasko became Associate Warden of SCCF and La Vista. In 2010, she became Warden of La Vista and Trinidad Correctional Facility. In 2011, she became Warden of SCCF and La Vista. She was then promoted to several executive positions at DOC during the period of 2012 and 2013, including Interim Deputy Executive Director, Director of Clinical and Correctional Services, in which she had executive oversight of all functions reporting to the clinical services division at DOC.

9. Ms. Wasko's experience at DOC includes years of oversight of mental health services, and development and approval of mental health policies and procedures.

May 2011 Corrective Action

10. On May 17, 2011, Complainant received a Corrective Action for spending work time on her computer to play on-line games and failing to timely complete offender grievances and employee mid-year evaluations. The document stated that she had a duty to the citizens of Colorado to be accountable and efficient in the use of State resources; as a supervisor, she is held to a higher standard of ethics and is expected to increase her performance and set an example for her subordinate staff.

11. The Corrective Action required Complainant to immediately comply with all DOC regulations, read and sign Administrative Regulation (AR) 1200-06, Computer Security, Access, and Usage, and write a paper on personal ethics of work performance. It also rescinded Complainant's internet access at work for six months.

12. At the meeting to discuss the Corrective Action with Complainant, Ms. Wasko wrote on the Computer Security policy that if Complainant violated the policy again in the future, her internet access would be permanently revoked. Complainant agreed with this and signed the policy.

13. Complainant's 2010-2011 annual evaluation was an overall Level 2. In the area of Accountability/Organizational Commitment she was given a Level 1 due to the discovery, during a period of leave, of "several aspects of her duties that had not been completed." Those included over 75 offender grievances that had not been logged into the system and grievances from March 2009 that had not yet been answered. In the area of Performance Management, Complainant received a Level 1 because she had not completed subordinate employee evaluations in a timely manner. In the area of Job Knowledge, a Level 2, the narrative noted that there had been concerns about her performance concerning offender grievances and about "supporting effective team work across behavioral health service areas." The evaluation also indicated in mitigation that there had been significant staff shortages during this rating period.

14. In her 2011-2012 annual evaluation, Complainant received an overall Level 2, with a Level 3 in Job Knowledge, and no Level 1's. The narrative noted that she had shown "much improvement since her last rating period," that she had volunteered to take a case load of seven male offenders (when other Mental Health Supervisors did not do so) because it would help with team cohesiveness, and that she had gone out of her way to provide therapeutic services to offenders involved in a tragic incident. One of those offenders had later specifically requested to speak with Complainant by telephone when he lost a family member. In the area of Customer Service, it was noted that Complainant had helped to perform education with SCCF staff on changes to the AR and Mental Health Watch standard.

15. The next evaluation for Complainant covered the period of April 1 through November 3, 2012, due to a change in supervision. Complainant received an overall Level 2, with all areas at that level. This evaluation noted that Complainant had all of the men on Unit 7 in her caseload, took over the bulk of a vacant position's caseload, was very conscientious about the care La Vista offenders receive, was well regarded by her staff, and was responsive to the needs of staff and offenders. In the Job Knowledge area, it noted that during a Mental Health Peer Review Audit on her crisis contacts and case load, Complainant met all identified standards.

2012 Reinstatement of Internet Privileges and January 2013 Disciplinary Action

16. In January 2012, Complainant met with Ms. Wasko regarding the reinstatement of her internet privileges. Ms. Wasko approved the reinstatement at that time.

17. Later in 2012, Complainant's subordinate staff complained that Complainant was spending excessive time in her office watching YouTube videos and laughing. Complainant's conduct was damaging employee morale at La Vista.

18. Complainant's superiors arranged to have technology staff track Complainant's internet usage, and confirmed that she was spending work time on a daily basis on personal internet usage. The predisciplinary process ensued; Ms. Wasko was present at the predisciplinary meeting.

19. On January 23, 2013, Renae Jordan, Interim Assistant Director of Prison Operations, Clinical Services, issued Complainant a disciplinary reduction in pay of $200 for six months. Due to Complainant's repeated violation of AR 1200-06, her internet access at work was removed permanently. The letter referenced Complainant's admissions in the predisciplinary meeting of having accessed internet websites for personal reasons on a regular basis since her access had been reinstated in January 2012. It also stated, "As a DOC staff member and a mental health supervisor, you have failed to model staff professionalism and acceptable behavior as noted in the Code of Conduct. As a supervisor, you are held to a higher standard of ethics and behavior."

January 2013 Transfer to SCCF

20. Complainant's repeated abuse of the internet during work hours damaged her relationship with subordinates at La Vista, who no longer respected her authority. Ms. Wasko determined that Complainant needed more supervision than she was receiving at La Vista.

21. SCCF had an additional layer of supervision immediately above Complainant in the chain of command. The position was that of Health Professional V, held by Tammy LaBorde. Therefore, Complainant was immediately transferred to SCCF.

22. SCCF is a Residential Treatment Program. The entire inmate population consists of the chronically mentally ill. The role of SCCF staff is to collaborate among disciplines for offenders to be successful in stabilizing their mental illnesses. SCCF employees have a dual mission of providing mental health treatment as well as maintaining safety and security.

23. Complainant was not happy about being transferred to SCCF.

February 2013 Training in CPR

24. In February 2013, Complainant participated in a full-day refresher course in Cardiopulmonary Resuscitation (CPR). This training teaches participants to first identify a meaningful rise and fall of the chest for thirty to sixty seconds, to determine whether an individual is breathing. Then, if meaningful breaths are not observed, participants are directed to employ CPR.

February 2013 Confirming Memo Regarding Mental Health Watch Packets/Reviews

25. On February 15, 2013, Ms. LaBorde issued a Confirming Memorandum to Complainant, commemorating their agreement that Complainant would take responsibility for assuring that all mental health watch documentation would be performed in a timely and complete manner. The agreement was necessitated by a backlog of improperly documented mental health watch assessments. All SCCF mental health staff were given the memorandum.

DOC Administrative Regulation 700-29, Mental Health Watches

26. One of the duties of the mental health clinicians such as Complainant is to perform mental health evaluations of inmates to determine whether an inmate is an imminent harm to himself or others. If the clinician determines that there is such a danger, then the inmate is immediately placed on a mental health watch.

27. DOC AR 700-29 requires that mental health clinicians conduct mental health assessments within one hour of contact by the Shift Commander. It states in part, "A mental health clinician will provide an assessment to determine the necessity for a mental health watch within one hour of contact by the Shift Commander. After hours, the mental health on-call clinician will come to the facility and provide the required evaluation."

28. If the mental health clinician is on-call during the graveyard shift when a Shift Commander requests an evaluation, under DOC Clinical Standard and Procedure for Mental Health: Mental Health On-Call, "On-Call mental health clinicians will be able to respond to emergencies by telephone within fifteen (15) minutes and on site within approximately one hour."

29. Subsection IV(G) of AR 700-29 IV(G) lists the components of a mental health evaluation, as follows:

"A mental health evaluation of an offender being assessed for mental health watch will generally consist of:

1. An on site, face to face evaluation by a mental health clinician.
2. A review of the offender's mental health and medical records.
3. Discussion with correctional DOC employees or contract workers regarding offender recent behavior and management needs.
4. An evaluation of the offender's current suicide plan, intent, means and other indicators of risk of self injurious behavior.
5. Evaluation of current and historical psychiatric disturbance (e.g. depression, anxiety/panic, psychosis, mania, paranoia, etc.)
6. Completion of the "DOC Self Injury Risk Assessment (attachment A). Note that offenders who are rated at a self-injury risk level 4, moderate risk of self injury, or higher must be placed on a mental health watch." (Emphasis in original.)

Special Controls, or Intake, Unit

30. Special Controls is a heightened security status for offenders that have been deemed in need of heightened physical control. It is usually used to house offenders that have become violent or destructive to themselves or others. For example, if an inmate defies an order of, or verbally or physically attacks, a correctional officer, the inmate may be sent to the Special Controls, or Intake, Unit, to gain control of the offender.

31. When an inmate is placed on Special Controls status, DOC policy requires correctional staff to arrange for a mental health clinician to perform a mental health assessment of the offender, to assure that the inmate should not instead be placed on a "Mental Health Watch."

32. If a mental health clinician deems an offender to be in need of a Mental Health Watch, the offender is removed from Special Controls. The order to place an inmate on a Mental Health Watch trumps the order placing an inmate on Special Controls.

33. Nursing and mental health clinician staff are in the Clinical Services chain of command at DOC; they report ultimately to the Director of Clinical Services for DOC.

34. Correctional officers are in the correctional chain of command at DOC; they report ultimately to the Warden of each facility.

Offender 1

35. Offender 1 was a 35-year old Hispanic male who first entered the DOC on September 19, 2006. He was released on February 12, 2008, and returned to DOC on July 12, 2010.

36. On May 31, 2012, Offender 1 entered SCCF and was placed in Administrative Segregation, or solitary confinement.

37. Offender 1 had no significant medical conditions other than his acute mental health diagnoses, which are not in the record. On a five-point scale for acuity of mental health conditions, Offender 1 was rated a 4 out of 5, with 5 being the most serious.

Offender 1's March 15, 2013 Release from Solitary Confinement

38. On March 15, 2013, Offender 1 was moved out of solitary confinement to a "close custody" cell. This movement was considered a "progression" and was based on his lack of disciplinary incidents since November 2012.

39. Offender 1 was compliant with his psychotropic medications and never refused his medication during the months of January, February, and March 2013.

40. Offender 1 handled this transition out of solitary confinement well, and did not display any negative behaviors on March 15 or 16, 2013.

Events of March 17, 2013

41. On March 17, 2013, at approximately 3:30 AM, correctional officers found Offender 1 on the floor of his cell, lying on his stomach with his face on the floor and his body slightly under the edge of the bunk. His arms were under his chest. Security staff asked him to come to the door. Offender 1 was unable to do so. He lifted his head up and down and did not speak.

42. Officers called the Shift Commander, stating that they weren't sure if something medical was wrong with the offender, or if it was behavioral. A registered nurse, L.R., was present at this time.[1] She did not perform an assessment of Offender 1 at this time and stated that Offender 1 was "faking." Based on this appraisal, the officers assumed that Offender 1 was defying their orders to respond to them.

43. Offender defiance of orders given by a correctional officer is not acceptable. The officers determined that Offender 1 should be forcibly removed from his cell for passive aggressive conduct, and placed in the Special Controls Unit. Once this order was given, a video camera was set up to monitor Offender 1. The video camera captured both audio and video.

Transfer of Offender 1 to Special Controls Intake Unit

44. At approximately 5:30 AM, correctional officers forcibly removed Offender 1 from his cell. At the time of his removal, Offender 1's breathing was at an elevated rate, his nose was bleeding, he had a large hematoma with bruising on his forehead, he had bruising on his arms and back, and he had urinated on himself. Offender 1's body was limp.

45. L.R. was present for the removal of Offender 1 from his cell. She failed to make any attempt to speak with Offender 1, failed to perform an appropriate nursing assessment of Offender 1, and failed to chart Offender 1's injuries.

[1] L.R. was terminated from her employment at SCCF due to her conduct on March 17, 2013, with Offender 1. Her privacy will be maintained herein.

46. L.R. took Offender 1's vital signs, which were abnormal. L.R. failed to initiate appropriate medical intervention for him. L.R.'s failure to initiate medical intervention for Offender 1 was a contributing factor in his death.

47. L.R. clocked out at 5:58 AM and the next nurse, P.V., clocked in at 5:59 AM.[2] The only nursing notes made by L.R. on the communication pass-on log for the oncoming nursing staff was that there had been a forced cell extraction for Offender 1.

48. Offender 1 was taken in a restraint chair, with wrists in chains attached to a stomach belt, and ankles chained together, to the Special Controls Unit. There was no reason to place him in a restraint chair because he was not acting violently, disruptively, and was not engaging in any self harming behaviors.

49. While in the restraint chair in the Intake Unit, Offender 1 had a grand mal seizure. His legs shook, causing the chains to hit the steel foot rest of the restraint chair; his legs stopped shaking; his eyes rolled back in his head; his body churned against the restraints; his upper body turned red; he slumped over on his right side; and he began to engage in "postictal" snoring, a loud snore that follows a seizure, for approximately fifteen minutes.

50. The Intake Officer had a duty to constantly monitor Offender 1 in that unit. He did not do so and did not notice the seizure had occurred.

51. When the Duty Officer learned that Offender 1 was in a restraint chair, she directed the Day Shift Commander to remove him from the chair. Approximately thirty minutes after the seizure, three correctional staff removed Offender 1 from the restraint chair and placed him on the floor. Offender 1 rolled over onto his stomach into a prone position, with ankle and wrist restraints still on his body. In the prone position, in chains, an inmate is vulnerable to having positional asphyxiation.

52. P.V. entered the Intake Unit at approximately 7:30 AM with Offender 1's medications. She approached the tray slot on the door to his cell and spoke to him through the slot, which is approximately twelve inches high and eighteen inches wide. Offender 1 did not respond to P.V. His breathing was rapid and his legs shook as she spoke to him. P.V. construed the lack of response to be a refusal to take his medications. P.V. then entered Offender 1's cell without speaking to him, administered two psychotropic medications into Offender 1's body, and departed.

53. P.V. failed to take Offender 1's vital signs or to perform a nursing assessment of Offender 1, and did not initiate appropriate medical intervention on his behalf. P.V.'s failure to initiate medical intervention for Offender 1 was a contributing factor in his death.

Page of Complainant for On-Call Mental Health Assessment

54. At 7:30 AM, the Shift Commander paged Complainant to come to SCCF to perform a mental health assessment of Offender 1, to determine whether it was necessary to place him on a Mental Health Watch.

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[2] P.V. was terminated from her employment at SCCF for her conduct on March 17, 2013. Her privacy will be maintained herein.

55. Complainant had not worked with Offender 1 previously and was unfamiliar with him. She had no knowledge of his mental health status, his medical diagnoses, his drug regimen, or his recent behavioral status.

56. Complainant spoke with the Shift Commander by phone, asking him questions about Offender 1's recent behavior and status. She learned during this conversation that he had just been progressed out of solitary confinement two days previously, and had been in Special Controls for two hours. The Shift Commander also informed Complainant that he was going to take Offender 1 back to the cell because "he's not doing anything." He also informed Complainant that Offender 1 "won't talk to us. I want you to come assess this guy, see if you know what is going on with him. He doesn't want to listen to me."

57. During their conversation, the Shift Commander informed Complainant that he planned to go into Offender 1's cell for his next check at 9:30 AM. Complainant informed him she would arrive at approximately 9:00 AM, and the Shift Commander said that would be fine.

58. The Shift Commander did not have authority to approve of the time Complainant arrived at SCCF for the mental health assessment of Offender 1.

59. Complainant lives approximately fifteen minutes from SCCF.

60. In the minutes prior to 9:00 a.m., Offender 1 had another grand mal seizure. Parts of his torso and his legs shook uncontrollably for several minutes. He then began "stridor breathing," which is very noisy breathing through the nose due to obstructed air passages, at a fast pace. Stridor breathing sounds like loud snoring.

61. The stridor breathing stopped at approximately 9:10 or 9:12 AM. At this time, Offender 1's chest stopped rising and falling. During the few minutes following his expiration, Offender 1's body occasionally released air from his lungs, a process known as "agonal breaths."

Complainant's Arrival

62. Upon Complainant's arrival at SCCF on March 17, 2013, she did not review Offender 1's mental health records or his medical records and did not confer with medical staff regarding his recent status, behavior, or medication compliance.

63. When Complainant arrived at the Intake Unit at approximately 9:15 AM, Offender 1 was lying on the floor in the cell in full restraints (legs and wrists) on his stomach, his arms folded so that his hands were under his torso, and his head was facing slightly to his right towards the toilet. His face was approximately four inches from the toilet base.

64. There was a very strong odor of urine when Complainant arrived, and she asked the Correctional Officer on duty if he was sure Offender 1 wasn't urine soaked.

65. Complainant then approached the tray window on the door to Offender 1's cell. She yelled to Offender 1, "What are ya doing? What is going on and why are you acting this way?" "Don't ya like it on 3 Right?" Offender 1 had been progressed to 4 Right, so an

officer corrected her. Hearing no response, Complainant stated, "I can see you breathing."

66. Offender 1's chest was not rising and falling. He was not taking breaths.

67. Complainant then turned to the Correctional Officer and whispered, "I can't tell if he's breathing."

68. The officer responded to Complainant that Offender 1 was breathing earlier and had been breathing "raspy" all morning. She responded, "Okay."

69. Complainant then stated to Offender 1, "Open your eyes. Thanks."

70. Offender 1 did not open his eyes, and it was not possible for Complainant to see either of his eyes through the tray window on the cell door.

71. Complainant then stated, "Well, I don't know," then laughed and stated, "Isn't that terrible?"

72. Complainant then informed the Shift Commander that Offender 1 was "not doing anything to warrant" mental health intervention. She stated, "I don't see any need to do anything for him mental health wise."

73. Complainant then left the tray window and conversed with the Shift Commander and Correctional Officer for several minutes. They all laughed together during this exchange. She informed them that she would be on 4 East and available if they needed her, and then left to go to another unit of SCCF.

74. Complainant spent more time conversing with the Shift Commander and Correctional Officer than she spent with Offender 1.

75. Complainant did not review Offender 1's medical records or mental health history after departing from the Special Controls Intake Unit area.

76. Approximately twenty minutes later, Correctional Officers attempting to move Offender 1 discovered that he was dead.

DOC Mental Health Services Documentation Policy; Crisis Contacts; DAP Format

77. DOC Clinical Standard and Procedure for Mental Health On-Call requires that "Crisis Contact documentation must be completed on all offenders seen by the on-call mental health clinician."

78. The DOC Clinical Services Division policy entitled, "Clinical Standard and Procedure for Mental Health: Mental Health Services Documentation," defines the format to be utilized for Crisis Contacts. It requires, "The format to be used for a Crisis Contact will be the HELPER model format," which includes: A) History of psychiatric disorders, emotional dysregulation, suicide attempts, family history and views of suicide and suicide attempts; B) Environmental factors (demographics/environmental); C) Lethality of suicidal thinking and behavior; D) Psychological factors; E) Evaluation/assessment of suicide risk; and F) Reporting/plan (what will be done to address the risk).

79. This mental health documentation policy requires that all mental health assessments, including Crisis Contacts, be in the DAP format: Data, Assessment, and Plan. The DAP format defines Data to include objective information that can be seen or heard, "including a description of the interview, quotations or summaries of what was said, observations of appearance and behavior, as well as relevant history from the record, previous encounters, or information from staff. The Data section serves as the factual basis for the Assessment and Plan." The Assessment is the "subjective information that documents the clinical opinion of the professional writing the note. It includes diagnoses, concerns, progression or regression in treatment....The Assessment section should drive its conclusions from information documented in the Data section." The Plan "documents what the professional plans to do with the information obtained in the Data Section and the conclusions made in the Assessment section."

80. The Crisis Contact must include information on the "BPRS," or "brief psychiatric reporting scale." One of the elements of the BPRS is the level of consciousness of the inmate.

81. The only mental health documentation made by Complainant on Offender 1 was a "Clinical Note," as follows,

> "As MH on call, was contacted by the shift cmdr to assess inmate's MH status due to being placed on special controls. He hadn't been responding to staff over night and was taken to intake for special controls placement. Upon arrival, MH went to intake and attempted to get a verbal reply from the inmate. He was lying prone on the floor in full restraints. He wouldn't respond verbally and MH stated to officer Roman that she couldn't see him breathe. MH then asked him to open his eyes or blink. He slightly opened his left eye and took a very deep breath. MH advised the shift cmdr he wasn't a MH issue and could be taken back to 4R.
>
> Non responsive except for slightly opening his eye and taking a deep breath.
>
> Offender died shortly after this session."

82. Complainant did not make a Crisis Contact note for Offender 1.

Complainant's Contacts with Ms. Phillips

83. At approximately 10:15 AM on March 17, 2013, after Complainant learned of Offender 1's death, she called Robin Phillips, the Health Services Administrator at SCCF. Ms. Phillips had already spoken to the Shift Commander about Offender 1's death. Complainant asked Ms. Phillips if the video camera in Offender 1's cell had audio. Ms. Phillips stated that it did. Complainant responded, "Shit." Ms. Phillips discussed the fact that the Shift Commander had informed Phillips that Complainant had stated it looked like Offender 1 was not breathing. Ms. Phillips asked Complainant if she had contacted medical staff about her concern about Offender 1 not breathing. Complainant responded that she did not notify medical staff because she told Offender 1 to take a deep breath and he did take a deep, audible breath. Ms. Phillips asked if Offender 1 was taking continuous breaths, and Complainant stated, "It was probably his last

breath." Complainant informed Ms. Phillips that the Correctional Officer had said Offender 1 had been breathing in a raspy manner all day. Complainant also told Ms. Phillips that she had asked Offender 1 to open his eyes and he had done so.

84. On March 21, 2013, Complainant came to Ms. Phillips' office to discuss a scheduling issue. Complainant then closed Ms. Phillips' door and stated that she wanted to discuss the incident with Offender 1 on the previous Sunday. Complainant stated to Ms. Phillips, "I probably could have saved his life if I had notified someone." Ms. Phillips responded that Complainant had stated on March 17 that he was still breathing. Complainant responded, "I think he took his last breath when I was there."

Wasko Review of Offender 1's Death

85. During the hours after the death of Offender 1, DOC Executive Director Tom Clements directed Ms. Wasko to review the entire incident. Ms. Wasko began to review the incident immediately.

86. On March 19, 2013, Mr. Clements was murdered. Within two weeks, Toni Carochi, Interim Executive Director of DOC, delegated to Ms. Wasko the predisciplinary process for all staff involved in the death of Offender 1.

87. Ms. Wasko watched the video of Offender 1. She collected all written information in DOC's possession about Offender 1. She spoke with at least twelve staff at SCCF who were directly involved with Offender 1 in March 2013. She reviewed Complainant's personnel file.

88. Ms. Wasko knew Complainant as a skilled clinician, well versed in performing mental health assessments and writing appropriate reports. After watching the video of Offender 1 prior to Complainant's arrival and during her time with him, Ms. Wasko concluded that Complainant's violation of the mental health assessment regulations on March 17, 2013 was egregious and willful.

89. When Ms. Wasko reviewed Complainant's clinical note on Offender 1, Ms. Wasko concluded that Complainant had failed to comport with the Crisis Contact documentation requirements, and had created untruthful documentation to explain her failure to perform a complete and appropriate mental health assessment of Offender 1.

90. Ms. Wasko was very troubled by the fact Complainant had just taken the full CPR training one month prior to assessing Offender 1, and had nonetheless failed to notice that Offender 1 had no meaningful rises and falls of the chest during her presence there. She was also very concerned about all of the staff, including Complainant, having left Offender 1 prone on the floor in restraints, thereby subjecting him to the danger of positional asphyxiation.

April 16, 2013 Predisciplinary Meeting

91. On March 27, 2013, Ms. Wasko sent Complainant a notice of predisciplinary meeting and placed her on paid administrative leave. The letter informed Complainant that she could have a representative present at the meeting.

92. On April 16, 2013, Complainant, Ms. Wasko, and Randy Lind, Associate Warden at SCCF, attended the predisciplinary meeting. Complainant elected not to bring a representative to the meeting.

93. Early in the meeting, Complainant informed Ms. Wasko that she had "followed instructions of the shift commander as to the time to report to assess Offender 1." Complainant also informed Ms. Wasko that she saw Offender 1's right eye slightly opened, and observed him "take a deep loud breath after I had instructed him to respond. In light of these facts, and taking in the totality of the circumstances that I was aware of, I assessed that there was no mental health reason to keep him on special controls and informed the shift commander that he could be sent back to the unit."

94. Complainant also stated that the situation was unusual because she had been told that Offender 1 was not doing anything that indicated he was an imminent harm to himself or others.

95. Complainant explained that she did not use the Crisis Contact model for documenting her mental health assessment, "because he wasn't responding to me."

96. Ms. Wasko asked Complainant if, during her assessment, she noticed that something wasn't right with Offender 1. Complainant responded that she couldn't see him breathing. Ms. Wasko asked, "What assessment did you do? Did you assess his current mental status and condition?" Complainant responded, "No." Ms. Wasko asked Complainant several questions about whether she had assessed Offender 1's level of consciousness, BPRS, or reviewed his treatment plan or chart for previous behaviors, or had any verbal interactions. Complainant responded, "No."

97. Ms. Wasko asked Complainant if she had checked to see if Offender 1 had been medication compliant prior to March 17, 2013. Complainant responded that she was pretty sure she had asked staff, and, "They said he hadn't been taking them, but that he was supposedly given medication that morning." Complainant was unable to identify anyone she had spoken with.

98. Ms. Wasko showed Complainant the video tape of Offender 1 prior to and during Complainant's time with him in the Special Controls Intake Unit.

99. During the meeting, Complainant stated that there were two things she could have done differently: arrived at SCCF sooner, and requested "medical back up as soon as I didn't see him breathing. . . Two things. And I could maybe have saved his life." Ms. Wasko asked, "So you're telling me, Cheryl, that you did not see him breathing?" Complainant responded, "Yes, I'm telling you that. I could not see any rise or fall, I couldn't see any of that, and that's when I became concerned, and that's when I instructed him further, you know, to do something. And what I saw him do, and I stick by this, is that I – his right eye barely opened, and he took that weird breath, you know, deep, loud breath. I saw those two things happen."

100. Later in the meeting, Complainant stated, "I did have that gut feeling that I needed to get somebody in there, and I don't know why I didn't follow up on it. I have no idea."

101. Ms. Wasko stated during the meeting, "I think we can agree a mental health assessment was not conducted." Complainant responded, "Correct."

102. At the close of the meeting, Ms. Wasko asked Complainant if there was anyone she wanted Ms. Wasko to speak with, anything else she wanted her to know. Complainant did not provide additional information.

Termination Decision

103. Ms. Wasko terminated the employment of both nurses who had contact with Offender 1 on March 17, 2013.

104. Ms. Wasko gave consideration to options other than termination for Complainant. However, she concluded that Complainant's violation of the mental health assessment and documentation regulations was willful and egregious. She also determined that previous corrective and disciplinary actions imposed on Complainant, as well as the February 2013 memorandum of agreement regarding mental health assessment documentation, had not resulted in Complainant adhering to DOC regulations. Therefore, giving Complainant another chance to improve was not warranted. Ms. Wasko also considered that as a supervisor responsible for modeling best practices and enforcing the standards of care she violated, Complainant had no excuse for her conduct on March 17, 2013.

105. Ms. Wasko viewed the events of March 17, 2013 as a continuation of Complainant's pattern of willfully violating DOC's regulations and Code of Conduct. She concluded that Complainant had repeatedly lied about seeing Offender 1 open an eye and take a deep, loud breath. Ms. Wasko felt she could no longer trust Complainant as an employee of DOC.

106. On May 3, 2013, Ms. Wasko hand delivered a letter to Complainant terminating her employment at DOC. The letter concluded that Complainant had violated the DOC Code of Conduct in the following ways: failing to treat Offender 1 professionally; failing to perform effectively and efficiently, casting doubt on her integrity and exercising poor judgment; willfully departing from the truth about the events of March 17, 2013 in her documentation of the mental health assessment; and bringing disrepute and discredit upon DOC.

107. The letter also cited Complainant for violating AR 700-29, Mental Health Watches, and the Clinical Standard and Procedure for Mental Health: Mental Health Services Documentation, Crisis contacts, as demonstrated by her documentation, which failed to include most of the required information set forth in Subsection (IV)(G). Ms. Wasko also found Complainant had violated the Clinical Standard and Procedure for Mental Health: Mental Health On-Call, for having failed to report to SCCF within one hour of the 7:30 AM page.

108. The letter noted that Ms. Wasko had considered several factors in making her decision, including: her 14-year employment with DOC; her performance evaluations for the last year had been satisfactory with areas of needs improvement; Complainant was currently under the sanctions of a disciplinary action for violating the Code of Conduct and Computer Security, Access and Usage policies; she had received corrective action; Complainant's inconsistent documentation and statements regarding whether Offender 1 was breathing or not and whether he opened his eye or eyes; her failure to advocate for the physical or mental well being of the offender while he was in her care and to respond

to her own observation that she could not tell if he was breathing or not; and her failure to take appropriate responsibility for her actions during the predisciplinary meeting.

109. Complainant timely appealed her termination.

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. XII, § 13(8); § 24-50-125, 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*. The Board may reverse or modify Respondent's decision if the action is found to be arbitrary, capricious or contrary to rule or law. § 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 and omissions upon which discipline was based. Complainant violated AR 700-29 by failing to arrive at SCCF within one hour of the call from the Shift Commander. She lived fifteen minutes away from SCCF and provided no explanation for taking one hour and forty-five minutes to report for duty. If Complainant had arrived within one hour, at approximately 8:30 a.m., Offender 1 would have been alive at the time of her assessment.

With regard to the sole purpose for which she was called to SCCF, Complainant failed to conduct a mental health assessment of Offender 1. The first, and foundational, component of a mental health assessment is the Data phase. Complainant obtained almost no data about Offender 1. She knew he had been transferred out of solitary confinement two days previously and that he had been nonresponsive to the Correctional Officers. She knew nothing about his diagnoses, his medications, his treatment plan, his behavior since release from solitary confinement, and his medical status. And, she took no steps to learn this information prior to or after her contact with him. Had she obtained this vital information, she would have known that

Offender 1 had had a smooth transition out of solitary confinement, that he had been compliant with all medications, and that he had not engaged in any previous passive-aggressive conduct in response to directives from prison staff. The sudden, dramatic change in Offender 1's behavior would have been red flag for Complainant to explore.

The first element of data collection in a mental health assessment is the face to face assessment of the offender. By definition, a face to face contact requires interaction between the caregiver and the patient. Complainant was on the other side of the door from Offender 1's cell. Offender 1 was prone on the floor, with his face pressed into the floor a few inches from the toilet. He never responded to Complainant. Complainant therefore needed to take additional steps to engage him directly. Because the offender posed no security concern, Complainant should have asked the Correctional Officer and Shift Commander present to escort her into Offender 1's cell, sit him up, and try to converse with him. Instead, Complainant talked at the offender through the door, ignored the signs that he was not conscious, and departed.

Having failed to obtain critical background information on Offender 1 or to determine the reason for his behavior of lying unresponsive on the floor, Complainant possessed no Data. With no Data, Complainant was unable to make an Assessment, the second component of the mental health evaluation. Lastly, she generated no Plan. She simply informed the correctional staff that Offender 1 could be released from Special Controls.

Complainant's violation of the mental health assessment standards set forth in AR 700-29 IV(G) was knowing, willful, and egregious. As the supervising mental health clinician at SCCF, Complainant was the resident expert in mental health assessments and was responsible for holding those under her supervision accountable to that regulation. Her misconduct was flagrant and serious.

Complainant's documentation of her contact with Offender 1 reflected the absence of an appropriate mental health evaluation of Offender 1, in violation of the governing mental health on call and documentation regulations. It also contained statements she knew to be false, suggesting that Offender 1 had in fact responded to her.

In summary, the preponderance of evidence demonstrates that Complainant violated the regulations cited in the termination letter.

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).

Complainant argues that Respondent's decision was arbitrary and capricious because Ms. Wasko held her accountable for the failures of the nursing staff who preceded her on March 17, 2013. This argument is unavailing. Ms. Wasko held each individual DOC employee

accountable for his or her separate role in the death of Offender 1. She appropriately evaluated Complainant solely on the basis of her own employment history, the regulations that governed her conduct as a mental health clinician, and Complainant's own acts and omissions on March 17, 2013.

Complainant's argument that she is somehow being unfairly targeted or skapegoated for the death of an inmate in DOC custody ignores her own repeated, willful breach of DOC regulations. One month prior to the incident with Offender 1, Complainant had received an all-day refresher course in CPR, reminding her to always look for a meaningful rise and fall of the chest for thirty to sixty seconds. This training should have been fresh in her mind on March 17, 2013. Complainant utterly failed to implement this training on March 17, 2013, because she was not focused on Offender 1. Instead, she spent more time talking with the correctional staff than she did assessing Offender 1.

Additionally, one month prior to March 17, 2013, Complainant had signed an agreement with her supervisor to timely comply with all mental health assessment documentation requirements. The DAP documentation requirements drive the assessment process – they reflect precisely the information the clinician must gather during the assessment. Complainant's failure to conduct a thorough assessment of Offender 1 is an indication of her intent to ignore the DAP format when later recording her deficient mental health evaluation of Offender 1. Thus, despite her signature on the agreement with her supervisor, Complainant failed to take the agreement seriously.

In summary, Complainant's conduct on March 17, 2013, starting at 7:30 AM and ending with her deficient, erroneous documentation, evinces a complete lack of accountability to Offender 1, to DOC, and to herself as a professional. Complainant was not held accountable for others' failures.

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

Respondent had a number of options available when determining what action to impose in this case. It could have demoted Complainant to a non-supervisory position. However, Complainant repeatedly violated agreements she made with DOC to comply with the regulations governing her employment. A corrective action, a disciplinary action, a transfer, and a memo of agreement with her supervisor, did not spur Complainant to elevate her performance to an acceptable level. Progressive discipline had failed. Therefore, termination was well within the range of reasonable alternatives.

Complainant requested an award of attorney fees and costs. Because she did not prevail in her appeal, no such award is appropriate.

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.

[redacted]

Dated this 14th day of November, **2013.**

Mary McClatchey
Senior Administrative Law Judge
State Personnel Board
633 17th Street, Suite 1320
Denver, CO 80202-3604

CERTIFICATE OF MAILING

This is to certify that on the 14th day of November **2013**, I electronically served a true copy of the foregoing **INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE and NOTICE OF APPEAL RIGHTS**, as follows:

Andrew M. Newcomb Esq.
[redacted]

Sabrina Jensen A.A.G.
Davin Dahl, 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 8-62, 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 8-65, 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 8-63, 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 8-64, 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 8-67, 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 8-70, 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 8-60, 4 CCR 801.