STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. **2023B023**

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

CHRISTINE MENDIAS,
Complainant,

v.

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

Senior Administrative Law Judge (ALJ) Susan J. Tyburski held the evidentiary hearing via web conference on July 25, 26 and 27, 2023. The record was closed on August 18, 2023 after receipt of post-hearing submissions from the parties.

Throughout the hearing, Complainant and her attorney, Mark Schwane, Esq., appeared via Google Meet. Respondent appeared through its attorneys, Assistant Attorney General Carlos Ramirez, Esq., and Senior Assistant Attorney General Jacob W. Paul, Esq., via Google Meet. Respondent's advisory witness was Appointing Authority Brian Gonzales.

A list of exhibits admitted into evidence and a list of witnesses who testified at hearing are attached in an Appendix.

MATTER APPEALED

Complainant, a certified employee, appeals her disciplinary demotion by Respondent, alleging retaliation in violation of the State Employee Protection Act (Whistleblower Act), § 24-50.5-101, *et seq*., C.R.S. Complainant argues that she did not commit the alleged misconduct for which she was disciplined, and that Respondent's disciplinary action was arbitrary, capricious, and contrary to rule and law.

Respondent denies Complainant's claims and alleges that Complainant committed the misconduct for which she was disciplined. Respondent argues that its disciplinary action was not arbitrary, capricious, or contrary to rule or law. Respondent denies that it retaliated against Complainant in violation of the Whistleblower Act.

For the reasons discussed below, Respondent's decision to demote Complainant is **reversed.**

ISSUES TO BE DETERMINED

1.) Did Complainant commit the misconduct for which she was disciplined?

2.) Was Respondent's disciplinary action arbitrary or capricious?

3.) Was Respondent's disciplinary action contrary to rule or law?

4.) Did Respondent retaliate against Complainant in violation of the Whistleblower Act?

5.) What is the appropriate remedy?

FINDINGS OF FACT

Background

1. Complainant was employed as a Mental Health Clinician II at the Department of Human Services (DHS), Colorado Mental Health Institute at Pueblo (CMHIP), from 2018 to November 5, 2022. (Stipulated)

2. Complainant worked in the Community Re-Entry Unit (CRU) in the Psychosocial Program at CMHIP. (Stipulated)

3. CRU is a medium/minimum security facility focusing on community integration. Respondent admits patients from judicial, state mental health, and other community facilities for long- and short-term treatment under court authority, as well as transfers from within CMHIP.

4. As a Mental Health Clinician II, Complainant's job duties included running groups for patients, having one-on-one meetings with patients, monitoring patients, training staff, and supervising patients who had jobs. (Stipulated)

5. Complainant also served as an Information Technology (IT) supervisor for the CRU.

6. A Mental Health Clinician II is a non-nursing position.

7. Complainant holds a Master's degree in Sociology and, as an adjunct instructor, teaches courses at Colorado State University.

8. Complainant received consistently Satisfactory ratings on her annual performance evaluations in 2019, 2020, 2021 and 2022.

9. On July 15, 2021, Complainant received a corrective action for "not following proper chain of command, not notifying [her] charge nurse when leaving the unit, treating others with dignity and respect, making unsubstantiated allegations possibly leading to harming the reputation of others, assigning blame, lack of accountability, and reluctant [sic] to follow directions."

10. At all relevant times, Complainant's immediate supervisor was Cynthia Howard, Registered Nurse (R.N.) II.

11. At all relevant times, Complainant's second level supervisor was Carla Carriere, R.N. III.

12. At all relevant times, Complainant's third line supervisor was Lead Nurse Tiffany Greenfield, R.N. IV.

13. At all relevant times, Complainant's Appointing Authority was CMHIP Psycho-Social Program Chief Nurse Brian Gonzales.

Patient Advocacy

14. Complainant's job description indicates that a Mental Health Clinician II "[c]onsistently acts as a patient advocate."

15. From her job description, Complainant understood that patient safety was "number one."

16. In Complainant's October 14, 2020 mid-year performance evaluation, Manager Christine Barun noted: "Christine communicates her concerns to Lead Nurse. She treats clients respectfully. She leads a group and is able to communicate effectively with clients, acting as their advocate."

17. In Complainant's April 1, 2021 annual performance evaluation, Manager Glenn Buckallew gave Complainant an Outstanding rating for Customer Service, commenting: "[Complainant] prides herself when it comes to patient care and their concerns."

18. In Complainant's April 1, 2022 annual performance evaluation, Lead Nurse Greenfield commented that Complainant "provides accurate, consistent and honest information to the patients. Is able to meet the needs of the patient in a timely manner and anticipates future needs of the patient. She listens to the patient and is able to understand the patient from their own point of view."

19. Paragraph III(C)(25) of the CMHIP Code of Conduct 30.10 instructs employees that they "will NOT … Fail to enforce and/or report another staff member who is not following policies, procedures, guidelines, and addenda."

July 5, 2022 Medical Incident

20. On July 5, 2022, Patient[1] suffered an acute hypoxic respiratory failure and cardiac arrest in the CRU. Patient was transported to a local emergency room where Patient died on July 8, 2022. (Stipulated)

21. Complainant was not present on the CRU at the time of Patient's medical incident. (Stipulated)

22. When Complainant reported to work on July 6 or 7, 2022, several patients told Complainant about what happened to Patient.

23. One of the patients told Complainant that he watched the medical incident involving Patient through a window in the door of his room. This patient told Complainant that Patient came out of his room and collapsed. Nurse M.P.[2] was on duty. When Nurse M.P.

[1] To protect patient privacy, the key patient involved in this appeal shall be referred to simply as "Patient."

[2] Because the identity of this nurse is not essential to the determinations made in this Initial Decision, initials are used to protect the nurse's privacy.

approached Patient, she froze and took no action. Other staff eventually attempted to aid Patient and called an ambulance.

24. Several patients expressed their concerns about the medical incident involving Patient to Complainant, and stated that they did not feel safe under Nurse M.P.'s care. These patients told Complainant that Nurse M.P. killed Patient.

25. On July 7, 2022, Complainant sent the following email to Lead Nurse Tiffany Greenfield: "Can we look into having a group (Trauma) for the patients on the north side. They experienced a very traumatic experience, listening to the code, people and a loss."

September 2, 2022 Nursing Staff Meeting

26. On September 2, 2022, Complainant participated in a meeting with nursing staff where she brought up patient concerns about trauma and safety. (Stipulated)

27. The meeting was held in the day hall of the south wing of the CRU. The day hall was cleared of patients for the meeting, and patients were unable to hear what was said in the meeting.

28. Chief Nurse Gonzales was not present at the September 2, 2022 nursing staff meeting.

29. During the meeting, Complainant told Lead Nurse Greenfield that some patients were "not feeling safe" because they believed that Nurse M.P., who was still working on the unit, was responsible for the Patient's death.

30. During the meeting, Nurse Howard asked Complainant, "Haven't you ever made a big mistake?" and Complainant replied "yes, but I haven't killed anyone."

31. Nurse M.P. was not present in the meeting.

32. Lead Nurse Greenfield requested the names of the patients who expressed concerns about safety. Complainant provided the patients' names to Nurse Greenfield.

33. After the meeting, Lead Nurse Greenfield informed Chief Nurse Gonzales of Complainant's comments.

First Rule 6-10 Meeting

34. On September 8, 2022, Complainant received an email from Chief Nurse Gonzales, which told Complainant that he would be scheduling a meeting pursuant to Board Rule 6-10 with Complainant. (Stipulated)

35. The Notice of Rule 6-10 Meeting described Complainant's potential misconduct as "failing to treat others with respect and making unsubstantiated allegations possibly leading to harming the reputation of others, and assigning blame."

36. On September 20, 2022, Chief Nurse Gonzales held a meeting, pursuant to Board Rule 6-10, with Complainant. (Stipulated)

37. During the Rule 6-10 meeting, Chief Nurse Gonzales questioned Complainant about the statements she made during the September 2, 2022 nursing staff meeting.

Nursing Board Complaint

38. On September 8, 2022, Complainant filed a complaint with the Colorado State Nursing Board concerning Nurse M.P., related to Nurse M.P.'s response to Patient's medical emergency on July 5, 2022. (Stipulated)

39. Complainant filed the Nursing Board complaint because she did not believe that the patients' concerns about Nurse M.P. were being addressed by Respondent.

40. Complainant's Nursing Board complaint stated:

> A patient, struggling to breathe came out of [their] room, collapsed on the floor, [Nurse M.P.] RN, who was in charge came over to the patient and stated, "I don't know what to do". NO CODE WAS CALLED, The code cart was not retrieved and CPR was not started for 20 minutes. Patient was brain dead when they reached the hospital.

41. Complainant's description of the medical incident involving Patient and Nurse M.P. was based on what other patients who observed the incident told her.

42. Sometime in September 2022, Nurse M.P. received a copy of Complainant's Nursing Board complaint, and shared it with Lead Nurse Greenfield.

43. Lead Nurse Greenfield shared Complainant's Nursing Board complaint with Chief Nurse Gonzales.

44. After reviewing a copy of Complainant's Nursing Board complaint, Chief Nurse Gonzales filed a complaint concerning Nurse M.P. with the Nursing Board on September 27, 2022.

45. Chief Nurse Gonzales' job responsibilities include filing a Nursing Board complaint if he finds that someone is struggling or having a difficult time demonstrating that they are providing appropriate care to patients within their scope of practice.

46. Chief Nurse Gonzales' Nursing Board complaint stated:

> After an incident review and speaking with [Nurse M.P.] it was identified that [they] needed additional training in code 0 drills and medical emergencies. Since this training need was identified, [Nurse M.P.] has not been allowed to work on a unit without having another RN work along side of [them]. [Nurse M.P.] received additional training on code O drills, CPR, and medical emergency on 7/15/22, 7/19/22, 7/20/22, 7/21/22, 8/14/22, 8/29/22, 8/30/22, 9/5/22, and 9/6/22. On 9/27/22 a code O drill was initiated to evaluate [Nurse M.P.]'s ability to perform after all of the additional training. During this drill [Nurse M.P.] failed to, 1.Verify scene safe. 2. Tap the dummy to identify if they are responsive or not. 3. Verify if anyone called a code 0 to telecom. 4. Complete a full assessment of the patient. 5. Verify that the day hall was cleared from patients and wellness was continuing.

> 6. Initiate C-spine precautions. 7. Assess medical hx. 8. Assign someone to document. 9. Debrief with the team after the code. In order to keep patients safe, the employee will continue to not practice without the supervision of another RN or left alone with patients without supervision of another RN, while we go through the progressive discipline process.

47. On April 4, 2023, the Nursing Board issued a Stipulation and Final Agency Order concerning Nurse M.P. In this Stipulation and Final Agency Order, Nurse M.P. admits the following:

> On or about July 2, 2022, a patient suffered a medical emergency. [Nurse M.P.] failed to respond appropriately to the emergency and did not immediately call a Code Zero or Medical Emergency. [Nurse M.P.] also failed to appropriately care for the patient while waiting for outside emergency personnel.

48. In its Stipulation and Final Agency Order, the Nursing Board found the following "Grounds for discipline" applied to Nurse M.P.'s actions, pursuant to § 12-255-120, C.R.S.:

> (c) Has acted in a manner inconsistent with the health or safety of persons under his or her care;
>
> (f) Has practiced nursing in a manner that fails to meet generally accepted standards for the nursing practice.

Second Rule 6-10 Meeting

49. On October 11, 2022, Chief Nurse Gonzales reconvened the Rule 6-10 meeting to discuss the Nursing Board complaint filed by Complainant concerning Nurse M.P., and to further discuss the information and issues addressed in the first Rule 6-10 meeting.

50. During the reconvened Rule 6-10 meeting, Chief Nurse Gonzales confronted Complainant with her Nursing Board complaint concerning Nurse M.P. Chief Nurse Gonzales asked numerous questions about why Complainant filed this complaint and about the statements contained in this complaint.

Chief Nurse Gonzales' Disciplinary Action

51. On October 24, 2022, Chief Nurse Gonzales issued a disciplinary action to Complainant demoting her to a Client Care Aide (CCA) II. (Stipulated)

52. In the Notice of Disciplinary Action, Chief Nurse Gonzales described two statements Complainant reportedly made during the September 2, 2022 nursing staff meeting: "[Nurse M.P.] killed [Patient]" and "Nurse II Cynthia Howard asked you if you had ever made a mistake and you responded to her saying that you never killed anyone like [Nurse M.P.] did."

53. In the Notice of Disciplinary Action, Chief Nurse Gonzales also described the allegations Complainant made in her Nursing Board complaint concerning Nurse M.P.'s failure to assist Patient during the medical incident on July 5, 2022.

54. In the Notice of Disciplinary Action, Chief Nurse Gonzales concluded that Complainant "acted inappropriately and violated CDHS Code of Conduct and CMHIP Code of Conduct 30.10." Chief Nurse Gonzales did not identify what specific provisions of these Codes of Conduct he concluded Complainant violated.

55. In the Notice of Disciplinary Action, Chief Nurse Gonzales explained: "I arrived at my decision because the behaviors you demonstrated and policies you violated, creates [sic] a negative impact on co-workers and patients while working here at CMHIP."

56. Complainant's demotion was effective November 5, 2022. Complainant was assigned to the Geriatric Unit supervised by Dave Poelhein, RN III.

57. Complainant's new duties as a CCA II involved assisting patients with daily physical care, including helping patients with toileting and showering, brushing patients' teeth or dentures, and cleaning patients and their beds when they soiled themselves.

58. Complainant was not trained to provide these physical care services to patients.

59. On October 28, 2022, Complainant filed a timely appeal of the Disciplinary Action with the State Personnel Board.

Chief Nurse Gonzales' Post-Discipline Comments About Complainant

60. During a supervision meeting on November 1, 2022, Chief Nurse Gonzales made the following comments about Complainant to Nurse Poelhein: "Watch out for her. She will report you. She is looking to report people." Chief Nurse Gonzales learned that Complainant was "fighting" her demotion and commented: "They better fucking dismiss it. There's nothing there."

61. During a supervision meeting on November 22, 2022, Chief Nurse Gonzales made the following comments about Complainant to Nurse Poelhein: "Oh, she's a fucking bitch. I hate her."

Complainant's Earnings

62. Prior to her demotion on November 5, 2022, Complainant was earning $25.73 per hour.

63. After her demotion, effective November 5, 2022, Complainant was earning $18.85 per hour.

64. Both before and after her demotion, Complainant worked full time, or 40 hours per week.

65. Complainant resigned from her position with Respondent effective April 24, 2023. (Stipulated)

ANALYSIS

A. RESPONDENT'S BURDEN OF PROOF TO ESTABLISH GROUNDS FOR DISCIPLINE

The Colorado Constitution guarantees that certified state employees "shall hold their respective positions during efficient service." Colo. Const. Art. XII, § 13(8). A certified state employee may be disciplined "only for just cause based on constitutionally specified criteria." *Dep't of Institutions v. Kinchen*, 886 P.2d 700, 707 (Colo. 1994).

Section 13(8) lists the following specific criteria upon which discipline may be based:

> … written findings of failure to comply with standards of efficient service or competence, or for willful misconduct, willful failure or inability to perform his duties, or final conviction of a felony or any other offense which involves moral turpitude, or written charges thereof may be filed by any person with the Appointing Authority, which shall be promptly determined.

Colo. Const. Art. XII, § 13(8).

The Colorado Supreme Court has clarified certified employees' rights in two crucial decisions. In *Kinchen*, the Supreme Court held that Respondent has the burden to prove by a preponderance of the evidence that the alleged misconduct on which the discipline was based occurred in a *de novo* hearing. *Kinchen*, 886 P.2d at 706-708. In disciplining an employee, an Appointing Authority must establish a constitutionally authorized ground. *Id.* at 707. The ALJ is required to make "an independent finding of whether the evidence presented justifies a [disciplinary action] for cause." *Id.* at 706. The Colorado Supreme Court explained that, in attempting to justify a decision to discipline a certified public employee, this burden of proof is appropriate because "the Appointing Authority is the party attempting to overcome the presumption of satisfactory service" by the employee. *Id*. at 708.

More recently, the Colorado Supreme Court clarified the two-part inquiry required in an ALJ's review of a disciplinary action:

> [I]n reviewing an Appointing Authority's disciplinary action, the ALJ must logically focus on two analytical inquiries: (1) whether the alleged misconduct occurred; and if it did, (2) whether the Appointing Authority's disciplinary action in response to that misconduct was arbitrary, capricious, or contrary to rule or law.

Dep't of Corrections v. Stiles, 477 P.3d 709, 717 (Colo. 2020). The Colorado Supreme Court explained that the second analytical inquiry is necessary if the Appointing Authority establishes that the conduct on which the discipline is based occurred:

> If the Appointing Authority establishes by a preponderance of the evidence that the alleged misconduct occurred, the Board or the ALJ must turn to the second analytical inquiry. At that stage, the Board or the ALJ must review the Appointing Authority's decision in accordance with the statutorily mandated standard of arbitrary, capricious, or contrary to rule or law.

Id. at 718. *See also* § 24-50-103(6), C.R.S.

B. RESPONDENT FAILED TO ESTABLISH THAT COMPLAINANT COMMITTED THE MISCONDUCT FOR WHICH SHE WAS DISCIPLINED.

In his Notice of Disciplinary Action, Chief Nurse Gonzales concluded that Complainant "acted inappropriately and violated CDHS Code of Conduct and CMHIP Code of Conduct 30.10." Chief Nurse Gonzales did not identify what specific provisions of these Codes of Conduct Complainant violated.

During the evidentiary hearing, Chief Nurse Gonzales explained that his conclusion that Complainant violated the CDHS Code of Conduct and CMHIP Code of Conduct 30.10 was based on two statements Complainant made during the September 2, 2022 nursing staff meeting: (1) "[Nurse M.P.] killed [Patient]," and (2) in reference to Nurse M.P., "At least I didn't kill anyone." Chief Nurse Gonzales was not present at the September 2, 2022 nursing staff meeting. Chief Nurse Gonzales testified that he reached this conclusion after reviewing all the available witness reports concerning the September 2, 2022 nursing staff meeting.

The witness reports describe different versions of Complainant's statements during the September 2, 2022 nursing staff meeting. In her written report, Nurse Carriere stated that Complainant said, "the patients are scared and worried since a certain staff member still works here. They are afraid to have [Nurse M.P.] work here since she killed [Patient]."

In another written report, Nurse Howard said that Complainant "stated that several of our patients were upset because they had seen staff member [Nurse M.P.] working on the unit. [Complainant] stated that these patients asked her why M.P. is on this unit after what she had done to [Patient]. [Complainant] also stated that these patients have stated to her that they were fearful with having M.P. one [sic] this unit."

Chief Nurse Gonzales interviewed Nurse Dawn Genzler about the September 2, 2022 meeting. Chief Nurse Gonzales' written description of this interview indicates that he asked Nurse Genzler whether Complainant's statements about [Nurse M.P.] during that meeting were appropriate. Nurse Genzler replied that Complainant "had to say it because a patient reported it." Nurse Genzler also told Chief Nurse Gonzales: "I don't get why [Nurse M.P.] is on the unit."

During the hearing, several witnesses who were present at the September 2, 2022 meeting described Complainant's comments. Nurse Carriere testified that she was "shocked" by Complainant's suggestion that Nurse M.P. was to blame for Patient's death. However, Nurse Genzler testified that "it was clear that," in making statements concerning Nurse M.P., Complainant "was speaking on behalf of the patients" who witnessed the medical emergency involving Patient. Like the patients who were raising concerns, Nurse Genzler testified that she did not understand why Nurse M.P. was still on the unit after the way she acted during the medical emergency involving Patient, and that it was upsetting to see Nurse M.P. there. Similarly, Nurse Carriere testified that Nurse M.P. "was a risk to continue to practice on the unit" because of her inability to handle a Code Zero incident. Nurse Howard testified that, in addition to the patients, a number of the staff members were upset about Nurse M.P.'s failure to act during the medical emergency involving Patient and would discuss it on the unit – not always discretely.

Considered as a whole, the witness statements support Complainant's testimony that, in stating that Nurse M.P. was responsible for Patient's death, she was reporting what the other patients on the unit were telling her.

As for Complainant's second statement, Nurse Howard reported that she asked Complainant, "Haven't you ever made a big mistake?" and Complainant replied "yes, but I haven't killed anyone." Complainant admitted making this statement in response to Nurse Howard.

The preponderance of the evidence establishes that Complainant, while relaying patients' concerns during a September 2, 2022 nursing staff meeting, made a statement suggesting that Nurse M.P. was responsible for Patient's death. While Complainant may not have used the best choice of words to convey the patients' concerns, the Nursing Board ultimately found that the patients' concerns about Nurse M.P.'s inability to appropriately respond to a medical emergency were justified. On April 4, 2023, the Nursing Board issued a Stipulation and Final Agency Order concerning Nurse M.P. The Nursing Board concluded that, in failing to respond appropriately to the emergency involving Patient, Nurse M.P. "acted in a manner inconsistent with the health or safety of persons under his or her care," pursuant to § 12-255-120(c), C.R.S.

In raising patients' concerns about Nurse M.P., Complainant was acting as an advocate on behalf of her patients. Paragraph III(C)(25) of the CMHIP Code of Conduct 30.10 instructs employees that they "will NOT … Fail to enforce and/or report another staff member who is not following policies, procedures, guidelines, and addenda." In her annual performance evaluations in 2021 and 2022, Complainant was consistently commended for listening to, and anticipating, patients' needs and concerns. In Complainant's October 14, 2020 mid-year performance evaluation, Complainant was specifically commended for acting as an advocate for patients and reporting their concerns to the Lead Nurse.

The preponderance of the evidence establishes that, in relaying patients' concerns about Nurse M.P.'s inadequate response to the July 5, 2022 medical emergency involving Patient, Complainant did not act inappropriately or violate the CDHS Code of Conduct and CMHIP Code of Conduct 30.10.

C. RESPONDENT'S DISCIPLINARY ACTION WAS ARBITRARY AND CAPRICIOUS.

Even if Respondent had established that Complainant somehow violated the CDHS Code of Conduct and CMHIP Code of Conduct 30.10, Chief Nurse Gonzales' decision to demote Complainant from a Mental Health Clinician II to a CCA II was arbitrary and capricious.

In determining whether an agency's decision is arbitrary or capricious, the ALJ 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 persons fairly and honestly considering the evidence must reach contrary conclusions. *Lawley v. Dep't of Higher Educ.,* 36 P.3d 1239, 1252 (Colo. 2001).

In reaching the decision to discipline Complainant, Chief Nurse Gonzales failed to give candid and honest consideration of the evidence before him on which he was authorized to act in exercising his discretion. As discussed above, Chief Nurse Gonzales was not present at the September 2, 2022 nursing staff meeting. The witness reports obtained by Chief Nurse Gonzales describe different versions of Complainant's statements during that meeting, as well as concerns other nurses had about Nurse M.P. following the medical incident involving Patient. During the Rule 6-10 discussions, Complainant repeatedly stated that she was reporting what the patients

who witnessed the medical incident involving Patient and Nurse M.P. told her. Chief Nurse Gonzales testified that he did not believe Complainant's explanation and discounted the witness statements that supported Complainant's explanation.

In addition to failing to give candid and honest consideration of the available evidence, Chief Nurse Gonzales imposed a penalty that was not commensurate with Complainant's alleged misconduct. Demoting Complainant from a Mental Health Clinician II to a CCA II – a completely different classification from the classification for which Complainant was educated and hired – was an extremely punitive action. Complainant holds a Master's degree in Sociology and, as an adjunct instructor, teaches courses at Colorado State University. Complainant not only suffered a more than 25% reduction in pay, she was transferred to a position in which she could no longer use her education and mental health skills. Instead, Complainant was required to assist patients with their daily physical care needs, helping patients with toileting and showering, brushing patients' teeth or dentures, and cleaning patients and their beds when they soiled themselves.

Chief Nurse Gonzales' punitive action, in and of itself, smacks of retaliation. The preponderance of the evidence establishes that reasonable persons fairly and honestly considering the evidence must reach a contrary conclusion concerning the appropriate discipline – i.e., that a demotion from a Mental Health Clinician II to a CCA II was not justified by Complainant's comments during the September 2, 2022 meeting.

D. RESPONDENT'S DISCIPLINARY ACTION VIOLATED BOARD RULES.

During the evidentiary hearing, Chief Nurse Gonzales testified that the reason he decided to demote Complainant to a CCA II was his conclusion that Complainant was not providing necessary care to patients. Chief Nurse Gonzales based this conclusion solely on the absence of chart notes concerning the care Complainant provided to patients.

Neither of the Rule 6-10 Meeting Notices issued by Chief Nurse Gonzales identify Complainant's insufficient care for her patients as a source of potential corrective or disciplinary action. Chief Nurse Gonzales did not question Complainant, or conduct any investigation, concerning Complainant's care of her assigned patients. In its closing arguments, Respondent does not mention this testimony and has apparently abandoned this rationale for Chief Nurse Gonzales' decision to demote Complainant. Nevertheless, Chief Nurse Gonzales' testimony about this apparent reason for his decision to demote Complainant to a CCA II indicates that he disciplined Complainant for reasons other than, or in addition to, the ones identified in his Rule 6-10 Meeting Notices and his Notice of Disciplinary Action.

Board Rule 6-9 requires an appointing authority to provide Notice of a Rule 6-10 Meeting to an employee "at least seven (7) days prior to the meeting." Board Rule 6-9 further requires: "The notice shall inform the employee of the alleged performance issues or conduct that may result in discipline."

Board Rule 6-10(C) provides, in pertinent part: "When considering discipline, the appointing authority shall meet with the employee before making a final decision…" Board Rule 6-10(D) requires the appointing authority to:

1. Disclose the alleged performance issues or conduct that may result in discipline;

2. Disclose the source of the information about the alleged performance issues

or conduct (unless prohibited by law); and

3. Give the employee an opportunity to respond to the alleged performance issues or conduct.

Board Rule 6-10(H) further provides: "The employee shall be allowed at least seven (7) days after the Rule 6-10 meeting to provide the appointing authority any additional information relating to the subjects discussed during the meeting." Board Rule 6-10(I) requires the appointing authority to "consider all the information discussed during the Rule 6-10 meeting and any additional information provided by the employee." Finally, Board Rule 6-13(A)(1) requires an appointing authority issuing discipline to "provide a written Disciplinary Letter to the employee that includes … [t]he factual basis and specific reasons for the discipline."

Because Chief Nurse Gonzales' decision to demote Complainant to a CCA II was based on a reason he failed to identify or investigate during the Rule 6-10 process, Chief Nurse Gonzales' disciplinary action violated Board Rules 6-9, 6-10 and 6-13.

E. RESPONDENT RETALIATED AGAINST COMPLAINANT IN VIOLATION OF THE WHISTLEBLOWER ACT.

The Colorado State Personnel Board has jurisdiction over appeals alleging violations of the Whistleblower Act. § 24-50.5-104, C.R.S. and Board Rule 8-24.

The Whistleblower Act protects state employees from retaliation when an employee discloses actions by state agencies that are not in the public interest. *See* § 24-50.5-101(1), C.R.S. and § 24-50.5-103, C.R.S. The Board may use its discretion to set whistleblower complaints for hearing under § 24-50.5-104(1), C.R.S. In order to establish a *prima facie* case of whistleblower retaliation, Complainant must establish (1) that she disclosed information to Respondent pertaining to a matter of public interest, (2) that she was disciplined as defined by the Whistleblower Act, and (3) that the disciplinary action occurred on account of the disclosure of information. *See* § 24-50.5-103(1), C.R.S.; *Ward v. Indus. Comm'n*, 699 P.2d 960, 966-68 (Colo. 1985).

1. Complainant's *Prima Facie* Case

To establish a *prima facie* case of whistleblower retaliation, Complainant must first demonstrate that she made a disclosure of information protected by the Whistleblower Act. The Whistleblower Act defines "disclosure of information" as "the written provision of evidence to any person...regarding any action, policy, regulation, practice, or procedure, including, but not limited to, the waste of public funds, abuse of authority, or mismanagement of any state agency." § 24-50.5-102(2), C.R.S. Disclosures may be presented in writing or offered orally. *Ward*, 699 P.2d at 967.

The Whistleblower Act protects state employees from retaliation by their appointing authorities or supervisors because of the disclosure of information about state agency actions that include, but are not limited to, the waste of public funds, abuse of authority, or mismanagement of any state agency. *Ferrel v. Colo. Dep't of Corrections*, 179 P.3d 178, 186 (Colo. App. 2007). While speech pertaining to internal personnel disputes and working conditions ordinarily will not involve public concern, speech that seeks to expose improper operations of the government or questions the integrity of governmental officials clearly concerns vital public interests. *Gardetto v. Mason*, 100 F.3d 803, 812 (10th Cir. 1996).

The patients' concerns about Nurse M.P. Complainant shared with Lead Nurse Greenfield, and subsequently with the Nursing Board, involve matters of public concern, and thus meet the definition of protected disclosures outlined in § 24-50.5-102(2), C.R.S.

In addition to establishing that she engaged in protected disclosures by raising issues of public concern, Complainant must also demonstrate that she made "a good faith effort to provide to [her] supervisor or appointing authority or member of the general assembly the information to be disclosed prior to the time of its disclosure." § 24-50.5-103(2), C.R.S. If Complainant makes a disclosure about a matter of public concern to one of these persons or entities, a single disclosure is sufficient to satisfy the requirements of the Whistleblower Act. *Gansert v. Colorado*, 348 F.Supp.2d 1215, 1228 (D. Colo. 2004). Complainant's statements to Lead Nurse Greenfield during the September 2, 2022 nursing staff meeting meet this requirement.

As to the second element of a *prima facie* whistleblower retaliation case, Complainant suffered an adverse employment action. The Whistleblower Act defines "disciplinary action" as, "any direct or indirect form of discipline or penalty, including, but not limited to, dismissal, demotion, transfer, reassignment, suspension, corrective action, reprimand, admonishment, unsatisfactory or below standard performance evaluation, reduction in force, or withholding of work, or the threat of any such discipline or penalty." § 24-50.5-102 (1), C.R.S. Chief Nurse Gonzales' demotion of Complainant to a CCA II position falls within the Whistleblower Act's definition of a "disciplinary action." Thus, Complainant has established the second element of a *prima facie* case of whistleblower retaliation.

Finally, to meet the third element of a *prima facie* case of whistleblower retaliation, Complainant must establish that the "disciplinary action" resulted "on account of the employee's disclosure of information." § 24-50.5-103(1), C.R.S. Colorado case law implementing the Whistleblower Act fails to define the standard by which this causal connection is established. Therefore, case law implementing the anti-retaliation provisions of CADA and Title VII provide useful guidance. The necessary causal connection may be demonstrated by evidence of circumstances that justify an inference of retaliatory motive, such as protected conduct closely followed by adverse action. *Chavez v. City of Arvada,* 88 F.3d 861, 866 (10th Cir. 1996); *Anderson v. Coors Brewing Co.*, 181 F.3d 1171, 1179 (10th Cir. 1999).

Complainant made her initial protected disclosures during a September 2, 2022 nursing staff meeting. After learning of Complainant's comments during the nursing staff meeting, Chief Nurse Gonzales scheduled a Rule 6-10 meeting with Complainant on September 20, 2022. On September 8, 2022, Complainant filed a Nursing Board complaint. After Chief Nurse Gonzales received a copy of Complainant's Nursing Board complaint, Chief Nurse Gonzales scheduled a second Rule 6-10 meeting with Complainant. Chief Nurse Gonzales issued a notice of disciplinary action, demoting Complainant to a CCA II, on October 24, 2022. The close temporal proximity between Complainant's protected disclosures and Chief Nurse Gonzales' disciplinary action justifies an inference of retaliatory motive, the third element necessary for a *prima facie* case of whistleblower retaliation.

In addition to temporal proximity between Complainant's protected disclosures and Chief Nurse Gonzales' disciplinary action, the preponderance of the evidence establishes that Complainant's disclosures about patient concerns on September 2, 2022 prompted Chief Nurse Gonzales to initiate a disciplinary process under Board Rule 6-10. Once Chief Nurse Gonzales learned that Complainant had filed a Nursing Board complaint, he filed his own Nursing Board complaint concerning Nurse M.P. Chief Nurse Gonzales then conducted a second Rule 6-10

meeting with Complainant and closely questioned Complainant about her Nursing Board complaint.

The substance of the Rule 6-10 meetings conducted by Chief Nurse Gonzales focus on Complainant's disclosures. These disclosures were identified in Chief Nurse Gonzales' Notice of Disciplinary Action as the basis for his conclusion that Complainant "acted inappropriately" and created "a negative impact on co-workers and patients while working here at CMHIP." Thus, the preponderance of the evidence establishes the third element of a *prima facie* case of whistleblower retaliation: that disciplinary action occurred on account of Complainant's disclosures. § 24-50.5-103(1), C.R.S.; *Ward v. Indus. Comm'n*, 699 P.2d at 966-68.

Further, the punitive nature of the demotion imposed by Chief Nurse Gonzales justifies an inference of retaliatory motive. As discussed above, Chief Nurse Gonzales' decision to demote Complainant from a Mental Health Clinician II to a CCA II was an extremely punitive action. Complainant not only suffered a more than 25% reduction in pay, she was transferred to a position in which she could no longer use her education and mental health skills. Instead, Complainant was required to assist patients with their daily physical care needs, including helping patients with toileting and showering, brushing patients' teeth or dentures, and cleaning patients and their beds when they soiled themselves. Complainant testified that she had no experience or training for this kind of work, and described the loss of the Mental Health Clinician II position for which she was educated as "horrible." This punitive demotion of Complainant by Chief Nurse Gonzales constitutes additional support for an inference of retaliatory motive.

Finally, Chief Nurse Gonzales' comments to Nurse Poelhein provide direct evidence of retaliatory animus towards Complainant. Upon her demotion to the position of CCA II, Chief Nurse Gonzales assigned Complainant to a Geriatric Unit supervised by Nurse Poelhein. A few days before Complainant was scheduled to begin working in the Geriatric Unit, Chief Nurse Gonzales warned Nurse Poelhein: "Watch out for her. She will report you. She is looking to report people." During a subsequent meeting with Nurse Poelhein on November 22, 2022, Chief Nurse Gonzales made the following comments about Complainant: "Oh, she's a fucking bitch. I hate her."

Nurse Poelhein's testimony about Chief Nurse Gonzales' comments was consistent and credible. When questioned about these comments, Chief Nurse Gonzales stated he could not recall them, but did not deny making them. Therefore, the preponderance of the evidence establishes that Chief Nurse Gonzales made these comments about Complainant, demonstrating Chief Nurse Gonzales' animosity towards Complainant following her protected disclosures.

2. Respondent's Reasons for Complainant's Demotion

If the employee states a *prima facie* case of a whistleblower violation, the agency may then defeat the claim by demonstrating it would have reached the same decision in the absence of the protected conduct. *Ward v. Indus. Comm'n*, 699 P.2d 960, 966 (Colo. 1985). Employers may violate the Act if they had both legitimate and retaliatory motives in issuing the discipline. *Taylor v. Regents of the Univ. of Colorado*, 179 P.3d 246, 249-50 (Colo. 2007).

The preponderance of the evidence establishes that Chief Nurse Gonzales' disciplinary action was the direct result of Complainant's disclosures of patients' concerns. As discussed above, Chief Nurse Gonzales attempted to raise an additional reason for his decision to demote Complainant for the first time during the evidentiary hearing. Chief Nurse Gonzales testified that he concluded Complainant was not providing necessary care to patients. Chief Nurse Gonzales

based this conclusion solely on the absence of chart notes concerning the care Complainant provided to patients. However, Respondent provided no specific evidence of Complainant's patients' chart notes during the evidentiary hearing. Further, Chief Nurse Gonzales made no effort to investigate the care Complainant was actually providing to patients and failed to notify Complainant of this potential reason for discipline during the Rule 6-10 process. Due to the lack of supporting evidence, this alleged reason is not worthy of credence.

The ALJ finds that Respondent failed to demonstrate, by a preponderance of the evidence, that Chief Nurse Gonzales would have reached his decision to demote Complainant in the absence of Complainant's protected disclosures.

F. REMEDY

1. Complainant's Back Pay

In disciplining Complainant for raising patient safety concerns, Respondent retaliated against Complainant in violation of the Whistleblower Act. Section 24-50.5-104(2), C.R.S., of the Whistleblower Act provides, in pertinent part:

> If the state personnel board after hearing determines that a violation of section 24-50.5-103 has occurred, the state personnel board shall order, within forty-five days after such hearing, the appropriate relief, including, but not limited to, reinstatement, back pay, restoration of lost service credit, and expungement of the records of the employee who disclosed information…

In addition to retaliating against Complainant in violation of the Whistleblower Act, Respondent's decision to demote Complainant was arbitrary and capricious, as well as contrary to Board rules. Therefore, Complainant is entitled to be reimbursed for the loss of pay she suffered as a result of her demotion, up to the date she resigned. *See Department of Health v. Donahue*, 690 P.2d 243, 250 (Colo. 1984) (explaining that "[w]here a legal injury is of an economic character ... legal redress in the form of compensation should be equal to the injury.") The Colorado Court of Appeals has held: "When a public employee is wrongfully terminated, [she] is entitled to receive an amount of damages which will make [her] whole; [she] is not entitled to any windfall." *Lanes v. O'Brien*, 746 P.2d 1366, 1373 (Colo. App. 1987).

Complainant's demotion was effective November 5, 2022 and reduced Complainant's pay from $25.73 per hour to $18.85 per hour, or by $6.88 per hour. Both before and after her demotion, Complainant worked full time, or 40 hours per week, until she resigned effective April 24, 2023. Therefore, Complainant is entitled to be reimbursed for lost wages resulting from her demotion in the amount of $6,673.60 (970 hours at $6.88 per hour). Complainant is also entitled to PERA contributions on this back pay award, as well as statutory interest at the rate of 8% per annum pursuant to § 5-12-102(2), C.R.S.

2. Complainant's Additional Claims for Damages

In her closing argument, Complainant argues that she is entitled to reimbursement of lost annual leave in the amount of $1,839.70 (5.5 months at 13 hours/month at $25.73/hour) and holiday leave in the amount of $660.48 (8 days, at 12 hours, at $6.88). However, Complainant provided no evidence of such losses, or how they were incurred, during the evidentiary hearing, and no explanation of these claims in her closing argument. The back pay award already reimburses Complainant for the reduction in her hourly wage working a 40-hour week, which

would include any annual or holiday leave that Complainant took during that time. Therefore, Complainant has failed to establish grounds for the requested award of lost annual or holiday leave.

Complainant also argues that Complainant is entitled to lost annual leave used in conjunction with FML to care for her mother after Respondent changed her work schedule, in the amount of $5,017.35 (195 hours at the rate of $25.73). Again, Complainant provided no specific evidence of such losses during the evidentiary hearing. Therefore, Complainant has failed to establish grounds for the requested award of lost FML/annual leave.

Finally, Complainant argues that, in addition to being made whole for her losses, she is entitled to an additional amount of $15,468.33 as "compensatory damages for the emotional distress, financial harm beyond simply the loss of pay in the form of credit card interest and harm to her reputation caused by the Respondent." Complainant provided no specific evidence of such losses during the evidentiary hearing, and no legal authority for such an award beyond stating that § 24-50.5-104(2), C.R.S., places "no limits" on the relief available to Complainant. Complainant has not only failed to establish grounds for the requested award of compensatory damages, but the ALJ finds that an award of such damages would constitute an improper economic windfall. *See McCoy v. Dep't of Soc. Servs., Div. of Aging & Adult Servs.*, 796 P.2d 77, 79 (Colo. App. 1990).

3. Complainant's Proposed Discipline of Chief Nurse Gonzales

Section 24-50.5-104, C.R.S., provides that, whenever the Board determines that an appointing authority or supervisor has violated the Whistleblower Act,

> … the appointing authority or supervisor shall receive a disciplinary action which shall remain a permanent part of the appointing authority's or supervisor's personnel file, and a copy of the disciplinary action shall be provided to the employee. The disciplinary action shall be appropriate to the circumstances, from a mandatory minimum of a one week suspension or equivalent up to and including termination. In considering the appropriate disciplinary action pursuant to this subsection (4), the appointing authority or supervisor of the appointing authority or supervisor who has committed such violation shall consider the nature and severity of the retaliatory conduct involved.

In her closing argument, Complainant argues that, because of his violation of the Whistleblower Act, Chief Nurse Gonzales should be demoted to a Nurse I position. However, under § 24-50.5-104, C.R.S., the proper authority to determine the appropriate discipline to be imposed on Chief Nurse Gonzales for his violation of the Whistleblower Act is Chief Nurse Gonzales' appointing authority or supervisor.

4. Attorney Fees and Costs

Section 24-50.5-104(2), C.R.S., of the Whistleblower Act provides, in pertinent part:

> If the state personnel board after hearing determines that a violation of section 24-50.5-103 has occurred … the state personnel board shall order that the employee filing the complaint be reimbursed for any costs, including court costs and attorney fees, if any, incurred in the proceeding.

See also Board Rule 8-51(D), which provides: "Pursuant to § 24-50.5-104(2), C.R.S. attorney fees shall be assessed against the department if the Board finds a violation of the Whistleblower Act."

As discussed above, Chief Nurse Gonzales violated § 24-50.5-103, C.R.S., of the Whistleblower Act. Therefore, Complainant is entitled to reimbursement "for any costs, including court costs and attorney fees, if any, incurred in the proceeding."

Complainant is also entitled to an award of attorney fees and costs pursuant to Board Rule Board Rule 8-51(B):

> "[A]ttorney fees and costs may be assessed against a party if the Board finds that the personnel action from which the proceeding arose … was frivolous, in bad faith, malicious, a means of harassment, or was otherwise groundless.
>
> 1. Frivolous means that no rational argument based on the evidence or law was presented.
>
> 2. In bad faith, malicious, or as a means of harassment means that the appeal or defense was pursued to annoy or harass, made to be abusive, stubbornly litigious, or disrespectful of the truth.
>
> 3. Groundless means that despite having a valid legal theory, a party fails to offer or produce any competent evidence to support the theory.

As discussed above, Chief Nurse Gonzales' retaliatory discipline of Complainant for reporting patient concerns was in bad faith, malicious, and a means of harassment. In addition, the ALJ finds that Chief Nurse Gonzales' testimony during the evidentiary hearing was disrespectful of the truth. During the evidentiary hearing, Respondent failed to produce any competent evidence to support the reasons for Complainant's demotion, as articulated by Chief Nurse Gonzales, rendering Chief Nurse Gonzales' disciplinary action groundless. Therefore, under Board Rule 8-51(B)(2) and (3), Complainant is entitled to an award of attorney fees and costs.

CONCLUSIONS OF LAW

1. Respondent failed to establish that Complainant committed the act for which she was disciplined.

2. Respondent's decision to discipline Complainant was arbitrary and capricious.

3. Respondent's decision to discipline Complainant was contrary to Board Rules 6-9, 6-10 and 6-13.

4. In disciplining Complainant for raising patient safety concerns, Respondent retaliated against Complainant in violation of the Whistleblower Act.

5. The appropriate remedy is an award to Complainant of lost pay resulting from her demotion, as well as PERA contributions on this back pay award and statutory interest at the rate of 8% per annum, and an award of attorney fees and costs.

ORDER

1. Respondent's disciplinary demotion of Complainant's employment is **reversed** and shall be expunged from Complainant's personnel file.

2. Respondent shall **reimburse** Complainant for her lost wages in the amount of $6,673.60. This amount is subject to the employer's PERA contribution, as well as interest of 8% per annum.

3. Respondent shall **reimburse** Complainant for her reasonable and necessary costs and attorney fees incurred in the proceeding before the Board.

4. Complainant shall submit a bill of attorney fees and costs to the Board on or before **October 9, 2023**. Upon receipt of Complainant's bill of attorney fees and costs, Respondent shall have ten (10) days to file any objections, or otherwise respond.

Dated this 28th day
of September, 2023, at
Denver, Colorado.

/s/ [redacted]
Susan J. Tyburski
Senior Administrative Law Judge
State Personnel Board
1525 Sherman Street, 4th Floor
Denver, CO 80203

CERTIFICATE OF SERVICE

This is to certify that on the 28th day of September, 2023, I electronically served true copies of the foregoing **INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE** and the attached **NOTICE OF APPEAL RIGHTS** addressed as follows:

Mark A. Schwane, Esq.
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Carlos Ramirez, Esq.
Assistant Attorney General
Jacob W. Paul, Esq.
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Carlos.Ramirez@coag.gov
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[redacted]

APPENDIX

EXHIBITS

COMPLAINANT'S EXHIBITS ADMITTED: The following exhibits were stipulated into evidence: Exhibits A, B, C, D, E, F, G, H, I, J, M, N, O, R, S, BB, HH, JJ, KK, SS, TT, XX, YY. The following additional exhibits were admitted into evidence without objection: Exhibit V, DD, NN, QQ, UU, VV, AAA. The following additional exhibits were admitted into evidence over objection: X, CC, PP.

RESPONDENT'S EXHIBITS ADMITTED: The following exhibits were stipulated into evidence: Exhibits 1, 2, 7, 8, 9, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35. The following additional exhibits were admitted into evidence without objection: 3, 4, 5, 6.

WITNESSES

The following is a list of witnesses in the order in which they testified during the evidentiary hearing:

David Poehlein, former R.N. III
Christine Mendias, Complainant
Brian Gonzales, Appointing Authority
Tiffany Greenfield, R.N. IV / Lead Nurse
Cynthia Howard, R.N. II
Carla Carriere, R.N. III
Tracey McCormack, Social Worker
Jamie West, R.N. I
Dawn Genzer, R.N. I

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 served to the parties. § 24-4-105(15), C.R.S. and Board Rule 8-53(A)(2).

3. 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 served to the parties. §§ 24-4-105(14)(a)(II) and 24-50-125.4(4), C.R.S. 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. 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. Univ. of S. Colo.*, 793 P.2d 657 (Colo. App. 1990) and § 24-4-105(14) and (15), C.R.S.

4. The parties are hereby advised that this constitutes the Board's motion, pursuant to § 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. Board Rule 8-53(C). 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. 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. *See* Board Rule 8-53(A)(5)-(7). For additional information contact the State Personnel Board office at (303) 866-3300 or email at dpa_state.personnelboard@state.co.us.

BRIEFS ON APPEAL

When the Certificate of Record of Hearing Proceedings is served 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 8-54.

ORAL ARGUMENT ON APPEAL TO THE BOARD

In general, no oral argument is permitted. Board Rule 8-55(C).

MOTION FOR RECONSIDERATION

Motions for reconsideration are discouraged. *See* Board Rule 8-47(K).