STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. **2025B011(C)**

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

RYAN REED,
Complainant**,**

v.

DEPARTMENT OF HUMAN SERVICES, COLORADO MENTAL HEALTH HOSPITAL IN PUEBLO,
Respondent.

Senior Administrative Law Judge (ALJ) Susan J. Tyburski held the evidentiary hearing via web conference on January 16-17, 2025. The record was closed on January 17, 2025.

Throughout the hearing, Complainant and his attorney, Casey Leier, Esq., appeared via Google Meet. Respondent appeared through its attorney, Assistant Attorney General Michael J. Bishop, Esq., via Google Meet. Respondent's advisory witness was Christine Tafoya, Chief Nursing Officer.

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 the disciplinary termination of his employment by Respondent, alleging retaliation in violation of the State Employee Protection Act (Whistleblower Act), C.R.S. § 24-50.5-101, *et seq*. Complainant argues that he did not commit the alleged misconduct for which he 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 he 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 terminate Complainant's employment is **affirmed.**

ISSUES TO BE DETERMINED

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

2.) Was Respondent's disciplinary action arbitrary, capricious, or contrary to rule or law? If so, what is the appropriate remedy?

3.) Did Respondent retaliate against Complainant in violation of the Whistleblower Act? If so, what is the appropriate remedy?

FINDINGS OF FACT

Background

1. The Colorado Mental Health Hospital in Pueblo (CMHHIP) is an acute care psychiatric hospital that provides inpatient behavioral health services for adults, adolescents, and geriatric patients. CMHHIP also operates as a forensic hospital, treating individuals who have been deemed incompetent to proceed and individuals found to be not guilty by reason of insanity in Colorado criminal courts. (Stipulated)

2. Complainant, Ryan Reed, was employed as a Clinical Safety Specialist I (CSS) at CMHHIP. He was employed at CMHHIP as a CSS I from 2014 until his termination on July 23, 2024. (Stipulated)

3. Complainant was a certified employee.

4. In 2022, Complainant received a rating of 2.4 out of 3, an overall "Successful" performance evaluation.

5. In 2023, Complainant received a rating of 3 out of 5, an overall "Effective" performance evaluation.

6. At all relevant times, Complainant was assigned to the Adolescent Behavioral Treatment Unit (ABTU).

7. Complainant was responsible for ensuring a safe and therapeutic environment for CMHHIP's patients, including monitoring patients, interacting with patients in a positive and respectful manner, and defusing and de-escalating incidents.

8. Complainant was required to adhere to Respondent's policies concerning interactions with patients.

9. Section III(B) of Respondent's Policy No. 24.06, "Clinical Safety Specialist Assignments and Duties," provides: "The CSS is expected to be an active participant in maintaining a stable treatment environment milieu..."

10. Section I of Respondent's Policy No. 16.20, "Abuse/Neglect of Minors," provides:

> It is the policy of [CMHHIP] that the position of trust held by any employee who has contact with patients of minor age requires continual professionalism and particular regard for their safety and welfare.

11. Section I(A)(1) of Respondent's Policy No. 16.20, "Abuse/Neglect of Minors," lists "Examples of anti-therapeutic or unprofessional behavior toward patients" including "Use of unnecessary force."

12. Section III(C) of Respondent's Policy No. 30.10, "CMHHIP Employee Code of Conduct," prohibits CMHHIP employees from using "excessive force," engaging "in verbal or physical abuse of patients," or using "threatening, abusive or profane language, gestures or demeanor."

13. Section I of Respondent's Policy No. 6.45, "Clinical Risk Management," provides:

> It is the policy of [CMHHIP] that physical/manual restraint, seclusion, mechanical restraint, and medical protective restraint be used only in emergency situations for the safety of the patient and others when less restrictive interventions have been ineffective in protecting the patient or others from harm. When emergency physical intervention is used, only the minimum amount of intervention necessary to prevent physical injury, as trained, is authorized.
>
> All patients have the right to be free from seclusion and restraint of any form that is imposed as a means of coercion, discipline, convenience, or retaliation by staff. The dignity and privacy of patients will be preserved to the greatest extent during the implementation and monitoring of these interventions. Non-physical interventions, based on the patient's clinical condition, must be tried prior to the use of restraint or seclusion except in situations where the patient's behavior presents an immediate danger. When the use of restraint or seclusion is indicated, **the intervention will be terminated when dangerous behaviors are no longer evident.** (Emphasis in original.)

14. In August 2023, Complainant completed training in "Milieu Management," "Verbal Defense & Influence," and "Mandt Verbal Physical Intervention."

15. On January 3, 2024, Complainant completed training in "Seclusion, Restraint, and Medical Protective Restraint Use" pursuant to Respondent's Policy No. 6.45.

<u>January 30, 2024 Incident</u>

16. Around 7:00 p.m. on January 30, 2024, Complainant was on duty in the ABTU day hall. Complainant was responsible for monitoring and managing the milieu in the ABTU day hall.

17. Four adolescent patients, including Patient 1[1], were in the ABTU day hall. Complainant was sitting in a chair at the side of the day hall.

18. Patient 1 had a deck of playing cards and threw the cards up in the air. One of the cards landed on Complainant's chest. Complainant put the card in his pocket and remained sitting in the chair. Complainant did not speak to Patient 1.

19. After a couple minutes, two of the patients, including Patient 1, started picking up individual cards from the floor and throwing them across the day hall. These two patients then started throwing cards at each other.

20. While the patients were throwing cards, Complainant continued to passively sit in a chair at the side of the day hall.

21. One of the patients moved in front of Complainant. Patient 1 threw a card in that direction that accidentally hit Complainant in the face.

22. Complainant immediately jumped up from his seat and aggressively walked towards Patient 1. Complainant told Patient 1 Complainant was going to escort him to a timeout area.

23. Patient 1 immediately laid on the floor in a submissive posture with his hands behind his back.

24. Complainant grabbed Patient 1 by his arms and attempted to lift him up.

25. Patient 1 resisted Complainant. The other patients attempted to assist Patient 1 and assaulted Complainant.

26. A number of other staff arrived to assist Complainant. After approximately two minutes, staff succeeded in restraining and removing all the patients from the day hall.

Manager Horn's Initial Investigation

27. In January 2024, Complainant's Appointing Authority was Jeff Horn, Clinical Safety Specialist Manager.

28. On January 31, 2024, Manager Horn placed Complainant on paid administrative leave "pending the investigation of allegations of patient abuse" during the January 30, 2024 incident.

29. Manager Horn reviewed video of the January 30, 2024 incident and concluded that Complainant had an angry reaction to being hit with the playing card by Patient 1. Manager Horn concluded that Complainant should have engaged with the patients when they started throwing cards and should have redirected their behavior.

[1] The identities of the adolescent patients are protected.

30. Manager Horn decided that Complainant could be returned to work with additional training concerning appropriate engagement with patients.

31. On February 1, 2024, Manager Horn ended Complainant's administrative leave and returned Complainant to work.

Return of Complainant to Administrative Leave

32. On or about January 31, 2024, CMHHIP's Chief Executive Officer (CEO) was notified of the January 30, 2024 incident.

33. CEO Marshall met with Leora Joseph, Respondent's Director of Office of Civil, Forensic & Mental Health. They viewed the video of the January 30, 2024 incident.

34. Director Joseph was horrified by Complainant's actions during the January 30, 2024 incident.

35. Director Joseph was in the middle of a campaign for Denver District Attorney. CEO Marshall told Director Joseph she would handle the January 30, 2024 incident. Director Joseph had no further involvement in the matter.

36. CEO Marshall contacted Christine Tafoya, Chief Nursing Officer (CNO), who supervised Manager Horn.

37. After talking with CEO Marshall, CNO Tafoya contacted Manager Horn to discuss his decisions concerning Complainant. Manager Horn admitted to CNO Tafoya that he did not understand the different investigation processes and his role as an administrative authority.

38. CNO Tafoya instructed Manager Horn that he needed to place Complainant back on administrative leave and conduct a thorough administrative investigation to determine whether Complainant committed a MANE (Mistreatment/Abuse/Neglect/Exploitation) violation during the January 30, 2024 incident. CNO Tafoya directed Manager Horn to contact Cara Dasher, Director of Administrative Investigations, to investigate whether Complainant's actions during the January 30, 2024 incident constituted patient abuse.

39. On February 2, 2024, Manager Horn placed Complainant back on paid administrative leave.

Other Investigations

40. The Pueblo Police Department investigated the January 30, 2024 incident and submitted a request to the Tenth Judicial District Attorney's Office to charge Complainant with "Child Abuse" under C.R.S. § 18-6-401(1)(a).

41. On April 2, 2024, the Tenth Judicial District Attorney's Office determined that there was "insufficient evidence" to pursue criminal charges against Complainant for his actions during the January 30, 2024 incident.

42. On April 10, 2024, Manager Horn asked Investigator Dasher to investigate whether Complainant's actions during the January 30, 2024 incident constituted patient abuse.

43. During her investigation of the January 30, 2024 incident, Investigator Dasher interviewed four staff members, including Complainant. Investigator Dasher also reviewed video of the incident, patient medical records, Complainant's training records, and relevant training materials, policies, regulations and statutes.

44. In an Investigation Report issued on April 29, 2024, Investigator Dasher concluded that it was more likely than not that Complainant committed patient abuse. Investigator Dasher explained:

> By placing his hands on the patient, Mr. Reed exacerbated the situation. This caused the patient to become agitated and he began trying to escape Mr. Reed's hold. This decreased the safety in the milieu as the patient's peers became agitated watching the incident, then physically involved themselves in the incident. Due to the other patients becoming physically aggressive towards Mr. Reed, the other staff had to respond. This posed a significant risk of injury to the staff and patients.

Rule 6-10 Meeting

45. On May 6, 2024, CNO Tafoya rescinded Manager Horn's appointing authority over Complainant.

46. On May 6, 2024, CNO Tafoya sent Complainant a Notice setting a 6-10 meeting for May 15, 2024.

47. On May 13, 2024, Program Assistant Tre' Bartell, on behalf of CNO Tafoya, sent Complainant an email stating that the Rule 6-10 meeting was rescheduled for June 6, 2024 at 10:00 a.m.

48. On June 5, 2024, CNO Tafoya emailed Complainant a letter confirming an agreement to reschedule the Rule 6-10 meeting for 1:30 p.m. on June 6, 2024 so that Complainant and his attorney could review video of the January 30, 2024 incident prior to the meeting.

49. Complainant and his attorney viewed video of the January 30, 2024 incident prior to the Rule 6-10 meeting on June 6, 2024.

50. After viewing the video of the January 30, 2024 incident, Complainant and his attorney met with CNO Tafoya and her representative Justin Icenhower, Human Resources

Specialist, for a Rule 6-10 meeting on June 6, 2024. During this meeting, CNO Tafoya discussed her concerns about the alleged MANE violation committed by Complainant during the January 30, 2024 incident.

51. During the Rule 6-10 meeting, Complainant alleged that, when Patient 1 threw the playing cards in the air, he told the patients to stop throwing cards, but the patients did not comply. Complainant explained that he considered being hit in the face with a playing card by Patient 1 to be an assault and intended to escort Patient 1 to a timeout area.

52. During the Rule 6-10 meeting, CNO Tafoya informed Complainant and his attorney that they could submit additional information by June 20, 2024.

53. On June 14, 2024, Complainant filed a petition for hearing with the Board, alleging that initiation of the Rule 6-10 process was retaliation for disclosures Complainant made about Director Joseph's improper intervention in the disciplinary process. Complainant argued that these alleged disclosures were protected under the Whistleblower Act.

54. On June 20, 2024, Complainant's attorney submitted a written statement on behalf of Complainant, arguing that Complainant was an "exemplary" employee whose actions on January 30, 2024 did not constitute a MANE violation. Complainant's attorney alleged that Director Joseph improperly intervened to reverse Complainant's return to work by Manager Horn because she was a candidate for the office of Denver District Attorney.

Termination Decision

55. On July 23, 2024, CNO Tafoya discharged Complainant from the position of CSS I. (Stipulated)

56. In the Notice of Disciplinary Action, CNO Tafoya noted that, in the video of the January 30, 2024 incident, Complainant did not speak to the patients throwing cards or take any action until one of the cards accidentally hit him in the face. CNO Tafoya reached the following conclusions concerning the January 30, 2024 incident:

> I find that your actions constitute a substantiated incident of physical abuse of a minor constituting a MANE violation. I further find that the manner [sic] you conducted yourself is unacceptable, dangerous, and goes against the training you received.

57. In reaching the decision to terminate Complainant's employment, CNO Tafoya considered the video of the January 30, 2024 incident, Complainant's performance history, the information contained in Investigator Dasher's investigation report, the applicable policies concerning appropriate engagement with patients, Complainant's training on those policies, and the information and arguments provided by

Complainant, as required by Board Rule 6-11.

58. In reaching her decision, CNO Tafoya followed the requirement of The Vulnerable Persons Act, C.R.S. § 27-90-111(15)(a), to place the safety of Respondent's adolescent patients above any other interest. CNO Tafoya concluded that she could not trust Complainant to remain in a position that was responsible for working with and caring for such patients.

59. Complainant timely appealed Respondent's termination of his employment and filed a second whistleblower complaint. This appeal was consolidated with Complainant's petition for hearing filed on June 17, 2024.

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* C.R.S. § 24-50-103(6).

B. COMPLAINANT COMMITTED THE MISCONDUCT FOR WHICH HE WAS DISCIPLINED.

CNO Tafoya terminated Complainant's employment because of an incident of physical abuse of a minor constituting a MANE violation that occurred on January 30, 2024.

As a CSS I, Complainant's responsibilities included monitoring adolescent patients, interacting with patients in a positive and respectful manner, and defusing and de-escalating incidents that arise. A video of the January 30, 2024 incident was admitted into evidence. The video establishes that, around 7:00 p.m., Complainant was on duty in the ABTU day hall with four adolescent patients. Complainant was sitting in a chair against one wall of the day hall. Patient 1 had a deck of playing cards and threw the cards up in the air. One of the cards landed on Complainant's chest. Complainant put the card in his pocket and remained sitting in the chair. Complainant did not speak to Patient 1 or provide any direction to the patients.

Patient 1 and a second patient started picking up the cards from the floor and throwing the cards at each other. The two patients began running around, dodging and jumping to avoid being hit by the cards. During this activity, Complainant continued to passively sit in the chair. Complainant took no action to calm the patients down or discourage them from throwing cards.

At one point, Patient 1 threw a card towards the other patient, who had moved in front of Complainant. The card thrown by Patient 1 accidentally hit Complainant in the

face. Complainant jumped up from the chair and aggressively approached Patient 1. Patient 1 immediately laid down on the ground with his hands behind his back. Complainant grabbed Patient 1 by the arms and attempted to raise Patient 1 to his feet. Patient 1 began resisting. The other patients attempted to intervene and assaulted Complainant. Other staff arrived and, after a couple minutes, succeeded in restraining and removing all the patients from the day hall.

Complainant alleged that Patient 1 "assaulted" him by throwing the playing card in his face. Complainant testified that he intended to escort Patient 1 to a secluded area. Instead of asking or directing Patient 1 to stand up, Complainant grabbed Patient 1's arms and began to lift him, causing Patient 1 to resist Complainant's hold. Complainant's actions prompted the other patients to attempt to assist Patient 1 in resisting Complainant. Complainant acknowledged that grabbing Patient 1's arms was not an approved intervention tactic. Complainant's actions on January 30, 2024, as recorded on video, do not show Complainant acting in a positive or respectful manner towards the patients in the day hall, or attempting to defuse or de-escalate the patients' behavior. The preponderance of the evidence establishes that Complainant's aggressive actions towards Patient 1 exacerbated, rather than de-escalated, the behavior of the patients in the day hall.

Manager Horn credibly testified that, in watching the video of the incident, he could see that Complainant was angry with Patient 1 for hitting him in the face with a card. Instead of laying hands on Patient 1, Manager Horn testified that Complainant should have engaged with the patients when they started throwing cards and redirected their behavior. Director Joseph, who watched the video of the January 30, 2024 incident, credibly testified that she was "horrified" by Complainant's actions. After investigating the January 30, 2024 incident, the Pueblo Police Department submitted a request to the Tenth Judicial District Attorney's Office to charge Complainant with "Child Abuse" under C.R.S. § 18-6-401(1)(a). The Tenth Judicial District Attorney's Office ultimately determined that there was "insufficient evidence" to pursue criminal charges against Complainant. However, CNO Tafoya determined that Manager Horn had not properly investigated Complainant's actions on January 30, 2024, and directed him to conduct an administrative investigation into whether Complainant committed a MANE violation. At Manager Horn's request, Investigator Dasher conducted this investigation. Investigator Dasher determined that Complainant's actions on January 30, 2024 exacerbated the situation, decreased the safety in the day hall milieu and posed a significant risk of injury to the staff and patients. Investigator Dasher concluded that it was more likely than not that Complainant committed patient abuse.

Policy No. 6.45, "Clinical Risk Management," provides that patient restraints should "be used only in emergency situations for the safety of the patient and others when less restrictive interventions have been ineffective in protecting the patient or others from harm." Policy No. 6.45 emphasizes: "All patients have the right to be free from seclusion and restraint of any form that is imposed as a means of coercion, discipline, convenience, or retaliation by staff." Towards that end, Policy No. 6.45 requires that "non-physical

interventions … must be tried prior to the use of restraint or seclusion except in situations where the patient's behavior presents an immediate danger."

During the January 30, 2024 incident, Complainant made no effort to attempt a "less restrictive" intervention before grabbing Patient 1's arms. While the patients' activity of throwing cards was annoying, it was not an "emergency" situation where anyone was at risk of harm. Complainant's aggressive restraint of Patient 1 clearly violated Policy No. 6.45. In doing so, Complainant employed excessive force, in violation of Section I(A)(1) of Respondent's Policy No. 16.20, "Abuse/Neglect of Minors," and Section III(C) of Respondent's Policy No. 30.10, "CMHHIP Employee Code of Conduct." Complainant's use of excessive force against Patient 1 constituted a MANE violation.

The preponderance of the evidence establishes that Complainant committed the misconduct for which he was disciplined.

C. RESPONDENT'S DISCIPLINARY ACTION WAS NOT ARBITRARY, CAPRICIOUS, OR CONTRARY TO RULE OR LAW.

1. Respondent's Disciplinary Action Was Not Arbitrary or Capricious.

In determining whether an agency's decision was 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).

CNO Tafoya directed Manager Horn to ask Investigator Dash to investigate whether Complainant's actions during the January 30, 2024 incident constituted patient abuse. Investigator Dash interviewed Complainant and other staff members, and reviewed video of the incident, patient medical records, Complainant's training records, and relevant training materials, policies, regulations and statutes. After Investigator Dash issued her investigation report, CNO Tafoya revoked Manager Horn's appointing authority and took over the Rule 6-10 process. CNO Tafoya held a Rule 6-10 meeting with Complainant and his attorney on June 6, 2024. Prior to the meeting, CNO Tafoya arranged for Complainant and his attorney to review video of the January 30, 2024 incident. During the Rule 6-10 meeting, CNO Tafoya discussed her concerns about the alleged MANE violation committed by Complainant during the January 30, 2024 incident. CNO Tafoya allowed Complainant to explain his actions during the January 30, 2024 incident, and informed Complainant and his attorney that they could submit additional information after the meeting. The preponderance of the evidence establishes that CNO Tafoya used "reasonable diligence and care to procure such evidence as [she was] by law authorized to consider in exercising [her] discretion." *Lawley*, 36 P.3d at 1252.

In reaching the decision to discipline Complainant, CNO Tafoya considered the video of the January 30, 2024 incident, Complainant's performance history, the information contained in Investigator Dasher's investigation report, the applicable policies concerning appropriate engagement with patients, Complainant's training on those policies, and the information and arguments provided by Complainant. The preponderance of the evidence establishes that CNO Tafoya gave this evidence "candid and honest consideration." *Lawley*, 36 P.3d at 1252.

Complainant argued that, in January 2024, Respondent was in the process of transitioning to a new approach to engaging patients, known as Mandt Verbal and Physical Intervention. Complainant argued that he had not received adequate training on the new Mandt techniques, as he did not complete the final day of that training. However, the preponderance of the evidence established that Complainant had completed the majority of the new Mandt training in August 2023, as well as training in "Milieu Management" and "Verbal Defense & Influence." Complainant acknowledged that grabbing Patient 1's arms was not an approved intervention tactic.

A few weeks prior to the January 30, 2024 incident, Complainant completed training in "Seclusion, Restraint, and Medical Protective Restraint Use" pursuant to Respondent's Policy No. 6.45. As discussed above, Policy No. 6.45 requires that "non-physical interventions … must be tried prior to the use of restraint or seclusion except in situations where the patient's behavior presents an immediate danger." Because the patients' activity of throwing cards did not present "an immediate danger" to anyone, Complainant's aggressive restraint of Patient 1 violated Policy No. 6.45, as well as Policy No. 16.20, "Abuse/Neglect of Minors," and No. 30.10, "CMHHIP Employee Code of Conduct," and constituted a MANE violation.

The Vulnerable Persons Act, C.R.S. § 27-90-111(15)(a) requires an appointing authority considering discipline for a MANE violation to "give weight to the safety of vulnerable persons over the interests of any other person." In placing the safety of Respondent's adolescent patients above any other interest, CNO Tafoya concluded that she could not trust Complainant to remain in a position that was responsible for working with and caring for such patients. CNO Tafoya reached "conclusions from the evidence such that reasonable persons fairly and honestly considering the evidence" would not be compelled to "reach contrary conclusions." *Lawley*, 36 P.3d at 1252.

The preponderance of the evidence establishes that Respondent's termination of Complainant's employment was not arbitrary or capricious,

2. Respondent's Disciplinary Action Was Not Contrary to Rule or Law.

CNO Tafoya followed the provisions of Board Rule 6-10. Complainant's attorney was allowed to represent Complainant throughout the Rule 6-10 process. CNO Tafoya held a Rule 6-10 meeting with Complainant, during which she discussed her concerns about Complainant's actions during the January 30, 2024 incident. Complainant was

allowed to view the video of the January 30, 2024 incident, and had ample opportunities to respond to the allegations and information from CNO Tafoya.

In reaching the decision to discipline Complainant, CNO Tafoya considered all of the factors outlined by Board Rule 6-11(A). CNO Tafoya also complied with Board Rule 6-11(B), which provides:

> In considering any disciplinary action of an employee who has engaged in mistreatment, abuse, neglect, or exploitation against a vulnerable person, the appointing authority shall give weight to the safety of vulnerable persons over the interests of any other person.

Patient 1 meets the definition of a "vulnerable person" served by Respondent "who is susceptible to abuse or mistreatment because of the individual's circumstances…" *See* C.R.S. § 27-90-111(2)(e).

The preponderance of the evidence establishes that Respondent's termination of Complainant's employment was not contrary to rule or law.

D. RESPONDENT DID NOT RETALIATE AGAINST COMPLAINANT IN VIOLATION OF THE WHISTLEBLOWER ACT.

The Colorado State Personnel Board has jurisdiction over appeals alleging violations of the Whistleblower Act. C.R.S. § 24-50.5-104 and Board Rule 8-24. In order to establish a *prima facie* case of whistleblower retaliation, Complainant must establish (1) that he disclosed information to Respondent pertaining to a matter of public interest, (2) that he was disciplined as defined by the Whistleblower Act, and (3) that the disciplinary action occurred on account of the disclosure of information. *See* C.R.S. § 24-50.5-103(1); *Ward v. Indus. Comm'n*, 699 P.2d 960, 966-68 (Colo. 1985).

Respondent's termination of Complainant's employment meets the definition of "disciplinary action" outlined in C.R.S. § 24-50.5-102 (1). Complainant's initiation of the Rule 6-10 process may also meet this definition of "disciplinary action," as the Notice of 6-10 meeting indicates that Respondent may take disciplinary action against Complainant. Therefore, Complainant has established the second element of a *prima facie* whistleblower case. However, Complainant failed to present any evidence establishing the other elements of a *prima facie* whistleblower case.

To establish the first element of a *prima facie* case of whistleblower retaliation, Complainant must demonstrate that he 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." C.R.S. § 24-50.5-102(2). Complainant did not offer any evidence that he made any such disclosure.

Complainant alleges that Director Joseph improperly intervened to reverse Complainant's return to work by Manager Horn because she was a candidate for the office of Denver District Attorney. However, there is no evidence in the record that Complainant made any disclosures concerning Director Joseph's alleged improper intervention. The only allegations concerning Director Joseph in the record appear in Complainant's June 14, 2024 petition for hearing protesting the Rule 6-10 process and a June 20, 2024 written response provided by Complainant's attorney to CNO Tafoya following the Rule 6-10 meeting. The June 20, 2024 response is a statement made by Complainant's attorney, not Complainant. Both documents are intended to address a personnel dispute. Disclosures pertaining to individual personnel disputes, internal policy concerns, working conditions, or issues with supervisors typically fall under the personal grievance category and are not whistleblower disclosures. *Gansert v. Colorado*, 348 F.Supp.2d 1215, 1222 (D. Colo. 2004). Therefore, Complainant has failed to establish the first element of a *prima facie* case of whistleblower retaliation.

To establish 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." C.R.S. § 24-50.5-103(1). Neither Complainant's June 14, 2024 petition nor the June 20, 2024 response constitute a disclosure that precedes the initiation of the Rule 6-10 disciplinary process. Further, because Complainant failed to provide any evidence that he made a disclosure of information protected by the Whistleblower Act, Complainant failed to establish that the initiation of the Rule 6-10 process and the subsequent termination of Complainant's employment was a result of such disclosure. Therefore, Complainant has failed to establish a *prima facie* case of whistleblower retaliation.

Even if Complainant had presented evidence establishing a *prima facie* case of whistleblower retaliation, CNO Tafoya credibly testified that she initiated the Rule 6-10 process and terminated Complainant's employment because of his actions on January 30, 2024. No evidence was presented to the contrary. Thus, the preponderance of the evidence establishes that Respondent did not retaliate against Complainant in violation of the Whistleblower Act.

CONCLUSIONS OF LAW

1. Respondent established that Complainant committed the act for which he was disciplined.

2. Respondent's decision to discipline Complainant was not arbitrary, capricious, or contrary to rule or law.

3. Respondent did not retaliate against Complainant in violation of the Whistleblower Act.

ORDER

For the above reasons, Respondent's termination of Complainant's employment is **affirmed** and Complainant's appeal is **dismissed with prejudice**.

Dated this 3rd day of March, 2025, 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 3rd day of March, 2025, 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:

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[redacted]

APPENDIX

EXHIBITS

COMPLAINANT'S EXHIBITS ADMITTED: The following exhibits were stipulated into evidence: Exhibits L, N, T, V, W, X, Y, Z, CC, EE, FF, GG, HH. The following additional exhibits were admitted into evidence without objection: Exhibits E, F, H, J, O, S. The following additional exhibits were admitted into evidence over objection: Exhibits A, C, D, G, I, R, .

RESPONDENT'S EXHIBITS ADMITTED: The following exhibits were stipulated into evidence: Exhibits 1, 2, 3, 4, 8, 9, 10, 13, 22. The following additional exhibits were admitted into evidence without objection: Exhibits 5, 6, 11, 14, 17, 18, 19, 23, 24. The following additional exhibits were admitted into evidence over objection: Exhibits 7, 12.

WITNESSES

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

Leora Joseph, Director of Office of Civil, Forensic & Mental Health
Ryan Reed, Complainant
Dr. Marika Bower, Psychologist I
Jeff Horn, Clinical Safety Specialist IV
Cara Dasher, Director of Administrative Investigations
Christine Tafoya, Chief Nursing Officer

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.

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 neutral and certified court reporter 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).