

State Personnel Board, State of Colorado

Case No. 96 B 098

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

GLENN LANG,

Complainant,

v.

DEPT. OF HUMAN SERVICES, COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO,

Respondent.

Hearing on this matter was held November 19, 1997 and February 10 - 11, 1998 before Administrative Law Judge G. Charles Robertson at Colorado Mental Health Institute at Pueblo ("CMHIP"), Administration Building, Conference Room D, 1600 West 24th Street, Pueblo, CO.

MATTER APPEALED

Complainant appeals the disciplinary termination of his employment as a psychiatric clinical technician at CMHIP.

Complainant's actions of using foul language and entering a patient's room unattended in violation of CMHIP policy are actions for which corrective or disciplinary action may be imposed BUT the disciplinary termination was NOT within the range of reasonable alternatives available to the appointing authority and the discipline imposed was in violation of Board Rule R8-3-1, 4 CCR 801-1. Thus, Respondent's actions were arbitrary and capricious or contrary to rule or law.

PRELIMINARY MATTERS

Respondent, CMHIP, was represented by Toni Jo Gray, Assistant Attorney General. Complainant, Glenn Lang ("Complainant" or "Lang") was represented by David E. Ware,

Attorney at Law, 229 Colorado Avenue, Pueblo, CO 81004.

1. Procedural History

The Notice of Appeal in this matter was filed on January 24, 1996. The matter was initially set for hearing on March 26, 1996. On February 26, 1996, Respondent moved to continue the matter, suggesting the hearing dates of April 8, 9, 15, or 16, 1996. On March 11, 1996, ALJ Jones granted the continuance and the matter was set for hearing for April 16, 1996.

On April 15, 1996, Complainant moved to continue the hearing. The request was based on the fact that a discovery dispute had erupted between the parties and Complainant had been unable to complete discovery. Respondent opposed this motion, arguing that it was a last minute request for a continuance. On May 20, 1996, a Notice of Hearing was issued setting the hearing for June 17, 18, and 19, 1996. On May 30, 1996, Respondent requested a prehearing conference because Respondent's Motion to Quash, an element of the discovery dispute, had not been ruled upon. On June 5, 1996, ALJ ruled on the Motion to Quash. On June 10, 1996, a Notice to Set by Telephone was issued. The parties were directed to appear by telephone on June 17, 1996. At the telephone setting, the hearing was once again delayed and scheduled for September 23, 24, and 25, 1996. The hearing was vacated again as a result of ALJ Jones ruling that the matter would be continued until the end of a parallel criminal matter based on this incident.

In February 1997, ALJ Jones again ordered that the hearing be set as soon as the companion criminal trial was completed. The criminal matter was dismissed on April 4, 1997. Respondent requested that the hearing be set for either the week of April 28, 1997, May 5, 1997, or May 27, 1997. Complainant responded to the request by stating that he was not available until the week of July 14, 1997. Complainant also argued that he was prepared to proceed in early June but Respondent's counsel was to be out of the country at that time.

The matter was eventually set for hearing on July 22, 23, and 30, 1997. The hearing set for July was vacated until November 17, 18, and 19, 1997 as a result of Complainant's counsel having to appear as a witness in an unrelated criminal prosecution. Complainant's counsel had been subpoenaed to appear in the unrelated criminal prosecution by another assistant attorney general.

On November 13, 1997, as a result of ALJ Jones leaving her employ with the State Personnel Board, the hearing was once again continued. ALJ Robertson commenced the evidentiary portion of the hearing on November 19, 1997. It was completed on February 10, and 11, 1998.

2. Motions to End Accrual of Back Pay and Motion for Sanctions

A. Back Pay End Accrual Date

On June 11, 1996, Respondent first filed a Motion for Back Pay End Date. Respondent argued that on April 15, 1996, Complainant untimely requested that the hearing be continued as a result of not completing discovery. Discovery had been delayed as a result of confidential medical records being requested. On July 29, 1996, ALJ Jones ruled that the amount of back pay to be awarded to complainant, in the event that he prevails on the merits, will be made apart of the initial decision of the ALJ in this matter. On August 8, 1996, the ALJ ruled that discovery in this matter would be stayed pending the resolution of the criminal matter associated with the same incident.

Subsequently, the issue of the back pay end date again arose. On September 17, 1996, ALJ Jones ruled that the ALJ shall receive evidence at the administrative hearing concerning the issue of complainant's entitlement to back pay during the pendency of these proceedings. ALJ Jones clarified her previous order and stated that discovery in the matter would be stayed until completion of Complainant's criminal trial.

On August 11, 1997, Respondent filed a Second Motion to End Back Pay Accrual. The premise of this motion was that the matter had been originally set for hearing on April 16, 1996 and that as of August 11, 1997, the hearing had not been held. Respondent further argued that it was prepared to proceed to hearing on July 22, 23, and 30, 1997 and that Complainant was responsible for inexcusable delay. Respondent moved for Complainant's eligibility for back pay to end on September 13, 1997 (45 days after the July 30, 1997 hearing date). Again, ALJ Jones postponed ruling on the motion and ordered that any ruling would be held in abeyance until the initial decision.

Section 24-50.125.4, C.R.S. provides, in part:

If an . . . employee is responsible for any inexcusable delay in conducting the hearing or in the issuance of a decision, that person shall not receive back pay or any other award for the period of delay. . . .

There was no inexcusable delay in this matter which could be attributable to the parties. First of all, Respondent initially asked for a continuance because of Respondent counsel's unavailability. Second, the last minute continuance requested by Complainant on April 15, 1996 was the result of a discovery dispute which had occurred between the parties. The record reflects that Complainant could not complete discovery because of a legal issue as to whether or not the medical records of a patient were discoverable. Resolution of this legal issue involved the district court. The fact that Respondent agreed to stipulate to certain facts related to the discovery request does not necessarily resolve the discovery dispute. Third, because of a delay in ruling on a Motion to Quash by ALJ Jones, the matter was continued until September 23, 24, and 25, 1996. This was no fault of the employee. Fourth, Respondent argued that Complainant

failed to timely pursue resolution to its discovery request in district court and that this constitutes inexcusable delay. However, Complainant provides a reasonable argument demonstrating that Complainant did not cause inexcusable delay up through the September 23, 1996 hearing date. Because the criminal case was continued on this matter until November, 1996, the ALJ continued the hearing until completion of the case.

On October 2, 1996, Respondent requested that the hearing be set despite the pending criminal case. At this point, the criminal case was continued until February, 1997. Complainant responded by asking for sanctions. That request of sanctions, in the form of attorney fees is **DENIED**. Respondent's pleading, which argued to have the hearing set as soon as possible, was not unreasonable, nor was it frivolous, vexatious and without substantial merit. The ALJ ruled not to reset the case until the completion of the criminal case. Again, no act of the employee directly caused this delay in hearing.

In May, 1997, the hearing was set for July 22, 23, and 30, 1997. Both parties were unavailable until such time. Again, there was no inexcusable delay on behalf of either party. The matter was continued again because counsel for Complainant was subpoenaed to appear in a unrelated criminal case. This was an excusable delay. The matter was reset for November. That hearing date was vacated as a result of ALJ Jones transferring to another division. The matter was reset for November, 1997 and February, 1998. No inexcusable delay can be attributed to either party.

As a result of this long chain of events, it cannot be found that either party caused an inexcusable delay in the proceedings. CMHIP's motions to end back pay accrual are **DENIED**.

B. Motion for Sanctions

On September 17, 1996, Complainant filed a Motion for Sanctions, requesting that any testimony or statements of Earline Franklin be excluded from hearing. ALJ Jones ruled that a ruling on this matter would occur at the time of hearing. Complainant argued that Respondent's counsel improperly advised Earline Franklin as to whether or not she should appear at a properly noticed deposition. Ms. Franklin did not appear for the initially scheduled deposition. Despite Complainant's argument, Complainant was given an opportunity to depose Earline Franklin and the date of hearing accommodated this opportunity. Complainant's Motion for Sanctions is **DENIED**.

3. Witnesses

Respondent called the following witnesses during its case-in-chief: (1) Complainant, Glenn Lang; (2) Linda Acosta, Nurse II, CMHIP, Pueblo, CO; (3) Kimberly Ortiz, Nurse II, CMHIP, Pueblo, CO; (4) Earline Franklin, Nurse, CMHIP, Pueblo, CO; and (5) Steve Shoenmakers, M.S., Director, Institute for Forensic Psychiatry. On rebuttal, Respondent called

(1) Linda Dotson, Division Chief of Nurse Forensics, CMHIP, Pueblo, CO; and (2) Roger Lucchesi, Registered Nurse, CMHIP, Pueblo, CO. On February 10, 1998, Respondent indicated that one of its witnesses, Al Secora (“Secora”), an employee at CMHIP was not present to testify. Respondent noted that this witness had been available to testify at all times since the commencement of the appeal. However, no steps were taken to preserve the testimony of Secora. In addition, Respondent called Marleen Langfield, Sr. Assistant Attorney General, to support Respondent’s requests for a back pay end accrual date.

Complainant called the following witnesses which included: (1) David Bargean, Psychiatric Clinical Technician, CMHIP, Pueblo, CO; (2) Randall Harris, former Psychiatric Clinical Technician, CMHIP, Pueblo, CO; (3) Richard Casares, Psychiatric Clinical Technician, CMHIP, Pueblo, CO; (4) Walt Schuerman, Corporal, Dept. of Public Safety, CMHIP, Pueblo, CO; (5) Orlando Trujillo, Dept. of Public Safety, CMHIP, Pueblo, CO; (6) Loretta Zeman, Registered Nurse, CMHIP, Pueblo, CO; (7) Mary Warren, Registered Nurse, CMHIP, Pueblo, CO; (8) Carl Salazar, Psychiatric Clinical Technician, CMHIP, Pueblo, CO; (9) Donna Meilusnic, Registered Nurse, CMHIP, Pueblo, CO; (10) Leah Hill, retired Registered Nurse, CMHIP, Pueblo, CO; and (11) Complainant, Glenn Lang.

4. Exhibits

CMHIP offered the following exhibits:

1. Disciplinary letter dated January 18, 1996 to Glenn Lang from Steve Shoenmakers, M.S., Director, Institute for Forensic Psychiatry.
2. Correspondence and Notification of R8-3-3 Meeting dated December 4, 1995 to Glenn Lang from Steve Shoenmakers, M.S., Director, Institute for Forensic Psychiatry.
3. Police Report dated November 18, 1995 by Corporal Walt Schuerman regarding incident on November 18, 1995.
4. Written statement of Earlene Franklin, dated November 18, 1995.
5. Transcript of R8-3-3 meeting of Glenn Lang held December 20, 1995.
6. Transcript of telephone conversation between Earlene Franklin and Steve Shoenmakers, M.S., Director, Institute for Forensic Psychiatry, dated January 17, 1996.
7. CMHIP Policy No. 16.15, Patient Rights, effective 5/15/94.

8. Anecdotal Note, dated June 14, 1981.
9. Anecdotal Note, dated March 26, 1988.
10. Written statement of Kimberly Ortiz, dated November 18, 1995.

Respondent's Exhibits 1, 2, 3, 4, 5, 8, 9, 10 were admitted over objection. Exhibit 7 was admitted without objection. On November 19, 1997 Exhibit 6 was not admitted. On February 10, 1998, Exhibit 6 was admitted for the sole purpose of demonstrating Steve Shoemakers, M.S., Director, Institute for Forensic Psychiatry's actions in investigating the incident.

Complainant proffered no exhibits.

The administrative law judge conducted a physical inspection of the premises in which the incident occurred on November 19, 1997.

5. Sequestration Order

A sequestration order which instructed witnesses not to discuss this matter or their testimony with other witnesses during the course of the hearing was entered at the commencement of the hearing.

ISSUES

1. Whether the Complainant engaged in the actions for which discipline was imposed;
2. Whether the disciplinary termination was within the range of reasonable alternatives available to the appointing authority; and
3. Whether Complainant has failed to mitigate damages, or in the alternative, whether Respondent should be entitled to offset against any back pay awarded to Complainant any amounts earned by Complainant.

FINDINGS OF FACT

1. Complainant was employed by CMHIP as a Psychiatric Clinical Technician II, and certified to that position in 1993. Complainant had worked for CMHIP since 1978.
2. On March 26, 1988, Complainant received an anecdotal note to his file concerning his inappropriate style of expressing himself in written communications. In three

communications, Complainant expressed his frustration with the maintenance staff by wanting to “give them a little kick” and his frustrations regarding stale job postings. In two of the communications, Complainant stated that when the “shit” was outdated (referencing the job postings), it should be thrown out. The note and communications were not made to any CMHIP patients. No corrective or disciplinary action was taken based on these written communications or the anecdotal note.

3. Approximately three years later, in 1991, Complainant received a second anecdotal note to his personnel file which indicated that he had made sarcastic remarks on two occasions to a maintenance worker at CMHIP. Again, the note did not indicate that any such remarks were made to a CMHIP patient. No corrective or disciplinary actions were taken based on this note.
4. On November 18, 1995, Complainant was assigned to work the third shift on Ward GW-12 (“GW-12”) of the Institute for Forensic Psychiatry at CMHIP. GW-12 was located on the sixth floor of Building 121 at CMHIP. GW-12 was one of two wings on the floor. GW-6 was the second wing on the floor. GW-12 housed CMHIP patients who were determined to be incompetent to stand criminal trial or were found guilty by reason of insanity by a court of law.
5. The wings were separated by a lobby which included the elevator and a guard station. Each wing had swinging doors which could be shut between each wing and the lobby. Customarily, the doors remained open. The guard station was locked and the employees within the station were not to assist in providing patient care to the patients on the floor. The patient care staff did not have access to the employees within the station. The station’s purpose was to ensure that GW-6 and GW-12 were secure.
6. Each wing contained a “day room” or lounge physically located adjacent to the lobby. Past the day room, each wing consisted of a hall with a number of rooms down each side of the hallway. CMHIP patients were housed within those rooms. Closest to the day room was a nurse’s station. Each station was equipped with a panic button in the event assistance was needed by staff. The panic button was to be used in the event of an emergency involving staff and CMHIP patients.
7. Because of the types of patients housed at CMHIP, employees of CMHIP received “Therapeutic Intervention for Patient Safety” training (“T.I.P.S.”). Such training involved teaching employees of CMHIP to protect themselves and CMHIP’s patients in the event of an altercation. The employees were trained to use only the force necessary to regain control of a violent situation. The techniques taught included:
 - i) using verbal statements or commands to help de-escalate a situation;
 - ii) blocking punches from CMHIP patients;

- iii) pushing or shoving a patient may be necessary on occasion;
- iv) using self-defense techniques to prevent patients from hurting themselves or staff;
- v) learning to “pin” or immobilize patients so as to de-escalate a situation, including techniques in taking a patient to the floor.

The training provided addresses situations in which a staff member is alone or when accompanied by other staff. A patient is never to be hit or struck.

8. On November 18, 1995, Complainant and Earline Franklin (“Franklin”) were on duty on GW-12. Franklin had been a registered nurse since 1993 and started at CMHIP in February 1995. On November 16, 1995, two days prior to working with Complainant, Franklin received notification that she had been “laid off” from CMHIP. Franklin had worked on the GW-12 ward previously, but it was not her normal assignment. Complainant regularly worked on GW-12.
9. Complainant’s duties included updating charts for patients, interacting with patients, and general housekeeping on the ward. In addition, Complainant and Franklin conducted checks of the ward periodically throughout a shift. The purpose of the ward checks was to insure that patients were receiving proper medical attention. Both Complainant and Franklin had recently been trained with T.I.P.S.
10. Rounds were to be conducted on each ward hourly during the shift. Because of the physical and mental conditions of the patients on these two wards, staff was not to enter a patient’s room alone. If staff had to enter a patient’s room, that staff member was to be accompanied by another staff member. Such a practice was implemented to protect the staff from patient assaults.
11. While not condoned by CMHIP, often only two staff members would be assigned to a ward during the third shift. Staffing the nurse’s station and conducting rounds simultaneously would be impossible.
12. As a part of a treatment program, patients of CMHIP could obtain industrial therapy (“I.T.”) assignments. These assignments consist of providing patients with low-level responsibilities. The I.T. assignments are made by the medical team responsible for any patient and are part of a multi-disciplinary treatment approach. Psychiatric clinical technicians and on-duty nurses do not have the authority to make such assignments.
13. Patients would occasionally be placed on a routine or program of being awakened during the night to be taken to the restroom by CMHIP staff. More often than not, any such program would be part of the treatment plan for a patient and be included in a patient’s chart. However, it was also practice that CMHIP staff, including the on-duty registered

nurse, could implement such a program without it being charted based upon a patient's past practices.

14. On November 18, 1995, GW-12 housed patient W.G.¹ W.G. was an elderly patient and had a history of abusive and combative behavior while at CMHIP. In the past, W.G. had been housed in a high security ward.
15. At approximately 3:00 a.m., Complainant conducted rounds on GW-12. Because only Franklin and Complainant were on duty, Complainant conducted the rounds by himself. Franklin remained at the nurse's station.
16. In the course of conducting the rounds and checking on patients, Complainant noticed urine outside W.G.'s room. It was apparent that W.G. had urinated on the floor, by or near the doorway.
17. Upon discovering the urine in the hallway, Complainant returned to the nurse's station to get a mop and cleaning supplies. Complainant then returned and entered W.G.'s room. Complainant awakened W.G. Complainant asked if W.G. needed to be accompanied to the restroom. W.G. was unresponsive, so Complainant raised his voice at W.G. W.G. refused to go to the restroom and argued with Complainant that he had not urinated on the floor. W. G. was not completely awake.
18. Franklin, having left the nurse's station, observed Complainant yelling at W.G. from the hallway adjacent to W.G.'s room. She left the incident to determine if there was anyone else available to provide assistance. She visually checked GW-12 and GW-6 by looking down the GW-12 hallway, through the day room, through the lobby, and into GW-6. A clear line of sight existed because at least one of the doors between GW-12, the lobby, and GW-6 was open. She saw no one. Franklin then called to GW-11 to ask for assistance. GW-11 is another ward located below the sixth floor location of GW-12. She was unable to reach anyone on that ward. She did not use the panic button.
19. Franklin returned to the doorway of W.G.'s room. During the course of the incident between Complainant and W.G., Complainant had assisted W.G. in sitting up on the edge of the bed. There was no evidence that W.G. had urinated on himself during his sleep, or in the bed.
20. Complainant insisted that W.G. get out of bed and help clean up the urine. In so doing, Complainant stated "I'm tired of your shit" to W.G. Complainant was then out of bed.

¹ The identity of the patients at CMHIP is confidential. During the course of this hearing, W.G.'s name was allowed to be revealed as the result of this matter already having been made public in the course of a police investigation. However, to identify the full name of W.G. would serve no purpose in this initial decision.

W.G. threw a punch at Complainant. Complainant blocked the punch, and grabbed at W.G. so as to prevent him from falling back onto the bed. Complainant made a statement to W.G. suggesting that if he got up to clean his urine, there would be an opportunity for an I.T. assignment.

21. Franklin again looked for assistance on the floor and failed to find any. She again called to GW-11 to ask for assistance and was unable to reach anyone. She returned to W.G.'s room. She failed to assist Complainant. She failed to verbally call out for help.
22. A scuffle ensued. Complainant initially pinned W.G. to the room wall, and restrained his hands so as to prevent injury to himself and W.G. At this point, both Complainant and W.G. fell to the floor. Complainant pinned W.G. to prevent the situation from escalating. At that point, the situation de-escalated and W.G. was helped to his feet. W.G. proceeded to begin to clean the floor and then returned to bed.
23. W.G. indicated he was not injured in the scuffle. Franklin did not conduct a physical assessment of the patient.
24. Based on her observations and being admittedly shaken by the incident, Franklin stated to Complainant that the use of physical force would get him in trouble. After waiting for a few minutes, she left the nurse's station and called to the supervisor's office and spoke with Kimberly Ortiz and Linda Acosta. Franklin claimed that after Complainant had pinned W.G. on the floor, Complainant had punched W.G. in the chest and slapped him three times across the face.
25. Approximately one hour later, officers of CMHIP's Dept. of Public Safety ("hospital police") arrived at the scene and conducted an investigation. At that time, Kimberly Ortiz and Corporal Walt Schuerman checked the status of W.G. and examined him for injuries. No injuries were discovered. There was no bruising or red markings on the chest or face. Subsequently, Ortiz ordered Complainant to leave the work site.
26. During the following day, CMHIP staff further examined W.G. and found a bruise on his leg. Corporal O. Trujillo was called to investigate and take a picture of the bruise. Upon examination by Trujillo, no bruise was found to photograph. The only marking on W.G.'s leg was a slight bump.
27. On December 4, 1995, a R8-3-3 meeting was noticed to Complainant by the appointing authority Steve Shoenmakers, M.S., Director, Institute for Forensic Psychiatry. The stated purpose of the meeting was to discuss allegations against Complainant of possible patient abuse. The meeting was held as provided in State Personnel Board Rule R8-3-3, 4 CCR 801-1 on December 20, 1995. Complainant was represented by counsel.

28. On January 18, 1996, Complainant was sent a termination letter indicating that it was the appointing authority's determination that Complainant had failed to comply with standards of efficient service or competence, and willfully failed or was unable to perform duties assigned. Shoemakers had concluded that Complainant had (1) entered the patient's room alone and (2) stated to a patient that "I was tired of your shit". Shoemakers also stated that he found Complainant's version of the events not credible and that the other witnesses, including Franklin, were very specific, descriptive and compelling in describing the incident.

29. CMHIP, Policy 16.15 provides, in part:

"Patient abuse" is any behavior by an employee that is anti-therapeutic, non-professional and/or affects the patient detrimentally.

Examples of anti-therapeutic or non-professional behavior or neglect include, but are not limited to:

Striking a patient.

Foul or offensive language.

Language that is personally derogatory of the patient . . .

Using unnecessary force.

Verbal or nonverbal threats, or intimidation, or retaliation.

The policy further provides:

Suspected patient abuse or neglect shall be reported immediately to the supervisor, who will notify the department head . . . and an investigation shall be started immediately to discover the facts surrounding the incident. Any employee who has knowledge of or is witness to suspected patient abuse or neglect and fails to report his to his supervisor is also responsible for patient abuse

The Dept. of Public Safety shall be called to assist in the investigation of the allegations of patient abuse or neglect

Upon completion of the investigation, if indicated, an employee may be subject to corrective and/or disciplinary action up to and including dismissal, by the Appointing Authority for that department or division.

30. Complainant had a reputation for gentle behavior and responsiveness to patients.

DISCUSSION

I. INTRODUCTION

Certified state employees have a property interest in their positions and may only be terminated for just cause. *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994). Such cause is outlined in State Personnel Board Rules R8-3-3 (C) and generally includes: (1) failure to comply with standards of efficient service or competence; (2) willful misconduct including either a violation of the State Personnel Board's rules or of the rules of the agency of employment; (3) willful failure or inability to perform duties assigned; and (4) final conviction of a felony or any other offense involving moral turpitude.

In this disciplinary action of a certified state employee, the burden of proof is on the terminating authority, not the employee, to show by a preponderance of the evidence that the acts or omissions upon which discipline was based occurred and just cause existed so as to impose discipline. *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994).

In *Charnes v. Lobato*, 743 P.2d 27, 32 (Colo. 1987), the Supreme Court of Colorado held that:

Where conflicting testimony is presented in an administrative hearing, the credibility of witnesses and the weight to be given their testimony are decisions within the province of the agency.

In determining credibility of witnesses and evidence, an administrative law judge can consider a number of factors including: the opportunity and capacity of a witness to observe the act or event, the character of the witness, prior inconsistent statements of a witness, bias or its absence, consistency with or contradiction of other evidence, inherent improbability, and demeanor of witnesses. Colorado Jury Instruction 3:16 addresses credibility and charges the fact finder with taking into consideration the following factors in measuring credibility:

1. A witness' means of knowledge;
2. A witness' strength of memory;
3. A witness' opportunity for observation;
4. The reasonableness or unreasonableness of a witness' testimony;
5. A witness' motives, if any;
6. Any contradiction in testimony or evidence;
7. A witness' bias, prejudice or interest, if any;
8. A witness' demeanor during testimony;
9. All other facts and circumstance shown by the evidence which affect the credibility of a witness.

As argued by both parties, this is a case based on credibility.

II. PARTIES' ARGUMENTS

Respondent argues that during the incident of November 18, 1995, only two competent individuals were present, Complainant and Franklin. W.G. being a patient of CMHIP, GW-12, could not be considered competent. Respondent argues that Complainant violated State Personnel Board rules, failed to comply with standards of efficient service or competence and willfully failed or was unable to perform duties assigned. Respondent further argues that Franklin is the more credible witness and that her version of the events of November 18, 1995 is to be believed. Respondent argues that Franklin initially reported the incident, had no vested interest in reporting the incident and was upset as a result of having observed the Complainant's behavior. As a result, she is more credible and her observations of Complainant's behavior are to be believed. Finally, Respondent maintains that the issue of patient rights must be weighed against the Complainant's rights.

Complainant argues the opposite. First and foremost, Complainant argues that he did not commit any of the abusive acts reported by Franklin. Complainant maintains that he did not violate the State Personnel Board rules and that he did comply with the standards of efficient service and competence, and did not otherwise fail to perform duties as assigned. In support of Complainant's position, Complainant notes that he has had years of experience with CMHIP, that he has an exemplary record and that he has a good reputation among his co-workers. In addition, Complainant points out that W.G. had a history of aggressive behavior and even admitted to throwing the first "punch." Complainant argues that Franklin's description of the events of November 18, 1995 should not be viewed as credible. Her testimony is said to be inconsistent and improbable. Finally, Complainant argues that because of Franklin's lack of credibility, Respondent fails to meet its burden of proof as recited in *Kinchen*.

III.

A. Entry Into Patient's Room

There is no dispute that Complainant entered W.G.'s room by himself and that he stated that he was "tired of his (W.G.'s) shit." Both Complainant and Franklin testified that Complainant entered the patient's room alone. The testimony of Linda Acosta ("Acosta"), a supervisor, was that staff was not to enter a patient's room alone because it was not safe and that patients were combative. The testimony of Mary Warren, a registered nurse who had worked with CMHIP for five years, and worked on GW-6 the night of the incident, confirmed that patient checks were to be conducted by two individuals and that it was not appropriate to have one person conduct patient checks while one individual observed from the nurse's station. Franklin testified that she was in the nurse's station doorway, watching Complainant as he conducted rounds. When the urine was discovered, she failed to accompany Complainant to W.G.'s room to clean it up. Rather, she observed Complainant getting the cleaning supplies and

proceed to waken W.G. Franklin's own written statement of November 18, 1995 indicates that she watched Complainant go back and forth to W.G.'s room with the cleaning supplies, but that she never accompanied him to the room to help clean up the urine OR, be present in W.G.'s room while Complainant cleaned up the urine. Franklin had failed to accompany Complainant, thus facilitating the need for Complainant to enter W.G.'s room alone to clean the urine.

Complainant maintains that he entered the room, awoke W.G. by raising his voice and asked him (1) if he needed to use the restroom and (2) to clean up the urine on the floor. Complainant maintains that this practice is in conformity with past practices at CMHIP. Warren supported Complainant's actions by testifying that often a program would exist allowing patients to be taken to use the restroom during a night and that such a program was only sometimes ordered by a treatment team. Warren further testified that such a program was to be used only if the patient was already awake. But, she also stated that a patient may have to be awakened in order to determine if the patient is soaked in urine and in need of changing. Richard Casares further supports the existence of the practice of awakening a patient by testifying that a patient might have to be awakened if they were heavily sedated in order to determine if the patient had urinated on himself. Even Franklin admitted during cross-examination that there were occasions when a patient would be awakened to use the restroom. In this case, it is unclear as to whether the patient was asleep or awake when Complainant entered his room. However, it is not necessarily incompetence or failure to perform duties as assigned in waking a patient in the middle of the night after the patient has urinated.

B. The I.T. Assignment and T.I.P.S.

Complainant admits making reference to the assignment of an I.T. assignment to coax W.G. into helping to clean up the urine. It is at this point that W.G. became combative. Complainant was in a situation in which he was required to clean up urine in a patient's room, check to see if the patient had soaked either his bedclothes or the bed, and had an assaultive patient. Franklin stated on cross-examination that she observed that W.G. was combative and assaultive. Complainant had to use his T.I.P.S. training. Part of that training included the use of verbal statements to attempt to de-escalate the situation. Complainant's offer of the I.T. position may have been such an attempt. In addition, the training provided that Complainant was to block punches from CMHIP patients. Complainant, having no assistance from Franklin, was compelled to utilize T.I.P.S. training, to try and protect himself and the patient. He had to immobilize the patient to de-escalate the situation. The struggle which occurred comported with the type in which T.I.P.S. training needed to be used.

C. Franklin's Credibility

Franklin's rendition of the incident is not credible. Franklin was not normally assigned to GW-12 nor did she have much experience with the assaultive patients on that ward. She states Complainant was yelling at W.G. Franklin also states that the incident occurred over a period of

five to ten minutes. Warren testified that while she was in the GW-6 lounge, she heard no yelling or calls for help, heard no scuffle, and observed no unusual activity between 3:00 a.m. and 4:00 a.m. when the hospital police arrived. Warren testified that if there had been any trouble, she would have heard it. She was only across the lobby and GW-12 lounge from the incident and was arguably within physical proximity to the event. Yet, she heard nothing over the purported five to ten minute incident. Franklin states she attempted to obtain assistance. Yet, she never used the panic button. She never called out for help. She never ran across the lobby to get assistance from GW-6's staff. Warren was on GW-6 and could have provided assistance. The only action Franklin took to obtain assistance was to purportedly call down to a ward on a different floor two times. If the situation was as dramatic as Franklin purports it to have been, she surely would have more effectively obtained assistance or would have intervened herself to de-escalate the situation.

Franklin initially stated that Complainant threw W.G. to the floor. Subsequently, she believed that Complainant and W.G. fell to the floor. Franklin testified that Complainant pushed W.G. then subsequently said no pushing occurred. She testified that Complainant struck the patient in the chest and in the face a number of times. Yet, there was no immediate assessment of the patient after the incident. The assessment of the patient occurred up to an hour later when the officers from the Dept. of Public Safety and the supervisor arrived. At that time, there were no physical markings on the patient. If Franklin had been concerned about patient abuse, shouldn't she have assessed the patient's condition? Couldn't Franklin have then obtained assistance from the staff on GW-6? She did call her supervisor and report the incident. Yet, an hour elapsed before any type of assessment was done. The assessment made after 4:00 a.m. was only preliminary. A second, more thorough assessment did not occur until the day shift, hours later. Franklin stated that Complainant used more than necessary force to restrain W.G. once the Complainant and W.G. were on the floor, Yet, prior to the individuals being on the floor, she testified that the force being used was only bordering on unnecessary force.

Franklin made numerous inconsistent statements throughout this incident. In addition, portions of Franklin's testimony of the incident and CMHIP's policies are contradicted by witnesses, compromised by her not observing the entire incident, represent a weakened memory of the event, and are unreasonable. Franklin's account of the incident cannot be viewed as credible.

At the same time, Complainant introduced evidence from a number of co-workers that he had a quiet demeanor and was cordial to co-workers, supervisors and patients. Donna Meilusnic, a registered nurse, worked with Complainant for at least one year, and had worked in the Forensics division of CMHIP for twelve years. Meilusnic testified that Complainant had always been respectful, caring, thoughtful and responsive to patients. This testimony was supported by Leah Hill, a 12 year veteran registered nurse at CMHIP. There is a demonstrative lack of evidence to support that Complainant was violent or aggressive towards patients over the course of his career with CMHIP. It must be noted that Complainant also contradicted himself in

describing the incident during the course of his testimony. However, the inconsistencies in his testimony do not rise to the level of impacting his credibility as do the inconsistencies in Franklin's testimony.

D. CMHIP's Policy 16.15

CMHIP's Policy 16.15 provides that *corrective action* or *disciplinary action* may be imposed in cases involving patient abuse. In this instance, Complainant admitted using foul or offensive language. He also admitted entering the patient's room without Franklin. However, Respondent has failed to prove by preponderant evidence that the scuffle that occurred subsequent to these admitted actions was in violation of Policy 16.15. Rather, it is more likely than not that the altercation ensued as the result of Complainant trying to determine if W.G. had urinated on himself or the bed. The fact that an I.T. assignment may have been offered, that W.G. was asked if he needed to use the restroom, and that W.G. was asked to clean up urine does not rise to such a level as to violate Policy 16.15 and may have been facilitated by the implementation of past practices of having patients use the restroom in the middle of the night and the implementations of T.I.P.S. to de-escalate the situation.

Given Complainant's admitted behavior, and that Respondent failed to demonstrate additional violations of Policy 16.15, the disciplinary termination imposed is outside the range of reasonable alternatives available to the appointing authority. The fact that Policy 16.15 allows for corrective actions as well as disciplinary actions suggests that unless the act is so egregious as to warrant termination, a corrective action should be used to improve an employee's behavior or performance. State Personnel Board Rule R8-3-1, 4 CCR 801-1 provides, in part:

The decision to correct or discipline an employee shall be governed by the nature, extent, seriousness and effect of the act, error or omissions committed; the type and frequency of previous undesirable behavior; the period of time that has elapsed since a prior offensive act; the previous performance evaluation of the employee; an assessment of information obtained from the employee; any mitigating circumstances; and the necessity of impartiality in relations with employees.

In the case of a certified employee, unless the conduct is so flagrant or serious that immediate disciplinary action is appropriate, corrective action shall be imposed before resorting to disciplinary action.

In this case, Complainant had received no corrective actions and was not given an opportunity to correct his behaviors or improve his performance. While the admitted acts of Complainant are not condoned, such acts cannot be viewed as so serious as to warrant termination. In addition, there are a myriad of mitigating circumstances in this case which account for Complainant's behavior. The actions of Complainant were not so flagrant or serious as to demand his termination for failure to comply with standards of efficient service or competence, or for willful

failure or inability to perform duties assigned.

CONCLUSIONS OF LAW

1. Complainant's actions of using foul language and entering a patient's room unattended in violation of CMHIP policy are actions for which corrective or disciplinary action may be imposed.
2. The disciplinary termination was NOT within the range of reasonable alternatives available to the appointing authority and the discipline imposed was in violation of Board Rule R8-3-1, 4 CCR 801-1.
3. The Respondent's actions were arbitrary and capricious or contrary to rule or law.

ORDER

1. Respondent is directed to rescind the January 18, 1996 disciplinary termination of Complainant's employment.
2. Respondent shall reinstate Complainant to the position he held at the time of his wrongful termination. Corrective action may be imposed based upon the findings of fact in this matter but such corrective action shall not be accompanied by any disciplinary action.
3. No party caused inexcusable delay in the process of this hearing. Complainant shall be awarded back pay and benefits from the time of his wrongful termination, offset by any amounts earned by Complainant subsequent to his termination.
4. Neither party is entitled to an award of attorney fees as provided in section 24-50-125.5, C.R.S.

Dated this 25th day
of March, 1998
at Denver, Colorado

G. Charles Robertson
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

EACH PARTY HAS THE FOLLOWING RIGHTS

1. To abide by the decision of the Administrative Law Judge ("ALJ").
2. To appeal the decision of the ALJ to the State Personnel Board ("Board"). To appeal the decision of the ALJ, a party must file a designation of record with the Board within twenty (20) calendar days of the date the decision of the ALJ is mailed to the parties. Section 24-4-105(15), 10A C.R.S. (1993 Cum. Supp.). Additionally, a written notice of appeal must be filed with the State Personnel Board within thirty (30) calendar days after the decision of the ALJ is mailed to the parties. 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. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Colo. App. 1990); Sections 24-4-105(14) and (15), 10A C.R.S. (1988 Repl. Vol.); Rule R10-10-1 et seq., 4 Code of Colo. Reg. 801-1. If a written notice of appeal is not received by the Board within thirty calendar days of the mailing date of the decision of the ALJ, then the decision of the ALJ automatically becomes final. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Colo. App. 1990).

RECORD ON APPEAL

The party appealing the decision of the ALJ must pay the cost to prepare the record on appeal. The fee to prepare the record on appeal is **\$50.00** (exclusive of any transcription cost). Payment of the preparation fee may be made 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.

Any party wishing to have a transcript made part of the record should contact the State Personnel Board office at 866-3244 for information and assistance. To be certified as part of the record on appeal, an original transcript must be prepared by a disinterested recognized transcriber and filed with the Board within 45 days of the date of the notice of appeal.

BRIEFS ON APPEAL

The opening brief of the appellant must be filed with the Board and mailed to the appellee within twenty calendar days after the date the Certificate of Record of Hearing Proceedings is mailed to the parties by the Board. The answer brief of the appellee must be filed with the Board and mailed to the appellant within 10 calendar days after the appellee receives the appellant's opening brief. An original and 7 copies of each brief must be filed with the Board. A brief cannot exceed 10 pages in length unless the Board orders otherwise. Briefs must be double

spaced and on 8 1/2 inch by 11 inch paper only. Rule R10-10-5, 4 CCR 801-1.

ORAL ARGUMENT ON APPEAL

A request for oral argument must be filed with the Board on or before the date a party's brief is due. Rule R10-10-6, 4 CCR 801-1. Requests for oral argument are seldom granted.

PETITION FOR RECONSIDERATION

A petition for reconsideration of the decision of the ALJ must be filed within 5 calendar days after receipt of the decision of the ALJ. The petition for reconsideration must allege an oversight or misapprehension by the ALJ, and it must be in accordance with Rule R10-9-3, 4 CCR 801-1. The filing of a petition for reconsideration does not extend the thirty calendar day deadline, described above, for filing a notice of appeal of the decision of the ALJ.

CERTIFICATE OF MAILING

This is to certify that on this _____ day of March, 1998, I placed true copies of the foregoing **INITIAL DECISION OF ADMINISTRATIVE LAW JUDGE** in the United States mail, postage prepaid, addressed as follows:

David E. Ware, Esq.
Altman, Keilbach, Lytle, Parlapiano & Ware, P.C.
229 Colorado Avenue
Pueblo, CO 81004

and in the interagency mail, addressed as follows:

Toni Jo Gray
Assistant Attorney General
1525 Sherman Street, 5th Floor
Denver, CO 80203
