

STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. 97B140(C)

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

ROBERT P. GUSICH,

Complainant,

vs.

DEPARTMENT OF CORRECTIONS,
DIVISION OF CLINICAL SERVICES,

Respondent.

This seventeen-day hearing was heard by Administrative Law Judge (“ALJ”) Michael Gallegos on May 8, 1998, October 6, 7, 8, 9, and 13 and November 13, 16, and 17, 1998, and by ALJ Mary S. McClatchey on May 25, 26, and 27, June 2, and 30, and July 9, 14, and 22, 1999. Complainant appeared and was represented by Bruce J. Pederson and Jacqueline P. Taylor. Respondent was represented by A.A. Lee Hegner.

MATTERS APPEALED

This case involves appeals of two disciplinary actions. The first concerns Respondent’s April 25, 1997 discipline of Complainant for misappropriation of state property, for which he received a three-month two-step reduction in pay, and for which he was charged the alleged amount of the misappropriated items, \$67.45. The second involves Respondent’s termination of Complainant on July 7, 1997, for creating a hostile workplace environment. Complainant asserts that Respondent violated the Colorado State Employee Protection Act, Section 24-50.5-101 *et seq*, C.R.S. (“whistleblower act” or “Act”) in imposing both actions.

For the reasons set forth below, Respondent’s actions are affirmed, with the exception of the deduction of \$67.45 from Complainant’s pay.

PRELIMINARY MATTERS

1. Witnesses.

Complainant called the following witnesses: Donald Lawson, Director of Operations, Clinical Services, Department of Corrections (“DOC”); Joanie Shoemaker, Clinical Team

Leader, Denver Reception and Diagnostic Center (“DRDC”), DOC; Tony Schenk, Chief of Pharmacy Services, DOC; Dr. Rose Hedgeman, Clinical Team Leader, Limon and Arkansas Valley Correctional Facilities, DOC; Annette Fucles, Investigator at Office of the Inspector General, DOC; Ophelia Nava, Nurse I, DRDC; Mynette Moulton, Pharmacy Technician, DRDC; Ron Johnsen, former Clinical Team Leader, DRDC; Sara Narowski, Pharmacist; John Wilson, Chief Criminal Investigator, Department of Labor and Employment; Phil DeFelice, Correctional Officer III, DOC; Napoleon Christian, Customer Support Coordinator, DOC; Kathy Dean, Nurse I, DRDC; Van Williford, Nurse I, DRDC; Wade Buchanan, Pharmacist, Canyon City, DOC; Brian Davis, former Physician Assistant, DRDC; Earlene Anderson, Nurse I, DRDC.

Respondent called the following witnesses: Donald Lawson; Annette Fucles; Joanie Shoemaker; Dr. Rose Hedgeman; and Bruce Emeson, Chief Pharmacist at Kaiser.

2. Exhibits.

Complainant’s Exhibits A-C, and E-JJJ were admitted by stipulation. Regarding Exhibit FFF, a large diagram was substituted for the 8 1/2 x 11 inch page constituting the original exhibit. Complainant’s Exhibit PPP is a lengthy document, of which only the first two and the last two pages were admitted, by stipulation. Complainant’s Exhibits KKK, LLL, MMM, and NNN were admitted without objection. Complainant’s Exhibits OOO and RRR were admitted over objection. Complainant’s Exhibit QQQ was offered but not admitted. Complainant’s Exhibits D and DDD were withdrawn and not offered.

Respondent’s Exhibits 1 - 28 were admitted by stipulation. Exhibit 29 was admitted without objection. Exhibit RRR was admitted over

3. Procedural Matters; Motions.

ALJ Gallegos presided over this hearing until January 22, 1999, on which date she recused herself from the case. (See Recusal Order). Pursuant to Section 24-4-105(3), C.R.S., ALJ McClatchey was assigned to the case.

At the outset of the hearing, witnesses were sequestered. The parties entered into a stipulated protective order, filed with the Board on September 18, 1998, and approved by the Board, under which any medical information relating to inmates in the custody of Respondent would be protected. In addition, a protective order was entered concerning the testimony of Joanie Shoemaker on October 9, 1998, regarding discipline of DOC employees other than Complainant. Any transcript prepared must assure that such testimony is not available to the public.

It was determined that Complainant would present his case first, since he bears the burden of proof in the State Employee Protection Act claim under Section 24-50.5-101, *et seq.*, C.R.S. (hereafter “whistleblower act” or “Act”). Respondent’s motion to bifurcate the hearing by separating the whistleblower action from the disciplinary actions was denied, on

grounds that to bifurcate would result in duplicative presentation of evidence.

Judicial notice was taken of Ward v. Industrial Commission, 699 P.2d 960, 967 (Colo. 1985), under which oral communications qualify as protected disclosures under the whistleblower act.

Respondent's Motion to Strike Complainant's Motion for Partial Summary Judgment as untimely was denied. Complainant's Motion for Partial Summary Judgment was denied. The Motion argued that Complainant had been terminated in part for the same act for which he had been disciplined, namely, misappropriation, violating the rule barring discipline for the same behavior twice. The Motion was denied on grounds there was a factual dispute concerning this issue.

On October 13, 1998, Complainant made a motion to strike all evidence regarding Jamie Stambaugh and Laurie Hansen, arguing that at the R8-3-3 meeting he had not been told of allegations concerning these two individuals, but the appointing authority had utilized them in making her decision to terminate Complainant. This motion was denied on grounds that all information utilized by the appointing authority was relevant in determining whether she had acted arbitrarily, capriciously, or contrary to rule or law.

At the close of Complainant's case, Respondent made a motion for directed verdict. This motion was denied on grounds Complainant had made a prima facie case of having made protected disclosures under the whistleblower act, and that evidence had been submitted that could lead a fact finder to conclude that such disclosures had been a substantial or motivating factor in the disciplinary decisions.

On September 10, 1999, the Board issued a Procedural Order stating that the Initial Decision in this matter would not be issued until October 22, 1999, due to docketing issues.

ISSUES

1. Whether the Complainant engaged in the acts for which he was disciplined;
2. Whether the disciplinary actions were within the range of reasonable alternatives available to the appointing authorities;
3. Whether the actions of the appointing authorities were arbitrary and capricious, or contrary to rule or law;
4. Whether Respondent retaliated against Complainant for making protected disclosures in violation of the Colorado whistleblower act.
5. Whether Complainant is entitled to an award of attorney fees and costs.

STIPULATED FACTS

1. Complainant's appeals to the State Personnel Board were timely filed.
2. The State Personnel Board has jurisdiction over this consolidated case.
3. Complainant was a certified state employee when disciplined by Respondent.
4. Complainant had not received any corrective or disciplinary actions regarding misappropriation of state property prior to being disciplined with a two step reduction by Don Lawson on April 25, 1997 for allegedly misappropriating state property.
5. Complainant had two first line supervisors, Joanie Shoemaker and Tony Schenk.
6. Approximately 45 employees worked within Clinical Operations at the DRDC during the period that Complainant was assigned to that facility.

FINDINGS OF FACT

1. In October of 1994, Complainant was hired on a contract basis as a Pharmacist II at DRDC in Denver, Colorado. DRDC serves as a temporary health screening and treatment facility for DOC inmates, prior to their being sent to more permanent incarceration centers.
2. On March 1, 1995, Complainant was hired as a permanent employee in the Pharmacist II position at DRDC. On March 1, 1996, Complainant completed his probationary term and became a certified employee.
3. Respondent's job duties as Pharmacist II at DRDC included the following: he was the pharmacist in charge of the DRDC pharmacy; provision of pharmacy services to the Limon, Golden, and Rifle Correctional Facilities ("LCF"), ("CCC"), and ("RCF"); supervision of the pharmacy technician at DRDC pharmacy; filling of prescriptions; acquisition and distribution of all drugs and some medical supplies for DRDC, LCF, RCF, and CCC; and fielding of telephone calls from other facilities.
4. The supervision structure at DRDC was such that Complainant always had two supervisors. One, Tony Schenk, located in Canyon City, was Chief Pharmacist for all DOC facilities. Schenk was responsible for supervising Complainant's clinical duties. The other position, Clinical Team Leader at DRDC, was held first by Ron Johnsen from October of 1994 until August 1995, and then by Joanie Shoemaker from August 1995 until Complainant's termination in July 1997. The Clinical Team Leader had administrative supervisory authority over Complainant and all medical staff, including physicians, dentists, nurses, the pharmacy staff, etc., at DRDC.
5. Johnsen received a number of complaints from nurses regarding Complainant's

behavior and work hours during his tenure as Complainant's supervisor. They complained that he was loud and intimidating, that they could not talk to him, that he would become angry and stomp off. They felt he was overbearing and intimidating at times.

6. Complainant liked to try to go home early. He had an informal agreement with Schenk and Johnsen that if his work was completed he could leave early.

7. Staff complained to Johnsen about Complainant leaving early. Johnsen told him to watch his time because staff were watching him, and to get the medications filled before leaving.

8. For the last couple hours of the day, because he wanted to leave early, if nurses came to Complainant with prescriptions to be filled, Complainant became rude, short, curt and angry with them. The nurses reported this to Johnsen. Nurses brought prescriptions late in the day because that is often when inmates were brought to the facility.

9. Johnsen spoke to Complainant about his being angry and rude to the nurses at the end of the day at least once or twice. Johnsen felt that Complainant could have improved his communication style with the nurses, to keep the tension down, rather than to elevate it.

10. Approximately five times Complainant left the facility before medication orders came into the pharmacy, causing a problem.

Problems with Veronica Gomez

11. Complainant worked with a pharmacy technician, Veronica Gomez. Gomez abused the sick and annual leave policies, often calling in on the day she would be absent with no prior notice. This was difficult on Complainant. He complained to Johnsen, Joanie Shoemaker (then Director of Nursing at DRDC), and Laurie Wiley, a nursing supervisor. Johnsen agreed that Gomez abused the leave policies.

12. Other than the leave policy abuse, Gomez was an excellent worker when she was at the facility. There were no complaints regarding her performance to Johnsen, although Complainant felt she was insubordinate with him at times.

13. Gomez felt intimidated by Complainant, who yelled at her and made her feel stupid. Complainant's treatment of Gomez was such that Gomez would cry when she got home, dreaded going to work, and ultimately was diagnosed with Situational Stress caused by her work situation. She was prescribed Zoloft. Her work related stress is in part what caused her to take excessive leave, although this did not excuse her failure to adhere to the leave policies.

14. Gomez called Schenk at home several times, crying, and told him Complainant had yelled at her, called her stupid, and that she felt intimidated by him. Gomez's husband also

called Schenk regarding the situation. There were a total of 20-30 phone calls.

15. Schenk mentioned Gomez's complaints to Complainant, but since she was transferring away from DRDC soon, he told Complainant to just "lay off" her until she left.

16. Gomez also complained about Complainant's treatment of her to Doug Massengail, a Pharmacist II in Canyon City, calling him crying and upset. He suggested she speak with Schenk and document the problems.

17. In June 1995, Gomez did make notes regarding Complainant's conduct:

June 19, 1995. Argument with Bob, this time it was over papers I was shredding. Bob walked into the pharmacy and asked me what I was shredding. I told him it was the old arrival lists. For some reason, this got him very upset. He started yelling at me that next time I shredded anything it would have to be approved by him and I could not shred anything without his knowledge. This got me very upset because I felt that his attack on me was unjustified. After the argument I phoned Tony in Canon to let him know what happened and how upset I was.

June 20, 1995. Argument with Bob again, this time it was over whether or not we needed extra help. I told him I didn't feel we needed any as long as we distributed the work evenly between us. His suggestion to that was, I don't care what you think, we do need an extra person. Again this was said in a very loud voice, what I perceived as yelling. I made an appointment with my doctor today. (June 23 at 5:00).

June 22, 1995. Meeting scheduled with Ron Johnsen. Hopefully we could resolve some of the conflicts between Bob and I.

June 23, 1995. Went to Dr. Steinberg today, discussed my problems at work with her. She gave me a prescription for Zoloft and told me it was situational stress caused by work. I told her I was anticipating a transfer to a different facility and hopefully it would relieve my stress.

18. On June 20, 1995, Complainant wrote a contemporaneous note, "Veronica didn't want to leave pharmacy at 4:15 after I told her '10 times' it was OK because all work and procedures were done. Veronica said I was yelling at her, but I wasn't. I even asked Mary Arnold in the hall & nurses [?] if I was yelling & she said she heard nothing."

19. After transferring to another DOC facility, in July of 1995, Gomez no longer needed the Zoloft. (Gomez did not transfer because of Complainant, although her transfer may have been expedited because of her problems with him.)

Jamie Stambaugh Grievance

20. On July 5, 1995, Complainant got into an argument with Jamie Stambaugh, a line nurse at DRDC. Stambaugh stated that she missed Veronica Gomez. Complainant felt insulted, took offense at this, and stated, "if you have something to say to me, say it to my face, not behind my back," or words to that effect. The two of them then got into a heated argument, both raising their voices to a level inappropriate in the workplace.

21. In the course of this heated exchange, Stambaugh attempted to force her way into

the pharmacy. Complainant blocked her entry and told her she had no right to be in the pharmacy without his permission. He came in close to Stambaugh, raising his arms in an intimidating fashion.

22. Stambaugh was a problem employee, who routinely overreacted to situations and got into heated discussions with many DRDC staff. She had mental health problems.

23. Stambaugh wrote a formal complaint of harassment to the Warden of DRDC. Johnsen investigated the incident, interviewing Complainant, Stambaugh, and others who were eye witnesses.

24. In discussing the fact of his large size and height, and his raised arms during the argument, Complainant admitted to Johnsen that he could be relatively intimidating to Stambaugh, but stated that he did not intend to hit her.

First Letter of Counseling

25. After his investigation, Johnsen determined that Complainant had raised his voice, and had used arm movements and a forward stance toward Stambaugh that were inappropriate. Johnsen wrote a letter of counseling to Complainant. The July 11, 1995 letter states,

“My preliminary investigation, while showing Ms. Stambaugh may have exaggerated, shows that you did raise your voice and present an intimidating posture to Ms. Stambaugh. In our discussion on July 11, 1995, you stated that Ms. Stambaugh’s behavior relative to this event as well as previous behavior around you have been unprofessional, thereby making it uncomfortable for you in the work place. While this may be true, there is no excuse for this type of behavior to any staff at any time. In summary, I am requesting that: 1) You do not display this type of behavior to Ms. Stambaugh or any other staff member in the future. Any further behavior of this type may lead to corrective or personnel actions. 2) Should you have any interpersonal problems with any staff member, you inform me as soon as possible. 3) That you apologize to Ms. Stambaugh for your unprofessional behavior. 4) That you work closely with Ms. Shoemaker to develop a procedure relative to who and under what conditions our staff may be authorized access to the Clinical Services pharmacy.”

26. Complainant did apologize to Stambaugh.

27. On July 5, 1995, Laurie Wylie, a nurse supervisor, wrote a memo to Johnsen, attaching Stambaugh’s complaint. Wylie related her own concerns about Complainant’s recent conduct, including, “I have reports from other staff indicating that they are noticing his negative attitude.” She states, “I am concerned about this because of the negative impact he is having on other staff.”

28. On a March 1 - June 1, 1995 Performance Progress Review Form for Complainant, signed by Complainant, Johnsen wrote the following:

Supervision/Human Resource Management: Needs to develop an understanding surrounding dealing with state employees and their ‘rights.’ Good.

Communications. Needs to work on communicating with one of our challenging staff and nursing staff at LCF. Should improve.”

29. On July 27, 1995, Johnsen gave Complainant his performance appraisal for the period March 1 to August 1, 1995, which Complainant signed, indicating his agreement. Johnsen gave Complainant three Needs Improvement ratings in: Supervision/Human Resource Management, Communications, and Interpersonal Relations. Johnsen gave Complainant an overall Good rating.

30. In the Performance Appraisal Narrative section, Johnsen wrote the following:

“Robert is doing a overall good performance. (sic) His only problem since starting with DOC is communication with his pharmacy tech and one of our RN's. These problems arise from Robert's poor understanding of supervising in a state system. His pharmacy tech has taken time off, e.e, sick leave with no advance notice. This has caused stress on both Bob and his tech resulting in hard feelings between them. Bob also had an altercation with one of our RN's. While Bob may have been 'set up' he did not handle the situation appropriately and raised his voice. Bob needs to work on tact/diplomacy and interpersonal relations with staff.”

31. Public prison pharmacy facilities are commonly antiquated, disorganized, poorly equipped, and inefficient. DRDC was no exception. Complainant's background was in private practice. When he arrived at the DRDC facility, he immediately became very concerned about the antiquated computer system, improper nursing practices, improper disposal of narcotics, and a number of other issues relating to regulatory and statutory rules governing pharmacy, controlled substances, and health care facility operations. Throughout his tenure at DOC, Complainant brought these concerns to the attention of line nurses, nursing supervisors, his own supervisors, and others.

32. Complainant testified that he made thirty-eight (38) disclosures of “violations” during his tenure at DRDC. These appear, in part, in his Chronology of Protected Disclosures, Exhibit UU, pages 9 - 12 (“Chronology”). He also testified regarding some additional specific and general, ongoing disclosures.

Failure to Dispose of Narcotics

33. Outdated narcotics that should have been disposed of were still at DRDC pharmacy upon Complainant's arrival. In November of 1994, Complainant discussed his concerns about insufficient disposal of old narcotics with Schenk. Complainant believed that the failure to dispose of the outdated narcotics violated regulations and laws governing proper disposal of controlled substances. He did nothing to dispose of them himself under Schenk's oversight.

Understaffing of Pharmacy; Lost Prescriptions and Medications by Nursing Staff

34. On May 18, 1995, at a meeting with Schenk and Schenk's boss, Don Lawson,

Director of Operations, Clinical Services, DOC, Complainant informed them of his belief that DRDC pharmacy was understaffed, and that the nursing staff operated were losing prescriptions and failing to appropriately track medications dispensed by the pharmacy, resulting in missing medication. He viewed these as pharmacy issues since he believed he was responsible for tracking medications and not overfilling or double filling prescriptions.

No Pharmacist on Duty

35. At times, the pharmacy technician was in the pharmacy while Complainant was absent, a violation of pharmacy regulations. Some time during Johnsen's tenure, Complainant mentioned to Johnsen that this was a violation of pharmacy regulations.

36. In August 1995 Joanie Shoemaker was promoted from Director of Nursing at DRDC to Clinical Team Leader, over DRDC and Limon, to replace Johnsen. From that time forward, she was Complainant's immediate supervisor at DRDC (with Schenk) until his termination.

37. At the time Shoemaker took over as Clinical Team Leader, Johnsen gave her his private files on the employees at DRDC, including Complainant, which were separate from the official personnel files at the Department of Personnel for DOC. It was standard management practice for DOC managers to keep separate supervisor files on employees.

38. When Shoemaker became Clinical Team Leader, she maintained her job as Director of Nursing for a number of months, until at least January of 1996. During this time, it was very difficult for her to fulfill her role as Clinical Team Leader. The position as Clinical Team Leader required that Shoemaker also be at other facilities much of the time. In the 23-month period in which she supervised Complainant, she only had time for approximately 12 contacts with him in the nature of either meetings or counselings.

Understaffing of DRDC Pharmacy

39. On August 30, 1995, in November of 1995, on February 7 and 26, 1996, and on June 4, 1996, Complainant informed Shoemaker that he believed the pharmacy was understaffed. On August 30, he requested additional pharmacy staffing of one extra pharmacist, one pharmacist assistant, and one pharmacy technician, all full time. He made a handwritten note dated August 30, 1995, which indicates, "In the last 4+ years we have seen a 167% increase in in-take & work load." The record does not disclose where Complainant found this figure.

40. Complainant testified at hearing and states in his Chronology that "Understaffing impedes legal compliance. PPMIS State Audit of DRDC confirms issue." PPMIS stands for Position and Post Management Information System. He also cited the PPMIS audit as support for his 167% increase in intake and workload.

41. The PPMIS Audit of the DRDC pharmacy, dated October 6, 1995, states

“The workload of DRDC pharmacy has increased steadily since opening. In FY 1991-1992 the pharmacy filled 24,268 prescriptions. In FY 1994-1995 they filled 31,028 prescriptions. This is an increase of **22%**, yet the staffing pattern has remained unchanged.” (Emphasis added).

42. The only legal compliance issue cited in the Audit is the following:

Problems exist in the ordering of prescription refills and pharmacy floor stock. Often nursing will order a refill on a prescription that was refilled the previous day. When this happens the pharmacy has to contact nursing and find out if the prescription has been lost or misplaced. Usually it is there and the nurse did not see it and did not know that someone else had reordered it.

The DRDC pharmacy staff believes that these problems are primarily caused by poor communication and most, if not all, of these problems could be resolved if the pharmacy staff had more time to work with the nurses to learn how things work in each other's services. I concur with this belief.”

43. The Audit requests one additional full-time pharmacist, and the main reason cited that the performance of additional duties would save the pharmacy money. The secondary reason is that such a pharmacist would provide back-up relief for the existing pharmacist when he is out of the facility.

44. Schenk and Shoemaker did not believe that an extra pharmacist was necessary at that time. They believed that the PPMIS audit's request for one additional pharmacist was appropriate for the future. They had numerous meetings regarding staffing matters at DRDC, including the pharmacy. They repeatedly informed Complainant that an additional pharmacist was something the legislature had to approve, a process over which they had little, if any, control. The Colorado legislature approved additional funding for a pharmacist position at DRDC in April of 1998.

45. During one discussion regarding staffing levels with Complainant, Shoemaker stated that perhaps she should send him and his pharmacy technician to the Canyon City facility to evaluate their respective work loads. Complainant took this statement as a threat.

46. In addition, Complainant discussed understaffing of the pharmacy with: Schenk and Massengail (a pharmacist II), on March 29, 1996; Schenk on June 4, 1996; Dr. T. Patterson (affiliation unknown) on June 10, 1996; Don Lawson, Director of Operations, Clinical Services, DOC, on June 11, 1996, A. Lee Boog, State Auditor's Office, on July 19, 1996, and Perry Nisson, independent consultant, on August 28, 1996.

47. The following findings are made regarding the issue of DRDC being understaffed:

A. During his entire tenure at DRDC, Complainant's official work hours and the pharmacy hours were 8 - 4:30, with a half hour for lunch. Complainant sometimes skipped lunch.

B. Pursuant to his agreement with Schenk and Johnsen, during the period of October 1994 to August of 1995, there were “many days Bob could go home early,”

according to Johnsen, because his work was completed.

C. At the time Complainant made his first “disclosure” regarding understaffing, Complainant could therefore not have had a good faith belief in the factual accuracy of that claim.

D. Shoemaker did not continue the agreement with Complainant regarding leaving early with Complainant. Nonetheless, he continued to leave early. Shoemaker found this to be frustrating, since Complainant informed her on a regular basis that the pharmacy was understaffed. On July 16, 1996, she typed up notes on a counseling session with him, which stated in part, “The other issue I discussed with him was my frustration in him leaving at 4:00 p.m. no matter the workload and that, during the crisis with the computer, he still consistently left the facility at 4:00 p.m. I discussed with him that he was an overtime exempt employee and that, according to personnel rules, I could require ten hours a week for two consecutive weeks without having to pay him any comp time at all. I talked about how I see the other supervisors and overtime exempt employees working and that sometimes they work some long hours.”

E. Complainant’s disclosures regarding understaffing were made to Shoemaker in August of 1995, and February, June, and July of 1996. During that period, from late August 1995 through mid-July 1996, **of 150 days recorded,¹ Complainant left work at least 30 minutes early, before 4 p.m., on 86 occasions. In fact, he arrived at work on time on only 2 out of 150 days, and left work at or after 4:30 on only 9 of 150 days.**

F. Complainant did not try to perform all duties in the DRDC pharmacy by working full days or a few extra long days. He worked predominantly short days throughout his tenure (at least through mid-February, the last recorded period). Complainant did not have the personal knowledge necessary to form a good faith belief that, if the DRDC pharmacist worked a full day on a consistent basis, and perhaps a little extra on occasion, all of the work could not be accomplished by one pharmacist. While contract pharmacists were brought in on occasion, this fact does not change the fact of Complainant’s failure to even attempt to get the work done. (The exception to this is when the computer was not functioning²).

¹ There is a reliable means of knowing what hours Complainant actually worked. DRDC had an electronic “palm reader,” which staff had to use to enter and exit the DRDC facility, and which tracked the employees’ arrival and departure times.

² When the computer was down, it was necessary to bring in a second back-up

“Notice of Waste in DRDC Operations.”

48. Complainant lists in his Chronology meetings he had with Shoemaker on December 5 and 6, 1995. On December 5, 1995, he informed Shoemaker that the pharmacy could save \$2500 per year by picking up mail and e-rays and deliveries by Pony Express instead of mail. He also informed her of ways to save \$140 and \$70 on Pepcid, as well as \$60 on Zantac, by changing certain practices.

49. On December 6, 1995, he informed Shoemaker that the pharmacy could save 20-30% of the drug cost by ordering medications by number of pills instead of by number of days. Shoemaker informed Complainant that all DRDC providers had to utilize the same system for ordering medications, and that in order to implement his idea, the entire system would need to be changed. She further explained that she did not have the authority to make that type of decision.

50. At an unknown time, either prior to or after that meeting, Complainant actually mentioned this idea to practitioners, (physician assistants) at least one of whom did in fact write prescriptions in quantity of pills. This resulted in medication errors due to the confusion it caused nurses.

51. On January 29, 1996, when Shoemaker learned about this, she angrily confronted Complainant. Complainant denied having discussed it with practitioners. However, Complainant’s own handwritten notes on this meeting indicate that he did. He states, “I didn’t tell the PA’s how to write RX’s. I told them to be ‘aware’ or ‘30-60-90’ & they said they would write those quantities, but also put down days because the nurse couldn’t figure it out.”

“OSHA” violation.

52. In early February, 1996, Complainant hurt his knee on his desk in the pharmacy (which apparently was too low for his long legs). It took 21 days to get the desk fixed. Complainant listed this problem as a violation of workers compensation laws and doctors orders in his Chronology.

Officers Administering Medications.

53. Complainant informed Shoemaker that he believed it was a violation of state health statutes for DOC correctional officers to administer medications to prisoners. Shoemaker

pharmacist to assist Complainant in performing his regular duties. This was a temporary problem when it occurred. See below.

informed him that this was expressly approved in the state health department statute, and offered to show him the statute. He told her he did not want to see it.

Lynn Hansen, Phyllis Griswald Complaints

54. Like Johnsen, Shoemaker received many ongoing complaints from nurses regarding Complainant's inappropriate interactions with them. Many nurses told her he was loud and aggressive with them. It was a common expression in the DRDC infirmary and clinic that Complainant "was on the war path" or "forgot to take his drugs again."

55. On January 30, 1996, Lynn Hansen, supervisor of the DRDC infirmary nurses, wrote a note and gave it to Shoemaker, concerning an incident where Complainant became agitated and raised his voice in an inappropriate manner. He had said to her, "The infirmary nurses are just lazy, they don't want to do anything. They just don't want to count it, they want me to have to count it." It is found that this incident occurred as related in the January 30 note.

56. On February 15, 1996, Phyllis Griswald, a line nurse at the Limon facility, filled out an Employee Incident Form on Complainant (unsigned by any supervisor) and gave it to Shoemaker. She had called the DRDC pharmacy to check on a medicine ordered five days previously, but not yet received. Her report states, in part,

Mr. Gusich became loud stating, "I will get it to you as soon as I can and I'm so busy and I'm here all by myself and I have to do Delta, Rifle, and the camps plus Limon and I just can't get it all done." He continued to talk loudly repeating what he had just said. When I was unable to say anything because he continued talking, I said 'Yes sir' and hung up the phone."

It is found that this incident occurred as related in the February 15 incident form.

57. Griswald also complained to Schenk about this incident and about Complainant's pattern of loud and aggressive, verbally abusive conduct.

58. On February 28, 1996, Lynn Hansen wrote a second memo to Shoemaker concerning Complainant's inappropriate behavior. It stated,

On Tuesday, February 27, 1996, I was in the dispensary nurses station. It was between 3:30 p.m. and 4 p.m. Bob Gusich approached me and asked if he could talk to me for a minute. I said sure. He said, 'Why are your nurses calling me for things like artificial saliva and other things at 5 til 3 p.m.?' 'They have been sitting up there all day, and wait until they are going home to call me for something.' I said 'Bob, if that is to (sic) late in the day for you to take care of it, why don't you just tell the nurses that when they call?' He said, 'Because I was told by Joanie to follow the line of authority, and that means that I come to you.' I said, 'Bob, the infirmary nurses are very busy, they have a heavy patient load right now, they are not sitting around. They are taking care of some very sick patients, doing tube feedings, dressing changes, things like that.' He said, 'Oh, they're not doing anything, that's a bunch of whooey.' He was walking away from me, in the direction of the pharmacy. I said, 'Thank you for your insight Bob, you wouldn't have a clue what goes on upstairs and I am getting tired of defending the infirmary staff to you.'

I am getting tired of these confrontations with our pharmacist, and feeling that I have to defend staff. His comments (sic) are insulting and uncalled for. If every day you are confronted by a red-faced, gasping for breath, angry pharmacist who doesn't want to be called by infirmary staff or bothered by them, then I think it is time that we are given an alternative avenue to take. Please advise how infirmary nurses are to proceed.

It is found that this incident occurred as stated in Hansen's memo.

59. Complainant was incapable of controlling his temper when confronting nurses about practices he was concerned about. He was loud, abusive, and rude towards them. He yelled and intimidated them. He was largely unaware of the effect his behavior had on others. Many nurses discussed his conduct with supervisors, including Shoemaker. His conduct was so problematic that some nurses avoided all contact with him.

60. Complainant yelled at the nurses for bringing him prescription requests after 2 p.m., and sometimes refused to fill them after that time. The computer system for ordering prescriptions and tracking pertinent information on inmates was open until 4:00 p.m. every day.

61. Complainant was justified in believing he could not legally fill prescription in accordance with generally accepted standards of pharmacy practice once the computer was turned off at 4:00 p.m, because all necessary information regarding drug combinations, potential allergic reactions, prior orders, etc., was on the computer.

62. Complainant believed that nurses could and should have brought him their orders earlier in the day. Sometimes prisoners were brought in early in the day; sometimes late.

Shoemaker Verbal Counselings of Complainant

63. Clinical staff brought their problems with Complainant to Shoemaker's attention on a routine basis. In addition, nursing supervisors brought their staff's concerns to her attention. After a pattern developed, she would discuss their concerns with him.

64. Shoemaker had a number of discussions with Complainant regarding the impact of his interactions on others and his impact on the work environment. Shoemaker tried to use concrete examples of his behaviors the nurses found objectionable, such as being loud, aggressive, red-faced, and yelling. She tried to point out how he was perceived. She did not use names because the complaining nurses sought to remain anonymous. She did not provide exact dates and times and details of the negative interactions.

65. Shoemaker sometimes documented her counselings of Complainant. On February 15, 1996, she documents an hour and a half meeting with him regarding his behavior, "He wants to talk straight & have names of people who are 'complaining' about him. . . I tried to talk about my concern about his stress level & how he reacts to that. He isn't stressed but 'frustrated.' . . . I talked to him about my frustration with offering suggestions which would

help him & them not being good ideas or helpful yet he can't say what would help. I told him my perception was when he got frustrated, he was very manic like. Said he would think about that."

66. Her notes further indicate that she told him he takes no responsibility for his problems with staff.

67. On April 23, 1996, Shoemaker wrote, "A few minutes prior to this conversation LaVonne had been down from the infirmary. She stated, Bob had just been upstairs & was hot. Her comment was 'has Bob had his drugs.' He was red faced and wouldn't leave so the infirmary staff could do rounds." Complainant was concerned "about orders from Infirmary. The pharmacy reordered meds today that were filled yesterday. He also has reorders for meds which he did not get the originals for. . . He was very quiet & appeared very controlled."

68. Whenever Shoemaker discussed behavior issues with Complainant, he always felt that someone else was at fault. In these discussions, it was clear to her that Complainant did not believe he yelled or intimidated staff. He was unable to recognize his inappropriate conduct or the effect it had on others. He would discuss the behavior of the staff, saying they were wasteful of DOC resources, or not doing their job. He would discuss their violations of protocols, such as nurses borrowing medication from one patient and giving it to another. Although Complainant testified at hearing that he was unable to determine whom Shoemaker was talking about in these counseling sessions, his responses to Shoemaker indicate that he did know whom she was talking about.

69. Shoemaker could see that Complainant did not believe her when she discussed his conduct, and that it would therefore be difficult for her to help him modify his behavior with others. When she would say to him that he was frustrated, he would deny he was frustrated.

70. Shoemaker often explained that many of his concerns were problems she had no administrative control over. She suggested to Complainant that he put his concerns into two lists, one that she and the management could do something about, and one that she and management could not do anything about. He never did this.

Nursing Violations

71. Complainant was concerned about the following issues:

A. Nurses came to Complainant with prescriptions that were either undated or not signed by a physician. Some nurses had prescriptive authority to refill medications via written protocols by physicians for inmates arriving from other facilities. Others did not. No evidence was presented regarding Complainant's knowledge of how often nurses had this authority.

B. Nurses borrowed medications from one patient to give to another patient. This situation occurred primarily in handling the morning medication line, or “med line.” The med line was an hour-long line of approximately 120 inmates waiting to receive their prescribed medications. When the inmate was in line, and his or her medication was not there, nurses would take the pill(s) from another prisoner’s supply. This, of course, had a domino effect on many other prisoners’ medication supplies, resulting in nurses running out of many inmates’ medications prior to the time the prescription ran out. Nurses would then need to reorder the medication earlier than they normally should need to.

C. Nurses sometimes lost medication that had been dispensed by the pharmacy, and came back to refill a prescription that had already been filled. This is the problem noted in the PPMIS audit. This could have been addressed by better communication between nursing and pharmacy staff; however, Complainant was unable to engage in productive, problem-solving discussions with nursing leadership.

D. Complainant believed that some nurses did not keep good track of needles dispensed from the pharmacy.

72. On April 11, 1996 and September 11, 1996, Complainant informed Rhonda Valdez, a nursing supervisor at DRDC, about these nursing problems. Valdez told him to bypass her and go directly to the nurses committing the infractions.

73. Complainant informed Shoemaker about these issues in mid-1996 and at a November 12, 1996 meeting discussed below. At Shoemaker’s suggestion, he also spoke to Patrice Baldwin. Shoemaker did not see the borrowing of medications to be a serious problem; she believed it was within the nurses’ scope of practice to make the professional judgement that it was necessary to borrow medications when working the med line. She also knew the prisoners often left the facility before completing their prescriptions. She also viewed this as a nursing issue, not a pharmacy issue. She therefore did little, if anything, to correct the medication borrowing problem during Complainant’s tenure at DRDC, much to his chagrin. Shoemaker discussed the other issues with her nursing supervisors.

74. Complainant also informed the following individuals about these issues: A. Lee Boog, State Auditor’s Office, July 19, 1996, and Perry Nisson, outside consultant, on August 28, 1996, Brad Kinney, Director of Nursing, on September 3, 1996, Brenda Hume, nurse, September 5, 1996, W. Anderson, State Pharmacy Board, September 5, 1996, Warden McGoff, DRDC, November of 1996, and D. Smith and D. Van Pelt, DOC Office of the Inspector General, on November 26, 1996, in the context of a grievance he would later file against Shoemaker.

75. On some unknown date, in response to his concerns, Shoemaker, Schenk, and Complainant had a meeting regarding the nursing practices. The record does not reflect the content or results of that meeting.

76. Shoemaker often asked Complainant to put his concerns in writing, which he never

did.

Inspections of Outlying Facilities

77. On March 29, 1996, Complainant informed Schenk and Doug Massengail, a Canon City pharmacist, that he felt he was being forced to violate pharmacy regulations by failing to inspect the outlying pharmacy facilities four times a year. Schenk failed to provide the relief pharmacist necessary to enable Complainant to conduct the quarterly inspections. During Complainant's tenure at DRDC, he inspected the Limon, Rifle, and Golden facilities twice each.

Computer Problems

78. In May and June of 1996, the computer at the DRDC pharmacy malfunctioned and become un-usable, once for at least a nine-day period, once for a two- day period. In May, Complainant informed Shoemaker, Schenk, and Massengail that the computer malfunctions were causing legal violations of prescription labeling and dispensing rules. When it occurred in June, he informed Shoemaker and Schenk again. The lack of a computer had a severe impact on pharmacy operations, as there was no back-up computer system to take over in this situation. Crucial patient information regarding drug interactions, allergies, and prior medication orders was not available in hard copy. In addition, Complainant had to make typewritten labels for prescriptions he filled, which usually lacked that crucial information.

79. Shoemaker responded to Complainant's concerns about the computer by suggesting he discuss it with the pharmacy/therapeutics committee. She explained that changing the DRDC computer system meant changing the entire system for all DOC facilities, and that it would require legislative approval of the funding. It was an issue over which she had little, if any, control.

80. In the June, 1996 meeting with Shoemaker and Schenk, Complainant informed them that the lack of air conditioning and ventilation in the pharmacy, as well as Understaffing. Complainant lists these as OSHA violations in his Chronology.

Improperly Secured Needles

81. Complainant also informed Shoemaker about improperly secured needles at the DRDC facility. A cabinet door was broken, and the needles were therefore not secured, in violation of pharmacy and controlled substances regulations. The record does not reflect what either Complainant or Shoemaker did about this issue.

Meetings with Consultant and State Auditor's Office

82. In August of 1996, Shoemaker and Schenk hired an outside consultant, Perry Nisson, to conduct an audit of all pharmacy and nursing operations at the DRDC clinic.

They directed Complainant to discuss all of his concerns regarding the computer, improper nursing practices, narcotic security and storage problems, etc, with him, which he did.

83. In addition, Shoemaker set up a meeting on July 19, 1996, between Complainant and a member of the State Auditor's Office, A. Lee Boog, and directed Complainant to inform her of all the computer problems, improper nursing practices, narcotic storage problems, and any other regulatory and statutory concerns he had regarding pharmacy and nursing operations. Complainant attended this meeting and did so. He also sent Boog a copy of the PPMIS Audit.

Complainant's Phone Incident with Schenk

84. On August 14, 1996, Schenk wrote Shoemaker a memo regarding "Incident with Bob Gusich." It states,

On Thursday, August 8, at approximately 3:00 pm I received a phone call from Bob Gusich. He was extremely agitated and was shouting throughout the entire conversation. His primary complaint was that Mynette had been [administratively] suspended without his knowledge. He was angry at me for not informing him of the situation. I told him that: 1) I had not found out about it until 5:00 p.m. on August 1 and I was on vacation from August 2 through August 7, and 2) It was not my place to inform him of the situation since it was confidential information at the time. I told him that it was inappropriate for him to be angry with me over this situation.

The conversation deteriorated rapidly after this and ended abruptly when he shouted something unintelligible and slammed the phone down.

85. During this phone conversation with Schenk, Complainant yelled loudly enough that Schenk had to hold the telephone away from his ear. He felt that Complainant was verbally abusive. Complainant did not respond to any of Schenk's comments, but continued to yell until he hung up on him. It is found that this incident occurred as stated in Schenk's memo.

Failure to Use DEA Form 222 and Outlying Facility Problems

86. On August 22, 1996, as well as on other occasions, Complainant told the Limon nurses, Phillis Griswald and Judy Bullard, that they needed to utilize a Drug Enforcement Agency ("DEA") Form 222 when they placed orders for controlled substances. This form was required by federal law. The Colorado Pharmacy Board had contacted Schenk about this violation by letter in April of 1996. Schenk and Shoemaker had repeatedly directed the Limon facility to use the form, which they ultimately did.

87. After performing his first set of inspections of the outlying pharmacies, he found violations of pharmacy practices. On August 29, 1996, Complainant informed Shoemaker about these, including the DEA license not being posted, DEA Form 222 not being used, DEA narcotics inventory not having been completed, expired drugs being in the facility. Complainant's Chronology states that on this date he informed Shoemaker of "rampant legal violations at various DOC Pharmacy facilities," however, Complainant testified that the

most important of these issues were immediately addressed.

88. Complainant became aware during an inspection that the Limon facility license renewal form was past due. It was only after persistent reminders to Shoemaker that it was sent in, after the third renewal notice. The Limon license never lapsed.

Perry Nisson Incident

89. On August 28, 1996, Perry Nisson, the independent consultant hired to conduct an audit of pharmacy and nursing operations at DRDC, came to the facility. Shoemaker and Schenk had directed Complainant to share with Nisson all of his concerns regarding the computer system, missing medications, nurses borrowing medications, and any other regulatory or statutory violations he felt were present at DRDC. In the morning, Complainant and Nisson met. Complainant did share all of his concerns with Nisson; Nisson was pleasant and agreeable.

90. After lunch that day, Nisson and Complainant were talking, and Nisson started to walk away, ending the discussion. Complainant said, "excuse me, Mr. Nisson, I was talking to you." Nisson turned around, and the two of them had a heated discussion. They moved to Complainant's area of the pharmacy, where the discussion continued.

91. During this incident, Complainant became loud, aggressive, and angry towards Nisson. Moulton, the pharmacy technician, was in the pharmacy, and was able to hear Complainant. She became frightened and left the pharmacy, and went to a nursing supervisor's office to "hide."

92. Complainant took notes on the Nisson encounter. They indicate that Complainant felt Nisson was rude by being late, had made insulting comments about DRDC staff, and was boastful regarding his high consultant fees and the car he drove. Complainant appears to have felt bitter and resentful towards Nisson. His notes state, "Bob [Complainant] had a chance to talk after 15 min of Perry, interrupted - Bob said "expound" in sentence & Perry corrected & ridiculed Bob - Perry interrupted Bob - Bob finally said "that's enough" & Bob said "would take a break". "Bob didn't talk loud to Perry! If he did, it was for one sentence only! 'Please don't walk away from me or turn your back on me.'"

93. It is found that Complainant lost his temper with Nisson during this encounter and addressed him in a loud, aggressive, and inappropriate manner.

94. Nisson did write a report based on his visit to DRDC, dated September 17, 1996. Nisson outlines many of the problems Complainant was concerned about, including the need to upgrade computer equipment, and the irregularities in providing medicine to inmates, such as multiple orders of the same drug for the same patient. He suggests purchasing better software, and use of a computer generated monthly medication administration record for nursing services to reduce medication errors, save nursing time and prevent duplication of drug therapy by the pharmacy. He also suggests "better

definitions of pharmacy policies and procedures could potentially minimize necessary interventions by nursing services as well as physicians and physician assistants.” He also recommends enabling the pharmacy to plan the workload.

95. The Nisson report notes in the introduction that “Prison pharmacies often are antiquated, disorganized, poorly equipped, and woefully inefficient. This has resulted in 20-25% of correctional facilities using private health care services.” The report makes no reference to Complainant, and does not reflect negatively on Complainant.

96. Shoemaker investigated the Nisson incident by discussing it with Schenk and Lawson, both of whom had spoken to Nisson. Moulton also reported what she heard to Shoemaker.

Second Letter of Counseling.

97. On September 23, 1996, Shoemaker wrote a letter of counseling to Complainant. The letter states:

I have discussed this letter with Tony Schenk, Chief Pharmacist, and he shares my concern regarding your continuing pattern of loud, inappropriate behavior with others. Most recently, you were loud, aggressive, and rude to Mr. Nisson, Pharmacy Consultant. As you are aware, the incident happened on Wednesday, August 28, 1996. Your version of the encounter is very different from that of Mr. Nisson; you stated that Mr. Nisson was rude and insulting. There were several alternatives available to you beside being loud and aggressive. You could have asked Mr. Nisson to leave the pharmacy or asked someone to witness the conversation, e.g. Mr. Massengail, who was at DRDC at that time. Regardless of Mr. Nisson’s behavior, it does not excuse your unprofessional conduct.

There have been additional incidents with different staff members which resulted from your anger. A recent example was your telephone conversation with Tony Schenk which ended in your slamming down the telephone. When you are angry, you are very loud, red faced, and aggressive. It does not appear that you are aware of how loud and aggressive you are when angry.

This behavior has been discussed with you both informally and formally. You received a counseling letter on July 11, 1995, and both your Progress Review of March 1, 1995, and PACE review of August 1, 1995, reflected this issue.

Occasionally, conflicts happen in the work place; however, your conflicts seem to be constant, and the behavior which results in these confrontations must stop immediately. My expectation is that you will no longer demonstrate loud, aggressive, and rude behavior. You will maintain an appropriate attitude with staff members and control your loud voice and aggressive behaviors.

98. The letter of counseling directs Complainant to attend an 8-hour workshop on interpersonal relations and dealing with coworkers within three months, refers Complainant to anger management and conflict resolution services at Colorado State Employee Assistant Program (C-SEAP), states that his behavior will be closely monitored for the next three months, and warns that further problems may result in future corrective or disciplinary actions.

October 1, 1996 Meeting with Shoemaker

99. On October 1, 1996, Shoemaker met with Complainant to give him the letter of counseling and to discuss it with him. She kept her door unlocked because she feared his unpredictable behavior, knowing she would be confronting him with negative feedback. She told him he was loud and inappropriate with staff. She did not mention any staff to him by name, and did not provide any dates or times of the incidents of inappropriate behavior she alluded to. Complainant requested names of accusers, as well as copies of all information in her private file on him. She gave him neither, seeking to protect the confidentiality of staff, at their request. She discussed his pattern of behavior. This was a difficult meeting for both parties, both of whom were loud and inappropriate with each other. Both felt the other was harassing. Shoemaker later apologized to Complainant for losing her composure at the meeting.

100. At the meeting, Shoemaker suggested that Complainant put his concerns regarding compliance issues in writing, and to rank them according to most critical to him. He replied that he didn't have time to rank. She then said that was fine, to give her the whole list, and that she would work on it. Complainant never provided her with this list.

101. At the October 1, 1996 meeting, Shoemaker also gave Complainant two completed performance evaluations. The first was for the period August 1, 1995 through February 29, 1996, which closed out the period of his probation. It was seven months late. Complainant had never signed the Planning Section. The overall rating was Good. In List Areas for Development, Shoemaker stated, "improve oral communication style." In the Interpersonal Relations section, she checked between the Needs Improvement and Good boxes, indicating some need for improvement, in two subsections. In the Performance Appraisal Narrative Section, she stated,

Bob must improve his interpersonal relationships and communication style. He is sometimes loud and aggressive in his interactions.

102. Complainant signed "agree" in the October 1, 1996 meeting with Shoemaker. He later went to the DOC Personnel office and changed his signature to "disagree," writing, "This is in reference to 'Jamie' only - & this was resolved with an apology & accepted & approved by Ron Johnsen." Shoemaker was never made aware of this.

103. The second evaluation Shoemaker gave Complainant was for the period March 1, 1996 (end of probation) through June 30, 1996. It was three months late. Complainant had never signed the Planning Section. It rated Complainant an overall Good. On the List Areas for Development section, she stated, "Interpersonal relationships, must control frustration, anger. Improve Communication style." In the Interpersonal Relations and Organizational Commitment and Adaptability sections, she rated him between the Needs Improvement and Good boxes, indicating some need for improvement. In the Performance Appraisal Narrative, Shoemaker stated,

Bob continues to have difficulty with his communication style and interpersonal relationships. Bob controls his frustration at times but still has some loud and aggressive encounters.

104. Complainant signed "agree" in the October 1, 1996 meeting with Shoemaker. He later went to the DOC Personnel office and changed his signature to "disagree," without Shoemaker's knowledge.

105. At the October 1, 1996 meeting, Shoemaker may have also given Complainant an incomplete copy of a third evaluation, for the period March 1, 1996 to February 28, 1997. This third evaluation was given to Complainant in June of 1997 when Complainant was working in Canyon City.

106. On October 2, Complainant met with Warden McGoff, and informed the Warden of the various violations of nursing and pharmacy protocols about which he had informed Shoemaker, that he felt she was doing nothing about. The Warden responded that Shoemaker, in her new position, was spread too thin, that they had given her too much to do as Clinical Team Leader. He suggested that Complainant have a follow-up meeting with Shoemaker.

November 2, 1996 Meeting with Shoemaker.

107. Complainant did schedule a follow-up meeting with Shoemaker, on November 12, 1996. Complainant made four pages of handwritten notes to prepare for that meeting, to which he referred. Complainant stated the following to her at this meeting: the contents of the September letter of counseling were lies, made up for the purpose of character assassination; she had a vendetta against him, had harassed and insulted him; his evaluations were unfair, late, full of malicious lies, that he had been under-rated, and constituted an abuse of authority; that there had been a pattern of discrimination against him based on harassment, lies and insults; that Shoemaker had engaged in mismanagement, gross negligence, unprofessionalism, misconduct, unethical conduct, and misappropriation of resources; that she had slandered and libeled him. He reviewed problems with DRDC operations, including medicine being borrowed from other patients, medicine missing, stock missing, narcotic inventory conducted [by her] while he was on vacation, officers giving medicine in the Golden facility, and sending in the DEA license renewal form in late, after the third notice.

108. Complainant accused Shoemaker of sexual intimidation because of her job position and her sex, and that she was forcing his illegal and unprofessional actions on him. He stated that he had only started having trouble at DRDC since she became administrator.

109. He told her that he considered everything he told her to be whistleblower allegations.

110. At this November 12 meeting, Shoemaker did not have much opportunity to respond to Complainant. She sat and listened for over one hour. She did list Lavanna Walker, Lynn Hansen and Phyllis Griswald, as people who had complained about him. When Complainant raised the issue of corrective officers giving medications to inmates, she again offered to give him a copy of the statute allowing the practice; he again refused the offer.

At the end of the meeting, complainant left Shoemaker alone in the room. She had tears in her eyes.

111. On November 15, 1996, Complainant met again with Warden McGoff. He informed the Warden that he felt personally and professionally insulted by Shoemaker's inaction on the issues he had raised with her. McGoff said he'd talk to Shoemaker and get back to him.

112. On November 18, 1996, Complainant met with McGoff again. He told him Shoemaker had promised to work in the pharmacy on a recent Friday, but had failed to do so. McGoff again stated that Shoemaker had too much responsibility, and that Shoemaker had suggested a mediator.

113. On November 26, 1996, Complainant spoke to two Office of Inspector General ("OIG") investigators about filing a harassment complaint against Shoemaker. He told them about the issues he had discussed with Shoemaker, concerning violations of regulations.

114. The OIG is the internal investigations unit at DOC, which investigates most issues involving employee violation of rules, regulations, or law. OIG investigators are trained professionally in investigative techniques, and many of them are former police officers.

115. On November 29, 1996 Complainant filed a complaint of workplace harassment against Joanie Shoemaker. The findings of the OIG Investigation were that no harassment had occurred. The OIG interviewed a number of the same individuals who were later interviewed for the Moulton hostile workplace environment/harassment grievance against Complainant, filed in April of 1997 (see below). Moulton and many others discussed their ongoing problems with Complainant's abusive behavior with the investigators; their comments are consistent with those made in the later OIG investigation regarding Complainant.

Mynette Moulton Grievance

116. Mynette Moulton was the pharmacy technician that replaced Veronica Gomez in July of 1996. She worked with Complainant in the pharmacy, primarily helping to fill orders and performing telephone work. Complainant disapproved of Moulton being hired due to her admitted history of drug and alcohol abuse.

117. Moulton found Complainant to be difficult to work with. He sometimes yelled at her and intimidated her, speaking to her in a sarcastic manner.

118. In the fall of 1996, she tried to resolve their communication problems by telling Complainant that he could be overbearing and that she needed to be able to say to him he needed to back off or give her a break. Complainant nodded his head up and down in agreement. For several weeks following that discussion, their working relationship was smooth.

119. Moulton discussed her problems with Complainant with Shoemaker often in 1996.
120. On December 18, 1996, Moulton was interviewed by the OIG concerning Complainant's harassment complaint against Shoemaker. In that interview, Moulton stated that Complainant is a good pharmacist, intelligent, but very difficult at times, very emotional, appears to have a persecution complex, and at times was not objective, becomes very angry and "rants and raves."

121. As the 1996 holiday season approached, Complainant became more irritable with Moulton. His behavior became "angry and unbecoming" according to Moulton, to the point where she decided she needed to begin documenting his behavior. On December 31, 1996, she began to take notes at home regarding his behavior at work.

122. On December 31, 1996, her notes indicate that Complainant had "snapped" at two people that morning, and that after returning from lunch, when it became clear he would not be able to depart at his planned 2 p.m. time, he had snapped at Patrice Baldwin. After Baldwin left the pharmacy, he "through a fit," stating that Baldwin was a smart aleck, and that Shoemaker could take his job away.

123. After the new year began, Complainant's attitude seemed to improve, in the view of Moulton. However, over time he once again became disagreeable with her and other staff.

124. In January, 1997, Shoemaker suggested that Moulton attempt informal resolution by discussing communication issues directly with Complainant. She did not do this again, because she feared that if she suggested to him that he was intimidating or offensive, it would trigger a confrontation, and that he would attack her verbally.

125. Moulton complained to other staff about Complainant's treatment of her. She told Dana Bustos, a Mental Health Coordinator, that he yelled at her and intimidated her, and that once he blocked her way out of the pharmacy. During these discussions Moulton was clearly distressed and visibly upset over the situation with Complainant.

126. Moulton also complained to Katherine Louis, Ellen Benoit, nurses, and Schenk. Moulton complained to Benoit on a continual basis that Complainant was "on a terror" or that she felt afraid of him.

127. Moulton took sick time because of the stress related to working with Complainant.

128. On February 25, 1997, Complainant attended the interpersonal relationships workshop required by Shoemaker in her letter of counseling.

February 28, 1997 Moulton Incident.

129. On February 28, 1997, Moulton and Complainant had a verbal altercation involving

the ordering of Lomotil in the pharmacy for the Limon clinic. Moulton told Complainant that the Limon clinic was no longer able to get the drug from their local pharmacy, and Complainant stated in a loud and irritated voice, "what are they getting it out there for. They are not supposed to do that." Moulton then made a number of phone calls to try to locate an alternative product. When Complainant returned to the pharmacy, Moulton was on hold with a company. Complainant asked her what she was doing, and when he learned she was attempting to help the Limon facility, he instructed Moulton to hang up while on hold. He said, "Let them get it at the pharmacy out there." She stated that she disagreed, and was attempting to tell him why she felt this was a refusal of service. He interrupted Moulton.

130. Moulton was already in a bad mood that day. When Complainant interrupted her, she became angry. She raised her hands in a surrender fashion and said, "I do not want to talk about it right now." She left the pharmacy to cool off. Complainant then consulted with Shoemaker on what to do about the order.

131. When Moulton and Complainant were back in the pharmacy, Complainant refused to talk to Moulton. When she asked him a question about the prescriptions he was printing off the computer, he slid the prescription to her on the counter.

132. Moulton then began a discussion of how she did not want to go home for the weekend with bad feelings, and that she wanted to clear the air. Complainant refused to discuss the communication issue, and kept returning to the Lomotil issue. He felt she had defied his authority, and he was angry about it. He told Moulton that she ordered any drug she wanted to. His temper escalated, and he started yelling at Moulton. She in turn yelled back at Complainant. She said, "stop yelling at me." He said he was not yelling. She said, "well if you're not yelling, I sure am yelling." He asked Moulton if she was "keeping documentation on him" and if she was "running around telling people that he yells at people." She said she was not the only one he yelled at, despite his repeated denials. Complainant asked her why she didn't tell him what others said about him. She responded that others' problems with him were not her business to tell him. He became sarcastic with her.

133. During this argument, Complainant said that there was such a thing as veiled threats. She asked what he meant by this, but he refused to answer. He called her pushy.

134. Ultimately, this altercation ended with Moulton crying in Shoemaker's office. Moulton was so upset she was unable to drive home.

135. Moulton expressed her disappointment that she had attempted to discuss the communication problem between herself and her supervisor, Complainant, but that it had turned into an even larger and more heated argument.

136. Shoemaker asked Moulton if there were any things about Complainant she felt were good, and was the relationship worth salvaging. Moulton answered yes, there were many

things that she liked about him, and she did value Complainant. She committed to work on the relationship.

137. A week after the February 28 incident Complainant informed Shoemaker he thought Moulton was crazy because she was talking and singing to herself. He also stated that she was trying to run the pharmacy herself.

138. Moulton and Complainant attempted mediation, which failed after two sessions. Moulton terminated mediation after Complainant made it clear that he felt she had mental problems and was not successful in her sobriety. Moulton violated the confidentiality agreement for the mediation session by informing Shoemaker of this, as well as one other staff member, and the OIG during her interview regarding her grievance (see below).

139. On April 14, 1997, after mediation failed, Moulton wrote and filed a six-page formal written grievance against Complainant for violating AR 1450-5, the DOC policy prohibiting workplace discrimination/harassment. She related the December 31, 1996 and February 28 incidents, and discussed Complainant's harassing and intimidating conduct in general.

140. After discussing the February 28 incident, she states her concerns about:

"the inability of Mr. Gusich to stay in the problem itself and attempt to come to some resolution, if even temporary until mediation was available, name calling (calling me pushy), pulling punches meaning the accusations of poor job performance not previously addressed or part of the issue which instigated the argument. Mr. Gusich also said to me during the argument that there was such a thing as veiled threats and he still has not answered me when I have asked him what he meant by that. Mr. Gusich's face was red, he was yelling, and his eyes were squinted in a fashion that I perceived as being very threatening."

141. The grievance also states,

"I have called in sick to work as a result of an upset stomach due to stress and fear in my workplace and have relayed this to both Ms. Shoemaker and her Administrative Assistant on different occasions. I have seen a concernable amount of prescription and technical errors since this incident because of my preoccupation with Mr. Gusich's presence and possible pestering behavior. I have lost many nights sleep as a result of not being able to get this situation off my mind. Because my working environment has overwhelming interfered in my personal life, (sic), I sought counseling through C-SEAP where even there it was felt that my best option may be to quit."

142. There is no evidence other than this statement by Moulton of any errors on her part; her work performance was not a problem at any time relevant herein.

143. Moulton's grievance references Complainant's "erratic and often explosive behavior." It states, "I have always felt that if I were to disagree with Mr. Gusich on any point at all, I would be leaving myself wide open for a verbal attack."

144. After receiving Moulton's grievance, Shoemaker referred it to the OIG for investigation.

145. On April 15, 1997, Complainant was placed on administrative leave with pay pending the investigation for harassment/hostile work environment by Moulton.

Misappropriation

146. On March 3, 1997, directly following the February 28 incident, Moulton contacted Shoemaker by phone and told her that Complainant was ordering some things in the pharmacy that she felt were for himself. One was Sweet Breath spray. He would order a box, keep them in the pharmacy, and was using them for himself. She said this was not a big deal, but she did have questions on some insoles being ordered that had never been ordered or prescribed for inmates. She noticed that after they came in, they had been on Complainant's desk, and now they were not there. Moulton promised to provide her with a copy of the requisition showing the products.

147. Moulton was motivated in part to tell Shoemaker about the Complainant's improper use of breath spray and shoe insoles by her ill feelings toward Complainant following the February 28 incident, and the history of his inappropriate treatment of her.

148. Moulton located requisition forms with the breath spray and insoles on them and gave them to Shoemaker. The insoles not previously ordered for inmates were for "Warmease" and gel insoles. Shoemaker then obtained and reviewed the requisitions for the prior fiscal year back to July 1, 1996, to see how often these items not used for inmates had been ordered.

149. Shoemaker called Schenk regarding the insole and breath spray issue. Schenk checked the formulary (the list of items customarily ordered by DRDC pharmacy) and the non-formulary special order items, and found none of the items Complainant had apparently ordered on either list. Shoemaker and Schenk discussed the fact there was no way to track who had ordered what on the computer, so there was no way to track the ordering of these items directly to Complainant.

150. Shoemaker then briefed Don Lawson regarding the Complainant's apparent ordering and use of the breath spray and insoles.

151. Once Lawson received appointing authority to look into the issue of potential misappropriation of state property, Lawson forwarded the invoices to the OIG for an investigation.

152. Lawson discussed with Shoemaker her searching Complainant's office to find any items he was using. Shoemaker did so, and found insoles in a drawer in his desk, and two breath spray bottles in the pocket of his lab coat.

153. The OIG investigator, Annette Fucles, asked Shoemaker to participate in the interview of Complainant regarding possible misappropriation of state resources. Shoemaker had technical information regarding the items used and the ordering process

for the pharmacy which Fucles needed.

154. When Fucles called Complainant to set up this meeting, she told him that she was investigating possible misappropriation of state funds, and did not inform him that he had a right to have a representative present. He did not request one.

155. On March 26, 1997, Fucles interviewed Complainant, with Shoemaker present. She took contemporaneous notes, which she then used to write her report. The report indicates:

Gusich advised that he had indeed ordered the men's insoles listed on the invoices through the pharmacy (see exhibit #1). Gusich further stated that he ordered the sweet breath also listed on several other pharmacy invoices (see exhibit #2). Gusich stated that he was told by other pharmacy staff that it was okay to order incidental items for personal use as long as it pertained to the job. . . Gusich related that his feet were 'killing' him and he wanted to be comfortable while working. He leaves the insoles at work. When Gusich was asked about ordering the sweet breath he related that he had a bad taste in his mouth. Gusich said he has not ordered any other personal items for himself or other staff. Gusich stated that he was sorry if he did anything wrong and vowed not order any other personal items through the pharmacy. (sic)

Gusich stated that he has given staff members items from the pharmacy such as eye drops and lotion . . . [and] ibuprofen tablets, blood pressure medication and other types of medication when staff have forgotten their medication. Gusich stated that he has told staff not to abuse the privilege and they have not done so.

156. Complainant said he made the breath spray available for other staff to use by leaving it out in the pharmacy. He offered to take his shoes off and show Fucles the insoles he was wearing which he had ordered from the pharmacy.

157. Complainant stated that he was told by his predecessor pharmacist, Al Stark, and Veronica Gomez, the pharmacy technician, that it was acceptable to order incidental items for personal use from the pharmacy, so long as it pertained to the job.

158. Complainant listed on his "Chronology" that he made protected disclosures regarding "abuse of DOC resources" at this meeting, meaning staff and managers' use of over the counter products, or "OTC's". There is no evidence supporting this claim. He stated that staff had not abused the privilege.

159. It was the custom at DRDC pharmacy throughout and prior to Complainant's tenure there for line staff and supervisors (including Shoemaker) to utilize OTC items such as ibuprofen for headaches, Band-Aids for cuts, etc. There was no written policy that specifically governed the issue of staff use of OTC's.

160. Shoemaker, Schenk, and Lawson all believed that the Complainant's ordering and use of breath spray and shoe insoles for his personal use was distinguishable from the

sporadic use of OTC's such as headache medication by staff and managers.

161. The OIG report was forwarded to Don Lawson for the 833 meeting. Lawson reviewed the report, which contained the Complainant's detailed admissions above regarding ordering the insoles and breath spray for personal use.

162. In early April, Shoemaker faxed the invoices for the breath spray and insoles to Lawson, and in a cover memo indicated that the total amount of the items ordered and used by Complainant was \$67.45. Shoemaker used the invoices to calculate this amount, but apparently used some items that were never delivered since they were out of stock. Lawson relied on Shoemaker for that amount, and never confirmed it or re-calculated it himself.

163. Shoemaker's calculation of \$67.45 was incorrect. The invoices attached to the OIG report containing the items ordered and delivered but never prescribed for or used by inmates are: 2/10/97 invoice for gel insoles, 3 at \$6.41 each, totaling \$19.23 and for Warmeze insoles, 3 at \$2.95 each, totaling \$8.85; 11/25/96 invoice for Sweet Breath Spray, 6 at \$1.22 each, totaling \$7.32; 9/4/96 Sweet Breath Spray, 6 at \$1.28 each, totaling \$7.68. Both sets of three insoles were introduced at hearing, and none of them had been used.

164. On April 15, 1997, Lawson sent a letter to Complainant scheduling an R8-3-3 meeting and informing him that it was to "investigate possible misappropriation of state property." It further stated, "You may, of course, bring any persons you deem necessary to protect your interest in this hearing."

165. Present at the 833 meeting were Lawson, Schenk, Complainant, Complainant's wife, Complainant's two attorneys, Bruce Pederson and Jackie Taylor, Brad Rockwell, DOC attorney, and Lawson's administrative assistant.

166. Lawson explained the allegations against him from the OIG report, including the items misappropriated and his statements to Fucles. Lawson did not give Complainant a copy of the report, pursuant to DOC policy. Schenk and Complainant reviewed many of the invoices together, and pointed out to Lawson that a number of the items on the invoices had never been received by DRDC pharmacy, since they were out of stock. Lawson also discussed arch supports, which Schenk and Complainant had to correct him on, since arch supports were not at issue.

167. At the 833 meeting, Complainant denied that he had made the detailed statements to Fucles and Shoemaker in the March 26 meeting that were clearly set forth in the OIG report. He said no misappropriation had taken place. He did not state that Fucles had misunderstood him, or that he had misunderstood her. He invited Lawson and the others to come to the pharmacy and see that the items were still there.

168. Complainant's attorney pointed out at this meeting that many of the items on the invoices were in the pharmacy, in unopened packages, and could easily be returned to the

distributor for a credit.

169. Lawson was shocked that Complainant denied making the statements to Fucles. He trusted Fucles as a highly ethical investigator, and knew of no reason for Fucles to have fabricated the contents of her report. He therefore concluded that Complainant was lying to him in the 833 meeting. He did not respond to Schenk and Complainant's statements about arch supports not being one of the items alleged to have been misappropriated, or to the fact that many of the insoles ordered were out of stock.

170. At the 833 meeting, Complainant stated that he had concerns regarding there being no licensed pharmacist on duty at all times when the DRDC pharmacy is open, and about the pharmacy door being propped open one or two times for several hours when the pharmacist was not on duty. He also stated that he had previously raised the issue of staff and managers at DRDC using pharmacy OTC pain relievers, eye drops, and decongestants for apparently personal use.

171. At the conclusion of the R833 meeting, Complainant's attorneys stated that they sought to provide a follow-up written statement. Lawson stated that would be fine. It is unclear whether Lawson committed to wait to receive the letter prior to imposing discipline.

172. Prior to receiving the written statement from Complainant's counsel, Lawson drafted his disciplinary letter on April 25 and sent it. Lawson decided to demote Complainant two steps in pay for three months, from \$4640.00 monthly to \$4209 monthly, and to dock his pay in the amount of \$67.45 for the value of misappropriated property.

173. Lawson would have merely used a corrective action in this situation if Complainant had stated he was sorry about his conduct. However, the fact that Complainant made statements to the investigator, then turned around and "lied to me" at the R833 meeting, caused Lawson to feel that Complainant's actions had been so flagrant and serious as to warrant discipline. Lawson felt that a person who lies about his conduct in an R833 meeting makes the offense more serious, warranting more serious intervention. The value of products did not impact Lawson's decision. Lawson relied on the lack of credibility of Complainant more than the misappropriation issue in electing to utilize discipline instead of corrective action.

174. Lawson determined that Complainant had failed to comply with standards of efficient service, had engaged in willful misconduct, and had willfully failed to perform his job.

175. Lawson's letter states, in part:

On March 25, 1997 you met with Annette Fucles, Investigator and Joanie Shoemaker, Clinical Team Leader for Denver Reception and Diagnostic Center (DRDC) to discuss allegations that you had obtained State property for your personal use, i.e. (Shoe inserts, insoles) and a breath freshener (Sweet Breath). During this meeting you admitted that you had ordered these items and had used them for your personal use. Your justification was that you had been told by other staff members that it was "OK" to order incidental personal

items for your job. You also stated that other items such as soap and alcohol are ordered for staff. . . .

I . . . expect a person of your stature to absolutely know that it is not permissible to use state property for personal use. Secondly, I do not find your statement credible that . . . you did not make the statements attributed to you by Investigator Fucles in Ms. Shoemaker's presence."

176. Lawson considered the following in electing to discipline Complainant: Complainant's leadership position as supervisor of the pharmacy; his experience in this area, namely, that he should know what was appropriate to order and personally use from the pharmacy and what was not; Complainant's statement he had never made any of his admissions to Fucles, the fact that he had not stated Fucles had misinterpreted or misunderstood him, the DOC staff Code of Conduct, and DOC AR 1450-12 (personnel board rules regarding corrective and disciplinary action).

177. In addition, prior to deciding on the level of discipline, Lawson studied three other personnel board cases involving misappropriation of state property. In one case, the value of the property was roughly \$6000, and the employee was demoted 5 steps for six months. In the other two, the amount misappropriated was \$30.00 or less, and one employee was terminated, the other was demoted for six months.

178. At the time Lawson decided to discipline Complainant, he did not view him as a whistleblower. The only issues Complainant had brought to Lawson's attention prior to the R833 meeting had been the May 18, 1995 discussion about missing medications and prescriptions, and his complaints about being short staffed and needing back-up when the pharmacy technician was absent.

179. On May 2, 1997, after receiving the letter imposing discipline, Complainant's attorneys wrote a follow-up letter to Lawson, and copied Aristedes Zavaras, Executive Director of DOC, and Schenk. They outlined concerns regarding the following: the lack of sufficient notice regarding the subject of the R833 meeting; the failure to consider Complainant's written statement in his defense prior to imposing discipline (breaching a promise to do so); and Lawson's disregard of Complainant's denials and clarifications regarding arch supports and out of stock items never sent to DRDC.

180. The letter also points out the fact that no guidelines were offered Complainant to differentiate between headache and cold OTC's and breath spray or shoe insoles, thereby rendering it difficult for Complainant to police his own supervisors and other staff regarding their use of OTC's.

181. With regard to the whistleblower act, the letter states,

As stated by Mr. Gusich in our meeting of April 23, 1997, he has several serious concerns regarding actions of supervisors and staff at DOC. Mr. Gusich intends to disclose these problems to appropriate authorities. CRS 24-50.5-101 et seq. The concerns raised by Mr.

Gusich are as follows: [no licensed pharmacist on duty at all times; pharmacy door propped open one or twice for several hours; double message regarding use of pharmacy stock for personal use]

In addition to the three concerns listed above which were previously raised with DOC officials, Mr. Gusich wishes to raise a new concern regarding the operation of the DOC pharmacy [the pharmacy technician being in the pharmacy working with controlled substances on a Saturday.]

Complainant's counsel state that because of the security violations in the pharmacy, an inventory might reveal missing controlled substances, and they suggest that "spot checks" be conducted for substance use of all people with recent access to the pharmacy.

182. There is no way to determine the precise amount or value of the items Complainant used. It has been previously found that the \$67.45 figure was not supported by the evidence. Based on his admissions, however, he ordered and regularly used breath spray and insoles for an ongoing period. At hearing, Complainant admitted to using the breath spray after taking smoking breaks. Complainant used shoe insoles acquired prior to July of 1996.³

183. On June 27, 1997, Complainant filed a complaint with the OIG regarding Moulton's violation of the mediation confidentiality agreement, and his allegation that Shoemaker had interfered with the mediation by unilaterally canceling it. This is listed on his Chronology as a protected disclosure.

Investigation of Moulton Grievance for Hostile Work Environment.

184. Fucles and Dennis F. Hougnon, another OIG investigator, conducted the investigation into the Moulton grievance. Soon after the investigation commenced, it was broadened to include hostile work environment complaints by many staff interviewed who had daily or very frequent contact with Complainant. This expansion was discussed with their supervisors, who approved it.

185. When the OIG investigates a harassment or hostile work environment complaint, and the two people involved have completely different stories, such as here, the standard procedure is to interview other witnesses for corroboration purposes.

³ The only invoice for insoles never prescribed for or used by inmates was from February 1997; yet, all six of those insole packages were introduced as Exhibit T, and none had ever been used. Shoemaker only obtained invoices back to July of 1996. Therefore, Complainant must have used insoles acquired prior to July of 1996.

186. Fucles and Hougnon interviewed nineteen individuals for their investigation, including Complainant, who was accompanied by his two attorneys, and Moulton.

187. Fucles did not believe it was her job as investigator to assess the motives or credibility of the people whom she interviewed. She believed it was the appointing authority's job to do that after receipt of the final OIG report.

188. Fucles asked witnesses she interviewed the open-ended question, what was the work environment like working with Complainant. Most of those she interviewed answered that Complainant routinely yelled, was loud, red-faced, and intimidating. Even those who had not been personal recipients of Complainant's inappropriate conduct corroborated Complainant's conflicts with and inappropriate treatment of Moulton and other staff.

189. A synopsis of the results of the OIG investigation, formalized in the May 8, 1997 report, follows:

A. Moulton stated, in part, "In September 1996, she attended basic training. When she got back she began to feel intimidated by Gusich based on his action, i.e. yelling." "Gusich's behavior was explosive sometimes and other times he was calm."

Corroboration of Moulton Grievance

B. Two witnesses who had no problems with Complainant, Dana Bustos and Ellen Benoit, verified that Moulton had had ongoing problems in interactions with Complainant. Bustos informed the OIG investigators, "that she has had conversations with Mynette during which Mynette complained about Gusich's behavior. She stated that Mynette stated that Gusich was yelling and intimidating her. Mynette described an occasion when Gusich was upset and yelling at her. Mynette stated that she felt that Gusich was blocking her way out of the pharmacy by standing near the door. Mynette left the pharmacy and Gusich did not physically stop her. Bustos also stated that Mynette told her that Gusich was talking about her recovery and was intimating she may be using drugs again. . . . Bustos stated that Mynette was clearly distressed and visibly upset over the situation with Gusich."

C. Ellen Benoit, a nurse at DRDC, stated that although Complainant is an intimidating person, she does not feel intimidated by him. She stated that Moulton "told her that she was having problems with him. When Benoit would drop off orders, Moulton would make comments such as 'Bob is a terror' or that she felt afraid of him. Complaints from Moulton came on a continual basis."

D. Shoemaker stated to the investigators: "she feels that Moulton's complaints are legitimate. She stated that Moulton came to her about the 'Lomotil' incident at the end of February, 1997. She stated that Moulton's complaint was that Gusich would [not] talk to her about the real issue which was Gusich being rude, yelling, and not listening to her. She

stated that Gusich wouldn't listen to Moulton but continued to focus on the fact that LCF got the Lomotil from another pharmacy and they, DRDC, could not get the drug. She stated that Gusich is unwilling to deal with the real issues and that is what Moulton was upset about." "Shoemaker stated that Mynette Moulton had talked to her a lot about Gusich's behavior towards her. She stated that Moulton came to her prior to October of 1996 which is when Gusich received a letter of counseling from her. She stated that Mynette talked to her about the Workplace Harassment A.R. [administrative regulation]. She stated that Moulton was concerned about time frames revolving around filing a grievance against Gusich. Shoemaker stated her advice to Moulton was that time frames were not an issue and to wait and see if Gusich's behavior improved. Shoemaker stated that during that time, she was doing corrective actions with Gusich to try to improve the behavior, such as documentation, counseling, the anger management workshop, letters of counseling, and the PACE."

E. Schenk stated that Moulton "had complained to him on several occasions about Gusich. He stated he advised Joanie Shoemaker of the situation and Shoemaker had Gusich and Moulton in mediation.

F. Patrice Baldwin, Nurse II, DRDC infirmary, stated, "She has seen him yell at Moulton. He was in her face and personal space."

Additional Evidence of a Hostile Work Environment

G. Three witnesses who did not object to Complainant's treatment of them, Ellen Benoit, Suzanne Tate, and Jeane Clarke, verified his inappropriate treatment of others. Suzanne Tate was an Administrative Assistant at the DRDC infirmary who had a good relationship with Complainant and who had never heard him raise his voice to a yell. Tate stated that "Gusich has told her that he has had conflicts with several of the staff members in the infirmary but she doesn't remember specifically who he was talking about. She stated that he said that the nurses were hard to get along with and uncooperative. . . . Tate stated that Gusich told her that specific nurses were incompetent and lazy." He also complained to her about DRDC circumventing state drug laws, and she had told him to document the violations.

H. Ellen Benoit stated, "When she has contact with him he is often loud with her. She advised him not to kill the messenger. . . . She describes him as 'out of control.' His behavior contributes to the difficulty of getting work done. This is a pattern of behavior. For example, if the pharmacy order[s] are written wrong or if they are not given to him on time. Anything can 'set him off.' His face was red and he raised his voice. It appeared that he was having a stroke. It looked as if he was off balance with his blood pressure problems. Everyone in medical has witnessed Gusich's behavior. Gusich often acted as if he did not want to be bothered. Other nursing staff don't like to go to the pharmacy, but she does not mind going. Often he won't fill medications if they are late. As a result the inmate goes without his medication. Working with Gusich means having to walk on eggshells. "

I. Jeane Clarke was a Dental Assistant who initially had problems with Gusich teasing her about her work hours, but who had explained to him that it offended her and he had stopped. At the time of her interview with the OIG, she had no problems with Complainant. Clarke had witnessed Complainant “yelling at staff in the medical room about getting (pharmacy) orders to him. Clark described his behavior as loud and ‘losing his cool.’ This behavior seemed frequent until he went on vacation (dates unrecalled). Currently he seems more reserved.”

J. Cindy Glassman, RN I, DRDC clinic, told the investigators, “when she wanted to get some syringes he asked her ‘why do you need needles.’ He would get upset over small issues such as if a date were missing from a prescription. He would begin to yell. She does not like to deal with him. Glassman told her supervisor Patrice Baldwin about her issues with Gusich. Glassman is aware that Baldwin talked with him. Glassman stated that Gusich makes the work environment stressful and the workplace is not normal.”

K. Katherine Louis, RN I, DRDC, told the interviewers that Complainant did not yell at her, and described his behavior with her as more “abrupt and gruff. . . When Gusich was leaving early they [other staff] had problems getting the medications they needed. She decided some time ago that she wasn’t going to let Gusich ‘ruffle’ her.” She had heard “Gusich make comments that he could not stand certain people, i.e. Rhonda Valdez, Patrice Baldwin, and Earlene Anderson.”

L. Rhonda Valdez, a nursing supervisor at DRDC, stated that “he does not have control of his emotions. Eighty percent of his behavior problems is related to how he talks to others. She has seen him red faced angry.”

M. Nurses who had already complained about Complainant, both verbally and in writing, were also interviewed.

N. Patrice Baldwin, a nursing supervisor at DRDC infirmary, stated, “When she met him he began yelling at her over a prescription that did not have a signature. He was also in her face and intimidating her. She has had this type of interaction with him since they met. Other nurses have told her that they don’t want to deal with him. Mostly because he would yell at them over minor issues such as dates not being on the prescription, no signature, or some other omission. . . Gusich wanted to receive all of the prescriptions by 2 p.m. . . It seems to her that every interaction with him is difficult. He yelled at her because he felt she was using too many syringes and asked her what she was doing with them. She felt his tone was accusing. Baldwin stated that she does not trust him and she feels as if she is on guard with him. He creates stress and the employees are put on the defense. Baldwin has talked with her supervisors about the conflicts. Sometimes if Shoemaker or Kinney [head nursing supervisor] would talk with him he would be nicer, but would return to his same behavior. . . Gusich displayed a lack of respect, he was demeaning and intimidating. . . She has seen him yelling at other nurses. Baldwin told him not to yell at her or the nurses. His behavior is harassing because she can not figure out if he was going to yell at her. He is difficult to work with. She doesn’t think he knows his interaction is not

normal. . . Baldwin feels he would benefit from some training in working with others.”

O. Schenk said that some of the nurses at DRDC won't even talk to Complainant due to his yelling and intimidating behavior, and confirmed that Gomez had complained about Complainant to him. He informed them about Complainant screaming at him on the telephone and hanging up on him. He stated he has no problems with the quality of his work and that he has good clinical skills.

P. The Limon nurses spoke to the interviewers. Griswald, a nursing supervisor, stated that even after her February 1996 incident report regarding Gusich being irate with her and raising his voice, he continued the behavior, and that that was usual behavior for him. Judy Bullard, the head nursing supervisor in Limon, stated that “she called DRDC to determine why certain medications were missing. Gusich began yelling at her. She has heard him yelling at other LCF staff even when she is five feet away from the phone. Gusich stated that LCF staff have attitude problems. . . Bullard has told Shoemaker about the communication problems with Gusich, but he doesn't take responsibility for his actions. Currently, LCF staff deal with the pharmacy technician when they have questions.”

Q. Doug Massengail, a pharmacist in another facility, confirmed that he had heard Complainant and Nisson argue, and stated that Complainant “was inappropriate in the manner that he handled it.” He stated that Gomez had called him crying and upset over Complainant's treatment of her.

R. Moulton stated that she had “witnessed him yelling and lecturing nurses. For example, a nurse handed him a prescription and it was not copied correctly. He began yelling that it was not filled out properly.”

S. Gomez, the former pharmacy technician, told the investigators that her problems with Complainant upset her so much that when she went home at night she was crying and upset. She stated that he yelled at her and made her feel small, and that once he ranted and raved for ten minutes about her shredding paperwork. She dreaded going to work, called off sick a lot, was diagnosed with Situational Stress caused by her work situation, and was prescribed Zoloft, an anti-depressant. Once transferred, she discontinued using Zoloft.

T. Clark and Bustos both stated that Moulton and Complainant had strong personalities.

U. Complainant “denied ever yelling at Mynette Moulton or treating her unprofessional. (Sic) Gusich stated that he never yelled at any staff member at DRDC and the Clinical Services. He stated that there were no problems with staff at DRDC other than with Nurse Jamie Stambaugh who tried to force her way into the pharmacy.” “Gusich denied hanging up on Tony Schenk and stated that he didn't yell at Schenk while on the telephone. Gusich had no knowledge of any type of problems that Veronica Gomez had with him. He stated that he was not advised of any problems concerning his behavior

towards Gomez by either Gomez or anybody else.” He also stated that Shoemaker had berated, intimidated, and harassed him, and had been very unprofessional in her role as clinical administrator.

190. On May 6, 1997, Complainant was transferred on a temporary basis to work in the Canyon City pharmacy. This imposed a hardship on Complainant due to the fact it was three hours from his home in Denver. He remained there until his termination on July 7, 1997.

Dr. Hedgeman’s Role as Appointing Authority

191. In May of 1997, Dr. Rose L. Hedgeman, Clinical Team Leader at Arkansas Valley Correctional Facility and Limon Correctional Facility, was given appointing authority to conduct the R8-3-3 meeting and to impose any discipline against Complainant regarding the Moulton grievance and hostile work environment allegations that surfaced in the OIG investigation. She was chosen due to her impartiality with respect to Complainant, whom she had never met.

192. Hedgeman had been with DOC for seven years, but was new to the disciplinary process. Prior to accepting this assignment as appointing authority, she had never terminated anyone, but had disciplined one employee.

193. Hedgeman was overwhelmed by the enormity of the OIG report and the volume of information in it. She found the conduct of Complainant to be “horrific,” and was baffled by his blanket denials in the face of such overwhelming evidence regarding his hostile and inappropriate conduct.

194. Hedgeman was concerned about there being no dates accompanying most of the narratives in the interviews contained in the OIG report (exceptions include Moulton, Griswald, Gomez, Schenk, Massengail, and Shoemaker). She called Fucles to see if she had any dates in her notes. Fucles did not, and she informed Hedgeman that dates didn’t matter, because the witnesses’ statements were there to validate Moulton’s grievance. Hedgeman did not accept this, and called all of the interviewees attempting to pin down dates. She was able to do so for the majority of the interviews. Her notes on dates are in general terms, such as “late 1996 - 1997.” Most of the dates are in 1996 and 1997; Gomez is the only one from 1995.

195. Hedgeman also needed guidance procedurally. She first called Don Lawson, who told her he could not discuss it with her and directed her to Personnel at DOC. She spoke with Al Weber at Personnel, who provided her with all appropriate administrative regulations from DOC and the State Personnel Board, as well as Complainant’s official personnel file.

196. Hedgeman spoke with DOC attorneys Brad Rockwell and Diane Michaud. Rockwell assisted her with how to structure her conclusions in writing; Michaud assisted her in providing information to Complainant on her thinking process, what she considered, how

she came to her conclusion.

197. Hedgeman gleaned from her discussions with the various individuals above that the OIG investigation was complete, that it was not her job to conduct further investigation. And that she was not supposed to re-interview witnesses regarding their allegations. She felt that to do so would be to inject subjectivity into the process. She concluded from her discussions that she would best maintain her objectivity to simply rely on the OIG report at face value.

198. Hedgeman therefore did not re-interview any witnesses. For instance, she did not question Moulton regarding why she was “not feeling very tolerant” on February 28, 1997, and whether that impacted the contents of her notes that day. She did not question any witnesses regarding their motives.

199. Hedgeman called Brad Kinney, the Director of Nursing at DRDC, to obtain names of who was in Complainant’s work group, to assure that an accurate sampling of DRDC staff had been interviewed.

200. Hedgeman spent weeks reading and studying the OIG report. On June 6, 1997, she made a chart, painstakingly outlining the content of each of the interviewees’ statements by categories: Recipient of behavior; witnessed behavior; non-recipient of behavior; comments by staff. There are twelve (12) individuals in the “recipient of behavior” column, nine of which have dates next to them. A thirteenth appears with a parentheses around it, Kathy Dean.

201. Hedgeman was aware that many of the nurses were complaining about the manner in which Complainant told them they were not giving him valid prescriptions, i.e., dates and signatures were missing or giving him late prescriptions. Hedgeman was concerned only with the manner in which Complainant spoke to them, not about the content of what he was saying.

202. Hedgeman did not question why Moulton’s grievance was accepted six weeks after the critical incident.

203. In reading the report, Hedgeman was not attuned to the possibility that witnesses might have an ax to grind against Complainant, or might have bad motives in complaining about him.

204. At hearing, Hedgeman testified that she did not know if all relevant witnesses had been interviewed that had something to say regarding Complainant’s behavior in the workplace. She relied on the OIG investigation.

205. Hedgeman scheduled an R8-3-3 meeting with Complainant and his attorneys for June 10, 1997, “to discuss information surrounding allegations of workplace harassment.” Present at the meeting were DOC attorney Rockwell, Complainant, and one of his

attorneys.

206. At the R8-3-3 meeting, Hedgeman read a long statement, commencing with a reference to the Moulton grievance, and then thoroughly summarizing the interviews of each of the following: Schenk; Massengail; Kinney; Gomez; Williford; Shoemaker; Baldwin; Bustos; Dean; Glassman; Valdez; Bullard; Clark; Griswald; Benoit; and Louis. She did not discuss the Moulton grievance in detail, and did not mention either Lynn Hansen or Stambaugh. At the time of this meeting, she had the February 1996 Griswald incident date and other dates, but did not have the additional dates she would later obtain through her phone calls to witnesses. Complainant would at that time have known the dates of the Moulton incidents, the Schenk hang-up, and the Nisson incident.

207. Complainant said nothing at the 833 meeting; his attorney spoke for him. He requested a copy of the OIG report and the Moulton grievance; pursuant to DOC policy, Hedgeman did not provide them with either. He objected to this as being a denial of due process and an abuse of DOC complaint procedures.

208. Hedgeman gave Complainant the choice of responding either verbally or in writing. On June 22, 1997, Complainant submitted his sixteen-page response.

209. Hedgeman was “amazed” by Complainant’s response letter, because he made such a sweeping denial of all the allegations, and because it contained a lot of information. Hedgeman felt that Complainant’s blanket denial, his failure to take any responsibility at all for the actions complained of, reduced his credibility.

210. The June 22 response letter raises a number of issues, each of which is outlined below, along with Hedgeman’s response thereto, where appropriate:

A. Complainant states, “I want to make it very clear at the outset that I generally deny all allegations that I have engaged in work place harassment. These charges are unfounded and untrue. In my pharmacy career of over 32 years, I have never before been accused of work place harassment.”

B. Procedural Defects. Complainant objected to not being given a copy of the OIG report or Moulton grievance; to the fact there were many new allegations raised which were not discussed in the OIG investigation interview; and the fact the allegations are general and stale in nature. With respect to the general and stale nature of the allegations, Hedgeman addressed this by calling each witness to obtain dates. She also called Personnel and learned that two years is not too old for a case involving a pattern of hostile work environment. Hedgeman viewed the 1995 information as part of a collective whole, part of a pattern of conduct of Complainant.

C. Complainant states that witnesses have repudiated their statements. Specifically, on pages 10-11 he states that Massengail stated that he never had to separate Complainant and Nisson. Hedgeman gave this little consideration because Massengail

was not a recipient of Complainant's harassing conduct. She did not feel it was necessary to call him to follow up. On Page 12 he states that Kathy Dean "is on record with the OIG as stating that she has never had any problems with my work place behavior." This is no different than the OIG report and the statement regarding same that Hedgeman read to Complainant at the 833 meeting. Hedgeman therefore did not follow up on this.

D. Complainant states the witnesses' statements are "based upon gossip, innuendo, and hearsay," with no dates, times, places, specific statements by Complainant, or other facts to support the allegations. See B above for her response.

E. Complainant objects that his physical characteristics of being tall and red complected, as well as being loud, are being used against him. Hedgeman viewed this as a weak argument.

F. Retaliation. Complainant states that "All of the witnesses described by you as making allegations against me are persons to whom I have made protected work place disclosures concerning violations of law, regulations and standards of conduct by them or their staff (hereafter "Violation(s)"). These people have a vested interest in discrediting me. Their credibility further suffers from the fact that many of these individuals have committed the very wrongs I stand accused of in this matter. These include yelling, being loud, being red faced, and slandering co-workers. A double standard is occurring in this case." He further states that many of his co-workers were not interviewed. He further states, "Each of the purported incidents about which the witnesses complain are incidents during which I confronted someone to reports to me or works with the pharmacy about a dereliction of duty or Violations involving them or their staff."

In the entire 16-page response letter, the only specific references to his objections to "violations" are: Baldwin "consistently ignored my efforts to promote compliance with the law, e.g. use of syringes"; Glassman "consistently ignored my efforts to promote compliance with the law, e.g. missing names and dates on prescriptions"; Valdez "consistently ignored my efforts to promote compliance with the law e.g. missing medicine cards and substituting one inmate's prescription medicine for another inmates' prescription," and Benoit was "motivated by retaliation against me for disclosing to her Violations engaged in by her, e.g. inappropriate stocking of medications for prisoner use over the weekends." Notably, there is no explanation of how the Baldwin or Benoit actions were violative of any regulation or law. That left only two specific, apparently legitimate alleged violations for Hedgeman to weigh against his general statement that "all witnesses" were retaliating against him.

Hedgeman followed up on the retaliation allegation by calling Schenk and telling him Complainant was reporting pharmacy violations and asking what they meant. Schenk responded that Complainant had brought pharmacy violations to his attention, that Schenk had asked for the information in writing, and that Complainant had not provided him with anything. Hedgeman then called Shoemaker, who stated that Complainant had provided her with nothing in writing either. Hedgeman noticed the fact that when some of the nurses

complained about Complainant's yelling, it was in the context of him telling them he needed a signature on a prescription, etc. Hedgeman felt that even if Complainant had been attempting to get nurses to comply with the law, he nonetheless had no excuse for yelling or being intimidating. Hedgeman viewed the allegation of retaliation by Complainant as a largely unsupported means of attempting to discredit his accusers, as part of his strategy of general denial. She saw it in the context of her belief that Complainant generally lacked credibility. The fact that he had failed to provide anything to his supervisors in writing also led her not to take the retaliation allegation seriously.

G. Complainant states that "Prior to the R-8-3-3 meeting nothing was said to me about these allegations either by DOC management or the OIG. None of the witnesses now complaining made contemporaneous complaints to the OIG or management at the time these things allegedly occurred." Hedgeman had documentation showing that Complainant knew that Schenk had informed Shoemaker within a week of Complainant yelling and hanging up on him; and that Complainant had received a letter of counseling for his pattern of behavior, stating, "when you are angry, you are very loud, red faced, and aggressive. . . This behavior has been discussed with you both informally and formally." She also had his progress reviews in which he was informed numerous times of his inappropriate interactions with staff. She had statements in the OIG interviews indicating that Shoemaker and Baldwin had spoken to him about his yelling at nurses. She also had the statement of Tate, an unbiased individual who had no problem with Complainant, that Complainant himself had admitted to her that he had had "conflicts with several of the staff members in the infirmary." She did not lend this claim much credence.

H. Complainant points out that the OIG investigation was purported to be about the Moulton grievance, but the R8-3-3 meeting concerned primarily the other allegations. He further highlights that all alleged incidents except the Moulton February 28, 1997 one occurred prior to his successful completion on February 25 of the course on interpersonal relationships. He states that Shoemaker had acknowledged in her most recent performance appraisal, in April of 1997, that he had improved in this area, and that his completion of the training and improved behavior "should have laid to rest any disciplinary issues involving these stale, past alleged incidents." Hedgeman was aware of these facts, but also noted that Shoemaker had still rated Complainant "Needs Improvement" in both Communication and Interpersonal Relations" on that evaluation. She felt that Shoemaker believed that these were still chronic problem areas for Complainant, but that Shoemaker wanted to acknowledge Complainant's efforts in the narrative section. Shoemaker's statement read, "Interpersonal Relations. Bob has improved in this area. There have been less conflicts with co-workers. However, Bob and the pharmacy technician [Moulton] are working with the state mediation program to resolve an interpersonal conflict."

I. After raising the general issues above, Complainant then reviews the statements of each witness mentioned in the 833 meeting, and rebuts their statements with denials and explanations.

J. With regard to Shoemaker, he points out that he raised a number of

whistleblower disclosures regarding “DOC Violations and mismanagement” in his November 12, 1996 meeting with her.

K. With regard to Schenk, he states that he made more whistleblower disclosures to him than to any other DOC management official, and that Schenk repeatedly ignored his disclosures.

L. With regard to Moulton, he states that her allegations “are motivated by revenge for my having detected and documented substandard job performance and violations of pharmaceutical laws and regulations.” There was no evidence available to Hedgeman to support this statement.

211. After closely reviewing Complainant’s response letter, on June 27, 1997, Hedgeman created a second chart outlining his “Responses to Allegations.” The chart contains the names of each witness in the OIG report, accompanied by detailed notes outlining Complainant’s response regarding each witness.

212. On July 1, 1997, Hedgeman created a third chart, entitled “Sequence of Events.” This is a detailed time line of the letter of counseling, Complainant’s performance appraisals showing “Needs Improvement” in Communication and Interpersonal Relations, his November 12, 1996 “lengthy discussion W/B” (presumably meaning whistleblower allegations) with Shoemaker, his harassment complaint against Shoemaker, his anger management workshop in February of 1997, the OIG report witnesses, and other entries.

213. Hedgeman did not view the fact that none of the witnesses other than Moulton had filed grievances against Complainant as significant, because she felt the primary purpose of their interviews was to substantiate Moulton’s grievance.

214. Hedgeman did not consider the Points to Consider section in the OIG report in making the decision to terminate Complainant. That section is created for the appointing authority’s use, but Hedgeman did not understand its purpose. This section listed such items as: did Shoemaker violate the DOC code of conduct by threatening to terminate Complainant without cause; did Moulton violate the code of conduct by engaging in unprofessional behavior; did Complainant violate the code of conduct by being dishonest with the OIG regarding past disciplinary action he received regarding his temperament; did Moulton violate sick leave policies after arguments with Complainant.

215. Hedgeman believed that Moulton felt very fearful and threatened by Complainant, and viewed Complainant’s conduct as a pattern over time, since 1995, of bad interpersonal relationships where he was loud or aggressive with co-workers.

216. Hedgeman believed that it took only one person be the victim of workplace harassment to justify a conclusion that the workplace was hostile. She believed that Moulton was the victim of hostile work environment imposed by Complainant.

217. Hedgeman also concluded that Complainant had created a hostile work environment

for the other individuals in the OIG report who had complained of his behavior. She was impressed by the fact that of the 18 people interviewed, 12 did have problems with Complainant and 4 did not. Those who didn't were not in his work group, such as the mental health worker and the administrative assistant.

218. Hedgeman concluded that Complainant had violated AR 1450-5, "Unlawful Employment Practices: Policy Prohibiting Workplace Discrimination/Harassment," which defines "workplace harassment" as "an intimidating, hostile, or offensive environment."

219. Hedgeman also concluded that Complainant had violated AR 100-29, "violence in the Workplace," which states, "Threats, threatening behavior, or acts of violence by anyone will not be tolerated." This policy defines "violence or threatening incidents in the workplace" as including, but not limited to, ". . . intimidation, threatening or hostile behaviors. . . ." The exact terms she felt applied to Complainant were "threats" and "intimidation, threatening or hostile behaviors."

220. Hedgeman took into account DOC's zero tolerance for workplace harassment, in the Code of Conduct, AR 1450-1, IV(B), which states, "workplace harassment, or discrimination, in any form will not be tolerated. "

221. Hedgeman considered Complainant's April discipline for misappropriation as prior discipline under the personnel rule requiring progressive discipline. She also referenced the State Personnel Board rule in effect at that time, P8-3(A), which stated, "Normally, no more than 2 disciplinary actions may be administered to an employee in any 12-month period. Thereafter dismissal shall be considered." After consulting the Director and two staff at DOC Personnel, she believed that this rule mandated that she consider termination. There is no evidence, however, that she believed that it mandated that she terminate Complainant.

222. Hedgeman determined that based on Complainant's longstanding pattern of hostile behavior towards others at DOC, she could not in good conscience have Complainant go back into the workplace. She decided termination was the appropriate discipline.

223. On July 7, 1997, Hedgeman wrote Complainant a letter imposing termination. Her seven-page letter clearly sets forth the issues and facts she considered, a discussion of her reasoning process, references she reviewed, her conclusion reached, and her decision. In addition to the considerations set forth above, Hedgeman considered the following in reaching her decision to terminate Complainant:

A. Complainant received training in January of 1996 and January of 1997 in the DOC Administrative Regulations dealing with workplace harassment, AR1450-5, AR 1450-1, and AR 100-29.

B. Performance Evaluations from March 1, 1995 through February 28, 1997 "document below standard performance (needs improvement) in certain areas pertaining to

Communications, Interpersonal Relations, and/or Organizational Commitment and Adaptability.” She was not aware that Shoemaker had given Complainant two evaluations late, on October 1, 1996.

C. On July 11, 1995, he was given a Letter of Counseling by Ron Johnsen, Clinical Team Leader, regarding a pattern of complaint of harassment by Jamie Stambaugh.

D. On September 23, 1996, he was given a Letter of Counseling by Joanie Shoemaker, Clinical Team Leader, regarding unprofessional conduct, e.g. loud, aggressive, rude behavior.

E. Between February and November 1996 Shoemaker documented discussions with him regarding his behavior.

F. Mynette Moulton, Pharmacist Technician, DRDC, who worked with Gusich, filed a grievance alleging workplace harassment dated April 14, 1997.

G. OIG interviewed 18 people, twelve of whom were recipients of his inappropriate behavior, including yelling, becoming loud, red-faced and angry, and intimidating. One staff member was questionable because she stated that she was not a recipient of any problem behavior. Three witnessed his behavior toward other staff. Four were not recipients of his unprofessional behavior.

H. Complainant responded: by denying all allegations; by stating that the allegations were old, stale, and amorphous; by claiming that the allegations lacked dates, times, places, witnesses, and details; and by stating that all of the witnesses were retaliating against him because he had cited them with violations of law, rule, regulation or standards, such as pharmacy violations; and by claiming that his physical characteristics of being tall, large, having a red complexion, and having a hearing impairment, were being used against him.

I. Her conversations with various staff to obtain approximate dates of alleged incidents of inappropriate behavior.

J. Dr. Hedgeman reviewed the following written materials:

- I. AR 100-29, Violence in the Workplace
- ii. AR 700-15, Pharmacy Services
- iii. AR 1450-1, Staff Code of Conduct, DOC
- iv. AR 1450-5, Unlawful Employment Practices: Policy Prohibiting Workplace Discrimination/Harassment
- v. AR 1450-12, Corrective and Disciplinary Actions
- vi. Colorado Code of Regulations governing R8-3-3 actions.
- vii. OIG investigative report dated May 8, 1997

- viii. Moulton grievance dated April 14, 1997
- ix. Internal audit conducted by Perry Nisson, Pharmacy Consultant, dated August 26-28, 1996
- x. Complainant's June 25, 1997 response letter.

224. Hedgeman stated in her letter, "It is difficult to believe that the aforementioned staff members at DRDC, CTCF, and LCF, would collectively retaliate against you based on your claims of citing pharmacy violations to them. Your conclusions are suspect."

225. Hedgeman concluded, "Mr. Gusich, you lack credibility, integrity and professionalism by denying any responsibility for your actions in this serious matter. You have violated AR 1450-5 by creating a hostile, intimidating and/or offensive work environment at DRDC."

226. On July 18, 1997, Complainant filed the instant appeal, as well as a claim of retaliation under the Colorado whistleblower statute. The retaliation claim was investigated by the Office of the State Personnel Director pursuant to statute; the investigative report was not offered into evidence at hearing.

Pertinent Regulations.

227. AR 1450-1, the DOC staff Code of Conduct, states that "staff . . . shall be treated professionally. . . ." It further provides, "Workplace harassment . . . in any form will not be tolerated." With regard to misappropriation, it states, "Staff shall not use or allow the use of state time, supplies or state-owned or leased property and equipment for their private interests. Loss, misuse, misplacement, theft or destruction of state property must be reported to appropriate supervisor immediately. Staff shall not appropriate any lost, found, evidential or DOC property to their own use."

228. AR 1450-5, the DOC Unlawful Employment Practices: Policy Prohibiting Workplace Discrimination/Harassment policy, dated June 1, 1997, provides:

Policy. It is the policy of the Department of Corrections to maintain a healthy work environment free of workplace harassment and discrimination. Violations of workplace discrimination/harassment will be dealt with firmly and appropriate personnel action will be taken, up to and including termination.

Reasonable Person Standard (as it applies to Harassment): In deciding whether comments or conduct were inappropriate, the behaviors will be reviewed from the perspective of a "reasonable or average" person's standards.

Workplace Harassment; An intimidating, hostile, or offensive environment.

DOC staff will treat each other in a professional manner with dignity and respect.

All records relating to complaints regarding discrimination and/or harassment are

confidential, and only a finding of guilt shall be placed in an employee's personnel file. A confidential file relating to discrimination and/or harassment investigations shall be maintained by the Inspector General.

Appointing Authorities will assure compliance and take immediate action to eliminate any form of workplace discrimination/harassment.

It is not necessary for a supervisor to have a signed complaint before causing an investigation into workplace harassment or discrimination if the supervisor has cause to believe violations have occurred or are occurring.

The DOC's Executive Director or designee will review investigations on discrimination/harassment and assign the appropriate Appointing Authority the responsibility for administering corrective or disciplinary action against the accused staff it applicable.

The Inspector General shall: . . . select and train personnel to investigate allegations of Workplace Harassment/Discrimination. . . No information pertaining to the investigation will be released except to the appropriate Appointing Authority. . .

(A May 15, 1996 policy preceded this one, identical in all relevant respects.)

229. AR100-29, DOC, Violence in the Workplace, provides:

Violence or threatening incidents in the workplace: Includes, but is not limited to infliction of any bodily injury; harmful psychological contact; destruction or abuse of property; intimidation, threatening or hostile behaviors. . . .

230. State Personnel Board Rule R8-3-1, in effect at all times relevant, provided:

(B) The decision to correct or discipline an employee shall be governed by the nature, extent, seriousness and effect of the act, error or omission 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.

(C) 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.

231. Under Board Rule R8-3-3(C), corrective actions and disciplinary actions may be administered to employees upon written findings of the following:

a. Failure to comply with standards of efficient service or competence;

- b. For willful misconduct including but not limited to violation of a Board or agency rule;
- c. Willful failure or inability to perform assigned duties.

232. Complainant seeks the following relief: dismissal of this disciplinary action; removal of any mention of the disciplinary action and the OIG report from his personnel file and other DOC files; reimbursement for back pay and lost benefits; written exoneration of the workplace harassment charges distributed to all parties with knowledge of the proposed disciplinary action or the IG investigation; reinstatement to the position at the DRDC pharmacy; rescission of his reassignment to Canon City; insertion of a notation in the official personnel files of Hedgeman and other DOC employees responsible for bringing the harassment charges against him; attorney fees and costs; reimbursement of job hunting expenses incurred since termination; reimbursement for pain and suffering or emotional distress caused by the termination; reimbursement for damage to his reputation.

DISCUSSION

I. SUMMARY OF ARGUMENTS OF THE PARTIES

Complainant argues that he was disciplined and ultimately terminated because he made repeated protected disclosures regarding violations of regulatory and statutory law by nursing and other staff at numerous DOC facilities. He argues that there was a rush to judgment, that he was subject to a preordained conclusion, and that exculpatory evidence was ignored.

With regard to the misappropriation issue, Complainant argues that there was no clear policy governing his conduct, and that he was therefore subject not only to a double standard (since other staff and managers utilized OTC items), but also to an arbitrary and capricious exercise of authority. He denies having committed misappropriation, stating that he only used breath spray, and provided the spray to other staff by leaving it out in the pharmacy. He points out that he could not have used the insoles because they are too small for him. He states that he ordered both items as alternate products for inmates' use.

With regard to the harassment issue, Complainant claims that the incidents about which DRDC and other facility staff complain all involved situations where he was attempting to correct noncompliant behavior of such staff. He denies ever having yelled or intimidated staff or having engaged in any conduct that would constitute work place harassment. He further alleges that all staff and supervisors who made complaints and allegations against him have conspired in an attempt to have him removed from his position.

Complainant also makes a number of procedural arguments, including the following:

there was no clear cut definition of misappropriation utilized in the process of investigating and disciplining him; Lawson violated R 8-3-3 by disciplining him prior to receiving his written response; that the OIG investigation was flawed since Fucles did not inquire into witnesses' possible motives; that Hedgeman's role was flawed for the following reasons: she never provided Complainant with a copy of the OIG report or Moulton's grievance, failed at the 833 meeting to disclose to Complainant that she was relying in part on three witnesses (Nisson, Stambaugh, and Hansen) whom he never had the chance to rebut, never interviewed witnesses to assess their credibility, failed to track down all dates, ignored Complainant's improvement evidenced in the April 1997 performance evaluation, and relied upon stale information.

Respondent argues that this case rests upon a credibility determination: either the Complainant is lying, or all of Respondent's witnesses and all twelve recipients of his harassment in the OIG report are lying. Respondent argues that the Board must believe Respondent's witnesses, in part since Complainant's credibility was destroyed at the close of the hearing by impeachment testimony presented by Complainant's former employer. Respondent points out that Complainant testified that he was terminated by Kaiser as a pharmacist for one instance of leaving work ten minutes early, and that no issues regarding problems with other employees were ever brought up. Respondent then called on rebuttal Complainant's supervisor at Kaiser from 1990 - 1993, who has no knowledge of this case, and who testified that Complainant was terminated for falsifying his time card over a week period and for creating a hostile work environment.

Respondent further argues Complainant did engage in the acts for which he was disciplined, that its managers and the OIG engaged in thorough investigations of Complainant's conduct, and that Respondent did not act in an arbitrary or capricious manner, and did not violate any rules or laws in taking disciplinary action against Complainant.

II. DISCIPLINARY DEMOTION FOR MISAPPROPRIATION

Certified state employees have a property interest in their positions and may only be terminated for just cause. Department of Institutions v. Kitchen, 886 P. 2d 700 (Colo. 1994). Such cause is outlined in State Personnel Board Rule R8-3-3, 4 CCR 801 (1998), in effect at the time of the actions at issue herein, 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 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 Respondent to prove by a preponderance of the evidence that the acts on which the discipline was based occurred and that just cause warrants the discipline imposed. Kitchen, 886 P. 2d 700 (Colo. 1994). The administrative law judge, as the trier of fact, must determine whether the burden of proof has been met. Metro Moving and Storage Co. v.

Gussert, 914 P. 2d 411 (Colo. App. 1995). The Board cannot reverse or modify an action of an appointing authority unless it finds the action to have been arbitrary, capricious, or contrary to rule or law. Section 24-50-103(6), C.R.S. (1999).

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

This case does rest to a great degree on credibility determinations. In order to determine whether Complainant committed the acts for which he was disciplined, credibility must first be addressed.

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 witnesses' bias, prejudice or interest, if any;
8. A witness' demeanor during testimony;
9. All other facts and circumstances shown by the evidence which affect the credibility of a witness.

Complainant's Lack of Credibility. Complainant proved generally to lack credibility. His testimony is rife with prior inconsistent statements, internal inconsistencies, and inherent improbability, and is overwhelmingly contradicted by other documentary and testimonial evidence. Examples follow.

Complainant testified with conviction that the reason Kaiser terminated him from employment after two and a half years was that he had, on one instance, left work ten minutes early. Respondent's counsel asked Complainant if there were any other

allegations, and he said no. He then asked Complainant if there were problems with other employees at Kaiser. He answered that no, it was not brought up. Complainant also stated to Hedgeman in his June 22 response letter that he had never been accused of work place harassment before.

Respondent then called Bruce Emeson, Kaiser's Chief Pharmacist and Complainant's supervisor from 1990 - 1993, on rebuttal. Mr. Emeson had no knowledge of this case, and no knowledge of Schenk, Shoemaker, Hedgeman, Lawson, or others who have played a major role in this case. He was not pleased to be a part of this hearing, and testified only because he was under subpoena. He was plainly without bias. Mr. Emeson testified that Complainant was terminated for falsifying his time card and for creating a hostile work environment.

After staff alerted him to the fact that Complainant was leaving work early, Emeson circulated a memo to all pharmacy staff, including Complainant, indicating shift start and end times, and the proper procedure for filling out time cards. Complainant and other employees were on an honor system, under which they hand-wrote the time worked on their time cards.

After circulation of the memo, Emeson personally observed Complainant's departure times over the course of one week. Over a Monday - Thursday period, Emeson documented that Complainant left early for a total of 85 minutes of missed work. Complainant then reported the 85 minutes of missed work on his time card. When Emeson confronted Complainant, he denied that he had left work early, even after being told that Emeson had personally observed it.

In addition to the time card falsification, Emeson testified at length regarding Complainant's problems with other workers, and the fact that he created a hostile work environment. People who worked with Complainant felt threatened and intimidated by him. He responded to questions with a condescending, "What?" implying the question was stupid and inappropriate. He made people feel stupid. He stood behind his pharmacy technician while she worked and drummed his finger, making her feel very uncomfortable in the workplace. She feared she would make a mistake due to the pressure he placed upon her. When this pharmacy technician changed shifts to get away from him, he yelled at her. Another pharmacy technician was intimidated by the same behavior and his piercing stare. One employee reported that he threw a stool against a wall in an angry outburst. When he brought hunting pictures in to work, they perceived his photos of his guns as a veiled threat that he may come to the pharmacy with a gun and shoot people. He was perceived as an angry, demeaning individual, not a team player.

Emeson had a meeting with Complainant and a union representative to discuss the hostile work environment situation. After advising Complainant of the complaints about him, he responded by denying the conduct, and acted as if the matters were about someone else, and did not pertain to him.

Prior to terminating Complainant, a second meeting was held to discuss both the time card falsification and hostile work environment. Complainant continued to deny his conduct. The termination letter from Kaiser states that he is being terminated for falsification of his time card and other concerns in the workplace. After firing Complainant, Emeson was fearful of retaliation by him.

The Emeson testimony directly impeaches Complainant's testimony regarding the reasons for his termination, and his statement in his June 22 response letter to Hedgeman that "In my pharmacy career of over 32 years, I have never before been accused of work place harassment."

A third example of impeachment involves Complainant's testimony and prior statements about Mynette Moulton. Complainant stated in his response letter to Hedgeman that Moulton's allegations of harassment "are motivated by revenge for my having detected and documented substandard job performance and violations of pharmaceutical laws and regulations." Complainant also testified that he "constantly counseled her and told her her performance was sub par. I was going to recommend to Shoemaker that she be terminated." He further testified that he did not complete a performance evaluation of Moulton, but if he had, he "would have given a narrative of my opinion she was not doing her job."

Respondent introduced into evidence Exhibit 29, a December 31, 1996 performance evaluation of Moulton for the period September 1, 1996 to November 30, 1996, completed and signed by Complainant. He rated her an overall 3.40, between a good (3) and commendable (4). He gave her no needs improvement or unacceptable ratings. There is no mention of any problem with her performance.

There is no evidence in the record that Complainant informed Shoemaker or Moulton of performance problems, or that he ever counseled Moulton. There is absolutely no evidence in the record that Complainant "detected and documented substandard job performance and violations of pharmaceutical laws and regulations" by Moulton.

Complainant stated to the OIG investigators that he "had no knowledge of any type of problems that Veronica Gomez had with him. He stated that he was not advised of any problems concerning his behavior towards Gomez by either Gomez or anybody else." However, his own handwritten note on June 20, 1995 states, "Veronica said I was yelling at her, but I wasn't." Further, Johnsen's July 1995 performance review specifically references his problems with Gomez.

Complainant testified consistently that he did not engage in any harassing behavior, did not yell at or have conflicts with DOC staff, and that he was not made aware that his behavior was problematic. His performance evaluations and counselings contradict this contention. In addition, his question of Moulton on February 28 as to whether she was telling others about him yelling at her and keeping notes on his conduct belies this testimony. It indicates that he knew he was mistreating her, and wanted to know if she was

doing something about it.

Suzanne Tate, a completely unbiased witness who was never “corrected” by him and never heard Complainant raise his voice to a yell, stated to the OIG investigators that Complainant had admitted to her he had had conflicts with “several of the staff members in the infirmary.” Tate had no reason to retaliate against Complainant. The only conclusion to be drawn is that Complainant has known for a long time that he has conflicts with staff, but decides to deny it under oath anyway.

Complainant testified in detail about the tasks he performed between 4 and 4:30 every day, after the computer had been turned off. However, the electronic “palm reader” demonstrated that he in fact left most days before 4:30, often by 4 p.m.

Misappropriation. Turning back to the question of whether Complainant committed the acts for which he was disciplined, Lawson disciplined Complainant for two things: ordering and using insoles and breath spray, and lying to Lawson at the R8-3-3 meeting about his statements to Fucles (and about the circumstances of his suspension). (Exhibit 22). Respondent has proven that Complainant committed both acts.

Complainant’s shifting positions in defense of the misappropriation charge demonstrate his lack of credibility on this issue. Initially, in the meeting with Fucles and Shoemaker, Complainant admitted ordering and using the insoles and breath spray. His admissions and explanations at that meeting have the ring of truth about them, and his approach at that meeting was appropriate to the situation. He offered to remove his shoes to show them the insoles. The breath spray and insoles were very low cost items; he must have appropriately believed that it was “no big deal.” There is no reason to disbelieve Fucles: she is an unbiased professional investigator, and she took contemporaneous notes at the meeting which she used to write her detailed report.

Complainant then denied making the admissions to Fucles at the April 23, 1997 R8-3-3 meeting with Don Lawson. His flat denial of his prior admissions to Lawson simply not credible. He repeated this denial in the letter to Lawson.

Lastly, at hearing, Complainant changed his position a third time by admitting to using the breath spray after taking smoking breaks at work. He also testified that at the time he ordered the spray, it was for the purpose of having a cheap alternative to saliva stimulators for cancer patients. This explanation lacks credibility, since he continued to re-order the spray despite the fact it was never prescribed for or given to inmates. He also explained that he ordered the new types of insoles because he felt that the youthful inmates needed the extra protection. He further explained that the insoles were too small for his large feet. This explanation also lacks credibility, since the insoles can be used for a wide range of sizes, and they were never prescribed for inmates. Even if the insoles were too small for him, he did use them, because he offered to take off his shoes and show them to Fucles and Shoemaker at the March 26, 1997 meeting.

In view of the above, Lawson reasonably relied on Complainant’s admissions at the

Fucles meeting in determining that he had ordered and used the insoles and breath spray, and that he lied. The only fact Respondent has failed to prove was that Complainant used insoles and breath spray with a specific value of \$67.45. There is no way to know the precise value of the products ordered and used by Respondent. The significance of this fact will be discussed below.

2. Was discipline within the range of reasonable alternatives available to the appointing authority?

Lawson testified that he would have issued a corrective action to Complainant if he had not lied to him regarding his prior admissions to Fucles. Lawson came into the 8-3-3 meeting expecting to discuss and follow up on Complainant's reasons for using the products and the issue of staff and management use of OTC's in general. He was shocked to hear Complainant's blanket denials, and was angry that a person in Complainant's position of leadership would lie to him in this situation.

Lawson was fully justified in believing that Complainant's lying to him was flagrant and serious enough to warrant disciplinary action. If high level state managers cannot trust the supervisors in the field to be truthful regarding their official conduct, the honor system upon which effective management relationships is based erodes. In imposing discipline on Complainant, Lawson sent an appropriate message that he would not tolerate any further acts of misrepresentation in the future, and he penalized Complainant for doing it the first time.

The value of the insoles and breath spray utilized by Complainant was irrelevant to his decision to discipline him. Therefore, the demotion stands.

However, it was unreasonable for Lawson to order Complainant to "re-imburse Colorado Department of Corrections for \$67.45." Lawson was told by Complainant and Schenk at the R8-3-3 meeting that many of the items ordered had not been received since they were out of stock. In addition, when Lawson referred to "arch supports" in the meeting, both Schenk and Complainant pointed out to him that arch supports were different from insoles. Lawson failed to follow up on this information, and never re-calculated the numbers to confirm that the \$67.5 figure was correct.

Complainant testified that he had been docked pay in the amount of \$67.45. Respondent provided no evidence rebutting this. Accordingly, DOC must reimburse Complainant for that amount.

3. Was the action of the appointing authority arbitrary, capricious, or contrary to rule or law?

Arbitrary and capricious action can arise in one or more of three ways: a) by neglecting or refusing to procure evidence; b) by failing to give candid consideration to the evidence; and c) by exercising discretion based on evidence in such a way that reasonable

people must reach a contrary conclusion. Van de Vegt v. Board of Commissioners, 55 P.2d 703, 705 (Colo. 1936).

As previously stated, Lawson was told by Complainant and Schenk that he was using incorrect information from the invoices. He failed to follow up on it. That constituted arbitrary and capricious action, and has been reversed above.

Complainant makes a number of procedural arguments in support of his request that the Board overturn the discipline for misappropriation. First, he argues that Lawson violated “the intent of the 833 process” by failing to wait for Complainant’s written response prior to imposing discipline. Rule 8-3-3(D)(1) states,

“When information received by an appointing authority indicates the possible need to administer disciplinary action to a certified . . . employee, the appointing authority shall meet with the employee involved, present the information that comes to the attention of the appointing authority and give the employee an opportunity to admit or refute the information or to present information regarding mitigating circumstances. This meeting is not a formal hearing, but an opportunity for the parties to meet and exchange information. . .

(a) The appointing authority shall consider written and/or oral information provided by the employee prior to making any final decision.”

At the R8-3-3 meeting, Lawson gave Complainant the opportunity to admit or refute the information presented, and he listened to all of Complainant’s statements made in his defense. Once Complainant denied making the admissions to Fucles, and denied having engaged in misappropriation, Lawson at that point reasonably believed he had all pertinent information regarding Complainant’s defense. While it is unfortunate that there was a misunderstanding between Complainant’s counsel and Lawson regarding whether he would consider a written follow-up, Lawson’s failure to do so here was not an intentional refusal to consider Complainant’s information. Rule 8-3-3(D)(1)(a) mandates that the appointing authority consider written “and/or oral” information. Here, the appointing authority complied with this rule by considering oral information.

Complainant next argues that Respondent failed to utilize progressive discipline, in violation of R-8-3-1(C). This rule states, “unless the conduct is so flagrant or serious that immediate disciplinary action is appropriate, corrective action shall be imposed before resorting to disciplinary action.” As discussed above, Lawson rightly felt that the trust he needed from his only pharmacist at the DRDC clinic had been breached. This raised a serious red flag regarding Complainant’s entire working relationship with Lawson. Disciplinary action was warranted here.

Complainant also asserts that whenever an agency disciplines an employee for violating a policy, that policy must be clear, understandable, and consistently applied, citing *Toothaker v. DOC*, State Personnel Board Case Number 97B057, April 22, 1997.

However, here, a written DOC policy, AR 1450-1, the staff Code of Conduct, stated, “Staff shall not use or allow the use of state time, supplies, or state-owned or leased property and equipment for their private interests.” Section IV(CC). In *Toothaker*, there was no written policy governing the conduct for which the employee was disciplined. Complainant further argues that this written policy was violated on a routine basis, and is being arbitrarily applied to Complainant here, since staff and management engaged in the routine use of OTC products. Lastly, he argues that “misappropriation” was never clearly defined for him in writing or orally, in terms of whether it includes ordering and using state property, and whether the use has to be off site.

Shoemaker, other supervisors, and line staff at DRDC all occasionally asked for and received OTC products from the pharmacy such as headache medicine (aspirin, motrin), cold medicine, Band-Aids, even blood pressure medication. Moulton once obtained Zolof from the pharmacy when she forgot her own. Schenk used the fax machine for personal use.

Staff used these products sporadically, on an as-needed basis, for the purpose of staying on the job (with the exception of Schenk’s fax use). By contrast, Complainant ordered specific items for his routine personal use. Complainant argues that his use of the breath spray and insoles was analogous to these uses because it was for his personal comfort in order to assist him in remaining on the job too. However, others’ use of the OTC items was sporadic, on an isolated, as-needed basis, due to a minor medical or painful condition that interfered with work. His bad taste in his mouth was not a painful condition interfering with work; it was a result of his smoking, something he chose to do daily.

Based on his statements to Fucles, Complainant used the breath spray on a regular basis, and he put the insoles in his shoes when he arrived at work and removed them prior to departure. Use of both products appears to have been a daily routine for him. If his feet were “killing him” every day, he needed to purchase a new pair of shoes, instead of using DRDC pharmacy resources to solve the problem. The weight of evidence suggests that Complainant ordered both products for his own use, not for prisoners. No physician requested the products; no physician ever wrote a prescription for either product.

Complainant’s ordering of the insoles and breath spray for personal use are clearly not major performance issues. Lawson felt this would have, alone, warranted only corrective action. The lying issue made the situation a serious one warranting discipline. It is not for the Board to second guess the administrators of the DRDC clinic and make a policy regarding what constitutes permissible use of pharmacy products; Respondent’s action here was a reasonable one based on the situation.

4. Defense Claim of Retaliation for Protected Disclosures

To state a claim under the Colorado whistleblower act, a certified employee must demonstrate two things: 1) he or she made disclosures that fall within the protection of the statute and 2) such disclosures were a substantial or motivating factor in the employer’s

adverse employment decision. Ward v. Industrial Com'n, 699 P.2d 960 (Colo. 1985). Once that initial burden has been met, the respondent agency may successfully rebut the retaliation claim by establishing by a preponderance of the evidence that it would have reached the same decision in the absence of the protected conduct. Id.

The Act defines protected disclosures as “the written provision of evidence **to any person**, or the testimony before any committee of the general assembly, 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.” Section 24-50.5-102(2), C.R.S. (emphasis added) The Legislative Declaration states that the “people of Colorado are entitled to information about the workings of state government in order to reduce the waste and mismanagement of public funds, to reduce abuses in government authority, and to prevent illegal and unethical practices.” Disclosure of information is not limited to written material, and includes oral or verbal disclosures. Ward, supra.

Prior to receiving the protection of the Act, an employee has the statutory obligation to “make a good faith effort to provide **to his supervisor or appointing authority or member of the general assembly** the information to be disclosed prior to the time of its disclosure.” Section 24-50.5-103(2), C.R.S.

The statute therefore requires that there be two separate recipients of the disclosure in order for it to enjoy the protection of the Act:

1. The employee must first disclose to “his supervisor, appointing authority or member of the general assembly.”
2. The employee must then disclose “to any person” or testify before any committee of the general assembly.

While the first recipient is clearly defined, the second is not. The Act does not define “any person.” Does it include nonsupervisory co-workers in the agency, or the employee’s spouse? There is no published case law in Colorado, nor are there any previous Board orders, defining “any person.”

If a statute is not ambiguous, its words and phrases must be given effect according to their plain and ordinary meaning unless the result is absurd. Colorado Dept. Of Social Services v. Board of City Comm’rs, 697 P.2d 18 (Colo. 1985). Here, “any person” is not ambiguous. The plain meaning of this phrase is: any person, whether inside or outside of the agency, whether a spouse or friend. No language in the Act expressly or impliedly limits the definition of “any person.” Further, the Act itself states that Colorado public employees “are citizens first.” It states,

The general assembly further declares that employees of the state of Colorado are citizens first and have a right and a responsibility to behave as good citizens in our common efforts to provide sound management of government affairs.

This construction of the Act favors the public interest over any private interest (of the offending manager). Section 2-4-201(1)(e), C.R.S.

An employee who discloses information that would otherwise fall under the protections of the Act loses that protection if any of the following three factors is present: (1) the employee discloses information that he knows to be false or who discloses information with disregard for the truth or falsity thereof [this has been held to require a good faith belief in the accuracy of the information disclosed and a reasonable foundation of fact for such belief, Lanes v. O'Brien, 746 P.2d 1366 (Colo. App. 1987)]; (2) the employee discloses information from public records which are closed to public inspection pursuant to section 24-72-204; or (3) the employee discloses information which is confidential under any other provision of law. Section 24-50.5-103(1), C.R.S.

A. Did Complainant make disclosures that fall within the protection of the Act prior to receiving the disciplinary demotion?

1. Missing Medications and Missing Prescriptions. On May 18, 1995, Complainant informed his supervisors, Schenk and Lawson, about the problems with nurses losing medications and prescriptions. In mid-1996 and on November 12, 1996, he informed Shoemaker about these problems. On July 19, 1996, he told the State Auditor's Office staffer, A. Lee Boog, and on August 28, 1996, he told Perry Nisson, the outside pharmacy consultant, about these problems. Complainant believed in good faith based on a reasonable foundation of fact that this was a system problem caused by mismanagement at DRDC, which had the potential to impact inmates' health and safety. Lost prescriptions could have resulted in inmates not receiving medications prescribed to them. They are therefore protected disclosures.

Respondent argues that these issues were not within the province or jurisdiction of Complainant as pharmacist, were strictly nursing division issues, and that his concerns are therefore not protected under the Act. Even if that were true, which this ALJ finds it is not, this argument fails under Lanes v. O'Brien, 746 P.2d 1366, 1371 (Colo. App. 1987), under which disclosures regarding other agencies are protected.

2. Nurses' failure to date and obtain physician signatures on prescriptions, borrowing of medications, and failure to keep track of all needles dispensed from the pharmacy. In mid-1996 and on November 12, 1996, Complainant informed Shoemaker of his concerns regarding these issues. On April 11, 1996 and September 11, 1996, Complainant informed Rhonda Valdez, a nursing supervisor, about them. On September 5, 1996, he informed Brenda Hume, a nurse at DRDC. He also informed the following individuals of these problems: A. Lee Boog, State Auditor's Office, on July 19, 1996, Perry Nisson, outside consultant, on August 28, 1996, Brad Kinney, Nurse III, DRDC, on September 3, 1996; W. Anderson, State Pharmacy Board, September 5, 1996, DRDC Warden McGoff, November 15, 18, and 20, 1996, and two DOC OIG investigators in the context of his harassment grievance against Shoemaker, on November 26, 1996.

With respect to the nurses' failure to obtain physician signatures on prescriptions, the record revealed that in some instances nurses were acting pursuant to written physician protocols, empowering them to renew prescriptions on incoming inmates. Complainant should have known this, but the record does not reveal whether he did or not, or whether he discussed it with Shoemaker. This is, once again, a problem borne of Complainant's inability to productively communicate with nursing staff. Nonetheless, there were at least some instances where no protocol was in place, putting Complainant in a position of having to refuse to fill medications, causing a delay in getting medications to inmates. This was a systems failure, caused in large part by mismanagement. Complainant's disclosures on this issue were protected.

Regarding the borrowing of medications, Complainant had a good faith belief that this routine practice condoned by management was potentially harmful to inmates, since they could run out of medications in the blister packs early, and not know how many pills had been given to another patient instead of the intended recipient. This disclosure was protected. Respondent argues that it has demonstrated that Complainant was legally in error regarding the issue of borrowing medications, and provides a citation to 21 CFR Sections 1306.14(b) and 1306.24(b) to prove it. However, it is uncontested that every pill Complainant dispensed from his pharmacy had a notation on it stating that it was a violation of federal law to give the pill to anyone other than the person to whom it was prescribed. Complainant had a good faith belief that meets the requirements of Lanes, 746 P.2d at 1373.

Regarding the alleged failure to track syringes, it was the standard protocol at DRDC to have an investigation into any missing syringe. Complainant introduced no evidence that this system failed to work appropriately. It is impossible to determine from the record whether Complainant had sufficient information to form a good faith belief that the syringes were in fact missing and were never traced. Therefore, no protected disclosure may be found.

3. Understaffing at DRDC Pharmacy. Complainant discussed his view that the DRDC pharmacy was understaffed repeatedly with Schenk, Shoemaker, Lawson, Boog, Nisson, and others throughout his tenure. It has been found previously that because of Complainant's refusal to work a full day on a regular basis at DRDC, he was incapable of knowing whether one full-time pharmacist could perform all necessary work there.

Complainant lacked a good faith belief in the accuracy of the information disclosed and a reasonable foundation of fact for such belief regarding the understaffing of the DRDC pharmacy. Under Section 24-50.5-103(1), C.R.S., he loses any protection he might otherwise have had.

4. Time and Attendance Abuse by Veronica Gomez. Complainant discussed with Johnsen his problems with Gomez abusing the annual and sick leave policies. Since this was an isolated personnel problem with his supervisee, not one implicating management

practices or waste at DRDC, this was not a protected disclosure.

5. "Notice of Waste in DRDC operations," December 5 and 6, 1995. Complainant told Shoemaker on December 5 the DRDC pharmacy could save \$2500 per year by using Pony Express instead of regular mail, and of ways to save \$140 and \$70 on Pepcid and Zantac. These are suggestions for saving money, on a micro level. However, there was no evidence presented that they relate to waste of public funds, abuse of authority, or mismanagement of the agency. To conclude that every helpful suggestion on how to save money constitutes a protected disclosure would not serve the purpose of the Act, which is to protect those who expose wrongdoing. To construe the Act as liberally as Complainant requests here would encroach on public managers' autonomy. Supervisors must be free to independently assess the costs and benefits of each cost-saving suggestion made by employees, free of the fear of an impending retaliation claim for failure to implement the suggestion. Lastly, there is no evidence he disclosed these issues to a second recipient after Shoemaker.

On December 6, 1996, Complainant informed Shoemaker the pharmacy could save 20-30% of the cost of drugs by ordering by number of pills, instead of number of days. Shoemaker informed him that it would require a modification of the entire system, and that she was powerless to implement the change. This suggestion also does not relate to waste of public funds as envisioned by the Act. The same analysis of the December 5 issues applies here; it was not a protected disclosure.

6. "Working conditions violate workers' comp & M.D. orders." Complainant informed Shoemaker that his low desk caused his knee injury. It took 21 days to have the desk fixed. He discussed it with no one other than Shoemaker. This is not a protected disclosure.

7. Outlying Pharmacy Violations. On March 29, 1996, Complainant informed Schenk and Massengail, a pharmacist in Canyon City, that he did not have time to conduct the quarterly inspections of the Golden, Rifle, and Limon pharmacies, due to Schenk's failure to provide a back-up pharmacist during his absence. He also discussed this issue with Nisson and Boog in the summer of 1996. Complainant had a good faith belief that the pharmacy regulations required these inspections, and the failure to conduct them potentially impacted patient health and safety. This issue concerned mismanagement, and it was a protected disclosure.

8. Computer malfunctions. In May and June of 1996, Complainant informed Schenk and Shoemaker that when the computer was down, he was unable to fill prescriptions legally. He had no access to critical patient information regarding patient allergies, drug interactions, medication history, etc. He also was unable to put all appropriate information on the labels (which normally printed off the computer). He also discussed this issue with Nisson and Boog in the summer of 1996. While Shoemaker and Schenk were apparently somewhat powerless to address the issue, Complainant viewed the failure to provide a back-up computer system (or at least an update to the hardware), as a large-scale mismanagement issue. The chronic computer problems had a serious potential impact on

patient health and safety. It was a protected disclosure.

9. Ventilation and air conditioning. Complainant informed Shoemaker and Schenk about having no air conditioning in the pharmacy on June 4, 1996, and now claims this was an “OSHA” violation . The record does not disclose whether he discussed it with anyone else. It was not a protected disclosure.

10. Limon’s Failure to Utilize DEA Form 222. Complainant informed the Limon nurses on August 22, 1996 that they needed to use the DEA Form 222 to order controlled substances. He also discussed it with Shoemaker on August 29, 1996. Both Shoemaker and Schenk discussed the issue with the Limon nurses on an ongoing basis, after receiving a letter from the state pharmacy board on it. Complainant knew this. Since Complainant knew that his supervisors were actively addressing the issue, his discussions could not be construed as pertaining to perceived mismanagement, waste, or abuse of authority. Moreover, Limon nurses soon started using the form. The purpose of requiring initial disclosure to one’s supervisor is to attempt to get the issue addressed, thereby vitiating the need to blow the whistle. This worked here. It was not a protected disclosure.

11. Improperly Secured Needles. Complainant informed Shoemaker at some point about improperly secured needles at the DRDC facility. No evidence regarding either a date or a second recipient of this disclosure was introduced. It was not a protected disclosure. Further, this is a micro issue that Complainant certainly had power to address himself, and then to report to his supervisor on.

12. Additional Violations in Outlying Pharmacies. On August 29, 1996, Complainant informed Shoemaker that outlying pharmacies (Rifle, Golden and/or Limon) did not have the DEA license posted, had not completed the DEA narcotics inventory, and had expired drugs in the facility. Complainant testified that the most important issues were immediately addressed. The record does not reflect whether he informed others of these problems. They are not entitled to the protection of the Act.

13. Improperly secured narcotics. On December 5, 1996, Complainant informed Shoemaker in his Rifle Inspection Report that narcotics were not being properly secured in the Control Center. By June of 1997, according to his next report, this problem had apparently been taken care of. The record does not reflect a second disclosure. This issue is not entitled to the protection of the Act.

14. “Abuse of DOC Resources.” Complainant lists this issue on his “Chronology” as something he discussed with Fucles and Shoemaker at the March 25, 1997 meeting investigating his alleged misappropriation. However, Fucles’ OIG report indicated that when he discussed DOC staff and manager use of OTC’s, he said, “he has told staff not to abuse the privilege and they have not done so.” This is hardly a protected disclosure. He clearly had no good faith belief at that time that there was a problem regarding abuse of DOC resources.

Complainant also lists “abuse of DOC resources” as a disclosure made at the 833

meeting with Lawson and Schenk on April 23, 1997. At that meeting, he discussed the difficulty in differentiating between what were acceptable OTC's for staff use, and what were not. This disclosure was made for the first time at the 833 meeting, and was never made again. Therefore, it is not protected. Further, he lacked a good faith belief that it was a problem and appears to have used it as a last-minute defense.

15. No licensed pharmacist on duty at all times. At the April 23, 1997 833 meeting with Lawson, Complainant stated his concerns about the pharmacy not having a licensed pharmacist on duty during all open hours, and about the pharmacy door being propped open for several hours when the pharmacist was not on duty. Although he made these disclosures again in his May 2, 1997 letter, that was after the disciplinary decision was made, and therefore was not a protected disclosure at the time the disciplinary action was taken. It is technically irrelevant to this retaliation claim. (It will be addressed below in the retaliation section regarding the termination, where it is found not to be protected).

16. Officers administering medications. Complainant claims that he made protected disclosures regarding DOC corrective officers administering medications to inmates. When he raised this issue with Shoemaker in 1996 and at the November 12, 1996 meeting, she offered to show him the state health department statute that permitted this practice. He refused the offer. When an employee fails to read the very law he or she claims is being violated, such an employee demonstrates a "disregard for the truth or falsity" of the disclosure under Section 24-50.5-103(1), C.R.S., and loses the protection of the Act.

B. Were Complainant's disclosures a substantial or motivating factor in Lawson's decision to temporarily demote him?

Lawson testified credibly that had Complainant not lied at the 833 meeting, he would have simply corrected him for his ordering and use of the breath spray and insoles. It was an extraordinary turn of events for Complainant to deny having made the very detailed statements attributed to him by Fucles in her report. Instantly, Lawson knew that Complainant was lying to him.

Complainant's 180 degree turn-around on the misappropriation issue left Lawson no choice but to take decisive action, to send Complainant a message that further lying would not be tolerated.

At the time he first heard about the misappropriation issue from Shoemaker, Lawson had been the recipient of only one of Complainant's protected disclosures. That disclosure was on May 18, 1995, nearly two years prior to the April 23, 1997 833 meeting on the misappropriation issue. It concerned missing prescriptions and medication. He also informed Lawson he felt the pharmacy was understaffed on numerous occasions.

No evidence was submitted that Lawson knew about any of the other protected disclosures made by Complainant, found above. Further, Complainant submitted no evidence that either Shoemaker or Schenk (or anyone else) discussed protected his

protected disclosures with Lawson.

Given the two-year passage of time between Complainant's protected disclosure to Lawson regarding prescriptions and medications being lost, it is concluded that Lawson did not view Complainant as a whistleblower when he disciplined him in April of 1997, and was not motivated by retaliation for protected disclosures in disciplining him.

At the 833 meeting, Complainant made disclosures to Lawson regarding the pharmacy door being propped open once or twice and there being no pharmacist on duty during all open pharmacy hours. In view of Lawson's understandable anger about Complainant's lying to him at this meeting, it is concluded that Lawson was not motivated by these disclosures in deciding to discipline Complainant.

III. DISCIPLINARY TERMINATION

1. Did Complainant commit the acts for which he was terminated?

Respondent met its burden of proving that Complainant engaged in a pattern of behavior over time that created a hostile work environment for Mynette Moulton as well as numerous other staff with whom he came into regular contact. He was incapable of confronting many staff about what he perceived as regulatory violations and about other mundane issues in any other than a hostile, inappropriate, loud, intimidating, demeaning manner.

The discussion above addressing Complainant's general lack of credibility is critical to this conclusion. He stated to Tate that he had conflicts with staff. He asked Moulton if she was telling others about his abusive behavior. He knew he had conflicts, and chose not to modify his behavior.

Moulton proved to be generally credible, particularly due to the large body of evidence in the record corroborating her claims, and her efforts to resolve her problems with Complainant at the lowest possible level prior to filing the grievance. Soon after her arrival at DRDC, she inquired with Shoemaker about the harassment grievance process. Shoemaker suggested that she attempt to resolve the problem directly with Complainant. Moulton did talk to Complainant about his volatile behavior at least once in 1996, and his behavior improved for a time. However, his inability to control his temper once again prevailed, and he re-commenced his abusive conduct towards her. Moulton understandably was fearful of confronting her boss, whom she also saw yelling at and lecturing nurses on a routine basis.

Moulton complained to other staff about Complainant's abusive treatment of her on a regular basis. Other staff saw Complainant yelling at her. Dana Bustos verified that Moulton was "clearly distressed and visibly upset" over the situation with Complainant. In December of 1996, when interviewed by the OIG regarding Complainant's harassment grievance against Shoemaker, Moulton stated that he was very emotional, was not

objective, and that he became angry and “rants and raves.” This was prior to her own grievance, when she had nothing to prove against Complainant.

On February 28, after attempting once again to discuss communication problems with Complainant, she found that he was unable or unwilling to do so, and was even more hostile. She then gave mediation a try, but learned there that Complainant felt she had permanent mental and substance abuse problems.

At that point, Moulton reasonably concluded that a grievance was her only remedy. She clearly felt trapped working for a boss who was abusive towards her, who was unable to address his abusive conduct with her, and who ultimately questioned her mental stability.

Complainant made no allegations to Moulton that she ever engaged in violations of laws or regulations of any kind, nor is there evidence that Complainant informed either Moulton or Shoemaker of any performance problems with her, despite his claims to the contrary. Moulton had no “ax to grind”. She did have a strong personality, and she refused to be abused and intimidated by Complainant. This does not mean that she was biased or conjured up stories about him.

The same absence of bias is true of Jeanne Clarke and Suzanne Tate. Clarke, a dental assistant, was never corrected by Complainant on any performance or regulatory issue, and he did not yell at her. She had no “ax to grind.” Yet she stated to the OIG investigators, “She has seen him yelling at staff in the medical room about getting (pharmacy) orders to him. Clark described his behavior as loud and ‘losing his cool.’ This behavior seemed frequent until he went on vacation (dates unrecalled.) Currently he seems more reserved.” As related above, Tate, who also had never been “corrected” by Complainant and had a good relationship with him, confirmed that he admitted to his conflicts with infirmity staff.

The testimony of Respondent’s witnesses regarding the hostile work environment issue was internally consistent and was further corroborated by a long history of documentation of Complainant’s problems with communication and interpersonal relationships, commencing with Johnsen. In July 1995, Johnsen rated Complainant three “Needs Improvements,” in Communications, Interpersonal Relations, and Supervision/Human Resource Management. He stated in the narrative section, “Bob needs to work on tact/diplomacy and interpersonal relations with staff,” and, “Needs to work on communicating with one of our challenging staff and nursing staff at LCF. Should improve.” He also cited his problems with Gomez.

There is no evidence of any bias or possible motive to retaliate against Complainant by Johnsen. Johnsen’s unassailed credibility works to bolster the credibility of Shoemaker and the other witnesses regarding Complainant’s continued pattern of inappropriate behavior. It also impeaches Complainant’s repeated claim that he was never told that he had problems with communication, and was never given the chance to change.

Complainant argues that all witnesses against him had a vendetta against him and were retaliating for his complaints about various violations of pharmacy and other regulations, and are therefore not to be believed. The above analysis should amply demonstrate that this is simply not the case. Moulton had no reason to retaliate against him; numerous unbiased witnesses corroborate those employees who were allegedly "corrected" by Complainant.

Complainant's performance problems commenced immediately upon his employment at DRDC. He was warned about them first by Johnsen, then by Shoemaker, and he failed to modify his behavior and improve his communication and interpersonal relationships with nurses. While the nurses were likely irritated by his demands that they change old practices (such as failing to adequately track prescriptions, giving him orders late in the day, and borrowing medications from other patients), the overwhelming weight of the evidence supports their claims (many of them contemporaneously documented and submitted to Johnsen and Shoemaker) that he was inappropriately rude and abusive towards them.

Shoemaker was generally credible. She admitted that her relationship with Complainant was difficult, that she yelled at him inappropriately at the October 1 meeting and on one other occasion and later apologized, and that she did not understand the real nature of Complainant's problems with nurses borrowing medications until after he was terminated. These facts do not present her in a positive light, yet she admitted them freely. She presented as an overworked new clinical supervisor of the DRDC facility who did not have sufficient time to appropriately monitor and track Complainant's performance. This fact contributed to her inaction regarding his discussions of violations with her; it also may have led to her surprising lack of action in dealing with his very real behavior problem. Her testimony regarding counselings of Complainant were corroborated by contemporaneous notes. There were minor problems with Shoemaker's credibility, such as her indication on Complainant's evaluation that he had completed all required inspections of the outlying pharmacies, when in fact he hadn't. But overall, her credibility was sound.

Complainant argues that even if it is found that he engaged in inappropriate conduct in 1995, 1996, and early 1997, these claims are stale, and he should be given the chance to improve. He points specifically to two facts in mitigation: his successful completion of the workshop on interpersonal relations on February 25, and his April 1997 evaluation from Shoemaker indicating he had improved in this area.

First, just three days following the workshop on interpersonal relations, on February 28, he engaged in the heated argument with Moulton, which he personally escalated. Moulton attempted, during that conversation, to discuss his interruption of her, and their communication problems generally. Complainant, however, was unable to address those issues with her, and escalated the argument by calling her pushy and making the bizarre statement that there is such a thing as veiled threats. It was clear from Moulton's notes and from Shoemaker's notes on her conversation with Moulton directly following the February 28 argument that Moulton's chief concern was Complainant's inability to discuss

their communication problems. In this sense, Moulton took the more professionally mature role of problem solver; Complainant took the role of someone not able to appropriately address communication issues, even with his own supervisee. It is apparent that the workshop had no effect on his ability to control his temper or discuss communication issues with Moulton.

With regard to the April 1997 evaluation, Shoemaker rated Complainant "Needs Improvement" in the Communication and Interpersonal Relations sections, despite her comments, "Bob's communication style has improved since the letter of counseling he receive on October 1, 1996. There have bee less conflicts with staff," and, "Bob has improved in this area. There have been less conflicts with co-workers. However, Bob and the pharmacy technician are working with the state mediation program to resolve an interpersonal conflict." Shoemaker was giving Complainant positive feedback for his efforts, while still communicating to him her concern over his problems with Moulton and his overall inability to improve enough to warrant a "good" rating. She stated that there had been "less" conflicts with staff, not "no" such conflicts.

Lastly, Complainant argues that he was disciplined for his physical characteristics, namely, being a large and imposing man, and being red-complected. Complainant is tall and red-complected, but he also admitted that he has no control over his tendency to blush even redder when angry or embarrassed, which was evidenced during the hearing on numerous occasions. This argument has no merit.

Complainant was terminated for violating AR 1450-5 by "creating a hostile, intimidating, and/or offensive work environment at DRDC." This regulation also requires, "DOC staff will treat each other in a professional manner with dignity and respect."

It is concluded that Complainant did create a hostile work environment at DRDC. The work environment for Moulton was particularly abusive, since she had daily contact with him. In addition, his treatment of Benoit, Glassman, Baldwin, Gomez, Griswald, and Bullard was especially hostile and offensive. While Complainant's abusive and intimidating behavior toward some of these individuals may have been sporadic, as opposed to constant, it was sufficiently offensive and hostile to drive many of them (and unnamed others) away from having any contact with him. It is the very nature of an abusive relationship for the recipient not to know when the abuse will occur again. This is why so many DRDC and LCF staff avoided all contact with him; they elected not to subject themselves to the possibility, or probability, that they would be attacked again. This certainly constitutes a hostile, intimidating and offensive environment.

The Board considered the testimony of the witnesses called by Respondent who had no problems working with him. Their testimony, while mitigating to a minor degree, does not work to alter the facts discussed above.

2. Was the discipline imposed, termination, within the range of reasonable alternatives available to the appointing authority?

Complainant created a work environment at the pharmacy for many staff that was intolerable. It would be unfair to force Moulton to work with Complainant again, or to subject any other future pharmacy technician to his behavior. If reinstated or even transferred, Complainant would undoubtedly continue in his abusive treatment of others, since the numerous warnings by Johnsen and Shoemaker in informal counselings, letters of counseling, and performance evaluations, from July 1995 through October 1996, did nothing to deter his behavior. Even the workshop in interpersonal relations in February, three days before his argument with Moulton, did nothing to improve his behavior towards her.

Complainant's behavior created such an offensive environment that many nurses avoided contact with him. They called the pharmacy and spoke to Moulton, not a licensed pharmacist, when they had pharmacy issues to address. Complainant was incapable of controlling his temper when engaging in normal, daily contact with nurses. Some of these contacts involved his "correcting" of their behavior, others involved everyday issues such as when they called him about an order they were awaiting from the pharmacy, or when they asked for syringes for the clinic or infirmary.

Many of Complainant's attacks on nurses appear to have been without any basis other than to serve his purpose of leaving early. When nurses brought prescriptions to him at or after 2:00 p.m., he often yelled at them for not doing so earlier in the day. When supervisors explained that nurses were busy with other tasks, he yelled at them, claiming the nurses under their supervision were just lazy. Complainant had a set idea regarding how he sought to operate the pharmacy, and he was unwilling to flex in order to accommodate the nursing staff. In fact, the PPMIS Audit cited by Complainant actually alerted him to the fact that better communication with nursing staff would alleviate much of the problems related to losing prescriptions and double filling medications. It stated, "The DRDC pharmacy staff believes that these problems [nurses ordering refills on prescriptions refilled the previous day due to lost prescriptions] are primarily caused by poor communication. . . ." However, Complainant was unable to respond to that suggestion due to his inability to control his volatile temper and predilection for leaving early.

OIG report witnesses stated that the environment at the DRDC pharmacy "was not normal," was "highly frictional and adversarial," that "his behavior is harassing because she can not figure out if he was going to yell at her," and that "Working with Gusich means having to walk on eggshells."

It would be unfair to force the DRDC and LCF clinical staff to re-commence working with Complainant. It is essential to the normal functioning of any work environment that employees be able to communicate with each other free of the stress and fear that they will be subjected to yelling, intimidation, or confrontation. Complainant's presence as DRDC pharmacist made those normal relationships impossible to achieve.

In the health care context, this need for open, free, relaxed communication is even more compelling. Nursing staff must feel free to ask the pharmacist about potential drug interactions, health and medication history, and other pharmaceutical issues. In addition, as confirmed by the findings of the PPMIS Audit, open and smooth communication between nursing and pharmacy staff is critical to addressing system problems such as those Complainant was concerned about.

In view of the above, termination was within the range of reasonable alternatives available to the appointing authority.

3. Did the appointing authority act in a manner that was arbitrary, capricious, or contrary to rule or law?

Arbitrary and capricious action can arise in one or more of three ways: a) by neglecting or refusing to procure evidence; b) by failing to give candid consideration to the evidence; and c) by exercising discretion based on evidence in such a way that reasonable people must reach a contrary conclusion. Van de Vegt v. Board of Commissioners, 55 P.2d 703, 705 (Colo. 1936).

Hedgeman investigated this matter thoroughly and without bias. In fact, her handling of the immense body of information was painstakingly meticulous. She created three charts, summarizing, organizing, clarifying, and weighing the information before her. One chart was dedicated solely to assessing Complainant's sixteen-page response letter. She consulted two attorneys and the DOC personnel staff on how to perform her task procedurally. She called witnesses to verify dates. She acted with the utmost responsibility and objectivity in considering all relevant information presented to her.

Complainant argues that Hedgeman's failure to personally investigate the motives of the witnesses cited in the OIG report constituted arbitrary and capricious action. It is a matter of record that Fucles was not alerted to the possibility of bias or motive to retaliate (for complaints about violations of regulations, etc.) when she interviewed the witnesses; she testified that she was not attuned to this possibility. There is no evidence suggesting that the other investigator, Hougnon, did any investigation on this issue. Dr. Hedgeman relied on the statements of witnesses in the OIG report as facts.

Hedgeman did follow up on the retaliatory motive issue. She spoke to both Schenk and Shoemaker, and learned that he indeed had discussed pharmacy violation issues with them, but had failed to put anything in writing. This reasonably led her to take his claim less seriously. But most importantly, Hedgeman viewed his claim of witness bias in the context of her overall assessment of Complainant's lack of credibility.

In another case, under different circumstances, an appointing authority's failure to re-interview witnesses regarding their potential motive to retaliate might constitute an arbitrary and capricious failure to obtain necessary information. However, under the facts

of this case, this ALJ finds that it did not, for the following reasons:

1. The primary purpose of the investigation had been to corroborate Moulton's grievance. Complainant stated to Hedgeman that Moulton's allegations "are motivated by revenge for my having detected and documented substandard job performance and violations of pharmaceutical laws and regulations." However, he never backed up this claim with any evidence of any kind.⁴ The fact that he used the retaliation argument against Moulton, when there was absolutely no evidence to support it, destroyed his credibility to Hedgeman, and served to render his retaliation claims against all other witnesses worthy of little credence. It amounted to crying "wolf" one too many times. Further, numerous witnesses corroborated Moulton's allegations.

2. There was a lengthy paper trail throughout Complainant's tenure at DRDC documenting the history of the pattern of his harassing behavior, which served to corroborate Moulton's and the other witnesses' statements. This history included Ron Johnsen's letter of counseling and three Needs Improvement ratings on communication issues at the outset of Complainant's employment; the Gomez notes; the Lynn Hansen memos; the Griswald incident report; the Shoemaker notes of counselings of Complainant; the Schenk memo on the phone harangue and hang-up; the Shoemaker letter of counseling; and the Shoemaker PACE evaluations further showing a need to improve communication and interpersonal skills.

The informal counselings memorialized by Shoemaker's notes, the letters of counseling, and the negative evaluations of his communication and interpersonal relationships put Complainant on notice of his offensive conduct. Yet he argued to Hedgeman in his response letter that he had not been warned about his behavior. Hedgeman weighed the documentation of his inappropriate behavior and statements of twelve recipients of his offensive conduct against Complainant's sweeping assertions of retaliation, backed up by only two specific, credible examples of "violations" he had pointed out, and concluded reasonably that his claim lacked credibility.

⁴ The only information in the record that could possibly be viewed as backing up this claim is in Complainant's Exhibit KK, a partial list of "whistleblower disclosures," in which he claims to have informed Schenk on May 2, 1997, that Moulton was in the pharmacy working with narcotics without him present. However, this claim was undated and undocumented, and took place well after the incidents about which Moulton complained.

3. Hedgeman saw that not all witnesses against Complainant had been recipients of his “corrective” admonitions regarding “violations.” Even those witnesses who clearly had no problem working with or associating with Complainant corroborated the other witnesses’ statements. As related at length above, Tate was completely free of bias, and she confirmed that Complainant admitted to his conflicts with staff. Bustos and Clarke also corroborated his inappropriate treatment of staff.

4. Dr. Hedgeman did in fact notice that many of the witnesses’ complaints regarding Complainant involved Complainant’s objections about violations, such as failing to obtain physician signatures on prescriptions. She determined, appropriately, that the fact that Complainant was objecting to certain practices at DRDC did not excuse his engaging in harassing and hostile conduct towards staff when doing so. Further, the fact that none of the witnesses tried to hide the fact that they had failed to get physician signatures or had engaged in other problematic conduct meant that they were forthcoming in their interviews with the OIG. This gave Hedgeman no reason to doubt their motives.

5. Complainant’s credibility was severely damaged by his failure to take any responsibility for his part in the numerous incidents with staff. Hedgeman felt that he lacked credibility, integrity and professionalism by denying any responsibility for his actions.

Based on the above facts, which constituted overwhelming, internally consistent evidence to corroborate Moulton’s complaint, it was not arbitrary or capricious for Hedgeman to elect not to re-interview the witnesses in the OIG report.

Complainant also asserts that it was arbitrary and capricious for Hedgeman to ignore the improvement noted in his April 1997 performance evaluation, as well as the fact that he was given both evaluations on October 1, 1996 late, one by seven months, the other by three months. The argument regarding his improvement was addressed in part above. Hedgeman did not ignore the April 1997 comment by Shoemaker noting his partial improvement; she noted that this narrative statement was accompanied by a “Needs Improvement” and by a notation of the ongoing problem in his relationship with Moulton, clearly a serious problem in view of their close working relationship.

Further, the fact that Hedgeman did not notice that Shoemaker gave Complainant his evaluations late does not in itself constitute arbitrary and capricious action. Complainant was warned in no uncertain terms via those evaluations on October 1, 1996, regarding his pattern of inappropriate yelling and intimidation of staff. In December of 1996 and in late February of 1997, just days after attending the workshop on interpersonal skills, he engaged in behavior offensive to Moulton leading to the grievance against him. In view of this progression of events, and the other OIG witnesses that were recipients of his offensive conduct, it was not unreasonable for Hedgeman to give little weight to his minor improvement of eliciting “less complaints” against him.

Complainant also avers that Hedgeman failed to take his overall “good” evaluation ratings into account. The problems with his treatment of staff were such that they

reasonably outweighed the mitigation of his clinical competencies.

Complainant argues that it is fundamentally unfair for Hedgeman to make a decision to terminate his employment, when Shoemaker testified that she did not believe he had harassed either her or any other witnesses in the OIG report. However, Shoemaker also testified that she did believe he created a hostile work environment. The evidence strongly suggests that the primary reason Shoemaker did not spend more time correcting and/or disciplining Complainant for his inappropriate behavior was her busy schedule and lack of time to dedicate herself to the problem.

Complainant further points out that there was no evidence in the record that he engaged in harassment or creation of a hostile workplace environment after February 28, 1997. He argues that it is fundamentally unfair to terminate him in July of 1997 for conduct on and prior to that February date. However, this argument ignores the fact that all OIG investigations of grievances take time, and that the R8-3-3 process also requires further accumulation and weighing of evidence.

Complainant asserts that Hedgeman violated R8-3-3 by failing to mention three witnesses at the 833 meeting (Nisson, Stambaugh, and Hansen) upon whom she relied in part in reaching her termination decision. He claims that his resultant inability to respond to those allegations against him by deprived him of due process. Rule R8-3-3(D)(1) states,

“When information received by an appointing authority indicates the possible need to administer disciplinary action to a certified . . . employee, the appointing authority shall meet with the employee involved, present the information that comes to the attention of the appointing authority and give the employee an opportunity to admit or refute the information”

Rule R8-3-1(B) also provides,

“The decision to correct or discipline an employee shall be governed by the nature, extent, seriousness and effect of the act, error or omission 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.”

It is clear from Exhibit 24 that Hedgeman did not utilize the Nisson, Stambaugh or Hansen incidents as major components of her decision to render discipline against Complainant. None of them is listed as a “Recipient of Behavior.” She apparently used those three as “prior offensive acts” under rule R8-3-1, part of the general background context in which she viewed the OIG report.

At the R8-3-3 meeting, Hedgeman read a lengthy statement which referenced the Moulton grievance and detailed all allegations by all of those interviewed in the OIG report.

Hedgeman made it clear to Complainant that he was potentially subject to discipline for a pattern of creating a hostile work environment for these twelve individuals. She gave him more than adequate notice of the gravamen of the complaints against him. Nothing in R8-3-3 requires that appointing authorities detail every single possible "prior offensive act" under R8-3-1 considered in determining discipline. To require such a painstaking disclosure would alter the very nature of the R8-3-3 meeting into an actual hearing, instead of an exchange of information.

It was never the intent of the Board in promulgating R8-3-3 to force appointing authorities to disclose every single background detail they will consider in making the discipline determination. To interpret it as such would impose an undue burden on appointing authorities.

Complainant next argues that Respondent failed to utilize progressive discipline in terminating him, in violation of R-8-3-1(C). This rule states, "unless the conduct is so flagrant or serious that immediate disciplinary action is appropriate, corrective action shall be imposed before resorting to disciplinary action."

First, Complainant's conduct was flagrant and serious enough to warrant immediate discipline. Second, the purpose of the progressive discipline rule is to protect employees from being disciplined for behavior that has never been formally brought to their attention, thereby depriving them of the opportunity to improve. That purpose was met here. Both Johnsen and Shoemaker had repeatedly brought Complainant's offensive and inappropriate treatment of others to his attention on a regular basis since July of 1995, in evaluations and in oral and written counseling sessions. Complainant was on more than adequate notice that his behavior was problematic; he chose repeatedly not to take advantage of those opportunities to improve it.

Complainant also argues that Hedgeman erred by utilizing the temporary demotion for misappropriation for progressive discipline purposes under R8-3-1(C). His argument is that since his appeal of the temporary demotion was pending, it could not be utilized as prior discipline.

This argument fails. No language in the rule supports this interpretation. Further, if Complainant's interpretation of R8-3-1(C) were to prevail, appointing authorities would be forced to wait until judicial review of prior discipline had run its course before using it as progressive discipline. That could mean waiting anywhere from one to four years, depending upon whether the party sought and obtained Colorado Supreme Court review. Such a long delay is contrary to the policy of promoting efficient, well informed management of classified personnel. Further, appointing authorities must be free to discipline problem employees using all appropriate information available.

Complainant lastly asserts that since Hedgeman gave him no copy of either the Moulton grievance or the OIG report, he was deprived of due process, since it made it difficult to defend himself against the allegations. DOC AR 1450-5, provides that "the

Inspector General shall: . . . select and train personnel to investigate allegations of Workplace Harassment/Discrimination . . . No information pertaining to the investigation will be released except to the appropriate Appointing Authority.” Hedgeman followed this rule in refusing to release the OIG report and Moulton’s grievance to Complainant.

Exhibit GG, the text of Hedgeman’s statement to Complainant at the R8-3-3 meeting, demonstrates that she detailed summaries of 16 of the OIG witnesses to him in that meeting. She did not omit allegations against him.

Complainant appears to suggest that without written notification at the 833 meeting, the rule is violated. However, nothing in the rule requires the written provision of information to the employee. It requires a meeting and an exchange of information. Complainant was familiar with many of the allegations in the OIG report prior to the 8-3-3 meeting. He knew about the February 28 incident with Moulton. He knew from the Shoemaker letter of counseling about Schenk’s report of his yelling and hanging up; he knew from Shoemaker’s oral counseling, the letter of counseling, and discussions with nursing supervisors that nursing staff complained that he yelled and was intimidating in dealing with them. He responded to Shoemaker during these counseling sessions that since he had been correcting the nurses’ behavior, it was their conduct that was wrong, not his. This, plus his admission to Tate of his conflicts with nurses, demonstrate that he was well aware of who complained about his conduct, and what they found offensive. He was certainly not deprived of due process.

It is concluded that the termination of Complainant was not arbitrary, capricious, or contrary to rule or law.

4. Defense Claim of Retaliation for Protected Disclosures

A. Did Complainant make protected disclosures that fall within the protection of the Act prior to being terminated?

The discussion and conclusions above regarding Complainant’s protected disclosures are incorporated herein by reference. What follows is a summary of Complainant’s additional disclosures made between the time of the April 23, 1997 predisciplinary meeting on misappropriation, and July 7, 1997, the date upon which Hedgeman sent her letter of termination to Complainant.

1. No licensed pharmacist on duty at all times. At the April 23, 1997 833 meeting with Lawson, Complainant stated his concerns about the following: “it appears that the pharmacy does not have a licensed pharmacist on duty at all times when the pharmacy is open or available to unlicensed staff”, and, “There are multiple witnesses to the fact that on one or more occasions the pharmacy door has been propped unopen for several hours when the pharmacist was not on duty.” Complainant made these disclosures again in his May 2, 1997 letter to Lawson, copied to DOC Director Zavaras and Schenk. A pharmacy door left open once or twice and a vague assertion of the pharmacy not being properly

staffed at all times do not rise to the level of abuses in government authority or mismanagement protected by the Act.

2. “Mismanagement of DRDC, Violations of law.” Complainant claims in his “Chronology” to have made protected disclosures to Fucles and Hougnon at the May 6, 1997 investigatory interview. However, there is no other record support for this claim, and the tape recording of the meeting was not introduced as evidence. No findings or conclusions can be made on this issue.

3. “Abuse of Authority; Abuse of DOC complaint procedures, Inaction re: prior disclosures.” Complainant claims in his Chronology to have made these disclosures to Hedgeman and Rockwell, DOC attorney, at the June 10, 1997 833 meeting, and again to Hedgeman in his June 22, 1997 response letter. Regarding “abuse of authority,” and “inaction re: prior disclosures,” the only evidence supporting this claim is the June 22 letter, which contains vague allegations about DOC managers, nothing substantive. The only exception is his reference to nurses whom he cited for borrowing of medication from another patient, and failure to have a date and signature on a prescription. Complainant provided Hedgeman with no substantiated allegations of mismanagement, waste of resources, or abuse of authority. No abuse of authority protected disclosure was made.

Regarding “abuse of DOC complaint procedures,” Complainant’s procedural due process arguments raised in his June 22 letter, pertaining to Personnel Board and DOC rules, these are legal defense arguments made commonly in personnel cases. They are not the type of disclosure protected by the Act.

4. “Abuse of DOC Grievance & Mediation Procedures.” Complainant claims in his Chronology that his June 27, 1997 complaint to the Inspector General regarding Moulton and Shoemaker’s alleged violation of the mediation procedures is a protected disclosure. There was never a second recipient of this alleged disclosure, rendering it outside the scope of the Act. However, even if there had been a second recipient, this is not the type of disclosure that enjoys the protection of the Act. The letter asserts that Moulton violated the confidentiality agreement (supported by the evidence), and that Shoemaker interfered with the mediation process by “unilaterally cancel[ling] the mediation process” (not supported by the evidence). These are, again, isolated incidents on a micro level, which have nothing to do with mismanagement, abuse of authority, or waste of public resources. They were not protected disclosures.

5. “Dan McCue (Grant Thornton).” The record did not disclose the identities or positions of Dan McCue or Grant Thornton, listed on Complainant’s “Chronology.” These alleged disclosures were not made to a second recipient. No findings or conclusions can be made.

B. Were Complainant’s protected disclosures a substantial or motivating factor in Hedgeman’s decision to terminate him?

Once again, the conclusions regarding protected disclosures under the previous section are incorporated herein by reference.

Hedgeman knew the following about Complainant's protected disclosures at the time she made the termination decision.

A. Complainant had informed her in his June 22 letter that Moulton was motivated by retaliation for his detection and documentation of pharmacy laws and regulations and performance problems. He provided no evidence, and she had no independent evidence, supporting this bogus claim.

B. Complainant had informed her in his response letter that all other witnesses against him were motivated by retaliation for his correcting them on or calling attention to violations of regulations or laws. The only evidence he provided that sounded legitimate related to two nurses.

C. Complainant provided no specific examples of disclosures made to Shoemaker, Schenk, or any other manager, upon which they had failed to act. Schenk and Shoemaker had verified that he had complained about pharmacy violations.

D. She had no documentary evidence backing up Complainant's asserts of having made protected disclosures.

Hedgeman did not view Complainant as a whistleblower at the time she terminated him. She viewed him as an employee who had been warned in July 1995 and continually since then about his inappropriate and hostile treatment of other staff, and who had steadfastly refused to even acknowledge any responsibility for his part in conflicts with staff. She reasonably viewed his claims regarding retaliation as lacking in credibility. His protected disclosures did not form a substantial or motivating factor in her decision to terminate him.

Complainant presented no evidence that Hedgeman was inappropriately influenced in her decision making process by those managers to whom Complainant made protected disclosures, most notably Schenk, Shoemaker, and Warden McGoff. Hedgeman's only direct contact with Schenk consisted of the phone call to confirm he had discussed pharmacy violations. Her only contact with Shoemaker was to do the same. There was no evidence she had any contact with the Warden regarding Complainant.

Hedgeman did rely on statements made by Schenk and Shoemaker made to the OIG. Shoemaker's OIG interview summary reveals that she underplayed his problems with the nursing staff in general, and spoke accurately about the history of his problems with Moulton. In her discussion of his letter of counseling, she makes no reference to the pattern of offensive behavior she addressed therein, but refers only the pharmacy consultant and Schenk. The only nursing staff conflicts she mentions are those with the Limon nurses. There is no indication that Shoemaker either saw or took the OIG interview

as her opportunity to “do him in” in retaliation for his protected disclosures. Shoemaker’s OIG interview did not improperly influence Hedgeman’s performance of her duties as appointing authority.

Schenk’s interview summary contains more detail regarding Complainant’s inability to communicate with nursing staff. Schenk mentions that there have been numerous problems with other staff, and that some nurses won’t even talk to Complainant. Schenk’s interview contains an accurate depiction of Complainant’s interpersonal problems with both himself and other staff, fully corroborated by the other staff members’ interviews. He also commented on Complainant’s good clinical skills. While his interview contains more information than Shoemaker’s, there is nothing to indicate that he was attempting to retaliate against Complainant’s protected disclosures by relating the information he did. He was cooperating with the OIG investigation.

Complainant asserts that there was a conspiracy by DOC managers and staff to retaliate against him, implying that such managers and staff somehow secretly were able to influence Hedgeman’s decision. Since Complainant has raised this argument, the motives of Complainant’s supervisors will be more closely examined.

Shoemaker and Schenk hired Nisson to conduct an internal audit of the pharmacy and nursing operations, and directed Complainant to inform him of all problems. Nisson was hired in part to generate a written report, which would contain a convenient summary of pharmacy/nursing operational problems (which Complainant refused to ever do, despite Shoemaker’s repeated requests for a list of his concerns).

Shoemaker also directed Complainant to share all of his concerns about nursing and pharmacy violations with a member of the State Auditor’s Office, in July of 1996, after he had made the bulk of his protected disclosures. The State Auditor’s reports are routinely given high profile press coverage; this was not a quiet venue within which Complainant was directed to air his concerns.

These two directives to Complainant to share his information with outside sources reveal a notable lack of motive to mute, silence or stifle Complainant’s disclosures. It is this motive to silence that would underlie a retaliatory termination. There being none present in the record, it is difficult to make the leap to a finding that Schenk and Shoemaker somehow conspired to terminate Complainant.

It is concluded that Complainant’s protected disclosures were not a substantial or motivating factor in Respondent’s decision to terminate him.

IV. ATTORNEY FEES

Section 24-50-125.5, C.R.S (1999), allows the awarding of attorneys fees only upon a finding “that the personnel action from which the proceeding arose was instituted frivolously, in bad faith, maliciously, or as a means of harassment or was otherwise

groundless.” No attorney fees are warranted in this case.

CONCLUSIONS OF LAW

1. The disciplinary actions were within the range of reasonable alternatives available to the appointing authority, with the exception of the deduction of \$67.45 from Complainant’s pay for misappropriation of state property.
2. The actions of the appointing authorities were not arbitrary or capricious, or contrary to rule or law, with the exception of the deduction of \$67.45 for misappropriation, which was arbitrary and capricious.
3. Complainant made disclosures that fall within the protection of the Colorado whistleblower act.
4. Complainant’s protected disclosures were not a substantial or motivating factor in taking either disciplinary action against Complainant.
5. Respondent did not violate the Colorado whistleblower act.
6. Neither party is entitled to an award of attorney fees.

ORDER

Respondent’s actions are affirmed, with the exception that Respondent is ordered to reimburse Complainant in the amount of \$67.45.

DATED this _____ day of
October, 1999, at
Denver, Colorado.

Mary S. McClatchey
Administrative Law Judge

CERTIFICATE OF MAILING

This is to certify that on the ____ day of October, 1999, I placed true copies of the foregoing **INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE** in the United States mail, postage prepaid, addressed as follows:

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