

STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. 99B136

INITIAL DECISION

BETTY CRUZ,

Complainant,

vs.

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

Respondent.

This case was heard on August 5, 1999 and September 9, 1999. Respondent was represented by Jeanette Walker Kornreich, Assistant Attorney General, Office of the Colorado Attorney General. Complainant appeared and was represented by Carol Iten.

PRELIMINARY MATTERS

Witnesses.

Respondent called the following witnesses: Lee Ann Gilbert, Acting Director of Child and Adolescent Treatment Center ("CATC"), Colorado Mental Health Institute in Pueblo, Colorado ("CMHIP"), Colorado Department of Human Services ("DHE"); Cinda Hart, Nursing Supervisor, CATC; Herb Brockman, Clinical Team Leader, CATC; and Louis Gustofson, teacher aide, CATC.

Complainant called the following witnesses: herself and Chanel Miles, Crisis Intake Worker, Pueblo Department of Social Services (by telephone).

Exhibits.

Respondent's exhibits 1, 3, 6, 8, and 9 were admitted by stipulation. Exhibit 2 was admitted with no objection. Exhibit 10 was admitted over objection, and is subject to a protective order, to maintain the confidentiality of patient information. No exhibits 3 or 4 were introduced.

Complainant offered no exhibits.

Motions.

At the close of Respondent's case, Complainant moved for directed verdict. Complainant argued that Respondent violated R6-6 which requires progressive discipline. Complainant claimed that since she had received no prior corrective or disciplinary action, and since this incident was not flagrant or serious, it was improper to discipline her in this matter.

Respondent argued that the facility's probationary license status, issued in part for failure to properly report abuse allegations in the past, rendered this matter a serious one. In addition, Respondent argued that the repeated directives to Complainant to properly file the report, her recent training on proper reporting procedures, and her unilateral decision not to report it correctly, rendered her behavior to be flagrant in nature.

The motion was denied on grounds that the probationary license status did create a serious situation, requiring extra vigilance on the part of staff, particularly supervisors such as Complainant, to assure complete and accurate reporting of abuse allegations.

MATTER APPEALED

Complainant appeals her disciplinary reduction in pay in the amount of \$100.00 in June of 1999, for failure to properly report child sexual abuse allegations to the Colorado Department of Social Services. For the reasons set forth below, the action of the appointing authority is affirmed.

ISSUES

1. Did Complainant commit the acts for which she was disciplined?
2. Was the disciplinary action taken within the range of reasonable alternatives available to the appointing authority.
3. Was the action of the appointing authority arbitrary or capricious, or contrary to rule or law?

STIPULATED FACT

1. No internal CMHIP incident reports were filed on March 9, 1999, regarding the Aspen unit.

FINDINGS OF FACT

1. Complainant was a registered nurse at the Child and Adolescent Treatment Center (“CATC”) of Colorado Mental Health Institute in Pueblo, Colorado (“CMHIP”), of Colorado Department of Human Services (“DHE”) . Complainant worked on the Aspen Unit, comprised of youth that had been through the judicial system and were in the custody of the Department of Corrections. Most youth have a mental health diagnosis.

2. In January 1999, the Department of Youth Corrections (“DYC”), the entity responsible for licensing CATC, audited the Pueblo facility. DYC found that the facility was out of compliance in a number of areas, including child abuse reporting. The reports had not been timely or accurate. As a direct result of the audit, CATC was placed on a probationary license status on February 12, 1999. Staff were aware of the probationary license status, which was given significant press coverage.

3. In response to the audit, in February, all staff, including Complainant, were trained in proper child abuse reporting procedures. Appropriate child abuse reporting was also discussed in team meetings and staff discussions.

4. Hospital policy, standards of professional conduct, and Department of Social Services governing statutes require the timely reporting of child abuse allegations made in DYC facilities.

5. Timely reporting of child abuse allegations is considered to be within four (4) hours of the time the report is made.

6. On February 2, 1999, Complainant signed a form, (Exhibit 9), entitled, “Child Abuse Reporting Requirements, Child and Adolescent Treatment Center (CATC), Colorado Mental Health Institute at Pueblo (CMHIP). This form outlines the reporting requirements for CMHIP, DSS, and DHS. It also states,

“The role of staff is to report the abuse without making any judgments as to the validity of the allegation. . .

A child care worker who fails to report suspected child abuse or neglect commits a class 3 misdemeanor and will be punished as provided in section 19-1-103(1)(A), C.R.S. . . . In addition, the staff person may be subject to a corrective or disciplinary action for not following CMHIP and CATC Policies and Procedures.

I have read and understand the above requirements concerning my responsibility regarding child abuse reporting.”

7. On March 9, 1999, Complainant was working as an RN on the Aspen unit, on her 3 - 12 p.m. shift. As RN, she was the supervisor on her shift, with responsibility over two licensed practical nurses.

8. Between 4 and 5 p.m. on March 9, Complainant was running a community meeting of approximately 12-15 youth. One of the participants, David, age 12, stated that an 18-year old boy named "Bill" had mooned him in class that day, at approximately 1 p.m. David referred to this incident as "sexual abuse." Edwin, another older child, was "hysterical" about the incident, according to Complainant.

9. The group of boys in the community meeting started yelling, "kill Bill." It was a chaotic situation.

9. After the community meeting ended, Complainant immediately called her boss, Lee Ann Gilbert, Acting Director of the CATC, and the appointing authority, to report the incident.

10. Gilbert told Complainant to report it as per child abuse requirements. She told her to identify everybody she could that was a victim, which meant everyone who had witnessed the mooning incident. She reminded Complainant that she needed to complete a separate DSS report form for every victim/witness of the incident. She asked Complainant if she understood the reporting requirements; Complainant stated that she did.

11. In this conversation, Complainant stated that Gustofson, the teachers aide to whom the report had initially been made, should have done all reporting on the incident. Gilbert responded that while that was true, he had gone home for the day, and it was therefore her job to do the report. Gilbert repeated several times that she had to do it.

11. At the time Gilbert instructed Complainant to fully report the incident as child abuse, the Clinical Team Leader at the facility, Herb Brockman, was in her office. Brockman was responsible for all clinical aspects of the facility, and was Complainant's supervisor. Gilbert told him about the incident and asked him to follow up with Complainant to assure she reported it correctly, particularly assuring that she identified all potential victim/witnesses.

12. Complainant paged Brockman while he was in Gilbert's office, and he gave her more instructions on appropriate reporting. He told her to make sure she got the names of all potential victims.

13. Brockman had three conversations with Complainant that night to assure she was performing the reporting requirements correctly, at approximately 5 p.m., 7 p.m., and 9:30 p.m. In the 7 p.m. conversation, he also discussed with her the issue of whether to transfer Bill to another facility. He did not believe it was necessary or appropriate. In all three conversations, Complainant never indicated to him that she was having difficulty or needed help with reporting.

14. In the 9:30 p.m. conversation, Brockman learned that Complainant had failed to call DSS and complete the report form. Complainant told him that the Department of Youth Corrections staffer she had spoken to had said it was not important. He was surprised, because he knew she had no questions about his earlier instructions, and he expected that

she would have had it completed earlier in the evening. He reiterated that she needed to do it.

12. At approximately 5:15 p.m., Gilbert called Cinda Hart, the head nurse for the Sierra Vista unit, where this incident occurred, and other units. Gilbert instructed Hart to go to the unit to assess the situation and to see if she needed any assistance.

13. Hart arrived on the unit at approximately 5:20 p.m. It was fairly quiet, as the majority of clients were in their rooms. Complainant was at the nurses station, on the telephone, writing the internal incident report. Hart helped her with the incident report.

15. While at the facility, Hart went to talk with the students that had been in the classroom at the time of the incident. She learned who had been behind the perpetrator when he mooned them.

14. Complainant did not ask Hart for assistance with reporting. She did not indicate she was having trouble with reporting. Hart left the facility.

12. Gilbert called Louis Gustofson, the teachers aide to whom the report had initially been made. He was at home, having left the facility at approximately 4 p.m. She asked him about the incident, he verified it had been reported to him, and she directed him to come back and help Complainant with the reporting.

11. Complainant was unable to complete the forms right away because she had a room full of boys yelling, "kill Bill." She felt that she first had to assure the safety and security of Bill. This required numerous telephone calls, including discussions of whether to move him out of the facility completely, that evening.

12. It took Complainant a couple of hours, until approximately 7 p.m., to get the situation under control. Bill was segregated from the other clients that evening in his room.

13. At approximately 7 p.m., Gustofson arrived at the facility and offered to help Complainant with the reporting. She told him she had the reporting under control, and that he could write the progress notes in the patients' charts. He did so.

13. **DSS reporting.** DSS reporting consists of an immediate phone call to DSS, including a description of the incident and notification of the names of all potential victims, and filling out the DSS form. Since there were two boys that were particularly upset about the mooning incident, standards of care and statutory reporting standards required that Complainant fill out two DSS forms, one for David and one for Edwin, including full name of victim/witness; name and phone number of guardian(s) for the victim/witness; and verification that DSS had been called. Complainant failed to do all of this. Instead, she filled out only one form, and it contained no full names of either victim/witnesses (just David's first name), and no names of victim/witness guardians. Complainant also failed to

contact any guardians of victim/witnesses, a compulsory part of reporting an abuse incident.

14. Complainant did write in the full name of the perpetrator of the mooning incident, and the name and telephone number of his guardian.

15. Complainant noted that she called DSS at 9:30 p.m. to report the incident. She informed DSS about the incident, but not about the potential victim/witnesses. That was eight and a half hours after the incident had first been reported at 1 p.m. that day, five and a half hours after the deadline for reporting.

15. Complainant failed to comply with the internal agency and statutory reporting requirements.

16. Complainant never asked for help in completing the reporting forms that night.

17. Gustofson came to the facility for the express purpose of helping her complete the reporting process. She never asked him for help.

16. Complainant did call DSS to report the incident, and gave the names of ? As victim witnesses. During this conversation,

17. During the evening of March 9, 1999,

18. On March 10, 1999, Gilbert reviewed the DSS report completed by Complainant, and found that no victims or their guardians had been identified. She directed Hart to assist staff in completing a more accurate and complete report.

19. Hart knew who the victim/witnesses were from having spoken to them on the evening of March 9. She had asked the children in the classroom at the time of the incident to tell her what happened, who the perpetrator was, and who was behind him.

20. Hart met with Complainant at 1 p.m. to complete the report for DSS. Hart called DSS to let them know more witnesses had been identified than those reported the night before.

21. Hart asked Complainant if Brockman had directed to find out who the witnesses were. She said yes, but that she had not done so.

22. Hart then notified the legal guardians of the victim/witnesses about the incident.

18. **R6-10 meeting.** The R6-10 meeting was held on April 5, 1999. Complainant explained that it was chaotic on the evening of March 9, 1999. She said she wasn't sure it had happened. She did not indicate that she was confused on how to file the report. She

informed Gilbert that there had been two clients particularly upset about the incident.

19. Gilbert decided based on Complainant's responses that she had determined herself that it was not a serious incident, and that therefore she would not perform the reporting properly. Gilbert had herself given Complainant explicit, detailed instructions on how to report the incident. She had directed Complainant to do the reporting properly. She knew that Brockman had also told her to file the report and given her instructions. She felt that Complainant had defied these clear directives, and that this constituted a willful decision not to comply with her supervisor's directives.

20. Gilbert considered the February 2 document Complainant had signed, the fact that she understood the reporting requirements, the hospital policies and statutory reporting requirements, and the impact on other staff in trying to enforce the reporting requirements for all staff in the future. She was concerned that staff consider this a serious incident.

21. Gilbert also felt that although it was a chaotic situation during the community meeting, the crisis had passed by 6 or 7 p.m. that evening. The chaos did not diminish Complainant's reporting requirement.

22. On May 25, 1999, Gilbert sent a letter to Complainant informing her of her decision to issue both corrective action and disciplinary action for her failure to appropriately report the incident. The disciplinary action was taken because Complainant's "failure to report to the [DSS] is a serious violation of hospital and division policy and in opposition to specific direction given to you." Gilbert further stated,

"Due to the seriousness of failure to report, which is violation of the Child Protection Act of 1987 (C.R.S. 19-3-301) in the Colorado Children's code, I am issuing the following disciplinary action. Due to your willful failure to perform competently in this situation, and willful violation of agency rules and law, I am administering a disciplinary reduction in pay of \$100.00 for a one month period of time, effective June 1, 1999."

23. Complainant does not appeal the corrective action.

24. Complainant seeks a rescission of the disciplinary reduction in pay of \$100.00, and attorney fees.

DISCUSSION

Certified state employees have a property interest in their positions and may only be terminated for just cause. Department of Institutions v. Kinchen, 886 P. 2d 700 (Colo. 1994). Such cause is outlined in State Personnel Board 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. Kinchen, 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 she was disciplined?

Respondent proved that Complainant committed the acts for which she was disciplined, namely, willful failure to perform competently by failing to properly report the abuse allegation to DSS, and willful violation of agency rules and law.

Complainant filled out one DSS abuse report form, which had none of the most important information on it: the full name of the abuse victim, and the name and telephone number of the victim's legal guardian. The purpose behind the reporting requirement is to assure timely and accurate reporting of the alleged abuse so that the victim can be assessed and helped, if appropriate. Without this critical information, no action can be taken to help the victim.

Complainant felt that she should not have had to file the report, because she was the second, not the first, recipient of the report of abuse. After speaking to DYS, she determined on her own that this was not an incident worthy of reporting. This decision on her part was in direct violation of the February 2 policy statement she signed, which stated, "The role of staff is to report the abuse without making any judgments as to the validity of the allegation." It was also in violation of repeated direct orders from supervisors, including the Acting Director of the facility, Lee Ann Gilbert, as well as the Clinical Team Leader for the facility. It was only during the third phone call with Brockman at 9:30 p.m. that she finally called DSS and filled out the report. While there was good cause for her to delay calling DSS until perhaps 7 p.m., when the unit had calmed down, there was no good cause for the further two and a half hour delay until 9:30 p.m.

Complainant argues that a nondelegation clause in the February 2 abuse reporting requirement policy she signed abrogated her duty to report the incident. That provision states,

"The completion of the Alleged Child Abuse/Neglect Report and the necessary calls to the appropriate Department of Social Services, Department of Human Services, or police agency as mandated by policy can no be delegated to another staff person but must be completed by the staff person who first learned of the alleged abuse."
(Emphasis in original).

This clause means that the person who has received the report cannot delegate reporting to anyone else. Here, that meant the teachers aide, Gustofson. Nothing in this clause prevents an appointing authority from re-assigning the reporting duty to another staff member who received the abuse report, when the first recipient of the report has gone home for the day without reporting it. The purpose of this clause was to assure that staff who receive reports of abuse immediately take the responsibility for reporting it. Here, that meant Complainant.

Complainant lastly asserts that she did exactly what could reasonably be expected of her in this situation, since it was not her job to “investigate” the alleged abuse incident. She claims that to expect her to identify potential victim/witnesses is equivalent to requiring her to investigate the incident. Investigation is the job of DSS, not the staff person who receives the report of abuse.

However, this argument fails for common sense reasons. The purpose of the abuse reporting system, as stated above, is to identify potential victims. Recipients of the report of abuse are in the best position to know and inquire who all potential victims are. In this situation, David approached Complainant and informed her of the mooning incident, referring to it as “sexual abuse.” He clearly felt victimized by the incident, and was obviously an individual subject to the abuse reporting requirement. Edward was also “hysterical” about the incident, according to Complainant. This is a second potential victim who clearly should have been reported. Complainant claims that she was not absolutely certain that either the incident occurred, or that either of these two boys was a victim. However, again, her job is to identify potential victims to DSS, to pass this information on for professional investigative follow-up.

Complainant also argues that it would be wrong to require her to “interview” those present at the incident to see who was a victim/witness, claiming this constitutes “investigation.” However, it is absurd to assume that employees, once they receive a report of abuse, are to sit back and take no further action. To ask a simple question, did you see it, who here saw it, is not investigation. It is the common sense, minimal action necessary to determine the identity of potential victims.

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

Complainant knew that the facility was on a probationary license due to staff's history of untimely and incomplete abuse reporting. She had even signed a form five weeks prior to this incident stating that she agreed to and understood the abuse reporting requirements. On the evening of March 9, the appointing authority had personally directed Complainant to be sure to identify all potential victims. The clinical team leader had followed up on that directive with detailed instructions on reporting, in at least two telephone conversations. Finally, at the R6-10 meeting, Complainant stated that she did not believe that it had really happened, and that it was “chaotic” on the unit that night. However, the

appointing authority had sent the nursing supervisor, as well as the teaching assistant, to the unit to assist Complainant in the event she needed it. Complainant requested no assistance.

Under these circumstances, it was reasonable for the appointing authority to conclude that Complainant acted willfully. In addition, it was reasonable for the appointing authority to take into account the fact that Complainant was a supervisor, thwarting the facility's efforts to achieve compliance with abuse reporting requirements.

A \$100 penalty was reasonable and necessary to assure future compliance not only by Complainant but other staff.

3. Was the action of the appointing authority arbitrary and 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).

Here, the appointing authority thoroughly investigated the situation, and also had the benefit of first-hand knowledge of much of what happened on the evening of March 9, 1999. She considered the response of Complainant at the R6-10 meeting, and then made a reasoned decision based on all relevant information.

Complainant argues that progressive discipline should have been used in this case. This ALJ disagrees. The probationary license at the facility, issued in part for failing to properly report abuse, created a very serious situation at CMHIP. Complainant was a supervisor who set the tone for other staff in such things as meeting abuse reporting requirements. She willfully defied repeated direct orders of her supervisors to report this incident correctly. Her conduct was therefore flagrant in nature. Progressive discipline was not necessary under the circumstances of this case.

CONCLUSIONS OF LAW

1. Respondent's actions were within the range of reasonable alternatives available to an appointing authority.
2. Respondent's actions were not arbitrary, capricious, or contrary to rule or law.
3. Neither party is entitled to an award of attorney fees.

ORDER

Respondent's action is affirmed.

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 June, 1999, I placed true copies of the foregoing **PREHEARING ORDER** in the United States mail, postage prepaid, addressed as follows:

Betty Cruz
1005 Berkley
Pueblo, CO 81004

and in the interagency mail, to:

Steven A. Chavez
Office of the Attorney General
Department of Law
1525 Sherman St., 5th Floor
Denver, CO 80203
