

STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. 97B040

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

JIMMIE J. ARAGON,

Complainant,

vs.

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

Respondent.

The hearing in this matter was commenced on April 7, 1997, and concluded on April 21, 1997, with the submission of the parties' closing arguments. Respondent appeared at hearing through Toni Jo Gray, Assistant Attorney General. Complainant, Jimmie Aragon, was present at the hearing and represented by Carol Iten, Attorney at Law.

Respondent called complainant to testify at hearing and called the following employees of the Colorado Mental Health Institute at Pueblo (CMHIP) to testify as witnesses at hearing: Rosemary Trujillo; Bill Sherman; Doris Sundell; Marcie Ann Caraballo; Scott Hertnekey; and Irene Drewnicky. Complainant testified in his own behalf and called John Felix, a former employee of CMHIP, to testify at hearing.

Respondent's exhibits 1 through 6, 10, 13 through 16, 24, 25 and 27 were admitted into evidence without objection. Respondent's exhibits 8, 9, 12, 17 through 23, 28 and 31 were admitted into evidence over objection. Respondent's exhibit 30 was not admitted into evidence.

Complainant's exhibits C and E were admitted into evidence without objection. Complainant's exhibits F and G were admitted into evidence over objection.

MATTER APPEALED

Complainant appeals the termination of his employment.

ISSUES

1. Whether complainant engaged in the conduct for which discipline was imposed.
2. Whether this conduct constitutes grounds for disciplinary action under Board Rule, R8-3-3.
3. Whether the termination of complainant's employment was arbitrary, capricious, or contrary to rule or law.
4. Whether the doctrine of "after acquired evidence" has application to this matter.
5. Whether either party is entitled to an award of attorney fees and costs under section 24-50-125.5 C.R.S. (1988 Repl. Vol. 10B).

FINDINGS OF FACT

1. Complainant Jimmie Aragon (Aragon) was employed by CMHIP as a Licensed Psychiatric Technician (LPT) from June, 1992, to September 27, 1996, when his employment was terminated for failure to comply with standards of efficient service and competence and wilful misconduct. In September, 1996, Aragon was employed in the General Adult Psychiatric Unit (GAPS) Ward 67 at CMHIP. At this time, Aragon worked the third shift from approximately 11 p.m. to 7 a.m.
2. The average patient census on GAPS Ward 67 in September, 1996, was 29. The average patient stay at CMHIP ranged from eight days to 100 days. Staffing on Ward 67 during the third shift was minimal with only three to four staff members assigned to work. Patients on the unit vary in acuity. In September, 1996, patients suffered with adjustment disorder, exhibiting anti-social behavior, to schizophrenia, individuals who were acutely psychotic.
3. In September, 1996, Aragon was expected to provide direct patient care. He was trained as a LPT and expected to provide patient care, to ensure the patients' safety and ensure the safety of his fellow staff members. As a LPT, Aragon was expected to assist in maintaining a clean therapeutic environment for the patients. He was expected to observe and communicate with the patients. He administered medication to patients as directed by register nurses on duty. He was expected to check patients on an hourly basis. Patients placed in seclusion and restraints and on suicide watch were expected to be checked by the staff at 15 minute intervals.
4. The routine checking of the patients on GAPS was required for hospital accreditation. This practice was required by hospital policies and the nursing standards act which was applicable to LPTs. Patients on GAPS frequently did not make lots of noise when

intervention by the staff was required. An LPT on the third shift, when many patients are sleeping, is required to actually observe patients as they sleep to insure the patients' well being. An LPT was expected to check patient breathing and pallor during these routine checks.

5. In May, 1996, managers on GAPS were advised by a patient advocate that on Ward 67 third shift a patient was not checked while in seclusion and restraints and on suicide watch. As a result of this report, John Felix, the shift supervisor was counselled and directed to remind the third shift staff on Ward 67 of the need to and the importance of patient checks.

6. At or around September, 1996, routine checks were not properly conducted by other staff members at CMHIP and a patient died. The patient turned blue before his death was noted by the staff. The patient's coloring at the time the death was discovered was indicative of the fact that routine hourly checks of the patient were not conducted. This provided an example of the serious ramification from the staffs' failure to carry out this responsibility. Following the death of this patient, managers reemphasized the importance of carrying out this duty.

7. Aragon was aware of his responsibility to perform hourly checks on the patients. Aragon had been trained to check patients in seclusion and restraints and on suicide watch at 15 minute intervals. However, because of his failure to routinely perform this duty, he was less clear in September, 1996, about his responsibility in this area.

8. An admission and discharge log, also referred to as a "CMHIP Patient Location Accountability Sheet", containing the names of all the patients present on the unit is required to be prepared at the beginning of each shift. The staff working on the third shift receives a report from the staff working on the second shift concerning patient admissions and discharges that may have occurred during the second shift. The third shift staff is further advised of the condition of the patients under their care. Patients on suicide watch or in seclusion and restraints are brought to the staffs' attention. Any patient needing special attention or assistance also might be discussed during the change of shift report.

9. Aragon was expected to prepare the discharge and admission log at the beginning of the shift. The log was to be used during the staffs' periodic rounds checking the patients. The log has boxes with hourly intervals noted. Staff is expected to check each patient on at least a hourly basis noting in the boxes on the log sheet the location of the patient and initialling the notation.

10. On September 17, 1996, at the change of shift report, Aragon

was notified that patient C.C. had been discharged.¹ At some time thereafter, the admission and discharge log was prepared by Aragon.

Aragon kept patient C.C.'s name on the log despite the fact that the patient was discharged. Aragon also added to the discharge and admission log the name of patient R.G. This patient was not admitted to CMHIP until 2:30 a.m. on September 18, 1996.

11. On September 18, 1996, Aragon was responsible for checking the patients at 4:00 a.m., 5:00 a.m. and 6:00 a.m. He was expected to do so with the admission and discharge log in hand. At 4:00, 5:00 and 6:00 a.m., Aragon noted that patient C.C. was in his assigned room.

12. John Felix was Aragon's supervisor on the night of September 18, 1996. Felix was responsible for checking the patients at 12:00, 1:00, 2:00 and 3:00 a.m. Felix also noted that patient C.C. was in his room during these checks.

13. On September 18, 1996, at 9:00 a.m., Rosemary Trujillo, the lead nurse on Ward 67, was advised of the patient accountability sheets prepared by Felix and Aragon during shift III by a registered nurse and the unit coordinator. Trujillo observed the room where patient C.C. was housed the day before, noting that the bed in that room was stripped of sheets and blankets. It is the usual procedure that a patient strips the bedding before his discharge from an area. Trujillo noted that patient R.G.'s name was typed into the discharge and admission log used during shift III. Since the patient was not admitted to CMHIP until after the discharge and admission log was supposed to have been generated, Trujillo suspected that the form was generated late in the shift and the notations were inserted by the staff without actually checking the patients in their rooms.

14. Normally, a patient who is admitted after the start of a shift, and after the admission and discharge log is prepared, would have his name inserted into the form in script, not typewritten.

15. Irene Drownicky is the GAPS Division Director and the appointing authority for Aragon's position. On September 18, 1996, she was made aware that Aragon did not properly complete the admission and discharge log. She decided to conduct an investigation of the allegations of misconduct with regard to Aragon's failure to properly check the patients under his care. On September 19, 1996, she placed Aragon on administrative suspension with pay during the investigation. By the same notice,

¹ Patients C.C. and R.G., whose care is referenced herein, shall be referred to by their initials in order to protect their right to privacy.

Drewnicky advised Aragon that a Board Rule, R8-3-3, meeting would be held with him on September 24, 1996, to consider allegations that Aragon failed to comply with nursing standards by checking patients hourly and documenting the checks.

16. Aragon appeared at the R8-3-3 meeting with a representative. During the September 24 R8-3-3 meeting, Aragon's explanation of his conduct to Drewnicky was confusing. Aragon was curt and flippant in his responses to Drewnicky's questions. He appeared irritated and angry to be questioned by Drewnicky about his job performance. Aragon's representative requested a break in the meeting. It appeared to Drewnicky that the break was taken to advise Aragon to adjust his poor attitude.

17. During the R8-3-3 meeting, Aragon refused to accept responsibility for the care of the patients and the accountability of the hospital and the staff for completion of the documentation associated with the patients' care. Aragon focused on the use of the computer that generated the admission and discharge form. He explained in some detail about the time involved in getting the computer to print the form.

18. During the R8-3-3 meetings, Aragon did not claim that he actually went to the patients' rooms and observed them on an hourly basis. He used very generally language, explaining that he "counted the patients" or he "checked the patients". When Drewnicky questioned Aragon about the procedures he followed to check patients in seclusion and restraints, he was uncertain how frequently these patients had to be checked.

19. A second R8-3-3 meeting was held with Aragon on September 26, 1996. Aragon did not offer additional explanation for his conduct during this meeting. Following the R8-3-3 meetings, Drewnicky reviewed Aragon's employment record with CMHIP. It was noted that in August, 1996, he received a job performance ratings of "commendable". She considered all the information she received about Aragon's failure to perform patient checks on September 18, 1996. She determined that the information provided by Aragon at the R8-3-3 meeting was not credible.

20. Thereafter, Drewnicky decided to terminate Aragon's employment effective September 27, 1996. She decided that Aragon failed to recognize the seriousness of his actions and its impact on patient care, hospital accountability, and staff morale. His contemptuous attitude at the R8-3-3 meeting, in conjunction with his explanation of his conduct which was not credible, lead her to believe that he could not be rehabilitated and thus a lesser discipline was not acceptable.

21. Drewnicky held a R8-3-3 meeting with John Felix, the supervisor on duty on September 18, 1996, who also failed to properly check and note the condition and location of the patients

under his care on September 18, 1996. Felix explained at his R8-3-3 meeting that he actually checked the patients and that his notation that patient C.C. was in his room when he was discharged was a transcription error. Felix was not irritated or contemptuous during the R8-3-3 meeting. He appeared to understand what was required by the nursing standards act and claimed a clerical error in his failure to accurately note the patient's location on September 18. Drewnicky decided to demote Felix.

22. Following Aragon's termination and Felix's demotion, additional information was discovered about the way care was provided GAPS Ward 67 patients by the third shift staff. As a result of this information, Felix's employment was terminated on November 18, 1996, along with a number of other staff members.

DISCUSSION

Certified state employees have a protected property interest in their employment. The burden is on respondent in a disciplinary proceeding to prove by a preponderance of the evidence that authority exists for the action taken. *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994); Section 24-4-105 (7), C.R.S. (1988 Repl. Vol. 10A). The board may reverse or modify the action of the appointing authority only if such action is found to have been taken arbitrarily, capriciously or in violation of rule or law. Section 24-50-103 (6), C.R.S. (1988 Repl. Vol. 10B).

The arbitrary and capricious exercise of discretion can arise in three ways: 1) by neglecting or refusing to procure evidence; 2) by failing to give candid consideration to the evidence; and 3) by exercising discretion based on the evidence in such a way that reasonable people must reach a contrary conclusion. *Van de Vegt v. Board of Commissioners*, 55 P.2nd 703, 705 Colo. 1936).

Respondent contends that the actions proven to have occurred on September 18, 1996, constitute grounds for disciplinary action. Respondent further maintains that termination of complainant's employment was within the range of discipline available to a reasonable and prudent administrator.

Alternately, respondent argues that if the conduct proven here is not found to have provided adequate grounds for disciplinary action, under *McKinnon v. Nashville Banner Publishing Co.*, ___ U.S. ___, 115 S.Ct. 879, 886, 130 L.Ed. 2d 852 (1995), any award of back pay only should extend from September 27, 1996, the date complainant was terminated from employment to November 18, 1996, when complainant's co-workers' employment was terminated for misconduct similar to complainant's subsequently discovered misconduct.

Complainant contends that respondent failed to sustain its burden

of proof to establish that complainant's conduct on September 18, 1996, violated nursing standards, Board Rule, R8-3-3, or that the conduct warranted disciplinary termination. Complainant contends that his conduct was the same as that of his supervisor, John Felix, who was only demoted.

Further, complainant contends that termination of his employment should not be sustained on the basis of after acquired evidence. Complainant maintains that under *Loudermil v. Cleveland Board of Education*, 470 U.S. 532 (1985), procedural due process rights are afforded individuals in public employment. Complainant further maintains that affirming a termination on the basis of information which complainant was not made aware of or given the opportunity to address in a pretermination meeting with the appointing authority would be a denial of due process.

Alternately, complainant argues that if it is found that the "after acquired evidence doctrine" has application in public employment, respondent failed to sustain its burden to establish that the requirements for application of the doctrine were met.

The evidence presented at hearing amply supports the conclusion that complainant failed to check patients under his care on GAPS Ward 67 on September 18, 1996, as reflected by his notations with regard to patient C.C. and R.G. on the discharge and admission form. Based on the information the appointing authority received at the R8-3-3 meeting of September 24 and 26, 1996, it was neither arbitrary, capricious or contrary to rule or law to terminate complainant's employment.

No conflict or unfair treatment is found in the appointing authority's determination that employees involved in a related incident of misconduct deserve different treatment so long as the different treatment is not imposed on an impermissible basis such as race or sex. The testimony at hearing established that complainant presented himself at the R8-3-3 meetings in a manner that lead to the conclusion that he failed to understand the seriousness of the offense involved, that he lacked respect for the appointing authority, that he was not credible in his explanation of the events of September 18, and that the likelihood of rehabilitation of complainant's job performance was not present.

John Felix's response to the allegation of misconduct on September 18 lead to the conclusion that he was deserving of only a disciplinary demotion. At his R8-3-3 meeting, Drewnicky testified that he appeared to understand his obligation to safeguard the patients and that he informed her that his was a clerical error. Subsequent to the imposition of the disciplinary demotion on Felix, Drewnicky learned of conduct which resulted in the termination of Felix's employment. It was further discovered that Felix offered different testimony about his actions on September 18, 1996, at his R8-3-3 meeting, at an Unemployment Compensation hearing, and at the

administrative hearing in this matter.

Respondent's arguments with regard to the application of the "after acquired evidence doctrine" were considered and determined to be without merit. Since complainant's termination is supported by the evidence of his actions on September 18, the application of this doctrine need not be addressed. However, should it be determined that the evidence fails to support the disciplinary decision, it is found that after acquired evidence cannot be considered here where the case involves the termination of one with a property interest in his continued employment who under *Loudermil, supra*, is entitled to pretermination due process.

The evidence presented at hearing does not support an award of attorney fees and costs for respondent under section 24-50-125.5 C.R.S. (1988 Repl. Vol. 10B). There was no evidence that the appeal of complainant's termination was instituted maliciously, frivolously, as a means of harassment, in bad faith nor was it otherwise groundless.

CONCLUSIONS OF LAW

1. Respondent established by preponderant evidence that complainant engaged in the conduct for which discipline was imposed.
2. The conduct constituted wilful misconduct and a failure to comply with standards of efficient service and competence in violation of R8-3-3.
3. The decision to terminate complainant's employment was neither arbitrary, capricious, nor contrary to rule or law.
4. *McKinnon v. Nashville Banner Pub. Co., supra*, does not have application in public employment where there is a constitutionally protected property interest in employment and the employee is entitled to pretermination due process.
5. Respondent is not entitled to an award of attorney fees or costs.

ORDER

The action of the agency is affirmed. The appeal is dismissed with prejudice.

DATED this _____ day of
June, 1997, at
Denver, Colorado.

Margot W. Jones
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

EACH PARTY HAS THE FOLLOWING RIGHTS

1. To abide by the decision of the Administrative Law Judge ("ALJ").
2. To appeal the decision of the ALJ to the State Personnel Board ("Board"). To appeal the decision of the ALJ, a party must file a designation of record with the Board within twenty (20) calendar days of the date the decision of the ALJ is mailed to the parties. Section 24-4-105(15), 10A C.R.S. (1993 Cum. Supp.). Additionally, a written notice of appeal must be filed with the State Personnel Board within thirty (30) calendar days after the decision of the ALJ is mailed to the parties. Both the designation of record and the notice of appeal must be received by the Board no later than the applicable twenty (20) or thirty (30) calendar day deadline. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Colo. App. 1990); Sections 24-4-105(14) and (15), 10A C.R.S. (1988 Repl. Vol.); Rule R10-10-1 et seq., 4 Code of Colo. Reg. 801-1. If a written notice of appeal is not received by the Board within thirty calendar days of the mailing date of the decision of the ALJ, then the decision of the ALJ automatically becomes final. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Colo. App. 1990).

RECORD ON APPEAL

The party appealing the decision of the ALJ must pay the cost to prepare the record on appeal. The fee to prepare the record on appeal is \$50.00 (exclusive of any transcription cost). Payment of the preparation fee may be made either by check or, in the case of a governmental entity, documentary proof that actual payment already has been made to the Board through COFRS.

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

BRIEFS ON APPEAL

The opening brief of the appellant must be filed with the Board and

mailed to the appellee within twenty calendar days after the date the Certificate of Record of Hearing Proceedings is mailed to the parties by the Board. The answer brief of the appellee must be filed with the Board and mailed to the appellant within 10 calendar days after the appellee receives the appellant's opening brief. An original and 7 copies of each brief must be filed with the Board. A brief cannot exceed 10 pages in length unless the Board orders otherwise. Briefs must be double spaced and on 8 ½ inch by 11 inch paper only. Rule R10-10-5, 4 CCR 801-1.

ORAL ARGUMENT ON APPEAL

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

PETITION FOR RECONSIDERATION

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

CERTIFICATE OF MAILING

This is to certify that on the _____ day of June, 1997, I placed true copies of the foregoing **INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE** in the United States mail, postage prepaid, addressed as follows:

Carol M. Iten
AFSCME
789 Sherman St., Suite 640
Denver, CO 80203

and to the respondent's representative in the interagency mail, addressed as follows:

Toni Jo Gray
Office of the Attorney General
Department of Law
1525 Sherman St., 5th Floor
Denver, CO 80203
