

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

MICHELE TRUJILLO,

Complainant,

vs.

DEPARTMENT OF HUMAN SERVICES
PUEBLO REGIONAL CENTER,

Respondent.

This four-day hearing was held on October 10 and 11, and December 12 and 13, 2001, before Administrative Law Judge Mary S. McClatchey. Respondent was represented by Assistant Attorney General Joseph Q. Lynch. Complainant was represented by Nora Nye, Esquire.

MATTER APPEALED

Michele Trujillo ("Complainant") appeals her demotion from the position of Developmental Disabilities Technician ("DDT") II to DDT I on June 8, 2001. For the reasons set forth below, Respondent's action is affirmed.

ISSUES

1. Whether Complainant committed the acts for which she was disciplined;
2. Whether the discipline imposed was within the range of alternatives available to the appointing authority;
3. Whether Respondent's action was arbitrary, capricious or contrary to rule or law.

FINDINGS OF FACT

1. Complainant commenced employment with the Department of Human Services ("DHS") on October 18, 1997, as a temporary DDT I. That position ended on January 18, 1998. On June 3, 1998, Complainant was appointed to the position of DDT I, and was certified into the position on June 3, 1999.
2. At all times relevant, Complainant has worked at Wiggins House ("Wiggins"). Wiggins is a group home serving residents (aka "clients") who are profoundly retarded to severely retarded. These residents need a very high level of care from the staff. The residents must have assistance with all daily functions, including but not limited to bathing, eating, and toileting.
3. Of the five Wiggins residents in 2001, one was "medically fragile," meaning that he had a life-threatening condition. This resident had a seizure disorder, an asthma condition, and a bowel condition, all of which required approximately twenty-five daily medications. Another resident had a seizure disorder. Many of the residents had behavior disorders with aggression. Two had hyperactivity.
4. The staff at Wiggins consists primarily of Developmental Disabilities Technicians ("DDT's"). One of their primary duties is to administer medications to residents. DDT's are licensed to administer medications by the Colorado Board of Nursing, after receiving training and passing a test.
5. There is no nurse permanently stationed at Wiggins. A float nurse oversees Wiggins and three other group homes on a daily basis.
6. In early 2000, the test for the DDT II position was given. The DDT II position was designed to be lead worker for the DDT I's, to be a role model for the DDT I's, to set the example for the DDT I's, and to assure that they performed their work. The DDT II position at Wiggins had been vacant for a long period of time, and there had been a lack of leadership.
7. Complainant took the DDT II test in order to learn what was on it for future reference, expecting not to pass it on her first try. She passed the test, interviewed for the position, and was appointed to the position on March 6, 2000.
8. Many of the other DDT I's that had worked at Wiggins for many years took the DDT II test and failed. They resented Complainant for passing and for being appointed to a leadership role when she was so much newer to the home than they were.

The December 2000 Corrective Action

9. One of Complainant's duties as a DDT II was to conduct regular audits of client funds utilized for purchase of personal items. Complainant did not consistently follow or enforce agency policies with respect to documenting and auditing the client funds. This may have been due in part to a lack of training.
10. In addition, in December 2000, Complainant drove to the auditor's office in her personal vehicle, stopped on the way at a convenience store for a personal emergency, and neglected to lock her car. During the time Complainant was in the convenience store, someone broke into her car and stole all of the cash and receipts that were due to be audited that day (approximately \$25.00 in cash and over \$900.00 in receipts for the last six months worth of client purchases). Therefore, no audit could be conducted.
11. On December 26, 2000, Faye Weiser, Director of Pueblo Regional Center, DHS, Complainant's appointing authority, issued a Corrective Action to Complainant for: neglect of client funds and audit documents; failing to follow procedures for cash withdrawal; and failing to conduct audits on a weekly basis.
12. The Corrective Action listed four specific items that had to be corrected within a specific time. All four concerned her need to follow the auditing procedures and to communicate better with group leaders to assure correct auditing. Complainant corrected all four of those items in a timely manner, and the Corrective Action contains the dates of completion next to each of the four items to be corrected.
13. The section entitled, "You must complete the corrective action(s) listed above by the following date(s)" also stated, "The completion dates are listed above. Your immediate supervisor will be conducting regular reviews of your performance improvement. It is understood that you must comply with this process daily. We will consider this action corrected if the reviews completed by your supervisor demonstrate consistent performance improvement. This will be evaluated at your annual performance review."
14. The Corrective Action contains no mention of Complainant's performance in the area of "Leadership/Communication."
15. Faye Weiser verbally counseled Complainant about having used her personal vehicle to attend the audit. She advised Complainant that it was

the agency policy not to use a personal vehicle for state business unless a state vehicle was unavailable.

16. Many staff at Wiggins believed that Complainant had stolen the money that was to be audited. Upon her return to Wiggins, many of the staff shunned her.
17. Complainant's immediate supervisor, Beverly Tharp, Residential Coordinator of Wiggins and two other group homes, had a number of meetings with Complainant to assist her in developing rapport and respect from her staff. She made a number of suggestions to Complainant on how to improve her relationship with those she supervised. One of these suggestions was a team building session. Complainant turned down this offer, in part because one or two members of her staff said they were not interested in a team building session.
18. Complainant was never able to achieve a smooth working relationship with those under her supervision.
19. One reason for Complainant's unpopularity was Complainant's initiation of a change in policy on weekends at Wiggins. Complainant believed that it was the residents' right to sleep in on weekends after receiving their morning medication, since they were not scheduled for outings on those days. Other staff strongly disagreed with this. The issue was addressed at a house meeting, the chain of command supported Complainant's position, and the policy was modified to allow residents to sleep in on weekends.
20. Complainant made some innovations in supervising the staff at Wiggins. She initiated a new system of allowing staff to choose what tasks they would perform on shift, instead of imposing them on staff herself. She also used check-off forms as a means of tracking her staff's accomplishments.

Performance Evaluation: 2000-2001

21. On April 5, 2001, Beverly Tharp conducted her year-end performance appraisal of Complainant for the period May 2000 through April 2001. Tharp rated Complainant Fully Competent overall. Complainant signed "Agree" on this evaluation, and made no comments on it.
22. The evaluation form had five boxes to check: Peak Performer; one box below that; Fully Competent; one box below that; and Needs

Improvement.

23. Tharp rated Complainant at the box between Fully Competent and Needs Improvement in the category of Leadership/Communication. Tharp rated Complainant in that box in three out of the four Leadership/Communication categories. The first was, "Assures that established routines are followed to provide consistent services;" the second was, "Provides direction, feedback and training for staff; keeps supervisor aware of issues;" and third was, "Utilizes staff skills and responsibilities and resolves routine issues and concerns."
24. Tharp rated Complainant at Fully Competent in one sub-area: "Follows through with line charge responsibilities."
25. All of the above four ratings had been the same at the time of her interim evaluation on December 26, 2000.
26. Tharp commented at the end of the Leadership/Communication section, "needs more experience with staff in effectively resolving issues. Needs to be a better role model."

April 8, 2001 Incident Leading to Demotion

27. On April 8, 2001, Complainant was the DDT II on the morning shift. She arrived ten minutes late to work, feeling flustered.
28. At every shift change at Wiggins, the DDT assigned to administer medications "gives report" to the oncoming DDT that will administer medications on the next shift. Giving report includes walking through the home, reviewing the status of the residents, and sitting down with the medication book and counting the medications to assure the count is correct. Both DDT's then sign the medication book, certifying that the medication count is correct.
29. On April 8, 2001, Complainant was the employee assigned to give medications on her shift. Therefore, upon arrival, she took report from the DDT going off shift.
30. Wiggins policy requires that the DDT taking report take possession of the keys to the medication cabinet. Procedure 3.5A1, Accountability and Control of Drugs, in effect at Wiggins on April 8, 2001, states in part,
 - A. "1. Each medication cabinet in the agency is individually keyed for the storage of resident medications and treatments.

- B. 1. The employee assigned to administer medications, on a given shift, will be responsible for carrying the medication cabinet key on his person during the entire shift and be responsible for its contents . . .
- C. 5.(a)(3). Shift Accountability - All Schedule II drugs will be counted or measured at every shift change by the employee assigned to administer medications on each shift"
31. Wiggins staff assigned to administer medications often violated this procedure by failing to keep the medication cabinet key on their person during the entire shift. Complainant, despite her status as lead worker, was no exception.
32. On April 8, 2001, after Complainant took report, instead of taking possession of the medication cabinet key at the time she took responsibility for administering medications, Complainant left the key in the drawer directly below the medication cabinet.
33. Medications were scheduled via doctor's orders to be administered at 7:30 a.m.
34. It was Complainant's normal practice to administer medications as soon as she came on shift and took report. This took roughly fifteen minutes.
35. On April 8, however, when Complainant arrived, she saw a note indicating that the grocery shopping for Wiggins had not been done on Saturday, as it should have been. She decided to do the shopping immediately.
36. On April 8, the DDT I on duty that day, Janis Valenzuela, also arrived late, at 7:15 a.m., a few minutes after Complainant. When Complainant informed Valenzuela that she was going grocery shopping, Valenzuela assumed that Complainant had already administered medications, as usual. Complainant asked Valenzuela if everything would be all right in her absence, Valenzuela said yes, and Complainant departed for the grocery store.
37. At the time Complainant left for the grocery store, she was aware that Valenzuela's medication administration privileges had been revoked approximately two weeks prior. However, she assumed that Valenzuela's privileges had been reinstated, because she knew that Valenzuela had been scheduled to have the training necessary to be reinstated a few days before April 8.
38. Complainant did not ask Valenzuela whether she had been reinstated to

administer medications prior to her departure for the grocery store.

39. Valenzuela had in fact not been reinstated to administer medications. Therefore, the Wiggins residents did not receive their medication at 7:30 a.m. on April 8.
40. During Complainant's absence at the grocery store, the nurse arrived at Wiggins for her routine visit. She soon discovered that it appeared the 7:30 a.m. medications had not been given. The nurse attempted to reach Complainant by phone, but Complainant did not return the page right away. When Complainant did call Wiggins, the nurse did not take the call.¹
41. When Complainant returned to Wiggins at approximately 9:30 a.m., she confirmed that she had not given the medications. When the nurse informed her that Valenzuela had not yet been reinstated to administer medications, Complainant was upset and realized her error in not having discussed the medication administration issue with Valenzuela prior to her departure.
42. Faye Weiser was called at home on April 8 regarding the medication variance. Part of the report she received indicated that Valenzuela and Complainant may have had conflicting stories and that the entire truth was not being told. She therefore initiated an investigation into the April 8 medication error by the Department investigator, instead of handling it herself.
43. The investigative report encompassed not only the events of April 8, but also some staff allegations of general neglect of the Wiggins home.
44. The R-6-10 meeting took place on May 17, 2001. Faye Weiser had a representative present. Complainant was accompanied by her union representative, Kevin Ferris. Complainant and Ferris reviewed the investigative report, and were surprised that the scope of the report exceeded the events of April 8. Ferris objected to the fact that when Complainant was interviewed, she was never asked to respond to any of the general allegations of neglect of the Wiggins home. He stated that it was unfair for the R-6-10 meeting to include issues that Complainant had

¹ Complainant faulted this nurse for calling the doctor for new orders, if needed, prior to confirming that the medications had not been given. Complainant implied that this nurse was attempting to get Complainant into more trouble than the situation warranted. The nurse acted appropriately: all 7:30 medications were still in the medication drawer; a search of every wastebasket had revealed no medication cups used to administer the medications; it was critical to contact the doctor for alternate orders if necessary.

never been informed of, and requested an adjournment of the R-6-10 meeting in order to fully review the report.

45. Weiser granted this request, and gave Ferris and Complainant time to fully review the report on another day. Because the report was confidential, they were required to read it on the premises. They did so.
46. The R-6-10 meeting was re-scheduled to continue on a second day, May 24, 2001. At that meeting, Complainant and Ferris made it clear that the non-April 8 allegations in the report were unrelated to Complainant, so their concerns regarding the scope of the report had been put to rest.
47. Complainant and Ferris had a full opportunity to respond to any and all contents of the investigative report at the R-6-10 meeting.
48. At both R-6-10 meetings, Complainant admitted that she should have communicated with Valenzuela regarding whether her medication administration privileges had been reinstated, prior to leaving Wiggins. She stated, "I used poor judgment that morning. I used very poor judgment. . . it was a terrible mistake and thank God that nothing happened to anybody, I've never denied using poor judgment. . . I know that morning I should have used better communication. . . ."
49. At both R-6-10 meetings, Complainant told Weiser that she had left the keys with Valenzuela prior to leaving Wiggins. At the first R-6-10 meeting, Weiser asked, "how could you even expect that Janis was going to be passing the medications"? Complainant answered, "Well when I left I left the keys with her. I didn't take them with me." At the second R-6-10 meeting, Weiser asked, "And then before leaving the home for grocery shopping you had the keys with you?" Trujillo answered, "No, I didn't take them. . . I left them with Janis."
50. In fact, Complainant did not leave the keys with Valenzuela when she left Wiggins. She left them in the drawer below the medication cabinet.
51. Weiser asked Complainant why she had used her personal vehicle after having been told not to do so following the December 2000 corrective action. Weiser said it "appears very suspicious." Her concern was that it appeared as though Complainant would use her own car to take groceries home.
52. Complainant stated that it was more convenience for her to use her own car rather than the state vehicle that had been available.

53. Weiser felt extremely concerned that Complainant had engaged in two significant acts of neglect in a five-month period. The December 2000 corrective action was for neglect of client funds and failure to adhere to auditing policies. The April 8 events constituted neglect under PRC's Abuse/Mistreatment, Neglect & Exploitation policy, wherein "neglect" is defined in part as "a failure to act by a person who is responsible for another person's well being so that inadequate . . . medical care or supervision is provided. This may include, but is not limited to, denial of . . . medication"

54. Weiser felt that Complainant was not handling her leadership responsibilities as DDT II. She saw a pattern of poor judgment.

55. On June 8, 2001, Weiser sent Complainant the letter demoting her to DDT I, explaining her reasons therefore in detail. The letter stated in part,

"The investigation concludes that your conduct on April 8, 2001 was neglectful. Specifically, you did not administer medication to the people within your charge, even though you had signed as accepting this responsibility. After further review, it was also found that you had left the medication keys unattended in a kitchen cabinet drawer, a practice that is not supported in the medication administration policy. During the R-6-10 discussion you claimed that you had left the keys with the assisting technician. The technician and reporting LPN both refute this claim. In fact, the technician who you claim you gave the keys to was on suspension and did not have the authority to pass medications. If you had attempted to give the keys to her she reports that she would have refused to accept them.

Additionally that morning you chose to go grocery shopping and use your personal vehicle instead of the state vehicle that was available. It is understood that employees use a state vehicle when available. You claimed that you knew this procedure but did not follow it that morning. You did not provide any explanation other than it was poor judgment. This practice was reviewed with you in December following a R-6-10 meeting of which it was determined that you mishandled clients["] personal funds and failed to adequately safeguard the money. . . The use of your personal vehicle was reviewed with you at that time. Your supervisor as well as yourself reports that you had a clear understanding of this protocol.

During our R-6-10 discussion you admitted to using poor judgment the morning of 4/8. You stated that it would not happen again. I presented my disappointment and confusion about your judgment because as recently as December you had received a corrective action as a result of

an R-6-10 meeting. The corrective action was issued because of poor judgment and failure to comply with the safeguarding of personal funds in addition to communicating and providing adequate feedback to employees about household routines and requests. You function within the home as a D.D. Tech II being responsible for the work leadership of others. The failure to pass medications after accepting this responsibility is unacceptable and neglectful.

DISCIPLINARY ACTION:

1. Due to your failure to perform competently as a DD Tech II I have decided to demote your status to DD Tech I. This action is effective June 8, 2001. your salary as of June 1 is \$2337, effective June 8 your new salary as DD Tech I will be \$2103.30. This decision is based on the serious nature of failing to pass medication to people within your charge, failing to comply with the practice of use of personal vehicle which was fully understood by you, continued failure to exercise good judgment in a leadership role, and failure to satisfy the terms of the corrective action dated 12/26/00 which states that your performance in the area of Leadership/Communication needed improvement. This falls below the expectation of consistent performance improvement as stated in the corrective action.
56. The letter also included a corrective action in the area of medication administration.
57. Complainant seeks rescission of the demotion, reinstatement to the DDT II position, back pay, and an award of attorney fees and costs. She does not challenge the corrective action.

DISCUSSION

In this *de novo* disciplinary proceeding, the burden is on the agency to prove by preponderant evidence that the acts or omissions on which the discipline was based occurred and that just cause warranted the discipline imposed. Department of Institutions v. Kinchen, 886 P.2d 700 (Colo. 1994). The Board may reverse or modify Respondent's decision only if the action is found to be arbitrary, capricious or contrary to rule or law. Section 24-50-103(6), C.R.S.

A. Complainant Committed Most of the Acts for Which She was Disciplined.

Complainant committed the acts for which she was disciplined with the exception of failing to satisfy the terms of the December 2000 Corrective Action. Paragraph two of

the demotion letter states in part, "The investigation concludes that your conduct on April 8, 2001 was neglectful. Specifically, you did not administer medication to the people within your charge, even though you had signed as accepting this responsibility. After further review, it was also found that you had left the medication keys unattended in a kitchen cabinet drawer, a practice that is not supported in the medication administration policy."

Complainant admits that she neglected to communicate with Valenzuela regarding medication administration prior to her departure to the grocery store. She had taken report from the DDT going off shift, and under Wiggins policy was required to have the medication keys in her possession at all times. In view of these facts, and her role as lead worker on the shift, it was her responsibility to assure that the 7:30 a.m. medications were given. Her failure to do so was neglectful and could have jeopardized the health of one or more of the residents.

Complainant argues that the fact she assumed Valenzuela had been reinstated to administer medications should mitigate against the seriousness of her neglect. The problem with this argument is that it doesn't account for the fact that Valenzuela assumed that Complainant had given the medications prior to her departure, as was her usual practice. Therefore, even if Complainant's assumption had been correct and Valenzuela could have administered the medications, Valenzuela still would not have done so after Complainant's departure.

Complainant's failure to take possession of the medication keys while receiving report, in violation of Wiggins policy, constitutes the most serious part of her neglect. If she had followed this policy, she would have had to hand the keys to Valenzuela when she left, and would have discovered at that time that Valenzuela was still under suspension from administering medications. She would then have given the 7:30 medications prior to her departure.

Notably, Complainant was not forthright about the medication keys in the R-6-10 meetings with Weiser. In those meetings, while she admitted to having neglected to communicate with Valenzuela on April 8, thereby causing the medication variance, she stated twice that she had given Valenzuela the medication keys prior to her departure. This was simply not true. Weiser stated in her disciplinary action letter, "During the R-6-10 you claimed that you had left the keys with the assisting technician. The technician and reporting LPN both refute this claim. In fact, the technician who you claim you gave the keys to was on suspension and did not have the authority to pass medications. If you had attempted to give the keys to her she reports that she would have refused to accept them." At hearing, Valenzuela testified that Complainant never gave her the keys before leaving Wiggins. Complainant herself presented no testimony on this issue. The only reasonable conclusion is that Complainant did not give her the keys.

Complainant's failure to be truthful to Weiser about the full extent of her

misconduct on April 8 is extremely significant, and constitutes conduct that would lead a reasonable appointing authority to question her leadership. The DDT II is a conduit between the line workers and management. Management must be able to trust the DDT II to provide accurate information about the DDT I's, whether the work is being completed, and all other issues regarding the functioning of the group home.

Complainant argues that the general climate at Wiggins was such that at least 50% of the time the staff failed to keep the medication keys on their person. She further argues that this practice posed no risk to residents because they lacked the cognitive skills to know how to use the key to access the medications. Lastly, she argues that blindly following policies to the detriment of the residents is not in their best interest.

The lead worker position is a role model for other employees. She is the individual who creates the "general climate" in the home. Complainant abdicated this leadership responsibility by assuming an attitude that because everyone else does it, I can do it too. Complainant's lax attitude about the medication key policy was directly responsible for her failure to assure that the 7:30 a.m. medications were administered on April 8. A general attitude of laxness toward work policies is especially problematic in the medical context, such as that at Wiggins, where the residents are completely at the mercy of the staff for their well-being.

While it may be true that a blind adherence to all policies is not appropriate in every situation, the facts of this case demonstrate conclusively that the medication key policy was a crucial component of assuring that Wiggins residents receive their medications on time. By requiring the medication technician to retain the key on his or her person at all times, the policy ensures accountability for medication administration. Complainant demonstrated a lack of good judgment in failing to recognize the importance of this policy. Weiser's decision to demote Complainant in part for her "continued failure to exercise good judgment in a leadership role" is therefore appropriate. (Page 2, disciplinary action letter).

It is noted that Complainant's advocacy on behalf of Wiggins residents, to modify the sleeping-in policy on weekends to improve their quality of life, demonstrates her positive leadership qualities. This advocacy was appropriately done in the open, in house meetings, with a supervisor present, and the resulting change in policy was approved by the chain of command. However, such advocacy is different from flagrantly violating existing policies without open discussion and prior approval by supervisors.

Respondent also disciplined Complainant for using her personal vehicle to go food shopping on April 8, 2001. Wiggins had no written policy prohibiting use of a personal vehicle when a state car was available. However, Weiser, as appointing authority, had directed Complainant not to do so. Complainant's failure to follow this directive constitutes insubordination and appropriately subjected her to either corrective

or disciplinary action. Given the fact that she had previously been corrected for having done so, it is not surprising that Weiser viewed this issue as an important one. The appointing authority need not have a written policy in place to render each of her directives enforceable². Here, Complainant concedes that she and other Wiggins employees were on notice that they were to use a state car if available.

Complainant argues that the vehicle policy was unfairly applied to her. The evidence refutes this claim. However, even assuming this were true, arguendo, the circumstances of Complainant's December 2000 corrective action reasonably led the appointing authority to place a high priority on this policy as it related to Complainant. It was well within the appointing authority's discretion to require Complainant to use state vehicles for state business when available, and to hold her accountable for violating this directive.

Page two of the disciplinary action letter indicates that Complainant was also disciplined in part for her "failure to satisfy the terms of the corrective action dated 12/26/00 which states that your performance in the area of Leadership/Communication needed improvement." Complainant had not demonstrated consistent performance improvement since her last evaluation. However, the December 2000 corrective action cannot form the basis for discipline of Complainant.

Nothing in the December 2000 Corrective Action stated that she had to improve her performance in the area of Leadership/Communication. The term "Leadership/Communication" appears nowhere in the document. It is undisputed that Complainant satisfied all four criteria in the section entitled, "Corrective Action(s) You Must Take for the Above Areas." In fact, the dates of completion are listed right next to the actions she was required to take. In the section entitled, "You Must Complete the Corrective Action(s) Listed Above by the Following Date(s)," Respondent had noted, "We will consider this action corrected if the reviews completed by your supervisor demonstrate consistent performance improvement." All four of the areas of improvement were specific to the "use of personal funds" procedures, audits, and development of a communication system to assure accurate tracking of such use of personal funds. This document did not put Complainant on notice that she had to improve in the "Leadership/Communication" performance factors in order to satisfy the corrective action.

It was inappropriate for Respondent to utilize an alleged failure to comply with the corrective action as a ground for demotion.

That said, it was certainly proper for Respondent to utilize the April 2001 performance evaluation on its face, and Complainant's failure to reach Fully Competent

² In a different situation, such as where notice of the policy is in dispute, the absence of a written policy could defeat the employer's claim of misconduct.

in the Leadership/Communication area, as one of the criteria it used in determining what discipline to impose. Board Rule R-6-6 requires that appointing authorities consider "previous performance evaluations" prior to imposing disciplinary action.

With the exception of violating the December 2000 corrective action, Complainant committed the acts for which she was disciplined.

B. The Discipline Imposed Was Within the Range of Alternatives Available to the Appointing Authority.

The above discussion makes it clear that the discipline imposed was within the range of alternatives available to the appointing authority. Complainant's conduct on April 8 revealed that she had an inappropriate attitude regarding policies, that she failed to take her leadership role seriously, and that she willingly engaged in insubordination, by driving her own car, if it was convenient for her. Overall, she demonstrated a lack of respect for authority, including her own.

As noted above, Complainant does have leadership qualities. She cares deeply about her residents' well-being and quality of life. By advocating for the weekend sleeping-in policy (allowing residents to sleep in instead of getting up very early on weekends) she demonstrated that she placed the residents' needs above her own interest of being popular among her co-workers. Complainant also initiated new policies of allowing staff on her shift to choose the tasks they performed, instead of imposing them on staff.

Unfortunately, these strengths had to be weighed against her clear disregard for her own leadership role, as well as for authority in general. Her actions demonstrated that she did not take her position as a role model seriously. In the end, management determined that it could not trust her in the leadership role of DDT II. The evidence supports this decision as a reasonable one.

C. Respondent's Action was Not Arbitrary, Capricious or Contrary to Rule or Law.

In *Van DeVegt v. Board of County Commissioners of Larimer County*, 55 P.2d 703 (Colo. 1936), the Colorado Supreme Court defined arbitrary and capricious agency action as:

(a) neglecting or refusing to use reasonable diligence and care to procure such evidence as it is by law authorized to consider in exercising the discretion vested in it; (b) failing to give candid and honest consideration of evidence before it on which it is authorized to act in exercising its discretion; or (c) exercising its discretion in such manner after a consideration of evidence before it as clearly to indicate that its action is based on conclusions from the evidence such that reasonable men fairly

and honestly considering the evidence must reach contrary conclusions. 55 P.2d at 705.

See *Lawley v. Dep't of Higher Education*, ____ P.3d ____ (Colo. No. 00SC473, December 3, 2001), slip opinion page 31, n.15.

Weiser gave serious consideration to all information she had available to her. She made an extra effort to assure that Complainant had a full opportunity to provide her with mitigating information to consider prior to deciding whether to impose discipline, by scheduling two R-6-10 meetings instead of one.

Complainant attempted to demonstrate that Weiser was somehow biased against her because she elected to initiate a full investigation (by the Department's in-house investigator) of the incidents of April 8, as opposed to simply handling it by herself. However, the evidence demonstrated that Weiser had information regarding alleged comments made by both Valenzuela and Complainant that indicated a potential effort to cover up what had truly occurred. It was therefore appropriate for Weiser to delegate the investigation to a professional. Weiser's ultimate conclusion, as articulately stated in her demotion letter, is fully supported by the evidence she had before her.

Complainant has presented no evidence that Respondent's action was arbitrary, capricious, or contrary to rule or law. While she argued that it was unfair for Respondent to deprive her of a copy of the investigative report during the pre-disciplinary process, she was permitted to fully review it with her representative present in a private room. Then, a second R-6-10 meeting was held to enable her to fully address the contents of the report. Complainant cites no rule or law that was violated by this agency practice.

CONCLUSIONS OF LAW

1. Complainant committed the acts for which she was disciplined;
2. The discipline imposed was within the range of available alternatives;
3. Respondent's action was not arbitrary, capricious or contrary to rule or law.

INITIAL DECISION

Respondent's action is affirmed. Complainant's appeal is dismissed with prejudice.

DATED this _____ day of
February, 2002, at
Denver, Colorado.

Mary S. McClatchey
Administrative Law Judge
1120 Lincoln Street, Suite 1400
Denver, Colorado 80203

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), C.R.S. 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. The notice of appeal must be received by the Board no later than the 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), C.R.S.; Rule R-8-58, 4 Code of Colo. Reg. 801. 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).

PETITION FOR RECONSIDERATION

A petition for reconsideration of the decision of the ALJ may 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. 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.

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 is responsible for having the transcript prepared. To be certified as part of the record, an original transcript must be prepared by a disinterested, recognized transcriber and filed with the Board within 45 days of the date of the designation of record. For additional information contact the State Personnel Board office at (303) 894-2136.

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 2 inch by 11 inch paper only. Rule R-8-64, 4 CCR 801.

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 R-8-66, 4 CCR 801. Requests for oral argument are seldom granted.

CERTIFICATE OF MAILING

This is to certify that on the ____ day of February, 2002, I placed true copies of the foregoing **INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE** in the United States mail, postage prepaid, addressed as follows:

Nora Nye, Esquire
AFSCME
3333 Quebec Street, Suite 7500
Denver, Colorado 80207

and in the interagency mail, addressed as follows:

Joseph Q. Lynch
Assistant Attorney General
Employment Law Section
1525 Sherman Street, Fifth Floor
Denver, CO 80203
