STATE OF WISCONSIN PERSONNEL COMMISSION

WILLIAM A. MCCREEDY,
Appellant,

v.

Secretary, DEPARTMENT OF CORRECTIONS,
Respondent.

Case No. 00-0038-PC

INTERIM DECISION AND ORDER

A hearing was held in the above-noted case on October 5, 6 and 9, 2000. The parties' request to file post-hearing briefs was granted with the final brief due on December 26, 2000. The Proposed Decision and Order was issued on February 26, 2001, with an opportunity to file objections. Neither party filed objections.

The Commission consulted with the hearing examiner and agrees with her credibility determinations. Changes were made to the proposed decision and order as highlighted herein by alpha footnotes.

The statement of the hearing issue was agreed to by the parties as shown below (see Conference Report dated May 16, 2000):

> Whether there was just cause for the equivalent three-day suspension/written reprimand to appellant dated April 11, 2000.
> Subissue: Was the degree of discipline imposed excessive?

FINDINGS OF FACT

1. The appellant worked for respondent as a Health Services Unit (HSU) Manager at Kettle Moraine Correctional Institution (KMCI).

2. The "sister institution" to KMCI is Taycheedah Correctional Institution (TCI). At all times relevant to this case, the HSU Manager position at TCI was vacant. Other staffing problems also existed as noted in Exh. R-109, pp. 31-32.[1] [A]

3. On January 10, 2000, Kristine Krenke, TCI Warden, asked the appellant if he would observe the HSU at TCI to assess how procedures worked and to make recommendations on how to improve efficiency. She wanted the HSU in as good condition as possible before a new HSU manager would be hired. She knew the appellant as an honest person. She respected his judgment and ability. The appellant obtained permission from his supervisor to do as Warden Krenke requested.

4. The appellant was at TCI on January 19, 27 and 28, 2000 observing the HSU operations in response to Warden Krenke's request.[B] One issue Warden Krenke brought to the appellant's attention was the fact that the HSU at TCI was issuing more medications to inmates. She told him that problems had occurred in that medicines were not always refilled timely.

5. Michelle Greer was an inmate at Dodge Correctional Institution (DCI). She had a variety of health problems including asthma. She transferred to TCI on or about January 5, 2000. On February 2, 2000, she suffered an asthma attack in the TCI dining room and died.

6.[C] Ms. Greer was on several medications, including multiple medications for asthma. When Ms. Greer transferred to TCI, DCI staffed informed TCI staff of the medications Ms. Greer was taking, including a nebulizer for her asthma. Medicine is placed in the nebulizer thereby generating a medicated mist to open airways and decrease secretions. TCI staff (not the appellant) failed to include the nebulizer information in Ms. Greer's TCI medical record (Exh. R-109, pp. 26 & 30). Also, Ms. Greer received no nebulizer treatments after her transfer to TCI. The parties refereed to these problems as "the nebulizer issue."

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[1] Exh. R-109 is the final report of the Ad Hoc Committee dated March 7, 2000. This Ad Hoc Committee investigated the death of Ms. Greer.

[A] This sentence was modified for clarification.

[B] This sentence was modified for clarification.

[C] Minor clarifying changes were made to this paragraph.

7. On February 2, 2000, the appellant was home on his day off. He received a page from Warden Krenke. She asked the appellant to come to TCI right away because an inmate died in TCI's dining room. He agreed although he was not obligated to do so.

8. The appellant arrived at TCI on February 2, 2000, and went to Warden Krenke's office. She gave him background information on what had occurred. Warden Krenke asked the appellant to expedite the process. The two of them reviewed respondent's internal management procedure (IMP) to be followed when an inmate dies (Exh. A-3).

9. The IMP on death has several tasks.[2] Tasks 5 through 7 were to be performed by the HSU Manager, as noted below. The appellant completed the tasks on February 2 and 3, 2000.

Tasks	Steps
5) The [HSU] will gather the original medical record, copies of all incident reports, and all autopsy reports.	5) All information will be forwarded to Central Office.
6) The [HSU] may arrange for Critical Incident Debriefing for staff involved.	6a) Deaths may be traumatic for staff. 6b) Coordinate with institution Critical Incident Stress Debriefing Team
7) The [HSU] and Sector Chief will review each death with unit staff.	7a) To allow staff the opportunity to determine if there was a pattern of symptoms which might have resulted in earlier diagnosis and intervention. 7b) To allow staff to review events immediately surrounding a death to determine if appropriate interventions were undertaken. 7c) Medical Record copy will be destroyed after review or 90 days, whichever is first. 7d) Mortality Review Form will be completed and sent to Central Office.

10. The information gathered at the institution is sent to respondent's Health Information Manager in the Bureau of Health Services. Ultimately the information is shared with

[2] The cited IMP on death procedure was rescinded by respondent prior to Ms. Greer's death. Respondent had not issued a replacement procedure prior to her death.

the Mortality Review Committee (MRC) for in-depth analysis and determination of whether the institution's procedures or practices need improvement.

11. Respondent imposed discipline for the appellant's performance of tasks 7a, 7b and 7d in the chart above.[3] The discipline was imposed by letter dated April 11, 2000 (Exh. R-101), which was signed by Dick Verhagen, Administrator of the Division of Adult Institutions. The letter stated as shown below (in relevant part):

> This letter shall serve as your notice of a written reprimand equal to and carrying the weight of a three-day suspension under the Fair Labor Standards Act (FLSA). Although these work rule violations warrant a three-day suspension, as an FLSA exempt employee, you cannot be suspended for less than a full work week increment (5 workdays).
>
> An investigatory meeting was held on March 27, 2000, at which Deborah Grant, BPHR[4], Colleen Jo Winston, BPHR, Dale Poliak, BHS[5], Jane Gamble, your representative and you were present. A pre-disciplinary hearing was held on March 28, 2000, at which Deborah Grant, BPHR, Colleen Jo Winston, BPHR, Dale Poliak, BHS, Tom Nickel, your representative and you were present. At both these meetings you were given an opportunity to respond to the allegations of misconduct and work rule violations.
>
> This disciplinary action is a result of your violations of the following Department of Corrections Work Rule:
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> Work Rule #A4. "Negligence in performance of assigned duties."
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> You were the [HSU] Director at [KMCI], and you were assigned to complete the Mortality Review Forms for an inmate death on 2/2/00 at [TCI]. You were negligent in the performance of your assigned duties when you:
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> 1. Failed to conduct an adequate review of the medical profile related to the 2/2/00 death of the inmate at [TCI]. You admitted to conducting only a cursory overview of the medical profile when completing the Mortality Review Form for the 2/2/00 death of an inmate at TCI. You did not include the nebulizer issue on the Mortality Review Form, although it was an issue which should have been included.

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[3] A copy of the mortality review form completed by the appellant is in the record as Exh. R-102.
[4] BPHR is an acronym for respondent's Bureau of Personnel and Human Resources.
[5] BHS is an acronym for respondent's Bureau of Health Services.

2. Failed to conduct an adequate review in order to accurately complete the Mortality Review Form relating to the 2/2/00 death of the inmate at TCI. You answered "None" to Question #18 on the Mortality Review Form, "What deviations were found from policies and procedures?" In the investigatory interview conducted on March 17, you admitted you did not review pertinent policies and procedures prior to answering this question. You also admitted that you did not talk to the nurses involved regarding the phone conversations they had with security staff about the inmate's request to be seen by HSU. You admitted your answer to this question should have been, "Unknown" based upon the knowledge that you had at the time you completed the form.

3. Failed to accurately complete the Mortality Review Form. By your own indication on the Mortality Review Form, you recognized that the emergency kit was not taken when responding to the emergency situation on 2/2/00. You did not indicate on the DOC Mortality Review Form at #18 that this deviation occurred.

The accurate completion of Mortality Review Forms is an important step in determining the appropriateness of institution medical actions related to an inmate death. Your failure to conduct an adequate review of the medical profile and adequately as well as accurately complete the Mortality Review Form justify the discipline imposed.

You are advised that any future violations of the Department's Work Rules may result in progressive discipline including a full work week suspension without pay, or other discipline, up to and including discharge.

[A]12. The appellant answered questions at the investigatory interview on March 17, 2000 (Exh. R-105). He made the following statements at the interview: a) he looked at the medical profile when he completed the Mortality Review Form but not in-depth (Exh. R-105, p., 6), b) he did not notice a current order for a nebulizer (Exh. R-105, p. 6), c) an order for a nebulizer would be significant (Exh. R-105, p. 6), d) he did not review the policies and procedures when he completed the Mortality Review Form (Exh. R-105, p. 4), e) he did not talk to the nurses about their phone conversations with security staff (Exh. R-105, pp. 7-8 & 10), f) his answer to question #18 should have been "unknown" (Exh. R105, p. 6), and g) he knew at

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[A] The extensive quote was deleted and replaced by relevant facts.

some point that a medical kit was not taken in response to the emergency call (Exh. R-105, pp. 7-9).

13. A special Ad Hoc Committee was formed at the request of DOC's Secretary. The Committee was assigned to review the events surrounding Ms. Greer's death. The Committee had all the pertinent medical records, incident reports and the mortality review form completed by the appellant. The Committee interviewed staff at TCI and the appellant. The Committee issued a final report on March 7, 2000 (Exh. R-109). The committee faulted TCI staff for failing to note Ms. Greer's need for a nebulizer in the medical records (Exh. R-109, pp. 26 & 30). The committee discussed the appellant's review (Exh. R-109, p. 33) and did not fault him for failing to note the nebulizer issue (the first reason for the imposed discipline). The appellant had attached the medical profile to his form from which others reading his report could have identified the nebulizer issue. The appellant had called Mr Courtney Greeley, RN and Chair of the MRC, and received his permission to attach documents to the form.

14. The Ad-Hoc Committee's concerns about the review conducted by the appellant and about respondent's system of review are noted below (Exh. R-109, p. 33):

> Nurse Review
> The committee interviewed a nurse who was helping at TCI [the appellant], and who reviewed Inmate Greer's medical care, leading up to her death, for TCI. The nurse said that in his opinion the death did not warrant an investigation based on other deaths which he had been involved with in both DOC and his previous employment as a nurse to the jails. The nurse advised the Committee that without knowing what was said in the phone calls between the Captain and the charge nurse, and the Sergeant and the second nurse, there would be no way to determine if the nurses had acted appropriately in the death of Inmate Greer. If it was inconclusive if the nursing staff had acted appropriately in Inmate Greer's death, the Committee believes that TCI should have asked for or completed an immediate investigation to determine if the nurses had acted appropriately. If there was a question of competency on a member or members of the nursing staff, this should have been investigated before nursing staff would place another inmate at risk. The investigation should have been conducted immediately before memories changed or faded. The nurse based his review, in part, upon the fact that he had worked with the nurses who were involved in this incident for several days prior to the incident, and believed that they were competent nurses.

Red Flags in Incident Reports

The incident reports contained several red flags. The descriptions of Inmate Greer's condition by the Captain, and several officers was that she was gulping for air, breathing deeply, having difficulty catching her breath, was stopping on her way from the Prescott dining hall to the max unit, a distance of 325 feet, should have alerted the reviewers that she was exhibiting signs of medical distress. The reviewers should have requested why Inmate Greer was not seen, particularly given her history of severe asthma. The incident reports by the nursing staff involved were vague regarding the events which occurred on 2/2/00, and the knowledge the nurses had of her pre-existing medical conditions. Also, a red flag would be why the Captain, Sergeant, and other officers did not believe that the physical symptoms, which they observed her exhibiting, were not medical emergencies. The incident reports also provide numerous inconsistencies in time regarding the events which occurred that morning, such as when the sergeant and the second nurse had the phone conversation. Why was inmate Greer allowed to leave the max unit if she had reported ten minutes earlier that she would not be able to walk to HSU? Other red flags are why the emergency medical kit and oxygen were not immediately taken to the scene. If the nurses were not notified of the serious nature of the incident, they should have been. Communications need to be improved in times of medical emergencies, and systems should be reviewed to ensure that is accomplished. Also, one nurse said to the other at the scene words to the effect, "I told you we should have seen her." This would all warrant further investigation.

The DOC MRC has medical expertise and reviews inmate deaths. However, the MRC only meets four times a year to review death cases. This would cause a substantial delay in determining if the nursing practices met standards. Waiting for the MRC's report before TCI determined the facts surrounding the incident would also diminish the chances for a complete and thorough investigation to take place as memories fade and evidence is lost. TCI did not ask the doctor on staff to review the medical decisions nor did it ask the DOC central office health services staff to give its opinion on the medical appropriateness of the treatment provided to inmate Greer.

Also, a review of the systems involved to make certain that they were adequate to respond in an emergency situation is necessary. Without a review of the systems, a problem with the system could lead to a negative outcome for an inmate. TCI did obtain incident reports from most of the staff involved in the incident the day of inmate Greer's death.

15. Courtney Greeley, RN, was Chair of the MRC. He called a special meeting of the committee regarding Ms. Greer's death as opposed to waiting for the next scheduled quar-

terly meeting. Mr. Greeley considers the mortality review form completed by a HSU manager to be a form of preliminary data gathering. The appellant would have been aware of Mr. Greely's opinion because the appellant had been a member of the MRC. Mr. Greely observed that there would be no need for the MRC if the HSU Manager's report were expected to be "gospel."

16. Dr. Daley also was a member of the MRC. He and Mr. Greeley completed the same mortality review form that complainant did as part of the MRC process (Exhs. A-36 & A-37) although they were not given much time to complete the task. They had access to documents from which the nebulizer issue could have been discerned, like complainant they failed to disclose the nebulizer issue, yet they were not disciplined for failing to identify the issue.

17. There have been deaths at institutions where the institution failed to complete a mortality review form for as long as 5-6 months after the death occurred. Within a few years prior to Ms. Greer's death, an inmate died at one of respondent's institutions. The HSU Manager never completed the form despite repeated requests from the MRC. No one was disciplined for these failures. Prior to the appellant's discipline, no DOC employee had been disciplined for how they completed a mortality review form or for failing to complete the form at all.

18. Respondent does not train its medical staff in how to complete a mortality review form.

19. The appellant had no prior disciplinary record.

CONCLUSIONS OF LAW[A]

1. The Commission has jurisdiction in this case pursuant to §230.44(1)(c), Stats.

2. Respondent failed to meet its burden of establishing that just cause existed for imposing discipline.

[A] The third conclusion in the proposed decision and order was deleted because it was not needed.

OPINION[A]

The appellant contends that the discipline imposed should be rejected because just cause did not exist within the meaning of §230.44(1)(c), Stats. The Commission agrees.

This type of case presents three questions. The first question is whether respondent has shown to a reasonable certainty, by the greater weight of the credible evidence, that complainant committed the conduct alleged in the letter of demotion. The second question is whether respondent has shown to a reasonable certainty, by the greater weight of the credible evidence, that the conduct proven under the first question constituted just cause for imposing discipline. The third question is whether the imposed discipline was excessive. *Reinke v. Personnel Board*, 53 Wis.2d 123, 137-8, 191 N.W.2d 833 (1971), *Hogoboom v. Wis. Pers. Comm.*, Dane County Circuit Court, 81-CV-5669, 4/23/84; *Jackson v. State Personnel Board*, Dane County Cir Court, 164-086, 2/26/79 and *Mitchell v. DNR*, 83-0228-PC, 8/3/84.

The disciplinary letter contained the following three conclusions (see ¶11, findings of fact):

> 1. Failed to conduct an adequate review of the medical profile related to the 2/2/00 death of the inmate at [TCI]. You admitted to conducting only a cursory overview of the medical profile when completing the Mortality Review Form for the 2/2/00 death of an inmate at TCI. You did not include the nebulizer issue on the Mortality Review Form, although it was an issue which should have been included.
>
> 2. Failed to conduct an adequate review in order to accurately complete the Mortality Review Form relating to the 2/2/00 death of the inmate at TCI. You answered "None" to Question #18 on the Mortality Review Form, "What deviations were found from policies and procedures?" In the investigatory interview conducted on March 17, you admitted you did not review pertinent policies and procedures prior to answering this question. You also admitted that you did not talk to the nurses involved regarding the phone conversations they had with security staff about the inmate's request to be seen by HSU. You admitted your answer to this question should have been, "Unknown" based upon the knowledge that you had at the time you completed the form.

[A] The discussion section was changed to reflect the full Commission's decision rationale

> 3. Failed to accurately complete the Mortality Review Form. By your own indication on the Mortality Review Form, you recognized that the emergency kit was not taken when responding to the emergency situation on 2/2/00. You did not indicate on the DOC Mortality Review Form at #18 that this deviation occurred.

Respondent established in regard to the first item above that the appellant did not conduct an in-depth review of the medical profile when he completed the Mortality Review Form and that he did not notice an order for a nebulizer. In regard to the second item respondent established that the appellant did not review policies and procedures when completing the form, did not speak with the nurses about their phone conversations with security staff and that he should have answered "unknown" to question 18 on the form. In regard to the final item respondent established that the appellant knew at some point that a medical kit was not taken in response to the emergency call. (See ¶12, Findings of Fact.)

The next question is whether respondent has shown to a reasonable certainty, by the greater weight of the credible evidence, that the conduct proven under the first question constituted just cause for imposing discipline. Just cause for imposing discipline is established when some deficiency has been demonstrated which can reasonably be said to have a tendency to impair the employee's performance of duties or the efficiency of the group where the employee works. *Safransky v. Personnel Board*, 62 Wis. 2d 462, 474 N.W.2d 379 (1974).

Respondent's explanation for imposing discipline was included in the disciplinary letter as shown below:

> The accurate completion of Mortality Review Forms is an important step in determining the appropriateness of institution medical actions related to an inmate death. Your failure to conduct an adequate review of the medical profile and adequately as well as accurately complete the Mortality Review Form justify the discipline imposed.

It is true that an accurate and thorough investigation after an inmate's death could benefit the efficiency of the work unit by identifying any deficiencies in the delivery of health care services if such deficiencies were brought to the attention of staff for correction. The problem with respondent's explanation for imposing discipline is that respondent failed to establish that com-

pletion of the form at all was important to the work of the institution. In fact, respondent had rescinded use of the Mortality Review Form, had not established replacement procedures and previously had not imposed discipline for failure to complete the form at all. Moreover (as noted in ¶16, Findings of Fact) a physician and another nurse also missed the nebulizer issue when reviewing the institution's records and they received no discipline.

The Commission concludes from the foregoing discussion that just cause did not exist for imposing discipline. Even if a contrary conclusion had been reached, the Commission would conclude that no discipline was warranted, as discussed below.

Factors to consider when determining whether the discipline was excessive (the third question noted in the prior paragraph) include: a) the weight or enormity of the employee's offense or dereliction, including the degree to which, under the *Safransky* test, it did or could reasonably be said to tend to impair the employer's operation; b) the employee's prior record; c) the discipline imposed by the employer in other cases; and d) the number of the incidents cited as the basis for discipline for which the employer has successfully shown just cause. See, for example, *Kleinsteiber v. DOC*, 97-0060-PC, 9/23/98. Key to this inquiry are the facts that respondent had never before disciplined an employee for the way a Mortality Review Form was completed or even for failing to complete a form and that the appellant had no prior disciplinary record. These facts coupled with matters discussed previously lead the Commission to conclude that no form of discipline was appropriate here.

ORDER

Respondent's action of imposing discipline is rejected. The Commission retains jurisdiction for the questions of remedy and attorneys' fees and costs.

Dated: April 4, 2001

STATE PERSONNEL COMMISSION

Laurie R. McCallum /pm
LAURIE R. McCALLUM, Chairperson

Judy M. Rogers
JUDY M. ROGERS, Commissioner

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