STATE OF WISCONSIN PERSONNEL COMMISSION

MICHAEL BRICE,
Petitioner,

v.

Secretary, DEPARTMENT OF CORRECTIONS,
Respondent.

Case Nos. 00-0136-PC-ER, 00-0172-PC

FINAL DECISION AND ORDER

These matters are before the Commission after a hearing and the submission of post-hearing arguments. The parties agreed to the following statement of issues for hearing:

> Case No. 00-0136-PC-ER
> Whether complainant was retaliated against by respondent for engaging in protected fair employment activities in regard to the 5-day suspension without pay imposed by letter dated October 2, 2000, or in regard to the termination of his probationary appointment to a Supervising Officer 1 position imposed by letter dated October 3, 2000.
>
> Case No. 00-0172-PC
> Whether there was just cause for respondent's 5-day suspension of appellant without pay imposed by letter dated October 2, 2000.

A proposed decision and order was issued on July 3, 2001 Petitioner filed objections to the proposed decision. The Commission has adopted the proposed decision and added certain language to better clarify the basis for the decision. Those changes to the proposed decision are identified by alphabetical footnotes.

FINDINGS OF FACT

1 By letter dated October 2, 2000, respondent notified petitioner that he was being suspended for 5 days for violation of DOC Work Rules 1 and 4, commencing on October 9, 2000, and running through October 13, 2000. The letter (Resp. Exh. 116, p. 2) stated, in part:

> Work Rule 1 reads, "Insubordination, disobedience, or failure to carry out assignments or instructions."
> Work Rule 4 reads, "Negligence in performance of assigned duties."
>
> This action is being taken based on the following incident. On June 6, 2000 you were contacted to respond to an asthmatic inmate. Upon arriving you failed to take appropriate medical action as a First Responder and proceeded to secure the inmate for movement to TLU. This inmate had a severe asthma attack that required the inmate to be Med Evac'd to UW Hospital. Your failure to follow FLCI [Fox Lake Correctional Institution] Medical First Responder Program procedures (413.01) caused a potentially life threatening situation to occur

2. By letter dated October 3, 2000, respondent notified petitioner he was being removed from his Supervising Officer 1 position, effective October 15, 2000, "due to your failure to meet probationary standards." Attached to the letter was complainant's Performance Planning and Development report. That report included the following language:

> Lt. Brice has lost the confidence of the Correctional Officers under his supervision. Several Officers have complained about Lt. Brice's inappropriate comments or demeaning language. Lt. Brice's handling of crisis situations has come into question over his handling of the incident involving inmate Rainey
>
> Lt. Brice's supervision of inmates has been investigated and his decision-making skills have seriously jeopardized the health of an inmate with a severe asthmatic attack while removing him to TLU.
>
> Lt. Brice has made inappropriate comments to an individual he supervises.
>
> The actions of Lt. Brice involving an asthmatic inmate resulted in a very serious medical situation resulting in the inmate being Medavac'd [sic] to UW Hospital.

3. Fox Lake Correctional Institution (FLCI) is a medium security correctional institution operated by respondent. It includes separate housing units where inmates have a key to their own room.

4. The Segregation Unit at FLCI is a separate housing unit. In contrast to the rest of the institution, inmates in the Segregation Unit are in locked, secure cells, and are always in restraints when they are not in their cells.

5. Inmates can be placed into the Segregation Unit for disciplinary reasons. In addition, respondent's administrative rules provide that an inmate may be transported to the Segregation Unit for Temporary Lock-up (TLU). Placement in Temporary Lock-up is not a disciplinary action but is an action to separate the inmate from others, and to protect the inmate as well as staff.[A] Pursuant to §DOC 303.11, Wis. Adm. Code:

> (4) The institution may place an inmate in TLU and keep the inmate there if the decision-maker believes that one or more of the following is present:
> (a) If the inmate remains in the general population, the inmate may impede a pending investigation or disciplinary action.
> (b) If the inmate remains in the general population, it may be disruptive to the operation of the institution.
> (c) If the inmate remains in the general population, it may create a danger to the physical safety of the inmate or another
> (d) If the inmate remains in the general population, it may create a danger that the inmate will try to escape from the institution.

6. FLCI has a Health Services Unit (HSU) housed on the third floor of the Education unit. Respondent staffs the HSU with one or more nurses on the 1st and 2nd shifts and a physician on 1st shift. It is not staffed on the night shift, i.e. 10:00 p.m. to 6 a.m. During the time of the incident that is in question in these proceedings, (5:00 p.m. on June 16, 2000) the doctor was on leave and Nurse Wendy Vick was the only nurse at the institution.

7 The Control Center (sometimes referred to as "Control") is a separate building at FLCI that houses the various communication systems (paging, telephone, radio) for the institution.

8. Fox 21 and 22 are mobile patrol positions at FLCI that are staffed by security officers who are assigned to vehicles.

[A] This sentence has been rewritten for purposes of clarification.

9. The FLCI Control Center is located immediately inside the perimeter and slightly east of the northwest corner of the institution. The chapel is approximately 100 yards south of the Control Center. The Segregation Unit building is about 50 yards southwest of the chapel while the building housing the HSU is 100 yards southeast of the chapel. The Segregation Unit building is about 100 yards east of the HSU. Housing Unit 5 is about 200 yards southeast of the HSU. (Resp. Exh. 102)

10. During the evening shift on June 16, 2000, Capt. McClelland was the shift commander at FLCI. At that time, Dennis Meyer was the Security Director, Steve Beck was the Deputy Warden, and Thomas Borgen was the Warden. All wardens of the institutions within DOC's Division of Adult Institutions are supervised by Marianne Cooke, who, in turn, is supervised by Dick Verhagen, the Administrator of the Division of Adult Institutions.

11. Michael Marx was hired as FLCI's Human Resources Director during the first week in August of 2000.

12. In April of 2000, the petitioner was promoted from sergeant to lieutenant (Supervising Officer 1) at FLCI. Petitioner was still in his probationary period when respondent imposed the discipline that is the subject of these proceedings.

13. If no captain is present on the shift, the lieutenant can be in charge of the security for the institution. A lieutenant fields complaints from inmates and staff and can conduct investigations. It is a supervisory position. It is important that subordinates have confidence in a lieutenant.

14. Two of petitioner's female subordinates were Sgt. Cindy Homann and Officer Friday.

15. In June of 2000, Sgt. Homann filed an internal complaint with FLCI claiming that petitioner had sexually harassed her on two separate occasions. One of the instances was when Sgt. Homann had a cold and petitioner said that he was a First Responder and had a responsibility to rub Vicks on her chest. The second occasion was during a discussion about a job assignment that Sgt. Homann said she didn't recall

how to do. Petitioner responded: "Oh, it is just like having sex, you have to do it repeatedly to get good at it."

16. Respondent conducted an investigation of Sgt. Homann's allegations. Respondent concluded that petitioner's comments constituted sexual harassment. It was recommended that Warden Borgen give petitioner a written reprimand. Warden Borgen elected not to issue a written reprimand because respondent's policy was to terminate the probation of any employee serving a probationary period when that employee received a written reprimand or more severe discipline. Warden Borgen decided to impose a less formal and substantial level of discipline. He met with petitioner and orally reprimanded him.

17 Sgt. Homann and Correctional Officer Friday subsequently filed additional harassment complaints against petitioner Respondent investigated the allegations and concluded the incidents did not rise to the level of harassment.

18. FLCI provides a First Responder program for the inmates of the institution. The program is premised on the following policy:

> It is the intent of this program to provide emergency care for all medical and trauma emergencies regardless of status, gender, age, race, ethnic origin, or religious orientation. This program is in no way intended to take the place of normal Health Services operations within the institution, rather it is intended to augment this system by being able to provide rapid intervention of potentially life threatening, and acute, non-life threatening situations. This service is especially important during times when Health Services staff is not on site. (Pet. Exh. 11)

19. The First Responder program is staffed strictly by volunteers. There are approximately 12 to 14 First Responders at FLCI. Petitioner started volunteering as a First Responder early in 1999.

20. If a medical emergency occurs at FLCI when staff from the HSU are present, the First Responder and HSU staff both respond. However, the HSU is called first, and the First Responder is contacted second and serves as an adjunct and for learning/assessment purposes. (Resp. Exh. 116, p. 42) Typically the First Responder will reach the scene more quickly Under those circumstances, the First Responder

will do the initial assessment and, when the nurse arrives, there is a verbal communication and the nurse takes over

21 First Responders receive 40 hours of initial training and 18 hours of refresher training every 24 months. Training includes basic lifesaving, CPR, basic medical terms, taking pulse, checking if the individual is breathing, applying pressure to a wound, defibrillators and using oxygen.

22. Respondent maintains a First Responder bag in the Control Center The First Responder is supposed to either pick up the bag from the Control Center before reporting to the site of the medical problem, or have a patrol officer pick up the bag from the Control Center and deliver it so that it arrives at the same time as the First Responder

23. Effective May 18, 2000, respondent issued an updated version of the portion of its Policy and Procedures Manual dealing with the Medical First Responder Program (Comp. Exh. 11). The update included the following language:

> VIII Activation of Medical First Responders when HSU is onsite.
> A. When a perceived medical emergency exists in the institution, staff will call HSU with client name, location and description of the problem.
> B. Staff will then notify Control of the [medical] problem and Control will arrange transportation of HSU staff as needed. A Medical First Responder will also be activated and directed to the scene by Control.
> C. HSU staff will be in control of the "medical" aspect of the scene until the client is stabilized or transported out of the institution.
> D. The original reporting staff member, as well as the activated Medical First Responder, will produce documentation of the incident to Security and HSU using the appropriate forms.

24. In early February of 2000, Michelle Greer, an inmate at respondent's Taycheedah Correctional Institution, died as a consequence of an asthma attack. Respondent received significant adverse publicity from that incident. There was a series of newspaper articles and a legislative audit of the health care that is provided at correctional institutions. Respondent also carried out an internal review The entire correctional system was in a state of heightened awareness regarding the medical wellbeing of inmates as a consequence of Inmate Greer's death.

25. At all relevant times, petitioner was aware of the Greer incident.

26. On June 16, 2000, two FCLI inmates were suspected of meeting two outside visitors in a wooded area outside of the institution. Staff searched the wooded area during 1st and 2nd shifts on June 16th Resp. Ex. 113, p. 40.

27 At all times relevant to this proceeding, Courtney Rainey was an inmate at FLCI. Inmate Rainey suffered from exercise-induced asthma and had been prescribed both an inhaler, which is portable, and a nebulizer, which is plugged into a wall. Nurse Vick had experience treating Inmate Rainey's asthma. She had told him not to exercise. On June 6, 2000, Inmate Rainey was transported via med-flight for hospitalization due to his asthma.

28. Inmate Rainey had a history of disobeying orders. He was assigned to Housing Unit 5.

29. At approximately 3:00 p.m. on June 16, 2000, Inmate Rainey reported to Sgt. Engel, who was the officer on duty in Housing Unit 5, that he was having an asthma attack, with difficulty in breathing and some chest pains. Sgt. Engel arranged to have Inmate Rainey transported by Officer Kroll to the HSU Resp. Exh. 113, p. 18.

30. Nurse Vick examined Inmate Rainey at the HSU She listened to his breathing and noted that he had "mild" wheezing on exhalation in his lower lobes. Resp. Exh. 113, p. 22. He had already used his nebulizer The nurse started him on Theophylline, a long-term drug regimen.

31 Inmate Rainey returned to Housing Unit 5.

32. At approximately 5:00 p.m., Inmate Rainey again approached Sgt. Engel, said his asthma attack was worse and that he was having a real problem getting his breath. Resp. Exh. 113, p. 19. Sgt. Engel could tell that Inmate Rainey was having problems getting his breath. Resp. Exh. 113, p. 49. Sgt. Engel tried to call the HSU but the line was busy

33. Sgt. Engel then called the Control Unit and asked for a First Responder because of Inmate Rainey's condition. He also told Control to notify the HSU and a supervisor about the problem. Resp Exh. 113, p. 19.

34. Sgt. Engel kept Inmate Rainey sitting in the sergeant's office on Housing Unit 5 in order to keep an eye on him.

35. The Control Unit contacted petitioner, who was at the chapel, and told him to report to Housing Unit 5, as First Responder, for Inmate Rainey.

36. At that time, petitioner was unaware that Inmate Rainey had been seen by the HSU earlier in the day about his asthma.

37 Sgt. Engel also notified Sgt. Ramsey that a lieutenant and First Responder was en route to Housing Unit 5 because an inmate was having an apparent asthma attack and was having difficulty breathing. Sgt. Engel told Sgt. Ramsey that the inmate had a history of asthma attacks and would probably need to go to the hospital. Resp. Exh. 113, p. 16.

38. Before he reached Housing Unit 5, petitioner spoke with Officer Gravunder by radio, told him that Inmate Rainey was having problems breathing and told him to stand by in case petitioner needed the First Responder bag which was kept in the Control Building. Resp. Exh. 113, p. 6. Officer Gravunder was one of at least two mobile patrol officers on duty.

39. While petitioner was en route to Housing Unit 5, he encountered Officer Kroll, a second mobile patrol officer on duty. Officer Kroll informed petitioner that earlier in the day, at 3:00 p.m., she had taken Inmate Rainey to see the HSU nurse (Resp. Exh. 113, p. 14) and that Officer Kroll had later seen him running on the institution's track.

40. As soon as petitioner heard this, which was before he reached Housing Unit 5, he decided to place Inmate Rainey into TLU.

41. Sgt. Ramsey arrived at Housing Unit 5 and observed Inmate Rainey sitting in Sgt. Engel's office, bent over and taking short breaths. Both Sgt. Ramsey and

Sgt. Engels assured inmate Rainey that proper contacts had been made, he should try to relax and remain calm. Resp. Exh. 113, p. 16.

42. When she arrived with petitioner at Housing Unit 5, Officer Kroll observed that Inmate Rainey was having trouble breathing. Resp. Exh. 113, p. 15. She noticed that inmate Rainey was uncomfortable and "rattling" in his chest.

43. When petitioner arrived at Housing Unit 5, Sgt. Engel told him that Inmate Rainey was having an asthma attack and that it was worse this time than Sgt. Engel had ever seen before.

44. Petitioner immediately told Inmate Rainey that he was going to TLU because he had been running. Resp. Exh. 113, p. 64. Petitioner told Inmate Rainey to stand up and told Sgt. Engel to pat-search him and place him in handcuffs. This all occurred before petitioner did any type of medical assessment of Inmate Rainey.

45. Handcuffing an inmate and taking him to TLU will generate anxiety for the inmate.

46. Inmate Rainey told petitioner that he was having an asthma attack and that being placed in the Segregation Unit would make it worse. Resp. Exh. 113, p. 19. Inmate Rainey became upset with petitioner's order.

47 Sgt. Engel was unaware petitioner was at Housing Unit 5 in a First Responder capacity. Resp. Exh. 113, p. 49. Sgt. Engel called HSU a second time and reached Nurse Vick who was in the pharmacy. Sgt. Engel told her that Inmate Rainey was worse, was having problems breathing and that she should see him. At that time petitioner came on the line and said that Inmate Rainey had been seen running at the track and, as a consequence, he was going to be taken to TLU. Petitioner told Nurse Vick that if she wanted to see Inmate Rainey, she would have to see him in Segregation because that was where he was taking him. He hung up the phone on Nurse Vick.

48. Based on what Sgt. Engel had told her, Nurse Vick believed Inmate Rainey was having an asthma attack.

49. Petitioner told Officer Kroll to secure all wings on Housing Unit 5, to go to Inmate Rainey's room and collect his medications, and to take them to the Segregation Unit.

50. About 5:10 p.m., petitioner contacted Officer Gravunder by radio and directed him to come to Housing Unit 5. Officer Gravunder asked if he should bring the First Responder bag but petitioner did not reply. Resp. Exh. 113, p. 6.

51. When Officer Gravunder arrived at Housing Unit 5 (without the First Responder bag), petitioner was escorting Inmate Rainey towards the front door of Housing Unit 5. Inmate Rainey said he couldn't breathe and repeated, "I am going to die, don't let me die." Inmate Rainey resisted petitioner's order to get into the transport vehicle.

52. It took a couple of minutes to transport Inmate Rainey to the Segregation Unit. While they were in the jeep, petitioner told him to calm down and take deep breaths. Resp. Exh. 113, p. 7

53. Nurse Vick arrived inside the Segregation Unit just before the transport vehicle pulled up to the front of the building.

54. As Inmate Rainey was escorted from the vehicle, he collapsed onto his knees and urinated and defecated at the same time. This loss of muscle function is a symptom of impending death. Nurse Vick tried to treat Inmate Rainey in the building's vestibule where he had collapsed, but petitioner refused to let her do so.

55. Two officers carried Inmate Rainey into an observation room about 50 feet from the entrance to the building and lifted him onto the bed. His restraints were removed. His skin was cold and clammy and his fingers and lips had turned blue, indicating cyanosis. Inmate Rainey was not breathing, although he did have a pulse.

56. Nurse Vick gave Inmate Rainey a shot of epinephrine in his right thigh. She called for an ambulance and directed Officer Kroll to get some oxygen.

57 Inmate Rainey responded to the epinephrine. He was taken by ambulance to the Waupun Memorial Hospital. Shortly thereafter, he was transported via med-flight to University of Wisconsin Hospital and Clinics in Madison.

58. Various individuals filed written reports with FLCI regarding one or more aspects of the June 16th incident involving Inmate Rainey. Unless otherwise indicated, management at FLCI reviewed the reports and concluded that staff conduct described in the report was consistent with existing procedure.

a. Petitioner filed two incident reports, an accident report and an adult conduct report.

b. Officer Mary Kroll filed an incident report.

c. Sgt. Ramsey filed an incident report.

d. Sgt. Engel filed an informational incident report.

e. Officer Gravunder filed an incident report.

f. Nurse Vick completed a climate report in which she stated it was inappropriate, given the medical emergency, that Inmate Rainey was moved from his housing unit to the Segregation Unit. She stated that Inmate Rainey should have been brought to HSU or she should have been allowed to evaluate him at his Housing Unit. The report was prepared on a computer, was inadvertently destroyed by another nurse and never reached management.

59. On June 23, 2000, the Warden's Office at FLCI received a letter from Inmate Rainey. The letter included the following language:

> [A]s a first responder, Lt. Brice, did not have a first aid kit to treat my attack. There was lack of judgment on Lt. Brice, because my attack got worse, to where I had to be [taken] out by ambulance. He wrote me a conduct report for disobeying orders, and disruptive conduct. I did not disobey any orders and I did not be disruptive, because I have no reason [to] and I was having a asthma attack at the time. I hope you can look into this matter. . He should have been treating my attack first instead of placing me on T.L.U. Mr Warden, can you check into this matter and let your fellow officers know to deal with matters more [professionally].

60. On approximately August 30, 2000, Cindy O'Donnell, respondent's Deputy Secretary, received information about the incident involving Inmate Rainey. Ms. O'Donnell asked Marianne Cooke to look into the matter. Ms. Cooke brought the incident to the attention of Dick Verhagen and sent an e-mail to Warden Borgen at

FLCI, asking him to review the Incident Report filed by Officer Gravunder Warden Borgen asked Deputy Warden Steve Beck to track down the report. Until then, Warden Borgen had only seen the shift report from the day of the incident and Mr Beck was unaware of the incident.

CONCLUSIONS OF LAW

1 Case No. 00-0136-PC-ER is properly before the Commission pursuant to §230.45(1)(b), Stats.

2. Petitioner has the burden in Case No. 00-0136-PC-ER to show that he was retaliated against for engaging in protected fair employment activities as alleged.

3. Petitioner has failed to sustain this burden in Case No. 00-0136-PC-ER.

4. Case No. 00-0172-PC is properly before the Commission pursuant to §230.44(1)(c), Stats.

5. Respondent has the burden in Case No. 00-0172-PC to show that there was just cause for the subject discipline and that such discipline was not excessive.

6. Respondent has sustained these burdens in Case No. 00-0172-PC.

OPINION

I. Case No. 00-0136-PC-ER

Under the Wisconsin Fair Employment Act (FEA), the initial burden of proof is on the complainant to show a prima facie case of retaliation. If complainant meets this burden, the employer then has the burden of articulating a non-discriminatory reason for the actions taken which the complainant may, in turn, attempt to show was a pretext for retaliation. *McDonnell Douglas v. Green*, 411 U.S. 792, 93 S. Ct. 1817, 5 FEP Cases 965 (1973), *Texas Dept. of Community Affairs v. Burdine*, 450 U.S. 248, 101 S. Ct. 1089, 25 FEP Cases 113 (1981).

To establish a prima facie case in the retaliation context, there must be evidence that 1) the complainant participated in a protected activity and the alleged retaliator was aware of that participation, 2) there was an adverse employment action, and 3) there is

a causal connection between the first two elements. A "causal connection" is shown if there is evidence that a retaliatory motive played a part in the adverse employment action.

The Fair Employment Act's prohibition against retaliation is set forth in §111.322, Stats.[1] Petitioner contends he engaged in the following protected activities:

a. He protested the results of a union election by filing a complaint with AFSCME International.

b. He participated in the sexual harassment investigation initiated by Sgt. Cindy Homann. This allegation relates to Sgt. Homann's second and third complaints about petitioner but not the first.

c. He carried out his duties as a Supervising Officer 1 when he provided job counseling to Sgt. Homann. According to petitioner, it was immediately after petitioner provided the job counseling that Sgt. Homann filed her complaints about petitioner's conduct.

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[1] The statute provides, in part:

> Subject to ss. 111.33 to 111.36, it is an act of employment discrimination to do any of the following:
>
> (2m) To discharge or otherwise discriminate against any individual because of any of the following:
>
> (a) The individual files a complaint or attempts to enforce any right under s. 103.02, 103.10, 103.13, 103.28, 103.32, 103.455, 103.50, 104.12, 109.03, 109.07, 109.075 or 146.997 or ss. 101.58 to 101.599 or 103.64 to 103.82.
>
> (b) The individual testifies or assists in any action or proceeding held under or to enforce any right under s. 103.02, 103.10, 103.13, 103.28, 103.32, 103.455, 103.50, 104.12, 109.03, 109.07, 109.075 or 146.997 or ss. 101.58 to 101.599 or 103.64 to 103.82.
>
> (c) The individual files a complaint or attempts to enforce a right under s. 66.0903, 103.49 or 229.8275 or testifies or assists in any action or proceeding under s. 66.0903, 103.49 or 229.8275.
>
> (d) The individual's employer believes that the individual engaged or may engage in any activity described in pars. (a) to (c).
>
> (3) To discharge or otherwise discriminate against any individual because he or she has opposed any discriminatory practice under this subchapter or because he or she has made a complaint, testified or assisted in any proceeding under this subchapter

Earlier in the proceeding, petitioner also alleged that the disciplinary action that is the subject of Case No. 00-0136-PC-ER was in retaliation for a prior complaint of discrimination he filed with the Personnel Commission, Case No. 99-0017-PC-ER. However, he withdrew that contention during the course of the hearing.

Respondent takes the position that petitioner is barred from pursuing a retaliation claim based on item c. because he failed to articulate/identify such an allegation when he was given the chance to do so during a deposition. It is unnecessary for the Commission to rule on this argument because the activities described by the petitioner do not constitute protected activities under the Fair Employment Act.

Petitioner's alleged protected activities are unrelated to the purposes of the Fair Employment Act, and they fall outside the scope of §§111.322(2m) and (3), Stats. Complainant was the *subject* of the harassment complaint filed by Sgt. Homann. He was not the complaining party Sgt. Homann's conduct of filing the complaint would be a protected activity, but petitioner's action of being subjected to an investigation is not. According to the theory implicit in petitioner's allegation, an employer that had received a sexual harassment complaint filed by Employee A about the conduct of Employee B and had investigated Employee B's conduct would be barred from disciplining Employee B because to do so would constitute illegal retaliation for having participated in the sexual harassment investigation. Petitioner's theory would tie the employer's hands, and would generate a result that is totally inconsistent with the Fair Employment Act goal of eliminating discrimination. The Commission also notes that Sgt. Homann's conduct/motivation in filing several complaints against petitioner is not at issue here. Whether Sgt. Homann's complaints were well-founded or unfounded, the Commission's focus is on the motivation for respondent's decision to terminate the petitioner's probationary period as a lieutenant, and to impose the 5 day suspension.

Because the petitioner has failed to show that he engaged in any activities that are protected under the Fair Employment Act, his complaint of retaliation must be dismissed.[2]

In his objections to the proposed decision, petitioner contends that it was improper for respondent to rely on the incident involving Sgt. Homann as part of the probationary termination decision as long as he had previously been counseled for the same incident. Petitioner's contention is inconsistent with the concept of progressive discipline. It is also important to remember that the Commission is reviewing the probationary termination decision in terms of whether the respondent violated the Fair Employment Act, and not in terms of whether there was just cause for the termination decision.[B]

II. Case No. 00-0172-PC

The issue in this matter is whether there was just cause for respondent's action of suspending the petitioner from employment for a period of 5 days. The Commission does not address whether there was just cause for respondent's subsequent action of terminating petitioner's probationary employment as a Supervising Officer 1.[C]

The standards applied by the Commission in discipline cases were recently set forth in *Warren v. DHFS*, 98-0146-PC, 98-0164-PC-ER, 2/9/2001

> The two-step analysis for disciplinary cases was discussed by the Commission in *Barden v. UW-System,* 82-237-PC, 6/9/83, as follows:
>
> > First the Commission must determine whether there was just cause for the imposition of discipline. Second, if it is concluded that there is just cause for the imposition of discipline, the Com-

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[2] Even if petitioner had established a prima facie case of retaliation, the record indicates the respondent was motivated by its conclusion that it needed to discipline petitioner for his misconduct, and was not motivated by any of the alleged protected activities identified by the petitioner.

[B] This paragraph has been added for the purpose of clarifying the Commission's rationale.

[C] A just cause analysis of the probationary termination decision would be beyond the scope of the issues for hearing and would also extend beyond the Commission's jurisdiction. *Board of Regents v. Wisconsin Personnel Commission*, 103 Wis. 2d 545, 309 N.W.2d 366 (Ct. of App., 1981)

> mission must determine whether under all the circumstances there was just cause for the discipline actually imposed. If it determines that the discipline was excessive, it may enter an order modifying the discipline. (citations omitted.)

> The just cause standard was described in *Barden*, relying on the Wisconsin Supreme Court case of *Safransky v. Personnel Board,* 62 Wis.2d 464, 215 N.W.2d 379 (1974), as follows:
>
> > one appropriate question is whether some deficiency has been demonstrated which can reasonably be said to impair his performance of the duties of his position or the efficiency of the group with which he works. (citations omitted.)
>
> If just cause is shown, the focus of the inquiry shifts to the question of whether the discipline imposed was excessive. Some factors which enter into this determination include 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; the employee's prior record (*Barden v. UW*, 82-237-PC, 6/9/83); the discipline imposed by the employer in other cases (*Larsen v. DOC*, 90-0374-PC, 5/14/92); and the number of the incidents cited as the basis for discipline for which the employer has successfully shown just cause (*Reimer v. DOC*, 92-0781-PC, 2/3/94). *Kleinsteiber v. DOC,* 97-0060-PC, 9/23/98.

The underlying questions in an appeal of a disciplinary action are: 1) whether the greater weight of credible evidence shows that petitioner committed the conduct alleged by respondent in the letter of discipline; 2) if so, whether the greater weight of the credible evidence shows that such conduct constitutes just cause for the imposition of discipline; and 3) whether the level of discipline imposed was excessive. *Mitchell v. DNR*, 83-0228-PC, 8/30/84. In determining whether the decision to suspend the petitioner and not to impose some lesser discipline was excessive, the Commission cannot second guess the employer, and render its own independent decision in the matter, but can only examine the record to determine whether the action taken was excessive. *Ruff v. State Investment Board*, 80-105-PC, etc., 8/6/81.

A. Did the petitioner commit the conduct alleged in the letter of suspension?

The Commission's analysis must be based on the language in the letter of discipline. Misconduct for which an appellant was not charged in the letter of suspension cannot serve as the basis for discipline. *Powers v. UW*, 88-0029-PC, 5/10/90; affirmed by Dane County Circuit Court, *Powers v. Wis. Pers. Comm.*, 90 CV 3023, 2/12/91. In the present case, the relevant language is as follows:

> Work Rule 1 reads, "Insubordination, disobedience, or failure to carry out assignments or instructions."
> Work Rule 4 reads, "Negligence in performance of assigned duties."
>
> This action is being taken based on the following incident. On June 6, 2000 you were contacted to respond to an asthmatic inmate. *Upon arriving you failed to take appropriate medical action as a First Responder and proceeded to secure the inmate for movement to TLU.* This inmate had a severe asthma attack that required the inmate to be Med Evac'd to UW Hospital. *Your failure to follow FLCI Medical First Responder Program procedures (413.01)* caused a potentially life threatening situation to occur. (Emphasis added.)

The only misconduct alleged in the letter is petitioner's action as a First Responder and, more specifically, his alleged failure to "take appropriate medical action [before petitioner] proceeded to secure the inmate for movement to TLU." According to the letter, petitioner's conduct constituted 1) a failure to carry out assignments or instructions, 2) negligence, and 3) a failure to follow the First Responder procedures in §413.01 of FLCI's Policies and Procedures Manual. During the hearing and in its post-hearing briefs, respondent addressed some additional aspects of petitioner's conduct relating to the Inmate Rainey incident.[3] However, the Commission rejects respondent's suggestions that petitioner should be disciplined for his conduct after Inmate Rainey was se-

[3] For example, Marianne Cooke testified that she was concerned about 3 aspects relating to petitioner's judgment: 1) his response to the trouble call; 2) how it was handled when they got to the Segregation Unit (i.e. petitioner's action of refusing to allow Ms. Vick to treat Inmate Raney in the vestibule of the Segretation Unit); and 3) a delay in receiving a report from Officer Gravunder (where the delay was allegedly because complainant had told Officer Gravunder not to file a report). Unofficial Tr., p. 117.

cured for movement to TLU because it would extend beyond the limits of the conduct described in the letter of discipline.

The record shows that petitioner failed to serve as a First Responder with respect to Inmate Rainey. Once he was told that Inmate Rainey had been exercising contrary to the directive of the HSU, petitioner immediately decided to place him in TLU. Petitioner never conducted a medical assessment of the inmate. Instead, petitioner simply informed the inmate of petitioner's decision, informed Nurse Vick of the same decision and then followed security procedures for transporting the inmate to TLU.

Petitioner has acknowledged that before he arrived at the Housing Unit, he had decided to place Rainey into TLU:

> Q: You made that decision to place him in TLU when [Kroll] told you in the van and disobeyed HSU order by going on the rec field.
>
> A. That's correct.
>
> Q: So in fact you had made the decision to place him in Seg well before you arrived on the Housing Unit. Would that be fair to say that is true?
>
> A. Yes. (Unofficial Transcript, p. 235)

Petitioner offered a similar perspective when he was interviewed by Dep. Warden Beck on August 31, 2000:

> The information that I had was that HSU had told Rainey not to exercise; specifically not to run the track.
>
> My initial thought going to the Unit to see Rainey was, in general terms, he is a self-abuser, documented history of having done this before and with the potential to do it again. My initial intent was a TLU placement for his own welfare so that he would not be going out to Rec. (Resp. Exh. 113, p. 51)

Later on August 31, 2000, petitioner supplemented his comments during the interview and added another reason to get Rainey out of Housing Unit 5, i.e., that Rainey was disrupting the unit and petitioner wanted him out of the unit to diffuse the situation. (Resp. Exh. 113, p. 55)

When petitioner was re-interviewed, on September 29, 2000, he added information to his description of his own conduct:

> The training I had received as a First Responder, I did an initial medical assessment of Inmate Rainey. The way we were taught, as a responder (I had refresher training in April) was the first thing that is checked is ABC (airway, breathing, and circulation). The way we were told you check to make sure the person is verbally responsive; the way we are trained to do this is to get the person to talk to us. This also gives you the opportunity to check the level of [consciousness]. Again the way we are training if a person [responds] when I ask a question, the level of [consciousness], was he alert and again the training we had, if he can talk his airway is clear. I had inmate Rainey stand up and he did so without any problems (i.e. dizziness). Standing up with no dizziness is an indication that the heart is functioning well. I asked Inmate Rainey to check his airway, he responded the airway is clear. There was no apparent problem with his breathing (i.e. no wheezing or gasping). In fact his respiration was very normal. I looked for signs of no talking and quick breaths using ABC. He claimed to have breathing problems because of his complaint. I felt that he needed to be seen by HSU (they were on site). This initial assessment coupled with the knowledge of two hours previously he had been seen without a problem; I sensed no emergency. (Resp. Exh. 113, pp. 64-65)

Petitioner offered substantially similar testimony during the hearing.

The Commission does not find petitioner's testimony that he conducted a medical assessment to be credible. Petitioner admits he already had decided to place Inmate Rainey into TLU before he reached Housing Unit 5. He admits that he never checked Inmate Rainey's pulse. In addition, other persons present in the Housing Unit observed that Inmate Rainey was having difficulty breathing at that time and none reported that petitioner conducted a medical evaluation of Inmate Rainey. Officer Mary Kroll offered the following comment during Dep. Warden Beck's investigatory interview:

> When I arrived [in Unit #5 on June 16th], Rainey was in the office with Sgt. Engel sitting in the second chair and all I heard were Brice says 'Rainey, you are going to TLU.' I, myself, was a little surprised because I could see that Rainey was uncomfortable. I am not a medical person but I worked in HSU and I could see that he was rattling a little. Resp. Exh. 113, p. 56.

Sgt. Ramsey's incident report also indicates that Inmate Rainey exhibited obvious symptoms of respiratory distress and that petitioner's first action on arrival in Housing Unit 5 was to tell Inmate Rainey that he was being taken to the Segregation Unit for TLU:

> Inmate Rainy was sitting in Sgt Engel's office bent over and taking short breaths. Both Sgt. Engel & myself assured Mr Rainey the proper contacts have been made & to try and relax & remain calm.
>
> Lt. Brice/CO Kroll arrived on unit. He informed Mr Rainey he was being placed in T.L.U. Mr Rainey became upset/concerned with this order. (Resp. Exh. 113, p. 16)

Sergeant Engel, who called Control and asked for assistance from a First Responder, was not even aware that petitioner was at Housing Unit 5 as a First Responder. Sergeant Engel's incident report provides, in part:

> I sgt Engel called control to have a first responder for Rainey didn't look [too] good and also [have] them notify H.S.U. and a supervisor of the problem. Lt. Brice arrived and told inmate that he was being place[d] in TLU. Lt. Brice instructed me sgt Engel to pat search Rainey and put the handcuffs on. Inmate Rainey told Lt. Brice that he was having an asthma attack and being in seg would make it worst [sic]. Lt Brice place[d] Rainey in TLU without having the first responder or any H.S.U. staff check Rainey out before leaving the unit for seg. (Resp. Exh. 113, p. 18)

Sgt. Engel corroborated this description of events when he was interviewed by Dep. Warden Beck:

> I could see that he was having problems breathing getting his breath. I tried calling HSU but the line was busy. So I called Control.
>
> At that time I kept an eye on Rainey and had him sitting in my office so that if something happened, I would be there to help him. That is when Lt. Brice came down to the Unit and he walked in and told Rainey that he was placing him in TLU. Never asked what his situation was and Rainey told him that being placed in TLU was going to make it worse because of being placed in a closed area. That didn't matter to Lt. Brice. So that is when Lt. Brice instructed me to pat search him and to put the handcuffs on him. (Resp. Exh. 113, p. 49)

Sgt. Engel also told petitioner that Inmate Rainey was having an asthma attack and that it was worse than Sgt. Engel had ever seen. (Resp. Exh. 113, p. 49) At hearing, petitioner acknowledged that Sgt. Engel was dumbfounded when petitioner ordered him to pat down Inmate Rainey:

> Q At that point you asked Sergeant Engel to help you pat the inmate down didn't you?
>
> A Yes I did.
>
> Q And he did not help you because his jaw had dropped because he was surprised by something. Isn't that true?
>
> A Yes.
>
> Q And in point of fact you had to ask him three times before he got up and helped you pat the inmate down. Isn't that right?
>
> A That's correct.
>
> Q You think it is possible that the reason Engel's jaw dropped was that he was amazed at how you were acting?
>
> A Possible. (Unofficial transcript, p. 219)

All of this information contradicts petitioner's self-serving statements that he conducted a medical evaluation of Inmate Rainey's condition before securing the inmate for transportation to TLU. In reaching this conclusion, the Commission accepts the fact that petitioner was able to observe Inmate Rainey stand up and speak, but the Commission declines to characterize these observations as a medical evaluation of the type called for by the First Responder program. Petitioner simply told Inmate Rainey to stand up so that he could be placed into restraints, which was the start of the procedure for transporting an inmate to TLU. Petitioner failed to take appropriate[4] medical action before he proceeded to secure Inmate Rainey for transportation to TLU. This conclusion is further supported by the testimony of Deputy Warden Beck:

> Q In your opinion based on your years of experience as an officer and as a supervisor do you think that Brice needed to take Rainey to TLU?

[4] In fact, petitioner failed to take *any* medical action before beginning the transport procedure.

> A No. No reasonable person at that time would make that decision. I'm a trained First [Responder] when I was a Law Enforcement Officer I went through 48 hours of First Responder training back in 1984 and I had to continue to work on the role. My update training, my CPR training and as a Lieutenant and as a Captain and as an Officer 3 and Officer 2 and Officer 1 in all my career there is no justification for that time to place an inmate in TLU. The inmate was having problems, according to the inmate, he was having problems breathing. He was sitting in his chair He was bent over The unit was running and functioning. (Unofficial Transcript, p. 34)

Petitioner contends that "the record shows the First Responder policy had been revised and he was not made aware of the revision." (Post-hearing brief, p. 5) Dep. Warden Beck testified that the First Responder policy had been reviewed and updated after September 19, 1999, and that the updated policy (Pet. Exh. 11, issued on May 18, 2000) was *not* reviewed as part of respondent's investigation regarding petitioner's conduct. Respondent had numbered the September, 1999 version of the policy as a possible exhibit. However, that version of the First Responder procedures was never offered for admission and is not part of the record. The only version of the policy in the record is the version that both parties agree was in effect at the time of the Inmate Rainey incident as well as on the date petitioner was disciplined. While the petitioner may now be arguing that he was unaware of the updated policy until sometime after he was disciplined, he did not testify to that effect at hearing. Petitioner was a First Responder and it is reasonable to expect that he would have been made aware of any changes to FLCI's written First Responder policy as they were adopted. It is also reasonable to expect that petitioner, as a lieutenant, would have been made aware of all changes in FLCI's written procedures. Therefore, the Commission concludes that petitioner was, or should have been, aware of the updated version of FLCI procedure 413.01, regarding the First Responder Program, effective May 18, 2000.

Provision VIII. C. of FLCI's First Responder Policies and Procedures (Comp. Exh. 11), reads:

> HSU staff will be in control of the "medical" aspect of the scene until the client is stabilized or transported out of the institution.

This provision was not followed here. Petitioner, as the First Responder, never gave control to Nurse Vick who was the on-site HSU staff person. Instead, petitioner took control over both the "medical" and security aspects of matter. He informed Nurse Vick that he was transporting Inmate Rainey to the Segregation Unit and that if Nurse Vick wanted to examine him, she would have to do so there. He hung up on her

Petitioner's action also violated the very general language of Work Rules 1 and 4, set forth in the letter of suspension.[5]

B. Was there just cause for some level of discipline?

The next question is whether the greater weight of credible evidence shows that the subject conduct constitutes just cause for the imposition of discipline, i.e. can the conduct reasonably be said to impair petitioner's performance of the duties of his position or the efficiency of the group with which he works. *Safransky v. Personnel Board,* 82 Wis. 2d 464 (supra). Petitioner's conduct was a key factor in Inmate Rainey's later loss of consciousness and near-death. Medical treatment of inmates is a very important aspect of incarceration, the primary function of the Department of Corrections. Respondent had conducted a wide-ranging internal review of its medical procedures after the death of Inmate Greer earlier in 2000 at Taycheedah Correctional Institution. Respondent had also been the subject of intense scrutiny from the press and the legislature as a consequence of Inmate Greer's death and incidents involving other inmates. Warden Borgen testified that the incident involving Inmate Rainey could have been front-page media material in light of response to the Taycheedah incident. Haphazard or non-existent medical evaluation of inmates can obviously have severe consequences on the health of those inmates and on the success or failure of respondent in carrying out its function as a governmental agency. Ms. Cooke testified that petitioner's conduct regarding Inmate Rainey had the "potential for creating severe problems" for respon-

[5] This conclusion is supported by the testimony of Mr. Marx, FLCI's Human Resources Director. (Unofficial Transcript, p. 185).

dent if Inmate Rainey had suffered permanent disability or death. (Unofficial Transcript p. 120).

The petitioner's conduct constituted "just cause" for the imposition of discipline.[6]

C. Level of discipline

The final question in the just cause analysis is whether the 5-day suspension was an excessive level of discipline. In reaching its conclusion, the Commission has considered the fact that the petitioner had been orally reprimanded for two comments he had made to Sgt. Homann. This occurred shortly before the respondent commenced its investigation of the Inmate Rainey incident. Petitioner's work record was not unblemished at the time respondent imposed the 5-day suspension.

Complainant's status as a supervising officer is another fact that is clearly relevant to the level of discipline imposed in this matter It is appropriate for respondent to hold its supervisors to a high standard in light of the importance that supervisors set good examples for subordinate employees. In *Hebert v. DHSS*, 89-0093-PC, 6/27/90, the Commission upheld a five-day suspension where the appellant, a supervisor in a correctional institution, allowed two inmates to add a state-owned bedspread and a bathrobe to the list of the inmates' personal property in clear violation of institution policies and procedures and appellant had made personal use of a state typewriter on state time:

> Failing to set a good example for subordinate employees would certainly have a tendency to impair the performance of the duties of a supervisory position.

The potential consequences of the petitioner's conduct are apparent from the near-death of Inmate Rainey Petitioner's conduct in this matter had life-threatening consequences.[7]

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[6] In *Reimer v. DOC*, 92-0781-PC, 2/3/94, the Commission held that discipline was appropriate where respondent had established that appellant was negligent in the performance of his duties by failing, as shift commander, to become thoroughly familiar with institution policies, and by his decision to halt the evacuation of inmates during a fire, where appellant gave conflicting rationales for his decision and failed to consider all of the implications of his actions.

The record (Unofficial Transcript, p. 187) reflects that the health care supervisor at Taycheedah was suspended for 10 days as a consequence of the Inmate Greer incident. Respondent noted that the supervisor at Taycheedah was a health care professional, while petitioner had only been trained as a First Responder There is nothing in the record that indicates whether the health care supervisor at Taycheedah had actually provided treatment to Inmate Greer or whether any concerns about the treatment provided in the Greer Incident related solely to the actions of subordinate personnel. Given the absence of this information, the value of the comparison to the discipline imposed in the present case is weakened. However, there is nothing in the record to indicate that the discipline imposed on the health care supervisor at Taycheedah was inconsistent with the 5-day suspension imposed on the petitioner

All of the above factors support the conclusion that a 5-day suspension was not excessive.

D. Specific defenses raised by petitioner

In his post-hearing brief, petitioner raised some additional arguments that warrant discussion.

Petitioner contends respondent failed to give him notice that the termination decision was based, in part, on complaints from female subordinates. This argument relates to the decision to terminate petitioner's probationary employment. That decision is outside of the scope of the issue for hearing in Case No. 00-0172-PC.

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[7] Ms. Cooke provided the following testimony:

> Q Do you have an opinion whether or not the actions of Michael Brice on June 16th of last year in regard to inmate Rainey enhanced the Department's reputation in regard to taking good care of inmates?
>
> A I don't think it enhanced it.
>
> Q. Do you think it, how would you describe it then?

Petitioner also contends that Nurse Wendy Vick was not disciplined even though she had engaged in comparable conduct regarding another inmate. This contention is based on the death in Inmate Sherman at FLCI in 1998. Nurse Vick testified (Unofficial Transcript, p. 113) that Inmate Sherman had returned to FLCI after undergoing a surgical procedure. He collapsed in his cell and was discovered some time later. Nurse Vick was on her way out of the institution when the trouble call went out. She arrived at the cell within 3 minutes of the radio transmission, but found him pulseless, not breathing, cold and already cyanotic. She concluded that it had already been more than 15 minutes since his heart had stopped beating. CPR was initiated but it was unsuccessful. Petitioner theorized that Nurse Vick should also have used a defibrillator in an effort to restart Inmate Sherman's heart. Nurse Vick testified that her response to the incident was deemed exemplary. There is no basis in the record to support petitioner's suggestion that Nurse Vick was negligent because she did not use a defibrillator on Inmate Sherman.

Finally, petitioner contends that the insignificance of his alleged misconduct is established by the fact that management was aware of the Inmate Rainey incident for more than two months before it initiated any investigation. However, the only staff report that clearly stated the petitioner's conduct was inappropriate was the report prepared by Nurse Vick (Finding 58f) and that report was inadvertently destroyed before it reached management. Petitioner's reports cast his own actions in a very positive light.[8]

> A I would say that I that it had the potential for creating severe problems for the Department had the inmate suffered permanent disability or death. (Unofficial transcript, p. 120)

[8] One of petitioner's incident reports (#584546) dated June 16, 2000, reported the injury to Officer Gravunder. The report described the incident as follows:

> During a TLU placement, inmate Rainey passed out. Officer Gravunder was assisting with the TLU placement and helped lift inmate Rainey onto a bed where Rainey was to be examined. Officer Gravunder twisted his ankle during the lift. Inmate Rainey was difficult to lift due to his size, limp condition, sweat and other body fluids. Lt. Brice, CO Rooney, CO Mortroy and RN Vick witnessed Gravunder's injury. (Resp. Exh. 113, p. 8)

Petitioner's second incident report (#584547), described the incident as follows:

> Sgt. Engel notified me (Lt. Brice) at 5:10 p.m. regarding inmate Rainey having breathing problems. Upon arriving at H-5 and assessing the situation, I made the decision to place inmate Rainey into TLU status and to have RN Vick check Rainey in the Segretation Unit. Rainey has a history of asthma problems and has been directed by HSU to not go to recreation. Today Rainey was seen by HSU prior to 300 p.m. for an asthmatic treatment. Rainey then went to recreation and was observed running on the track. Officer Gravunder had observed Rainey running at Rec. Officer Gravunder (Fox 21) accompanied him to the H-5 office to place Rainey into TLU status. At this time Rainey was relaxed yet breathing with slight difficulty. When informed [text missing] to the inmates in the dayroom. Rainey was yelling "They're going to kill me" "Don't let them take me." The more agitated Rainey became, the more labored his breathing became. Rainey refused all orders to relax and to comply. Rainey was informed that RN Vick would check him upon his arrival at Segregation. Rainey continued to escalate his anxiety levels to the point where he collapsed and "soiled" himself at the entry to Segregation. Officers Gravunder and Rooney carried Rainey into Cell 9 where RN Vick immediately administered an epi-pen and oxygen. RN Vick immediately ordered an ambulance. While placing Rainey on the bed, Officer Gravunder injured his ankle
> (Resp. Exh. 113, p. 20)

Petitioner's accident report (Resp. Exh. 113, p. 12) described how Officer Gravunder was injured when lifting Inmate Rainey.

Petitioner completed an adult conduct report regarding Inmate Rainey's conduct on June 16th In the report, petitioner stated that inmate Rainey had disobeyed orders, engaged in disruptive conduct, and "created a risk of serious disruption at the institution." The description included the following language:

> As a State of Wisconsin Certified 1st Responder, I felt confident that Rainey's level of consciousness was more than adequate and proceeded with the TLU placement. Rainey continued yelling and refused my orders to be quiet, relax and calm down. Rainey finally managed to work himself into an asthma attack. Upon arrival at Segregation, Rainey was semi-conscious and had "soiled" himself. RN Vick was present in Segregation and immediately administered an epi-pen. Rainey did not respond and had to be carried to a bed for further treatment by RN Vick. (Resp. Exh. 113, p. 33)

Petitioner completed a "Notice of Offender placed in Temporary Lockup" on June 16th and described the "facts upon which decision is based" as follows:

> Inmate is asthmatic and was treated in HSU prior to 3pm today. Inmate then went to Rec and was running on the track causing another asthma attack. TLU placement to protect the inmate from himself. (Resp. Exh. 113, p. 35)

Many of the remaining reports did not clearly indicate that petitioner was serving as a First Responder when he dealt with Inmate Rainey.[9] Officer Gravunder's incident re-

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[9] Officer Mary Kroll filed an incident report (R113,14) on June 16, 2000, and noted that inmate Rainey had been injured.

> On the above given date and time I officer Kroll Fox 22 arrived on U5C with Lt. Brick for inmate Rainey and proceeded to inform Lt. Brice that earlier at 15:00 I took inmate Rainey to see HSU nurse per order of Control. Then on my second arrival with Lt. Brice inmate Rainey was having trouble breathing so, Lt. Brice informed inmate Rainey he was going to T.L.U. due to the fact he was at Rec earlier and ran. I Officer Kroll was informed by the Lt. Brice to secure all Wings on Unit 5 and go to inmate Rainey's room and collect his meds and bring them to U-8. On my arrival to Unit 8 outside the entrance door inmate Rainey went down and 2 officers had to carry inmate Rainey into the [observation] room. The H.S.U. nurse was on the scene to administer the necessary medical treatment. I was told to go to Control to get the responding medical log for the oxygen which was administered to inmate Rainey. Then I was told by Lt. Brice to proceed back to patrol the grounds on my delay as fox 22. Ambulance arrived.

Lt. Maxwell signed and wrote, "Proper procedure followed." Security Director Meyer acknowledged receipt of the report.

Sgt. Ramsey filed an incident report (R113,16) on June 16, 2000, because inmate Rainey had been placed in handcuffs when in Housing Unit 5. In his report, Sgt. Ramsey noted that inmate Rainey had been injured. The report included the following description of the incident:

> On the above stated date & time the following incident took Place: Sgt. Engel notified me (Ramsey that a Lt. and First responders were en-route to U-5 as an inmate was having an apparent asthma attack & difficulty breathing. St. Engel stated this inmate had a medical history of such and would probably need to go to the hospital. I immediately went to A-wing to assist Sgt. Engel. Inmate Rainy was sitting in Sgt Engel's office bent over and taking short breaths. Both Sgt. Engel & myself assured Mr. Rainey the proper contacts have been made & to try and relax & remain calm.
>
> Lt. Brice/CO Kroll arrived on unit. He informed Mr. Rainey he was being placed in T.L.U. Mr. Rainey became upset/concerned with this order. I then secured all wing doors on the unit and returned to assist Lt. Brice & CO Gravunder with physically placing Mr. Rainey in a vehicle & transported to T.L.U. CO Kroll returned to unit to pick up Mr. Rainey's breathing medication.

Lt. Maxwell signed and wrote, "Proper procedure followed." A notation by Security Director Dennis Meyer showed that copies were directed to the "Administrative Team for review", including Warden Borgen and Deputy Warden Beck.

port (Resp. Exh. 113, p. 6), filed on June 19, 2000, clearly indicated petitioner was filling the role of a First Responder but Officer Gravunder was not present until after Inmate Rainey had been handcuffed. It did not directly question petitioner's conduct and was received by management several days after the other reports.[10] Officer Gra-

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Sgt. Engel filed an informational incident report on June 16, 2000. The report included the following description:

> [At 3:00 p.m. on June 16th] inmate Rainey reported to me sgt Engel that he was having an asthma attack. Having trouble breathing and some chest pains. I sgt Engel called H.S.U. and talk[ed] to Sherri. Said to have Rainey transported up to H.S.U. Officer Kroll transported Rainey to H.S.U. H.S.U. sent him back to the unit. At 5:10 p.m. inmate Rainey came to my office and said that the asthma attack was worst [sic] and that he was having a real problem getting his breath. I sgt Engel called control to have a first responder for Rainey didn't look [too] good and also [have] them notify H.S.U. and a supervisor of the problem. Lt. Brice arrived and told inmate that he was being place[d] in TLU. Lt. Brice instructed me sgt Engel to pat search Rainey and put the handcuffs on. Inmate Rainey told Lt. Brice that he was having an asthma attack and being in seg would make it worst [sic]. Lt Brice place[d] Rainey in TLU without having the first responder or any H.S.U. staff check Rainey out before leaving the unit for seg. (Resp. Exh. 113, p. 18)

Lt. Maxwell signed the report and wrote, "Proper procedure followed." A notation by Security Director Dennis Meyer showed that copies were directed to the "Adm Team" for review, including Warden Borgen and Deputy Warden Beck. Again, it is noteworthy that Sgt. Engel's incident report reflects the fact that he did not know that petitioner was supposed to be filling the role of First Responder.

[10] Officer Gravunder's report [#522108] reads, in part:

> At approximately 5:00 p.m. on 06/16/00 I received a radio transmission from Lt. Brice to pick him up behind the chapel. When I arrived at Lt. Brice's position CO1 Kroll was already picking him up. Lt. Brice informed me that Inmate Rainey in HU#5 was having problems breathing and wanted me (CO1 Gravunder) to [stand by] in case they needed the First Responder bag out of Control. At approximately 5:10 p.m. Lt. Brice [indecipherable] me on the radio to 10-25 HU#5. I replied "10-4 Do you need the First Responder bag." Lt. Brice did not reply. Approximately 30 seconds later I arrived at HU#5. When I entered HU#5 I put my latex gloves on and observed Inmate Rainey was handcuffed. The inmate was bent over and being escorted by Lt. Brice towards the front door. Lt. Brice asked me to secure his other arm. As we were escorting the inmate out of HU#5 the inmate kept saying "I am going to die, don't let me die Lieutenant, please don't let me die."

vunder's report did not present the full picture of what had occurred.[11] It wasn't until the investigation that respondent pulled that picture together

The Commission notes that Inmate Rainey also sent a letter to Warden Borgen complaining about petitioner's conduct. That letter (Finding 59) was received in the warden's office on June 23rd In it, Inmate Rainey clearly stated that he was having an asthma attack and that petitioner failed to provide any medical assistance. However, the record is silent as to who saw the letter from Inmate Rainey and how FLCI responded, if at all. The record is also silent as to what the standard procedure is at FLCI for processing such a letter

Given this state of the record, the Commission cannot draw the conclusion that management at FLCI had accepted Inmate Rainey's version of events and had reached a conclusion that petitioner's conduct was, nevertheless, appropriate. Someone might argue it would be appropriate to draw an inference (that management approved of petitioner's conduct) from the absence of any response to Inmate Rainey's letter However, such an inference would not be reasonable because the record contains insufficient information about how such letters are normally processed. Even if such an inference was reasonable, it would not be fatal to the respondent's decision to impose the 5-day

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[11] The interview of Captain Gary McClelland, R113,61, shows he signed off on Incident Reports 5484546, 548891, 584894, 5844966, 584547 Capt. McClelland did not read Officer Gravunder's report until September 5, 2000. R113,62. [Note: This sentence in the proposed decision has been modified to more accurately reflect the record.] Capt. McClelland's understanding of what occurred is also set forth in the interview:

> I was briefed by Lt. Brice as indicated in the report that Rainey had been running in the gym in disregard to direction that he had been given by our Health Services and that due to his condition and his disobeying directions was placed in TLU so that he could be observed. Brice is a 1st responder and indicated his condition in the report. While in Seg, he experienced difficulty The people, Mr Garcia and Mr Meier, were contacted as I was told by Brice and later received medical treatment at Waupun Memorial again as he has indicated in the report. That is all I know.
>
> When I read the report and listened to Brice's verbal narration of what had transpired, I supported that and so indicated on that report.

suspension given the other information in the record. The employer could change its mind as long as there is just cause for the discipline finally imposed.[D]

ORDER

In Case No. 00-0136-PC-ER, the complaint is dismissed. In Case No. 00-0172-PC, the action of respondent is affirmed and the appeal is dismissed.

Dated: August 13, 2001 STATE PERSONNEL COMMISSION

JUDY M. ROGERS, Commissioner

KMS: 000136Cdec1.1

ANTHONY J. THEODORE, Commissioner

Parties:

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NOTICE
OF RIGHT OF PARTIES TO PETITION FOR REHEARING AND JUDICIAL REVIEW OF AN ADVERSE DECISION BY THE PERSONNEL COMMISSION

Petition for Rehearing. Any person aggrieved by a final order (except an order arising from an arbitration conducted pursuant to §230.44(4)(bm), Wis. Stats.) may, within 20 days after service of the order, file a written petition with the Commission for rehearing. Unless the Commission's order was served personally, service occurred on the date of mailing as set forth in the attached affidavit of mailing. The petition for rehearing must specify the grounds for the relief sought and supporting authorities. Copies shall be served on all parties of record. See §227.49, Wis. Stats., for procedural details regarding petitions for rehearing.

Petition for Judicial Review. Any person aggrieved by a decision is entitled to judicial review thereof. The petition for judicial review must be filed in the appropriate circuit court as provided in §227.53(1)(a)3, Wis. Stats., and a copy of the petition must be served on the Commission pursuant to §227.53(1)(a)1, Wis. Stats. The petition must identify the Wisconsin Personnel Commission as respondent. The petition for judicial review must be served and

[D] The last four sentences in this paragraph have been added to clarify the first sentence.

filed within 30 days after the service of the commission's decision except that if a rehearing is requested, any party desiring judicial review must serve and file a petition for review within 30 days after the service of the Commission's order finally disposing of the application for rehearing, or within 30 days after the final disposition by operation of law of any such application for rehearing. Unless the Commission's decision was served personally, service of the decision occurred on the date of mailing as set forth in the attached affidavit of mailing. Not later than 30 days after the petition has been filed in circuit court, the petitioner must also serve a copy of the petition on all parties who appeared in the proceeding before the Commission (who are identified immediately above as "parties") or upon the party's attorney of record. See §227.53, Wis. Stats., for procedural details regarding petitions for judicial review.

It is the responsibility of the petitioning party to arrange for the preparation of the necessary legal documents because neither the commission nor its staff may assist in such preparation.

Pursuant to 1993 Wis. Act 16, effective August 12, 1993, there are certain additional procedures which apply if the Commission's decision is rendered in an appeal of a classification-related decision made by the Secretary of the Department of Employment Relations (DER) or delegated by DER to another agency. The additional procedures for such decisions are as follows:

1. If the Commission's decision was issued after a contested case hearing, the Commission has 90 days after receipt of notice that a petition for judicial review has been filed in which to issue written findings of fact and conclusions of law. (§3020, 1993 Wis. Act 16, creating §227.47(2), Wis. Stats.)

2. The record of the hearing or arbitration before the Commission is transcribed at the expense of the party petitioning for judicial review. (§3012, 1993 Wis. Act 16, amending §227.44(8), Wis. Stats.

2/3/95