STATE OF WISCONSIN
BEFORE THE WISCONSIN EMPLOYMENT RELATIONS COMMISSION

CHRISTINE FRITSCHE, Appellant,

vs.

STATE OF WISCONSIN DEPARTMENT OF CORRECTIONS, Respondent.

Case ID: 1.0444
Case Type: PA

DECISION NO. 38952

Appearances:

Nicholas Fairweather, Attorney, Hawks Quindel 409 E. Main Street, Madison, Wisconsin, appearing on behalf of Christine Fritsche.

Anfin Jaw, Attorney, Department of Administration, 101 E. Wilson Street, 10th Floor, P.O. Box 7864, Madison, Wisconsin, appearing on behalf of the State of Wisconsin Department of Corrections.

DECISION AND ORDER

On March 30, 2021, Christine Fritsche (Fritsche) filed an appeal with the Wisconsin Employment Relations Commission asserting she had been suspended for five days without just cause by the State of Wisconsin Department of Corrections (DOC). The appeal was assigned to Examiner Raleigh Jones. A telephone hearing was held on May 19, 2021. The parties made oral arguments at the conclusion of the hearing.

On June 2, 2021, Examiner Jones issued a Proposed Decision and Order rejecting the five-day suspension by DOC. On June 3, 2021, DOC filed objections to the Proposed Decision. On June 8, 2021, Fritsche filed an Amended Reply to the objections.

Being fully advised in the premises, the Commission makes and issues the following:

FINDINGS OF FACT

1. Christine Fritsche is employed as a nurse clinician at the Prairie du Chien Correctional Institution (PDCI) and had permanent status in class at the time of her suspension.

2. The Department of Corrections is a state agency responsible for the operation of various correctional facilities, including PDCI in Prairie du Chien, Wisconsin.

3. On February 4, 2021, DOC suspended Fritsche for five days for various acts of alleged misconduct.

Based on the above and foregoing Findings of Fact, the Commission makes and issues the following:

CONCLUSIONS OF LAW

1. The Wisconsin Employment Relations Commission has jurisdiction to review this matter pursuant to Wis. Stat. § 230.44(1)(c).

2. DOC did not meet its burden of proof as to Fritsche's alleged misconduct.

3. The State of Wisconsin Department of Corrections did not have just cause, within the meaning of Wis. Stat. § 230.34(1)(a) to suspend Christine Fritsche for five days.

Based on the above and foregoing Findings of Fact and Conclusions of Law, the Commission makes and issues the following:

ORDER

The five-day suspension of Christine Fritsche by the State of Wisconsin Department of Corrections is rejected. DOC shall make Fritsche whole.

Issued at the City of Madison, Wisconsin, this 9th day of July, 2021.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

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James J. Daley, Chairman

MEMORANDUM ACCOMPANYING DECISION AND ORDER

Section 230.34(1)(a), Stats., provides in pertinent part the following as to certain employees of the State of Wisconsin:

> An employee with permanent status in class ... may be removed, suspended without pay, discharged, reduced in base pay or demoted only for just cause.

Section 230.44(1)(c), Stats., provides that a state employee with permanent status in class:

> ... may appeal a demotion, layoff, suspension, discharge or reduction in base pay to the commission ... if the appeal alleges that the decision was not based on just cause.

Christine Fritsche had permanent status in class at the time of her suspension and her appeal alleges that the suspension was not based on just cause.

The State has the burden of proof to establish that Fritsche was guilty of the alleged misconduct and whether the misconduct constitutes just cause for the discipline imposed. *Reinke v. Personnel Bd.*, 53 Wis .2d 123 (1971); *Safransky v. Personnel Bd.*, 62 Wis.2d 464 (1974).

Fritsche's suspension notice stated she was suspended for the following misconduct:

> On November 21, 2020 you failed to follow Policy 500.00.04 *Reporting Health Concerns to On-Call Nursing Staff* when you obtained assessment information solely from security staff rather than talk directly with the patient, and failed to make a follow-up call to determine whether the intervention you directed officers to take was effective. Later that same day, you reported that during rounds you saw this patient, and the patient had an initial pulse Oximetry of 86%. You were negligent in your nursing duties when you failed to follow policy 500.30.72 *Nursing Vital Signs Referral Parameters*, which notes that pulse Oximetry readings of same or less than 90% requires a same day referral to on-site ACP or with an on-call physician for further care.

The Commission begins its discussion with this premise: if the claims referenced above were substantiated, the Commission would have no trouble concluding that discipline was warranted. Nursing staff are supposed to comply with agency policies and nursing protocols and not be negligent in their nursing duties.

The question in this case is whether DOC proved the claims made in the disciplinary notice. Based on the following rationale, the Commission finds they did not.

The Commission begins with this factual context. In late November 2020, about 75% of the inmates at PDCI had tested positive for COVID-19. Because of that, the understaffed nursing staff at PDCI was working long hours to care for them. One of the inmates who had COVID-19, CJ, died on November 30, 2020. After he died, DOC instituted what is called a mortality review.

This is standard operating procedure and was not unique to CJ's death. In a mortality review, management reviews the nursing care received by the deceased prior to their death. After doing that, DOC decided that the nursing care CJ received from Fritsche on November 21 (nine days before his death) was lacking.

The discipline which DOC imposed on Fritsche for her alleged misconduct was a five-day suspension. In DOC's progressive discipline sequence, a five-day suspension is the last step before discharge.

Before the Commission reviews Fritsche's alleged misconduct on November 21, 2020, the Commission is first going to review these facts.

About 7 am, CJ's cellmate reported that CJ was having trouble breathing. Correctional Sergeant Sutter responded to the call for assistance and met CJ in the hallway. Sutter could tell that CJ was having trouble breathing and was in distress. Both then walked to the officer station in the day room and sat on a nearby table. Knowing that no nurse was present on site that day because it was a Saturday, Sutter called the on-call nurse, who was Fritsche. In doing that, Sutter used a landline phone from the officer's station.

After Fritsche answered the call, a conversation ensued. This conversation was not a traditional two-party conversation. Instead, it was a tripartite conversation between Sutter, Fritsche and CJ. The reason that was possible was because Sutter and CJ were seated right next to each other at the table, and the phone volume was loud enough that Fritsche could hear what CJ said to Sutter and vice versa. During the call, Sutter held onto the phone himself for its duration because inmates cannot use the phone at the officer's station in the dayroom. Thus, Sutter could not hand the phone to CJ so that he could speak directly to Fritsche. As a result, Sutter was the intermediary during the call. While there is a phone that inmates can use at PDCI, Sutter decided not to move CJ to that location to use that phone because Sutter thought that walking there would exacerbate CJ's labored breathing and shortness of breath.

The call started with Sutter telling Fritsche about CJ's labored breathing and shortness of breath. As she received this information from Sutter, she could hear CJ coughing and wheezing. Fritsche was familiar with CJ and his medical condition. Sutter then asked CJ if he had used his nebulizer yet[1], to which he responded in the negative. Upon hearing that, Fritsche told him to use the nebulizer and she would see him soon (because she was coming into PDCI). Fritsche then told Sutter to get CJ started on the nebulizer. Fritsche ended the phone call by telling Sutter that if CJ's condition worsened, a trip to the emergency room might be needed.

Fritsche then went into PDCI. After she arrived, she made rounds and checked on the condition of numerous inmates. CJ was the first patient that she saw. When Fritsche checked on CJ, he had done a nebulizer treatment as instructed. CJ's initial pulse oximetry was 86%. A couple

[1] A nebulizer is a small machine used to help breathing. It turns liquid medicine into a mist that is drawn into the lungs via a mouthpiece connected with a tube to the machine. The mist helps open the airway so breathing is easier. This description of how a nebulizer works is taken from *Fritz v. DOC*, Dec. No. 38787 (WERC, January 2021).

of minutes later, Fritsche did a second reading and this time CJ's pulse oximetry was 91-92%. Before Fritsche left PDCI, she checked on CJ a second time.

Afterwards, Fritsche called Lindsey Kochelek, a nurse practitioner at PDCI and updated her on the status of numerous inmates. The reason Fritsche made this call to Kochelek was because Kochelek had asked her to do it while she (Kochelek) was off work on medical leave. One of the inmates Fritsche provided an update on was CJ. Fritsche told Kochelek that that morning when she checked on CJ, he had an initial pulse oximetry of 86%, but several minutes later, the number was 91-92%.

At 5:30 pm that day, Officer Lammers called Fritsche regarding CJ's condition. During this call, Lammers told Fritsche that CJ was again short of breath and that his pulse oximetry was 86%. Lammers was able to tell Fritsche that specific pulse oximetry number because he (Lammers) read it off the finger O_2 monitor that he (Lammers) had hooked up to CJ. Upon being told what CJ's pulse oximetry number was, Fritsche told Lammers to send CJ to the hospital. Lammers did as instructed.

CJ died nine days later, on November 30, 2020.

The Commission will now address the charges made against Fritsche in the suspension letter in the order listed.

The first charge against Fritsche is as follows:

> On November 21, 2020 you failed to follow Policy 500.00.04 *Reporting Health Concerns to On-Call Nursing Staff* when you obtained assessment information solely from security staff rather than talk directly with the patient . . . .

It is apparent from DOC Policy 500.00.04 that nurses are to get their information about a patient's medical condition firsthand as opposed to second hand. In this case, DOC essentially faults Fritsche for not speaking directly to CJ during their 7 am phone call on November 21, 2020. However, in order for that to have occurred (i.e., for Fritsche to speak directly to CJ on the phone in a one-on-one conversation), Sutter would have had to escort CJ to the only room at PDCI where inmates can hold the phone themselves and have a one-on-one conversation with someone. Sutter decided not to have CJ walk further to that location because that walking would have exacerbated CJ's shortness of breath and labored breathing. That strikes us as an entirely reasonable judgment call on his part. What Sutter did instead was arrange for a tripartite phone conversation between himself, CJ, and Fritsche. He did this by sitting close enough to CJ at the table in the dayroom so that Fritsche could hear what CJ told Sutter. Additionally, after Fritsche spoke to Sutter, she could also hear what Sutter then told CJ. The Commission is satisfied that in the unique circumstances present here where Fritsche was able to hear everything that CJ told Sutter, and vice versa, that Fritsche's action comported with the policy. The Commission therefore finds that Fritsche's action in getting her information about CJ's medical condition during the phone call in question essentially complied with Policy 500.00.04. That being so, she did not violate that policy as alleged by DOC.

The second charge against Fritsche is that she "failed to make a follow-up call to determine whether the intervention you directed officers to take was effective." As was noted above, the "intervention" that she had directed in her phone call with CJ and Sutter was that CJ do a nebulizer treatment to address his labored breathing and shortness of breath. According to the allegation above, Fritsche "failed to make a follow-up call" afterwards to see if the nebulizer treatment had been effective. While it is true that Fritsche did not call back later that morning to check on CJ's status, it was not necessary for her to do so for this simple reason: after she received the phone call from Sutter, she went into PDCI and made the rounds checking on all the COVID-19 patients. The first patient that she saw that morning was CJ. By that time, CJ had had a nebulizer treatment and Fritsche gave him a full assessment. The wording in the suspension notice makes it appear that Fritsche did nothing else for CJ that day. That is not the case. The Commission therefore finds that DOC did not substantiate this second charge made against Fritsche either.

The third charge against Fritsche is as follows:

> Later that same day, you reported that during rounds you saw this patient, and the patient had an initial pulse Oximetry of 86%. You were negligent in your nursing duties when you failed to follow policy 500.30.72 *Nursing Vital Signs Referral Parameters*, which notes that pulse Oximetry readings of same or less than 90% requires a same day referral to on-site ACP or with an on-call physician for further care.

In reviewing this charge, the Commission has decided to break it down into the following parts. First, the phrase "you reported" refers to the fact that after Fritsche went into PDCI to check on the status of CJ and the other COVID-19 patients, she then called Kochelek. Kochelek is a nurse practitioner at PDCI. On that date, Kochelek was on medical leave because, as she put it, "she was fighting her own COVID battle at the time." In that call, Fritsche briefed Kochelek on the status of all the COVID-19 patients. Fritsche did that per Kochelek's request. Since Fritsche called Kochelek and briefed her on the status of the COVID-19 patients, the logical inference is that Kochelek is higher than Fritsche on the organizational chart. Second, in that call, Fritsche told Kochelek that CJ had "an initial pulse Oximetry of 86%." This refers to the fact that when Fritsche initially checked CJ's oximetry pulse, he had a reading of 86%. Fritsche also told Kochelek that several minutes later, when Fritsche checked CJ's number a second time, it had risen to 91-92%. The allegation against Fritsche is that she was "negligent in [her] nursing duties" and failed to follow "policy 500.30.72 . . . , which notes that pulse Oximetry readings of same or less than 90% requires a same day referral to on-site ACP or with an on-call physician for further care." The Commission finds that Fritsche did not violate that policy as alleged for these reasons. First, the record shows that when Fritsche was called by Lammers at 5:30 pm that day and was told that CJ again had shortness of breath and a pulse oximetry of 86%, she directed that CJ be transported to the hospital emergency room. That action comports with the language in the policy that there be a "same day referral" for a patient whose pulse oximetry falls below 90%. Second, if DOC wanted CJ transported to the hospital earlier that day, say in the morning when he first had a pulse oximetry reading of 86%, one would think that Kochelek would have told Fritsche to do that when Fritsche briefed Kochelek by phone on CJ's status. Kochelek did not do so. Third, to the extent that DOC

faults Fritsche for not calling another medical provider such as the on-call physician about CJ's status, the Commission finds that her call to Kochelek was sufficient. As a result, Fritsche cannot fairly be faulted for non-compliance with Policy 500.30.72. The Commission therefore finds that DOC did not substantiate the third charge against Fritsche either.

Since none of the claims in Fritsche's suspension notice have been substantiated, DOC failed to prove that Fritsche committed the misconduct she was charged with.

Inasmuch as DOC did not prove the first element of just cause, it is unnecessary to address the second element of just cause (i.e., whether DOC established that a five-day suspension was appropriate under the circumstances). Therefore, there was not just cause to suspend Fritsche for five days. Her suspension is rejected and she is to be made whole.

One final comment is in order. Nothing in this record shows that CJ's death on November 30, 2020 was caused by the nursing care he received from Fritsche nine days prior to his death.

Issued at the City of Madison, Wisconsin, this 9th day of July, 2021.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

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James J. Daley, Chairman