STATE OF WISCONSIN
BEFORE THE WISCONSIN EMPLOYMENT RELATIONS COMMISSION

MEGAN LEBERAK, Appellant,

vs.

STATE OF WISCONSIN DEPARTMENT OF CORRECTIONS, Respondent.

Case ID: 1.0684
Case Type: PA

DECISION NO. 40717

Appearances:

Jacob Aronson, 200 S. Madison St., Waupun, Wisconsin, appearing on behalf of Megan Leberak.

David Makovec, 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 October 4, 2024, Megan Leberak filed an appeal with the Wisconsin Employment Relations Commission asserting she had been discharged without just cause by the State of Wisconsin Department of Corrections (DOC). The appeal was assigned to Commission Examiner Katherine Scott Lisiecki.

A telephone hearing was held on December 2, 2024, by Examiner Lisiecki. The parties submitted written closing arguments on December 13, 2024. On December 20, 2024, Examiner Lisiecki issued a Proposed Decision and Order affirming the discharge of Megan Leberak by the DOC. The parties did not file objections to the Proposed Decision by the given deadline of December 26, 2024.

Being fully advised on the premises and having considered the matter, the Commission makes and issues the following:

FINDINGS OF FACT

1. Megan Leberak (Leberak) was employed by the State of Wisconsin Department of Corrections (DOC), as a nurse clinician at Waupun Correctional Institution (WCI). She had permanent status in class when she was discharged.

2. On October 21, 2023, Leberak assessed inmate C.W., who had razor blade lacerations

on his arms, told her that he had swallowed a razor blade two weeks before, and vomited. Leberak did not refer C.W. to the Psychological Services Unit, contact an advanced care provider, or send C.W. to the hospital.

3. On October 28, 2023, C.W. told Leberak he was still nauseated and was having a hard time eating or drinking. Leberak observed C.W. rolling his eyes in an unusual manner. Leberak did not conduct a neurological assessment or contact an advanced care provider.

4. Following an investigation, the DOC discharged Leberak for gross negligence.

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 over this appeal pursuant to Wis. Stat. § 230.44 (1)(c).

2. The State of Wisconsin Department of Corrections had just cause within the meaning of Wis. Stat. § 230.34(1)(a) to discharge Megan Leberak.

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

ORDER

The discharge of Megan Leberak by the State of Wisconsin Department of Corrections is affirmed.

Issued at Madison, Wisconsin, this 23rd day of January 2025.

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.

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

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

Leberak was employed as a nurse clinician at Waupun Correctional Institution (WCI). On October 21, 2023, Leberak assessed inmate C.W. C.W. told Leberak that he had swallowed a razor blade two weeks before. He had razor blade lacerations on his arms. Leberak tended to these lacerations but, despite seeing evidence of self-harming behavior, Leberak did not refer C.W. to the Psychological Services Unit (PSU). During the visit, C.W. vomited, and said it may be due to the razors he had ingested. Leberak testified that he threw up a small amount of digested food that did not contain blood. She testified that C.W.'s vital signs were normal and his stomach wasn't tender. Leberak did not contact an advanced care provider or send C.W. to the hospital. Instead, she ordered an X-Ray.

On October 28, 2023, Leberak assessed C.W. again. C.W. said he was still nauseated and was having a hard time eating or drinking. Leberak also observed C.W. rolling his eyes in an unusual manner. C.W. was not in acute distress and was responsive to Leberak's questions. Leberak did not conduct a neurological assessment or contact an advanced care provider.

On October 30, 2023, C.W. died from a stroke. He was 24.

Wis. Admin. Code N 7.03(6)(4)(a) defines "unsafe practice or substandard care" as "failing to perform nursing with reasonable skill and safety," "departing from or failure to conform to the minimal standards of acceptable nursing practice that may create unnecessary risk or danger to a patient's life, health or safety" in which actual injury to a patient need not be established, and "failure to consult or delay in consultation for clinical care beyond scope of practice."

Leberak was not negligent when she failed to contact PSU after C.W. reported self-harming. DAI policy 500.70.24 states that: "DAI staff shall refer inmates who appear to have deteriorating mental illness or evidence of a risk of physical harm to self or others to PSU staff. Any staff member, or patient by way of self-referral, may recommend that an inmate be placed in clinical observation." Gunderson testified that contacting PSU regarding C.W.'s self-harming was a standard of practice as a registered nurse. However, Leberak testified that her supervisor, Jill Wenzel, the Health Services Manager at WCI, told nurses not to contact PSU when an inmate self-harmed. Leberak submitted an email from Wenzel in which Wenzel informs the nurses that the security staff, not the nurses, are responsible for calling PSU when an inmate self-harms. Exhibit A-2. Wenzel bears responsibility for instructing her subordinates to ignore DAI policy.

Leberak was negligent when she failed to send C.W. to the hospital after he reported ingesting a razor. Leberak testified that the protocol for foreign policy ingestion was to order an X-Ray, and to only send inmates to the hospital if they were coughing up bright red blood or having complications. However, ingesting a razor blade is an obvious medical emergency, and even if C.W. was not vomiting blood, he could be suffering from an infection or secreting fecal occult blood. Holly Gunderson, an assistant director of nursing, testified that vomiting could indicate intestinal damage or an infection from the razor blade, both very serious medical issues. Leberak argues that the nursing protocol did not require her to send C.W. to the hospital unless he was actively bleeding, experiencing severe abdominal pain, or displaying acute abdominal distension, but the protocol did not prohibit her from sending C.W. if these conditions were not met. Leberak argues that Waupun was so understaffed that they would have been unable to send C.W. to the hospital. However, Warden Brad Mlodzik testified that inmates' health is a priority, and they would collapse posts in order to make sure a necessary medial trip happened.

Leberak was negligent when, a week later, she again failed to send C.W. to the hospital when he complained about continued nausea. Leberak argues that C.W. was visualized by nursing staff every day between October 21 and October 28, and that she is not solely responsible for his demise. However, Leberak was responsible for acting on the information she received while attending to patients. C.W. told her he was experiencing serious symptoms a week prior and was continuing to experience those symptoms.

Lastly, Leberak was negligent when she failed to perform a neurological assessment on C.W. after he started rolling his eyes into his head during a visit. Leberak testified that she thought C.W. was faking the eye rolling, and believed he could not have any issues because his vital signs were normal and he was able to speak with her. However, Gunderson testified that C.W.'s eye-rolling could be a sign of a neurological issue, such as a partial seizure. She testified that a nurse who observed that behavior should conduct a full neurological assessment, which is within the scope of a nurse clinician's practice. Gunderson testified that patients may have normal vital signs while having a stroke. Leberak was negligent in failing to perform a neurological assessment on C.W. after observing unusual eye-rolling.

Leberak argues that she did not violate professional standards because the State of Wisconsin Board of Nursing did not investigate or discipline her. However, as Warden Mlodzik testified, state agencies such as the DOC operate independently of licensing agencies and have

their own standards and processes. Leberak was discharged for failing to comply with DOC work rules and policies.

Leberak was grossly negligent when she failed to send C.W. to the hospital after he reported ingesting a razor, failed to send him to the hospital when he complained of nausea a week later, and failed to perform a neurological assessment on C.W. after she observed him rolling his eyes. Warden Mlodzik testified that C.W. might still be alive if WCI staff had simply followed DOC policies and procedures. Although Leberak does not bear sole responsibility for C.W.'s death, her failure to perform nursing with reasonable care and safety created unnecessary danger to C.W.'s life, health, and safety.

Turning to question of whether there is just cause for discharge, the record reflects that Leberak had no previous discipline. Thus, in this instance, the DOC skipped three steps in its standard disciplinary progression by discharging Leberak instead of giving her a one-day suspension. The Commission is satisfied that Leberak's acts of misconduct are sufficiently serious to establish just cause for the skip in progression to discharge.

Issued at the City of Madison, Wisconsin, this 23rd day of January 2025.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

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James J. Daley, Chairman