STATE OF WISCONSIN
BEFORE THE WISCONSIN EMPLOYMENT RELATIONS COMMISSION

SARAH MAGNUSSEN, Appellant,

vs.

STATE OF WISCONSIN DEPARTMENT OF CORRECTIONS, Respondent.

Case ID: 1.0703
Case Type: PA

DECISION NO. 40765

Appearances:

Deric Magnussen, 70 Park Lane, Fon du Lac, Wisconsin, appearing on behalf of Sarah Magnussen.

Nicole Porter, 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 December 6, 2024, Sarah Magnussen filed an appeal with the Wisconsin Employment Relations Commission asserting that she had been suspended for five days without just cause by the State of Wisconsin Department of Corrections. The appeal was assigned to Commission Examiner Katherine Scott Lisiecki.

A telephone hearing was held on February 10, 2025, by Examiner Lisiecki. The parties submitted written closing arguments on February 21, 2025. On March 5, 2025, Examiner Lisiecki issued a Proposed Decision and Order, affirming the five-day suspension of Magnussen by the DOC. Magnussen filed objections to the Proposed Decision on March 10, 2025. The DOC did not file a response and the matter became ripe for Commission consideration on March 18, 2025.

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

FINDINGS OF FACT

1. Sarah Magnussen (Magnussen) is employed by the State of Wisconsin Department of Corrections (DOC) as a Nurse Clinician 3 at Taycheedah Correctional Institution (TCI). She had permanent status in class when she was suspended.

2. On February 28, 2024, Magnussen received a call that an inmate suffered an unwitnessed fall.

3. Magnussen told her colleagues that she had "23 more hours to see her [the inmate]" and returned to browsing travel websites on her state computer. She failed to complete a telephone triage by speaking directly with the inmate. She failed to visit the inmate.

4. Following an investigation, the DOC suspended Magnussen for five days for negligence and engaging in unauthorized activities while on duty.

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 did have just cause within the meaning of Wis. Stat. § 230.34(1)(a) to suspend Sarah Magnussen 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 Sarah Magnussen by the State of Wisconsin Department of Corrections is affirmed.

Issued at Madison, Wisconsin, this 27th day of March 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.

Sarah Magnussen 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 Magnussen was guilty of the alleged misconduct and that 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).

Magnussen is employed as a Nurse Clinician 3 at Taycheedah Correctional Institution (TCI). On February 28, 2024, Magnussen was on duty when she received a call from a correctional officer informing her that an inmate had an unwitnessed fall in the shower. Magnussen did not speak with the inmate, because the inmate was no longer with the officer who had called. At the time of the call, Magnussen was browsing the Internet for cabin rentals. After ending the call, Magnussen told her colleagues that they had "23 more hours to see her [the inmate]," laughed, and returned to browsing travel websites on her state computer. One of Magnussen's colleagues, nurse Sarah Krueger, was alarmed by Magnussen's callous attitude and went to assess the inmate. Krueger reported the incident to her supervisors, who initiated an investigation.

Three registered nurses – Sarah Krueger, Nurse Coordinator Kera Haase, and Bureau of Health Services Director Jessica Gross – testified that an unwitnessed fall is a medical emergency, because there is a possibility that a head injury occurred. A medical emergency requires a timely triage and a registered nurse assessment in order to rule out head trauma. Two other nurses, Mary Lemmenes and Elizabeth Lemke, said an unwitnessed fall wasn't an "immediate emergency" but that the inmate should be triaged or seen as soon as practicable. (One nurse, Arik Ringmeier, testified that an unwitnessed fall was not an emergency; however, Ringmeier received discipline for ignoring this inmate's unwitnessed fall, and his testimony is self-serving).

Magnussen argues that she was not in violation of DOC policy because she had 23 hours to assess the inmate. DAI Policy and Facility Procedure 500.10.08, "Access to Care," specifically prohibits unreasonable delays to care and treatment. *See* Exhibit R-6, pg. 2. The policy further requires that a registered nurse speak directly with a patient who is seeking access to care, either

in person or over the phone. *See* Exhibit R-6, pg. 4. The policy requires registered nurses at TCI to enter a phone triage note in the electronic medical record (EMR) and complete a face-to-face triage and/ or nursing sick call within 24 hours. *See* Exhibit R-6, pg. 5. This policy has been in place since January 2023. Further, one of Magnussen's job duties, as a Nurse Clinician 3, is to "respond to emergencies in all areas of the institution, including tiers in cellblocks, housing units, recreation and work areas, both indoors and outdoors." *See* Exhibit R-2, pg. 4. Magnussen's failure to assess or speak directly to an inmate experiencing a medical emergency because she preferred to sit and browse the Internet is, definitionally, an unreasonable delay in care and treatment. Even if an unwitnessed fall did not constitute a medical emergency, it was unreasonable for Magnussen to browse the Internet rather than respond to a request for care.

Magnussen argues that she did not receive sufficient training from management. However, this is not a situation which requires special training. As a registered nurse, who was at the time of the call in pay status and otherwise unoccupied, Magnussen was responsible for immediately responding to a patient request for care, especially when that request likely constituted a medical emergency.

Magnussen argues that correctional officers are trained to recognize life-threatening situations, and that this unwitnessed fall did not constitute an emergency because the officers did not believe it was an emergency. Unfortunately, DOC policy does not support Magnussen in her eagerness to foist her professional responsibility for patients onto untrained officers. Director Gross testified that officer health training does not supersede access to care policies. Unlike registered nurses, officers are not able to make the clinical judgments required by the access to care policy.

Magnussen contends that she did not commit any misconduct because the inmate lied about falling. This is irrelevant. Magnussen could not have known this at the time, because she failed to either speak directly to the inmate or perform a timely assessment.

Magnussen argues that TCI changed its procedures after this incident, indicating that there was a problem with the existing procedures. However, we are not concerned here with how TCI has chosen to respond to this incident, but whether Magnussen violated the policies as they existed on February 28, 2024.

Magnussen argues that it was common practice at TCI to complete a phone triage without speaking directly to the patient. However, the evidence to support a common practice is mixed. Nurse Mary Lemmenes, as well as Kreuger and Haase, testified that nurses must speak directly with a patient. Nurse Kayla Mertzig said she was unaware, until recently, of a policy requiring nurses to speak directly to patients during a phone triage. Nurse Elizabeth Lemke testified that she didn't know whether there was a common practice regarding whether nurses speak directly with inmates on a call, then later testified that there was a common practice among nurses. Ringmeier testified that it was common practice to not speak directly with the patient; however, as mentioned previously, his testimony is self-serving. There is not a clear-cut common practice at the TCI HSU to complete a phone triage without speaking directly to the patient. Further, there is no evidence that management was aware that employees were using this common practice or consented to this

common practice. Gross testified that common practice could differ from policy, but that doesn't mean it's acceptable.

Magnussen further alleges disparate treatment. She claims that other employees completed phone triages without speaking directly with patients but were not disciplined. An employee who raises a disparate treatment claim has the burden of proving that contention. The Commission has long recognized that disparities in discipline may, under certain circumstances, affirmatively defend against discipline despite the existence of misconduct. Underlying that position is the notion that if an employer treats one employee significantly more harshly than a similarly situated coworker for similar misconduct, inherent unfairness exists. *See Morris v. DOC*, Dec. No. 35682-A (WERC, 7/15). Here, Magnussen has submitted access to care records that purportedly show that other TCI employees completed phone triages without speaking directly with patients. However, these records don't have enough information to demonstrate that the employees were similarly situated to Magnussen. There is no evidence that management was aware of these other situations, whereas Magnussen's misconduct was reported to management by Krueger. Further, when the incident was brought to management's attention, another similarly situated employee – nurse Ringmeier, who was the charge nurse at the time the call came in – also received discipline. Magnussen has not borne her burden of proving that she was treated more harshly than similarly situated employees.

Lastly, Magnussen contends that she is being retaliated against. She argues that she has made numerous complaints about her supervisor, Kera Haase, creating a hostile work environment, and that she has been disciplined as a result of these complaints. However, Magnussen offered no proof to establish that she was retaliated against. Magnussen entered no evidence of making complaints about Haase. Krueger, not Haase, reported Mangussen. Haase was not the decision-maker.

Magnussen was negligent when she failed to assess an inmate who had had an unwitnessed fall. Further, she was engaged in unauthorized activities while on duty by browsing the Internet for cabin rentals. Gross testified that Magnussen's deliberate delay in providing care could have seriously jeopardized the inmate's health, especially if the inmate had suffered a head injury or other complications from the fall. The State followed progressive discipline, following Magnussen's previous three-day suspension with this five-day suspension. There was just cause for the five-day suspension, and the suspension is therefore affirmed.

Issued at the City of Madison, Wisconsin, this 27th day of March 2025.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

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James J. Daley, Chairman