2828 Capitol Blvd.
PO Box 40911
Olympia, WA 98504-0911

CC: SOC Cheryl

VOICE (360) 586-1481
FAX (360) 753-0139
E-MAIL info-pab@pab.state.wa.us

STATE OF WASHINGTON

PERSONNEL APPEALS BOARD

HOME PAGE www.wa.gov/pab

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DEC 20 1999

Department of Corrections
OAS Human Resources

December 17, 1999

Mark Anderson
Teamsters Local 313
In House Counsel
220 S. 27th Street
Tacoma, WA 98402-2701

RE: Gloria Wagner v. Department of Corrections, Reduction in Salary Appeal,
Case No. RED-99-0057

Dear Mr. Anderson:

Enclosed is a copy of the order of the Personnel Appeals Board in the above-referenced matter. The order was entered by the Board on December 17, 1999.

Sincerely,

Don Bennett

Don Bennett
Executive Secretary

DB:kw
Enclosure

cc: Gloria Wagner, Appellant
Elizabeth Delay Brown, AAG
Jennie Adkins, DOC

1117

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PERSONNEL APPEALS BOARD

BEFORE THE PERSONNEL APPEALS BOARD
STATE OF WASHINGTON

GLORIA WAGNER,

Appellant,

v.

DEPARTMENT OF CORRECTIONS,

Respondent.

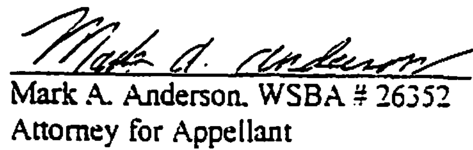
CASE NO. RED 99-0057

MOTION AND ORDER OF DISMISSAL

The appellant hereby notifies the Personnel Appeals Board that Respondent, the Department of Corrections, has rescinded the disciplinary action previously imposed, converting the reduction in pay to a letter of reprimand.

Because the Personnel Appeals Board has no jurisdiction over corrective actions, appellant now brings this motion to withdraw the above-entitled appeal.

Signed at Tacoma, Washington, this 10 day of December 1999.



Mark A. Anderson, WSBA # 26352
Attorney for Appellant

Teamsters Local No. 313
220 South 27th Street
Tacoma, WA 98402-2701
(253) 627-0103

1 This matter came on regularly before the Personnel Appeals Board on the
2 consideration of the request of the Appellant to withdraw his/her appeal. The Board
3 having reviewed the files and records herein, being fully advised in the premises, and it
4 appearing to the Board that the Appellant has requested to withdraw his/her appeal, now
5 enters the following:
6
7
8 **ORDER**
9 NOW, THEREFORE, IT IS HEREBY ORDERED that the Appellant's request to
10 withdraw his/her appeal is granted and the appeal is dismissed.
11
12 DATED this 17th day of December 1999.
13 WASHINGTON STATE PERSONNEL APPEALS BOARD
14
15 Walter T. Hubbard
16 Gerald L. Morgan
17 Anthony [illegible]
18
19
20
21
22
23
24
25
26

Teamsters Local No. 313
220 South 27th Street
Tacoma, WA 98402-2701
(253) 627-0103

CC: SOC
C. eryl

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AUG 2 1999
Department of Corrections
OAS Human Resources

1 BEFORE THE PERSONNEL APPEALS BOARD

2 STATE OF WASHINGTON

3

4 GLORIA WAGNER,	Case No. RED-99-0057
5 Appellant,	NOTICE OF RESCHEDULING APPELLANT'S MOTION FOR SUMMARY JUDGMENT
6 vs.	(ORAL ARGUMENT REQUESTED)
7 DEPARTMENT OF CORRECTIONS,	
8 Respondent.	

9 Notice is hereby given of rescheduling the hearing on Appellant's Motion for Summary
10 Judgment. The hearing will be held in the Personnel Appeals Board Hearing Room, 2828 Capitol Boulevard, Olympia, Washington, **Monday, October 18, 1999, beginning at 1:30 p.m.**

11 Pursuant to WAC 358-30-060(4) any affidavits to be filed in support of a motion shall be
12 served with the motion at least twenty-one days prior to the date scheduled for consideration of the
13 motion. Responses to the motion and any opposing affidavits shall be filed and served at least ten
14 days prior to the date scheduled. Any reply and any counter affidavits by the moving party shall be
15 filed and served at least three days prior to the date scheduled.

16 If the services of an interpreter are needed, notify Personnel Appeals Board staff. The hearing site is barrier free and accessible to the disabled.

17

18 DATED this 28th day of July, 1999.

19

20 WASHINGTON STATE PERSONNEL APPEALS BOARD

21 Teresa Parsons

22 Teresa Parsons, Hearings Coordinator
(360) 664-0479

23

24 cc: Gloria Wagner, Appellant
Mark Anderson, Attorney
25 Rob Kosin, AAG
Elizabeth Delay Brown, AAG
26 Jennie Adkins, DOC

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

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JUL 16 1999
Department of Corrections
OAS Human Resources

CC: SOC Cheryl

BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

GLORIA WAGNER, Appellant, vs. DEPARTMENT OF CORRECTIONS, Respondent.	Case No. RED-99-0057 NOTICE OF SCHEDULING APPELLANT'S MOTION FOR CONSOLIDATION (FOR PURPOSE OF SUMMARY JUDGEMENT ONLY) (ORAL ARGUMENT REQUESTED)

Notice is hereby given of setting Appellant's Motion for Consolidation (For Purpose Of Summary Judgement Only). The Board will hear oral argument on **Monday, August 16, 1999, beginning at 1:30 p.m., in the Personnel Appeals Board Hearing Room, 2828 Capitol Boulevard, Olympia, Washington.**

Pursuant to WAC 358-30-042(1) . . . written motions and any supporting affidavits shall be filed and served not less than five days before the date on which the motion has been noted for consideration by the board . . .; responses to the motion and any opposing affidavits shall be filed and served not less than one day before the date on which the motion has been noted . . .

DATED this 15th day of July, 1999.

WASHINGTON STATE PERSONNEL APPEALS BOARD

Maria F Aponte for
Teresa Parsons, Hearings Coordinator
(360) 664-0479

cc: Gloria Wagner, Appellant
Mark Anderson, Attorney
Elizabeth Delay Brown, AAG
Jennie Adkins, DOC

2828 Capitol Blvd.
PO Box 40911
Olympia, WA 98504-0911

STATE OF WASHINGTON
PERSONNEL APPEALS BOARD
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VOICE (360) 586-1481
FAX (360) 753-0139
E-MAIL info-pab@pab.state.wa.us

cc: ~~SOC~~ Cheryl

RECEIVED
JUN - 1 1999
Department of Corrections
OAS Human Resources

May 27, 1999

Gloria Wagner

RE: Gloria Wagner v. Department of Corrections, Reduction in Salary Appeal,
Case No. RED-99-0057

Dear Ms. Wagner:

This letter is to acknowledge receipt of your appeal by the Personnel Appeals Board on May 12, 1999. The Board will conduct a hearing of your appeal on a date to be determined. The time it takes to schedule a hearing date is affected by the availability of the parties and the number of appeals pending before the Board.

You may attempt to resolve this appeal with the assistance of one of the Board's contracted mediators. If mediation is jointly requested by the parties before June 28, 1999, a mediator will be assigned to meet with the parties in a good faith effort to negotiate a resolution of the appeal.

If you are represented by a union representative or an attorney, please encourage him or her to coordinate a request for mediation with the appointing authority of the employing agency, or the assistant attorney general who represents the agency. You may initiate this contact directly if you are not represented. Appeals assigned to mediators will be returned after sixty (60) days if the parties are unable to agree upon a date for mediation, and then scheduled for hearing on the Personnel Appeals Board calendar.

Please note that pursuant to WAC 358-30-190, all future correspondence or filings to the Personnel Appeals Board need to also be served on the opposing side.

Sincerely,

Don Bennett

Don Bennett
Executive Secretary

DB:kw
cc: Mark Anderson, Local 313
Linda Dalton, SAAG
Jennie Adkins, DOC

z:kw\newappl\wagner.doc

APPEAL FORM

WASHINGTON STATE PERSONNEL APPEALS BOARD
2828 Capitol Blvd.
P.O. Box 40911
Olympia, WA 98504-0911

PH: SCAN 321-1481
(360) 586-1481
FAX: (360) 753-0139

RECEIVED
MAY 12 1999
PERSONNEL APPEALS

[illegible]

PRINT OR TYPE - SIGN ON PAGE 2

RED-99-0057

PART I. APPELLANT IDENTIFICATION

NAME: Wagner, Gloria
(Last name, first name, middle initial)

HOME ADDRESS: [redacted]
(Number and street)
[redacted]
(City, state and ZIP code)

PHONE NUMBERS: WORK: (360) 794 - 2200
(Include area code)
HOME: [redacted]

EMPLOYING AGENCY OR INSTITUTION: Department of Corrections

AGENCY OR INSTITUTION THAT TOOK ACTION YOU ARE APPEALING: Special Offenders Unit

PART II. REPRESENTATIVE'S NAME, ADDRESS AND TELEPHONE NUMBER:

Mark A. Anderson
In-House Counsel
Teamsters Local No. 313

220 South 27th Street
Tacoma, WA 98402
(253) 627-0103

[illegible]

PART III. TYPE OF APPEAL

CHECK ONE OF THE FOLLOWING TO INDICATE THE TYPE OF APPEAL YOU ARE FILING:

XXX a. Disciplinary: (check applicable action(s).
____ Dismissal, ____ Suspension, ____ Demotion, XXX Reduction in Salary;

____ b. Disability Separation;

____ c. Rule or Law Violation (complete Part IV. of this form);

____ d. Reduction in Force/Layoff (complete Part IV. of this form);

____ e. Allocation (position classification) (complete Part V. of this form);

____ f. Declaratory Ruling (see WAC 358-20-050);

____ g. Exemption of Position.

PART IV. RULE VIOLATION OR REDUCTION-IN-FORCE APPEALS ONLY

What Rule(s) or Law(s) do you believe were violated?

Explain the particular circumstances of the alleged violation:

How were you adversely affected by the alleged violation?

What remedy are you requesting in this case?

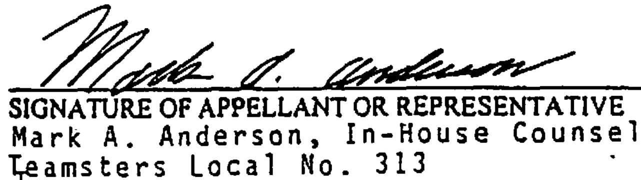
PART V. ALLOCATION APPEALS ONLY

Has there been a review of your allocation? Yes_____ No_____

If so, by whom?_____

What is your present classification?_____

To which class do you think your position should be allocated?_____



SIGNATURE OF APPELLANT OR REPRESENTATIVE
Mark A. Anderson, In-House Counsel
Teamsters Local No. 313

May 10, 1999
DATE SIGNED

RECEIVED
APR 21 1999
OFFICE OF THE ATTORNEY GENERAL
LABOR & PERSONNEL DIVISION

***** CONFIDENTIAL *****

DEPARTMENT OF CORRECTIONS
DISCIPLINARY ACTION AUTHORIZATION

Gloria Wagner
Employee's Name

2/4/99
Date Received at Headquarters

RN 2
Employee's Job Classification

SOC
Employee's Job Location

Chris Graham
Assigned Personnel Officer/Phone #

RECOMMENDED ACTION:

Reduction in Pay: RIP 5% x 6 months / $
(Percentage/Length) (Total $ Amount)

Demotion to: ______
(Job Classification)

Suspension: ______ / $
(Length) (Total $ Loss)

Dismissal: ______
(Effective)

4-28-99
Date completed form faxed to PO

The attached disciplinary action has been reviewed as noted below. "This information is provided under the attorney/client relationship and invokes that privilege. It should be considered CONFIDENTIAL in nature."

Initials/Title	Date	Approve	Disapprove	Comments
HR Administrator [signature]	4-20	✓		
AAG [signature]	4/21/99	✓		
Appropriate Deputy Secretary	4/21/99	[initials]		
DOC Secretary [signature]	4/28/99	✓		

Please hand deliver to all reviewers and return to Leslie Carrigg, HR, 8th Floor, upon completion.

✓

DRAFT

PERSONAL AND CONFIDENTIAL DELIVERY

Gloria Wagner

Ms. Wagner:

This is official notification that you will be reduced in salary within your present classification as a Registered Nurse 2 with the Department of Corrections at the Special Offender Unit of Monroe Correctional Complex, Range 45N, Step P, $3801 per month, to Step N, $3617 per month, effective ______ to _____ inclusive. (NOTE: 5% FOR SIX MONTHS)

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06 Revised Code of Washington, and the Merit System Rules, Title 356 Washington Administrative Code (WAC) Section 356-34-010 (1) (a) Neglect of duty, (h) Gross misconduct, (i) Willful violation of the published employing agency or department of personnel rules or regulations and 356-34-020, **Reduction in Salary - Demotion - Procedures.**

Specifically, you neglected your duty, committed an act of gross misconduct and willfully violated published agency rules, when, on 7/22/98, you failed to provide a physical assessment of Inmate and you also failed to document his medical complaint in the infirmary log, as well as, Inmate medical file.

The evidence indicates that you received a call in the infirmary at approximately 6:10 PM on 7/22/98 from Karen McLellan, Correctional Officer 2 on unit, that Inmate was complaining that he was having trouble getting air. You in turn asked C/O McLellan if Inmate was having a problem speaking, to which C/O McLellan responded, "no". You then stated to C/O McLellan that you were starting medication lines, that this was a usual complaint from Inmate that his cell was probably hot and

APR-20-99 04:21 PM HSR PERSONNEL OFFICE 360 794 2569 P.02

stuffy, and told C/O McLellan to have Inmate █ take a cool shower to help him feel better. You also told C/O McLellan, "if he continues to complain, call me back." You continued with medication lines and heard no more from the unit. As you finished medication lines, you informed RN 2 Mike Kalina of C/O McLellan's call regarding Inmate █ Without physically assessing Inmate █ complaint and as you had heard nothing more from the unit staff regarding Inmate █ complaint, you and RN 2 Kalina decided it was not an emergent situation and RN 2 Kalina agreed to check on Inmate █ at lockdown medication line, which was at approximately 8:30 PM. When RN2 Kalina checked on Inmate █ he was observed to be asleep and snoring. There was no indication that RN2 Kalina communicated with Inmate █ to check his physical status or with unit staff regarding any further complaints that Inmate █ may have made.

At approximately 10:34 PM on 7/22/98, which was after your shift and you were no longer in the institution, C/O 2 James Smith contacted the infirmary and asked RN 2 Leann Cave to check on Inmate █ C/O Smith further reported to RN 2 Cave that Inmate █ had not changed positions in approximately ninety minutes and that his feet appeared pale. RN 2 Cave indicated that she was unaware of any complaint from Inmate █ as there had been no documentation of any complaint from him in the infirmary log nor in Inmate █ medical record. It should be noted that Inmate █ died in his cell that evening.

During the Administrative Comments investigation of this incident, you indicated to Ella Ray Sigmund, CMHPM and Acting Associate Superintendent, that Inmate █ had made similar complaints in the past and that they were not always documented.

An Employee Conduct Report initiated on 8/3/98 describing this incident in greater detail is attached (Attachment #1) hereto and incorporated herein.

Inmate █ complaint of having difficulty getting air was significant to his documented physical problem of which all medical staff, including yourself, were aware. The knowledge of this medical significance is information you should have responded to.

The Department of Corrections Employee Handbook states, in part, under **Department Objectives,** on pages 1 and 2:

> The department's main objectives are to:
>
> - **Ensure safety for...offenders;** (emphasis added)

- **Treat all offenders...fairly and equitably;** (emphasis added)

- **Meet the national standards appropriate to the State of Washington** (emphasis added)

and also states, in part, under **Code of Ethics** on page 2:

> **High moral and ethical standards among correctional employees are essential for the success of the department's programs. The Department of Corrections subscribes to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service.** (emphasis added)

and further states, in part, under **Department Expectations,** on page 2:

> As a representative of the Department of Corrections, you will be expected to:
>
> - **Serve each offender with appropriate concern for their welfare...**(emphasis added)

On 11/24/93, you acknowledged receipt of the June 1993 Employee Handbook, further agreeing to become familiar with and have a thorough knowledge and understanding of its contents. Copies of pages 1 and 2 of the 1993 Employee Handbook (Attachment #2), and your acknowledgment of its receipt (Attachment #3) are attached hereto and incorporated herein.

The classification questionnaire (CQ) for your RN 2 position, HB36, which outlines its duties states, in part, under "Employee's Statement of Duties":

> **Provide ongoing nursing treatment and emergency treatment as necessary.** (emphasis added)
>
> **Maintains professional nursing care integrity as it applies to...delivery of service.** (emphasis added)

A copy of the CQ for your position, HB36, is attached (Attachment #4) hereto and incorporated herein.

As an employee and Registered Nurse 2 with the Department of Corrections at the Special Offender Unit of Monroe Correctional Complex, you have a

APR-20-99 04:22 PM HSR PERSONNEL OFFICE 360 794 2569 P.04

duty and obligation to:

1. Adhere to its policies and procedures, which are designed to ensure the efficient and effective management of the Department's programs;

2. Ensure the safety for offenders; to treat all offenders fairly and equitably; and to meet the national standards appropriate to the State of Washington;

3. Ensure the high moral and ethical standards the department expects of its employees to ensure the success of its programs;

4. Perform your duties in a professional, competent and compassionate manner;

5. Meet the expectations of the agency as a whole; and

6. Serve each offender with appropriate concern for their welfare.

Inmate complaint of having difficulty getting air is significant to his documented overall medical condition, which all medical staff, including yourself, were aware or should have been aware. Given his overall medical condition, there was, according to Dr. Jonas, WSRU Contract Physician, who I had review this incident, medical significance to his complaint, which you should have responded to. Even though you indicated during the course of the investigation of this incident that Inmate had made numerous medical complaints of a similar nature, it was noted in a review of his medical chart that those "similar" complaints had not been charted.

Additionally, while you relied on the observation of a correctional officer that he was able to speak, it should be noted that correctional officers are not medical staff and are not qualified nor are they expected to conduct medical assessments of inmates. Also, while you did not hear back from unit correctional staff of any further complaints from Inmate you took no affirmative action after completing medication lines to ascertain his physical status in person or by calling unit staff to check on him. Instead, you waited until approximately 8:30 PM to have Inmate checked on by RN2 Kalina. Finally, even though you had received an indication from correctional staff of Inmate physical complaint, you failed to appropriately document that complaint in either the infirmary log or his medical chart.

By your behavior in this incident, you have clearly demonstrated:

ie. handbook

1. A neglect of your duty and obligation to meet the reasonable expectations of the Department that you would adhere to its policies and procedures; that you would ensure for the safety of its inmates and treat all offenders fairly and equitably; to meet the national standards appropriate to the State of Washington; and that you would perform your duties in a professional, competent and compassionate manner, serving each offender with appropriate concern for their welfare. These charges are based on your behavior of failing to appropriately provide a physical assessment of Inmate ■ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate ■ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate ■ medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate ■ later that evening. During the Administrative Comments meeting with Ms. Sigmund, you also indicated that you did not document in his medical file any of the numerous similar complaints that he had made about his difficulty getting air and that his complaints were many and delusional in nature and that you did not document them as well.

2. A neglect of your duty to meet the reasonable expectations outlined in your Registered Nurse 2 position's Classification Questionnaire, HB36, to provide ongoing nursing treatment and emergency treatment as necessary; and to maintain professional nursing care integrity as it applies to delivery of service. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate ■ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate ■ was complaining that he was having trouble getting air; and your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate ■ medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate ■ later that evening.

3. A willful violation of the Department of Corrections Employee Handbook by your failure to: assist the department in meeting its objective of ensuring the efficient and effective management of its programs; to ensure the safety of its offenders and to treat all offenders fairly and equitably; meet the national standards appropriate to the State of Washington; meet the moral and ethical standards of the department that you would perform your Registered Nurse 2 duties in a professional and competent manner; and to serve each offender with appropriate concern for their welfare. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate █ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate █ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate █ medical chart. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate █ later that evening.

4. Gross misconduct by your blatant and flagrant disregard for the stated objectives and ethics of the Department of Corrections to ensure the safety of offenders; to treat all offenders fairly and equitably; to meet the national standards appropriate to the State of Washington; and to subscribe to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service, all of which adversely impacts the Department's ability to carry out its mission and functions. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate █ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate █ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate █ medical chart. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate █ later that evening.

APR-28-99 04:25 PM MSR PERSONNEL OFFICE 360 794 2569 P.07

In reviewing your personnel file I find:

1. A Memo of Counseling dated 9/24/98, from your supervisor, RN 3 Bollinger, which addressed your behavior of 8/31/98, dispensing medication to Inmate and failing to immediately chart that information, as required by law and as further directed by Ella Ray Sigmund, CMHPM in a memo to RN's dated 8/13/98. By your failure to do so, you were directly responsible for an overdose of medication received by Inmate

A copy of the foregoing document from your personnel file is attached (Attachment #5) hereto and incorporated herein.

In conclusion and full consideration of the foregoing, I have determined to reduce your salary as a Registered Nurse 2 as indicated in paragraph one of this letter.

Under the provisions of Washington Codes 358-20-010 and 040, you have the right to appeal this action to the Personnel Appeals Board, 2828 Capitol Boulevard, Olympia, Washington, 98504, within thirty (30) days from the effective date stated in paragraph one of this letter.

The Merit System rules (WACS), Department of Corrections' policies, Monroe Correctional Complex-Special Offender Center Field Instructions and the Collective Bargaining Agreement are available for your review upon request.

Kenneth DuCharme
Superintendent

KD:cg
Attachments

cc: Dave Savage, Deputy Secretary, OCO
Eldon Vail, Assistant Deputy Secretary, OCO
Phil Stanley, NW Regional Administrator
Jennie Adkins, Human Resources Administrator, OAS
Linda Dalton, Senior Assistant Attorney General
Cheryl Landers, NW Region Human Resource Manager
Bob Riordan, MCC Human Resource Manager
Personnel File

APR-20-99 04:24 PM MSR PERSONNEL OFFICE 360 794 2569 P.08

DEPARTMENT OF CORRECTIONS

EMPLOYEE PROFILE

Name		Classification	
Wagner, Gloria		Registered Nurse 2	
Status	**Current Range/Step**	**Amount**	**PID Date (Affects?)**
Permanent	45N / P	$3801	—

PROPOSED ACTION: Dismissal

DATES From / / To / / No. of Months

RANGE/STEP From To ($)

TOTAL LOSS ($)

A. PERSONNEL/PAY ACTIONS (Information obtained from P-2 Documents): Original date of hire, date(s) of agency/institution transfer(s), date(s) of promotion(s), date(s) of pay change(s) due to disciplinary action(s), etc. *List only information which is relevant to the action being proposed.*

	EFFECTIVE DATE	TYPE OF ACTION	DISCIPLINARY?
1	9/21/87	DATE OF HIRE	—
2	10/8/91	Transfer from WSR to SOC	—
3			
4			
5			
6			

☐ Above section continued on Page Two

B. EMPLOYEE PERFORMANCE EVALUATIONS

DATES (Mo/Yr) From To	Ratings * Far Exceeds	Ratings * Exceeds	Ratings * Normal	Ratings * Minimum	Ratings * Fails Min.	Type **	Comments (Note if EPE is part of Disciplinary Letter)
9/21/96 to 9/21/97		A, C	B, D, E			A	
9/21/95 to 9/21/96		A, C, D	B, E			A	
9/21/94 to 9/21/95		A, C, D	B, E			A	
9/21/93 to 9/21/94		C, D	A, B, E			A	
9/21/92 to 9/21/93		A, B, C, D	E			A	
9/21/91 to 9/21/92			A, B, C, D, E			A	
12/6/90 to 9/21/91		A, B	C, D, E			A	
12/6/89 to 12/6/90		A, C, D	B, E			A	

☐ Above section continued on Page Two

* *List Performance Dimensions:*

A - Accomplishment of Job Requirements
B - Job Knowledge and Competence
C - Job Reliability
D - Personal Relations
E - Communications Skills
F - Performance as Supervisor

** *Indicate Type of Evaluation:*

P - Probationary
A - Annual
T - Trial
S - Special

DOC 3-104 m (4/91) Page One

DEPARTMENT OF CORRECTIONS

EMPLOYEE CONDUCT REPORT

THIS FORM TO BE USED IN COMPLIANCE WITH POLICY DIRECTIVE NO. 857.005

INSTRUCTIONS AND TIME LIMITS:

1. The person making the report shall provide a clear description of the incident under "Description of Incident" and, with any witness(es) or person(s) having knowledge, shall sign in the space provided and submit to the supervisor of the involved employee within fourteen (14) calendar days after the date of discovery of an employee's alleged misconduct.
2. The form shall be submitted to the employee involved who shall complete the "Employee's Statement" and return the report to his/her supervisor within seven (7) calendar days following the date of receipt.
3. The appropriate supervisor shall review the facts of the incident, complete the "Supervisor's Report" and submit the report to the Office Head within seven (7) calendar days following the date of receipt.
4. The Office Head or designated representative shall review and within thirty (30) calendar days following the date of receipt determine whether misconduct has occurred. This shall be reported under "Administrative Comments" and shared with the employee. When the supervisor and Office Head are the same person, the supervisor's supervisor shall complete the Administrative Comments.

EMPLOYEE INVOLVED	ORGANIZATIONAL UNIT		
Gloria Wagner	MCC - Special Offender Center		
POSITION TITLE	DATE OF INCIDENT	TIME OF INCIDENT	
RN 2	7/22/98	6:10 PM	☐ AM ☐ PM

DESCRIPTION OF INCIDENT:

ON 7/22/98 AT APPROXIMATELY 6:10 PM, YOU WERE NOTIFIED BY CO KAREN MCLELLAN THAT INMATE [redacted] WAS COMPLAINING THAT HE "WAS HAVING TROUBLE GETTING AIR." YOU INSTRUCTED CO MCLELLAN TO HAVE INMATE [redacted] TAKE A COLD SHOWER

IN A MEMO YOU PREPARED TO RN3 TERESA BOLLINGER, YOU INDICATED THAT "INMATE [redacted] HAD COMPLAINED SEVERAL TIMES IN THE PAST ABOUT HOW HE COULDN'T BREATHE IN HIS CELL" AND THAT AS YOU "ASSUMED IT WAS THE HEAT AND STUFFINESS IN HIS CELL" YOU TOLD CO MCLELLAN "A COOL SHOWER MIGHT BE HELPFUL." AS YOU WERE DOING MED LINES, YOU CHOSE NOT TO GO SEE INMATE [redacted] ON THE UNIT, INFORMING RN2 MIKE KALINA OF INMATE [redacted] COMPLAINT AND FOR HIM TO CHECK ON HIM WHEN HE DID UNIT LOCKDOWN MEDS.

ON 5/18/19/20 1998, YOU WERE PRESENT WHEN RN3 BOLLINGER GAVE A VERBAL DIRECTIVE TO ALL RN2'S PRESENT THAT THEY WERE TO PHYSICALLY ASSESS ANY INMATE WHO COMPLAINED OF ANY PHYSICAL ABNORMALITY.

INITIATED BY:

NAME (PLEASE PRINT)	POSITION TITLE	SIGNATURE	DATE
Teresa Bollinger	RNC-3	Teresa Bollinger RN-3	8/3/98

WITNESS(ES):

NAME	POSITION TITLE	SIGNATURE	DATE

1134

3-30 (REV 3-85) -294-

Attachment 1

August 10, 1998

On 7/22/98 at approximately 6:10 PM, C/O Karen McLellen called the infirmary and informed me I/M [redacted] was complaining that he was "having trouble getting air". I asked "Is he having problems speaking?" she said "No". I told her I was just starting med lines, that this was a usual complaint from him, that his cell was probably hot and stuffy. I told C/O McKellen that a cool shower would probably help him feel better. I also said "If he continues to complain call me back". I then did med lines and heard no more from the unit.

As soon as we finished med-lines, I informed Mike Kalina, RN II of C/O McKellan's call. We decided it was not emergent and M. Kalina, RN II agreed to check on him at lockdown med-line since he was doing that side anyway. At 8pm as we were leaving to do lockdown medications, I reminded M. Kalina, RN II to check on I/M [redacted]. He said he would. After checking with staff on the unit and listening to I/M [redacted] usual snoring, he noticed nothing amiss and returned to the infirmary.

I/M [redacted] had no history of respiratory or cardiac problems. He was very somatic and often times delusional. He would frequently say, "I can't breathe in this cell, could you talk to someone and see if I can go outside and get some fresh air." He was never in any acute respiratory distress, his speech normal and clear, so I would give him reassurance and apologize for having no control over his lock down status.

The incident was not ignored. Because of his history of many somatic complaints, we did not feel it was emergent and since we received no call back from the unit, we thought that the situation had resolved. It is common practice to assess I/M's, especially those on lockdown status on the unit at lockdown med lines.

Gloria M Wagner RN

Gloria M. Wagner, RN II

cc: Mike Wilson
Teamster Business Associate
Local 313

Employee Conduct Report: Gloria Wagner, RN 2
September 21, 1998

Administrative Comments:

On August 3, 1998, you were issued an Employee Conduct Report (ECR) by Teresa Bollinger, RN 3. It is alleged misconduct occurred by you on the evening of July 22, 1998, when you failed to respond to provide a physical assessment on offender [redacted], after receiving a call in the infirmary at 6:10 PM from Karen Mclellan, Correctional Officer on [redacted] Unit. It was later that same evening [redacted] died in his cell on [redacted]-Unit.

Findings of this Review:

According to RN 3 Teresa Bollinger, on the dates of May 18, 19, and 20, 1998, you were present when she gave a directive to all RN 2's that they were to physically assess any inmate who complained of any physical abnormality. This directive was based on a memo directive this writer sent to Mrs. Bollinger. You report not being aware of this directive on July 22, 1998.

You assumed [redacted] was complaining about his difficulty getting air because it was a hot night and instructed CO Mclellan to have [redacted] take a cold shower and to call back if his problems persisted. Although by your own report and the report of others this was a common complaint of [redacted] CO Mclellan did not call back.

You were in the middle of doing med lines when you received the call from CO Mclellan.

You did not document this call in the infirmary log or [redacted] medical file. Nor had you documented in his medical file any of the numerous similar complaints that he had about his difficulty getting air. You state [redacted] complaints were many and often delusional in nature and that you do not document them always. You acknowledge knowing that if nurses do not document offender's complaints in their medical files and if offenders do not make the same complaints to their treating physicians, then they will not have this information.

You verbally reported [redacted] complaint to RN 2 Mike Kalina who looked in on [redacted] at approximately 8:30 PM to find him snoring as he slept. There was no verbal communication at this time between [redacted] and Mr. Kalina.

CO Taylor observed [redacted] lying on the floor naked about 9:30 PM. According to Mr. Taylor's report, at that time [redacted] indicated he felt better after taking a shower.

[redacted] was a difficult offender to assess for medical problems because he complained often about a number of medical problems, some of which could be verified

as not real and he was delusional (his belief system was idiosyncratic and often could not be verified).

According to Dr. Jonas, M.D., [redacted] treating physician, the aforementioned complaint of having difficulty getting air is significant to his documented physical problem of which all medical staff, including yourself, were aware. The knowledge of this medical significance should be information commonly known among nurses, according to Dr. Jonas. You state knowing the problem becomes a medical concern at the time s/he becomes neumoniatic.

Persons prescribed psychotropic medications are more susceptible to the effects of heat than are the general population. You indicate not having knowledge of this on the date of July 22, 1998.

You recently became certified as a psychiatric nurse and the above information was not included in the material you read for the exam you took to become certified.

You state you or any of the other nurses would never deliberately harm an inmate.

Conclusion: This reviewer finds misconduct for failing to respond to an offender complaining of having a medical problem (who later died), for the following reasons:

1. A CO is not a medically trained person therefore s/he relies on the medical expertise s/he cannot be relied on to provide a medical assessment of an offender 's physical complaints, nor should s/he be placed in the position to assume legal liability for having done so.

2. Although it was stated in Ms. Lareau's investigative report at the time RN 3 Bollinger verbally gave the physical assessment directive, included was not a time frame for meeting with the offender after receiving a complaint, [redacted] was not physically assessed at any time during the evening of July 22, 1998.

3. The fact that it was an unusually hot evening is all the more reason why RN 2 Wagner should have been more concerned for the welfare of [redacted] Her assumption he was having a minor reaction to the heat should have been confirmed or not by a physical assessment.

4. The fact that [redacted] repeatedly made the same complaint about having difficulty getting air should have raised a red flag to Ms. Wagner to (1.) do a physical assessment and (2) document this complaint in his medical chart for the treating physician to further assess. And to provide recorded information to nurses working the following shifts. As this information was not documented in any location, the fact [redacted] complained of having a physical problem did not get passed on to the next shift of nurses. RN 2 Cave reports she did not know of this complaint when she was called to look in on [redacted] at 10:34 PM, by CO Smith.

5. Although you were in the middle of doing med lines, you could have requested that correctional officers bring [redacted] to the infirmary for assessment while holding off on having the next group of offenders sent to med line.

Additonal Comments:

In addition to this writer's findings of misconduct for failure to respond to an offender's physical complaint, your failure to document in [redacted] medical file what according to Dr. Jonas, M.D. is pertinent medical information is also reason for misconduct. This lack of documentation failed to provide RN 2 Cave with necessary information she needed to properly assess [redacted] later that evening.

Ella Ray Sigmund, Office Head

Ella Ray Sigmund
Acting Associate Superintendent / CMHPM
9-18-98

CHASE RIVELAND
Secretary

pac ket

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

SPECIAL OFFENDER CENTER

P.O. Box 514 - Park Place • Monroe, Washington 98272-0514

9/9/98

TO: Gloria Wagner

FROM: Ray Sigmund
Acting Associate Superintendent

SUBJECT: ADMINISTRATIVE MEETING

I am scheduling a meeting with you on 9/10/98 at 2:30 p.m. in my office to discuss the Employee Conduct Report initiated by your supervisor. Attached please find copies of the following documents:

- Employee Conduct Report
- Employee Rights Pursuant to Article 8.2 of Institutions CBA

The purpose of this meeting is to give you an opportunity to explain your account of the incident prior to my making a decision as to whether or not misconduct occurred.

You are entitled to have an employee representative present at this meeting. No copies have been sent to your representative. If you choose to have an employee representative present, it is your responsibility to forward these documents to him/her yourself.

BB

Att: (2)

cc: Linda Gilstrap, Personnel

Chronological Description of Incident

C/O McLellan was unit Booth Officer on Shift III, July 22 1998. It was a very hot night and the air conditioners were not working well. C/O McLellan said that was acting normally during her shift and not yelling that night. At approximately 1810 activated the cell intercom by yelling that he was having trouble getting air. C/O McLellan replied to that she would notify the infirmary, and said that she sent an officer to check on him (I did not corroborate this.) C/O McLellan said that had enough breath to activate the intercom, which took a fairly loud noise to activate. C/O McLellan said that this was the only time that she knew of on this shift which complained or activated the intercom. She said that was known to have many complaints, but could not recall exactly if he had complained of trouble getting his air, or indeed any of his specific complaints, in the past. C/O McLellan said that there was nothing in presentation which was unusual or which alarmed her. She also said that the nurses had always been very attentive to and had always evaluated his complaints in a timely fashion. For her part, she said, she always relayed the inmates' complaints to medical without delay.

That night, RN2 Wagner was conducting medication lines when she received the call from Unit Booth C/O McLellan, stating that was complaining of having trouble getting air. RN2 Wagner asked C/O McLellan if was having problems speaking, and was told that he was not. Since it was such a hot night, RN2 Wagner thought perhaps the heat was bothering and suggested to C/O McLellan that a cool shower might help. RN2 Wagner further asked C/O McLellan to call her back if had any more problems; C/O McLellan's memo did corroborate this. RN2 Wagner said that she did not hear back from the unit, and so assumed was feeling better.

RN2 Wagner said that she completely trusted C/O McLellan and the rest of the unit staff to follow through with and let her know if he was having further problems. She (and several other nurses- Atchison, Cooper-Schmidt, and Kalina) said that complaint of having trouble getting enough air was a frequent complaint for him, that he was never in any respiratory distress when evaluated for this complaint, and that he frequently included the request to go outside and get some fresh air, saying that he could not get enough air in his cell. RN2 Wagner said that she had no reason to believe - either from past medical history or the presentation of his complaint that night - that was in any danger or that this was different in any way from previous similar complaints.

At about 1830-1845, after finishing the dinner medication lines, RN2 Wagner told Mike Kalina, RN2, about complaint and her conversation with C/O McLellan. The Shift III nurses split up their nursing duties, and that evening it was the responsibility of Mike Kalina RN2 to respond to non-emergency complaints on Unit. They decided that since this was a frequent complaint and hitherto without objective findings for

and since they had not heard back from the unit, RN2 Kalina would check on [redacted] at the 2000 medication rounds.

C/O McLellan stated that one of the officers who saw [redacted] about this time said that he was puffing a little, but nothing out the ordinary for him. [redacted] did take a cool shower, and the officers could hear him "whooping and hollering" in the shower (which did not, as RN2 Kalina later pointed out, indicate respiratory distress.)

Mike Kalina, RN2, and an officer checked on [redacted] at about 2030. RN2 Kalina said that [redacted] was asleep and snoring quite loudly (this was corroborated by C/O McLellan's 7/23 memo) as was his habit. [redacted] respirations at that time were even and regular and he appeared, when seen through the cell window, to be merely asleep and in no distress. Attempts made to awaken [redacted] by calling and knocking were of no avail. RN2 Kalina said that since these medications were voluntary medications, and [redacted] was known to sleep through this medication pass (despite the noise of the calling and knocking) nothing seemed out of the ordinary.

At some time between 1800 and 2200 (the exact time has not been determined) a religious volunteer (Dan Dierdorff) visited [redacted] He thought that [redacted] was "really out of it" that night. He was unable to communicate with [redacted] for the first time in "numerous visits." The volunteer said that he did not think [redacted] was in a life threatening situation and so did not ask an officer to check on him. In retrospect, however, he said [redacted] "looked like a man with a high fever."

C/O Benda checked on [redacted] about 2130 and [redacted] was lying on the cell floor. (Immediately after [redacted] death I asked several people who knew [redacted] if lying on the floor and/or being naked was unusual for him. No one thought it was very out of the ordinary for him. This was before my investigation and I do not remember who or when I asked, though.) C/O Benda asked [redacted] if he was feeling OK and according to C/O Benda, [redacted] replied "Yes, I'm a little hot, I took a shower, I'm OK."

I did not think it appropriate to interview, nor to include any information from a "declaration" written by SOC Inmate Sean Morin #912839. This is the inmate who could be heard yelling on the videotape of the entry of [redacted] cell the night he died. The point of Mr. Morin's letter is to debunk and expose actions and inactions by the nursing and custody staff. This memo is included in the packet of memos.

Nursing Interviews

RN3 Bollinger wrote the ECR. She alleges that RN2 Wagner chose not to go see [redacted] on the unit when C/O McLellan relayed [redacted] complaint. RN3 Bollinger stated that on May 18, 19, and 20, 1998 she announced at the noontime nursing meeting that all nurses were to physically assess any inmate who complained of any physical abnormality. Her concern is that RN2 Wagner neglected her duty by failing to physically assess [redacted] at the time of his complaint.

In my interview with RN3 Bollinger on 8/24, she stated that she had informed the nurses that they must bring down to the clinic and physically assess all patient complaints of potentially severe problems such as chest pain, shortness of breath, severe abdominal pain, etc. RN3 Bollinger says that she did not state a timeframe within which these problems were to be assessed, nor put her directive in writing, nor have the nurses sign that they had received this directive. RN3 Bollinger estimated that the SOC nursing staff receives 10-20 notifications of physical problems each week, not all of them severe. Further, when asked if she thought that the nurses should assess the 20th instance of a particular complaint by a particular patient like the 1st, she replied "yes."

I asked RN3 Bollinger what her thoughts were on the nurses performing "telephone triage" of patient complaints, that is, trying to ascertain over the telephone which complaints were significant enough to warrant physical assessment. While stating that the nurses have to use their clinical judgment to ascertain which problems are significant enough to warrant the patient being brought down to the clinic and assessed, she also stated that it was not the officers' job to judge what was an emergency or even to describe how the inmate appeared to them. (I happen not to agree with this last thought - the officers are trained observers and are well able to describe in layman's terms how someone looks. This is not asking the officers to make a medical judgment or call.)

Every nurse interviewed expressed the deep frustration and concern that they did not have enough time on their shifts to complete their tasks, and many thought the latter half of Shift III was the busiest and most difficult (although nights was, as well.) The general opinion was that there was no "slack" time between about 1615 and 2200; any urgency or emergency must be carefully evaluated for its significance because of the impact on the shift duties. Some examples given were: giving the "dinner" medications too late could impact the " bedtime" medications because many medications cannot be given too close together. One nurse running late could adversely impact the" bedtime" medication line for the whole institution. And many times there would be more than once special (time-consuming) problem per shift, such as an inmate requiring an involuntary shot or other medication as well as an urgency or emergency.

When asked, RN3 Bollinger stated that she had filed the ECR because RN2 Wagner had not followed the directive concerning physical assessment, and because she did not think that RN2 Wagner had used good medical judgment. RN3 Bollinger, also when asked,

stated that the reason she filed the ECR was for "someone else to investigate (the situation) and make a decision on whatever needed to be done."

In interviews with all of the seven full-time nurses at SOC, when specifically asked if they remembered RN3 Bollinger "announcing the expectation that every time an inmate voiced a physical complaint he would be visualized and assessed by a nurse," four - including RN2 Wagner - replied no, one replied no but it was standard operating procedure to do so, and two replied that they had heard her say this in the past but couldn't remember where or when.

Included in the ECR packet were DOP Policy 620.020 and TRCC Field Instruction 620.020 " Inmate Deaths." Neither of these seems applicable to this part of the situation. Also included is TRCC Field Instruction 610.020 "Inmate Health Emergencies" which states "The following conditions constitute a medical necessity for emergency transfer:....Any clinical situation that presents as life threatening or requires physician-level intervention...i.e. ...respiratory impairment..."

__Investigative Statement__

1. Appropriate communication occurred between nursing staff and custody staff. Nursing staff had asked for a "call back" if [redacted] had any further problems and a second call was neither made nor received.

2. Telephone triage is a necessary tool in this setting and must be used with accurate observations and reporting by custody staff combined with the use of good nursing judgment.

3. None of the nurses or officers who wrote memos or were interviewed about [redacted] [redacted] complaint of the evening of 7/22 thought he was having respiratory impairment or that he was experiencing a life threatening problem.. [redacted] "whooped and hollered" in his cool shower that evening. RN2 Kalina assessed [redacted] [redacted] sleeping (snoring) respirations as "rhythmic and regular" on his (RN2 Kalina's) 2030 follow-up of [redacted] complaint. [redacted] told C/O Benda at 2130 that he was OK. The one incongruity is in the religious volunteers' description of his visit with [redacted] - but the only potentially relevant observation which the volunteer made on that was done in retrospect

4. It is unclear whether RN3 Bollinger's verbal directive to visualize and assess every inmate who complained of a severe physical abnormality reached all the staff.

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Lt. Connors

DATE: 7-23-98.

FROM: c/o Jim Smith, Booth Officer

SUBJECT: Inmate [redacted]
DOC# [redacted]

At. approx. 10:34 pm on 7-22-98, RN Caves + I went to Inmate [redacted] cell ([redacted]) to offer him his nightly meds. Inmate [redacted] appeared to be sleeping. We tried waking him up by calling his name + knocking on his door. He did not respond + we took this as a med. refusal. At that time, it appeared to me that inmate [redacted] was breathing. At my 12:45 am. Tier V, I saw that inmate [redacted] was laying in the same position. He still appeared to be breathing but I was concerned that he hadn't moved + his feet looked pale.

When I got back to the unit booth, I called RN Caves + informed her that another inmate was requesting a PRN. I asked her if she would check on Inmate [redacted] when she came up to the Unit. I told her that he appeared to be sleeping but that I was concerned that he hadn't moved since she saw him at 10:34 pm. I told her also that his feet looked pale. I called Sgt. Milan at approx. 12:55 am. + informed him of the situation + that the nurse was going to check on him. He said to keep him informed.

(cont. on page 2)

1144

recycled paper

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Lt. Connors DATE: 7-23-98

FROM: c/o Jim Smith, Booth Officer SUBJECT: Continued from Page 1

cont.)

RN Caves arrived on Unit at approx. 12:56am, and along with c/o Brown, went to [redacted] cell + tried to wake him up. They could not. C/o Brown called to me in the booth and told me to call the Sgt. I called Sgt. Milan + told him that we could not wake up inmate [redacted] + that RN Caves was requesting him to come to the Unit. Sgt. Milan + RN Todd arrived on Unit at 1:05 am. Lt. Connors arrived on Unit at 1:17 am. C/o Netherton arrived on Unit at 1:22 am.

I opened cell 303 at approx 1:27 am. Lt. Connors ordered it opened. M/C was ntfd.

The cell was entered by c/o's Taylor + Brown, Sgt. Milan and RN Todd. A short time later I heard RN Todd say that Inmate [redacted] was dead. I ntfd. Main Control.

At. approx. 1:35 am. Lt. Connors declared cell [redacted] a crime scene. He left the unit with c/o Taylor at approx. 1:35 am. At. approx. 1:46 am. Sgt. Milan ordered c/o's Brown + Netherton to Secure cell [redacted]

1145

DOC 02-110 (3/91) BW-1

August 10, 1998

This memo is being written in response to the incident on 7/22/98 involving I/M [redacted] In my memo dated 7/24/98, I described the events on the swing shift that I encountered before going off duty.

I was asked to check in on I/M [redacted] during lockdown med line, which I did. When I came to his cell, I noted that he was snoring loudly, which was not unusual for him. His breathing pattern was even and regular. I/M [redacted] had a usual snoring habit that could be heard without the aid of the overhead speaker system. I/M [redacted] also has slept through the med lines at 8:00 PM, which because he was not on involuntary meds was always listed as a refusal. When I checked I/M [redacted] we attempted to awaken him by tapping keys on the window, opening the food slot, calling out to him, knocking on the door but he continued to sleep as evidenced by his rhythmic snoring. I did not notice any change in his skin color, evidence of sweating or other abnormalities. C/O McLellan stated that when I/M [redacted] had his cool shower he was whooping and hollering when he turned the shower on. This was not indicative of someone in respiratory distress. C/O McLellan also stated the I/M [redacted] verbalized the "he felt better" following the shower. After talking with the unit staff and listening to and visualizing I/M [redacted], I had no reason to believe that this was anything more than his usual somatic complaint.

I want to add also, that other staff has witnessed I/M [redacted] bizarre and somatic behavior. I/M [redacted] has made the complaint of not being able to get air, that he's cured his disease through prayer, people were entering his cell and were raping him during the night. He has also stated that people were entering his cell at night and drinking his blood, how he was Martin Luther King, Jr. re-incarnated. When I/M [redacted] was brought to the infirmary for blood draws, he would request to have all his blood removed. He also offered to perform sex acts for C/O's or Nurses to gain his freedom from his cell. He was also known to repetitively request of anyone that would listen, if they could buy him a "rock", because he hadn't had any crack cocaine for a long time. I have had the occasion to have I/M [redacted] complain that he has difficulty breathing while taking medications, drinking juice and smiling at me after finishing the juice.

Michael T. Kalina RN-2

Michael T. Kalina, RN II

cc: Mike Wilson
Teamster Business Associate
Local 313

CHASE RIVELAND
SECRETARY

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: T. Bollinger RN 3

DATE: 7/24/98

FROM: M. Kalenic RN 2

SUBJECT: I/M [redacted]

Before administering meds on [redacted] unit at 8pm pill line, I was reminded that I/M [redacted] had complained of difficulty breathing earlier in the shift. When I arrived at I/M [redacted] cell, he appeared to be asleep and was snoring loud enough to be heard at the cell door.

Attempts were made to alert the I/M to pill line. Since it wasn't an involuntary medication he could refuse it. There was no response, and the I/M continued to appear asleep and was still snoring, so it was construed as a refusal. I/M [redacted] has done same in the past many times. — Michael Kalenic RN

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS

MEMORANDUM

TO: Lt. Conners

DATE: 7-23-98

FROM: C/O S. Netherton

SUBJECT: Death of I/M [redacted]

On 7-23-98 at approx. 1:15 AM I was requested to report to [redacted] Unit with the camera from the shift office, when I arrived on the unit I ran the camera, recording the incident of discovering the death of this I/M.

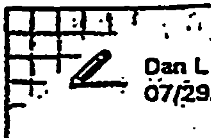
C/O S Netherton

DOC 02-110 (REV. 6/97)

recycled paper

To: WAGNER GLORIA DOC-DP-G1-GWD 1
From: MCLELLAN KAREN -DP-G1-KS6 2
Date: Thursday 23-Jul-98 at 8:53pm 3
Subject: INMATE [redacted] 4
ON 7-22-98 AT APPROXIMATELY 6:10 PM INMATE [redacted] CALLED THE [redacted] 5
UNIT BOOTH AND ASKED ME TO CALL THE INFIRMARY AND TELL THEM THAT HE WAS 6
HAVING TROUBLE GETTING AIR. I CALLED AND TALKED TO R.N. WAGNER WHO TOLD 7
ME TO HAVE INMATE [redacted] TAKE A COLD SHOWER. SHE ASKED ME TO LET HER 8
KNOW IF HE DID NOT GET BETTER. AFTER INMATE [redacted] TOOK HIS SHOWER I HAD 9
C/O TAYLOR CHECK ON HIM. HE WAS LAYING DOWN AND APPEARED TO BE KEY. 10
ABOUT A HALF HOUR LATER C/O BENDA CHECKED AND FOUND THE SAME THING. 11
DURING 8:30 MEDS. R.N. KALINA AND I WENT TO INMATE [redacted] CELL AND FOUND 12
HIM ASLEEP AND SNORING. 13
AT APPROXIMATELY 9:30 P.M. C/O BENDA WENT TO INMATE [redacted] CELL TO 14
CHECK ON HIM, HE WAS LYING ON THE FLOOR. C/O BENDA SAID ARE YOU OK? 15
INMATE [redacted] SAID "YES I'M JUST A LITTLE HOT, I TOOK A SHOWER AND AM 16
FEELING BETTER". HE THEN LEFT THE TIER. 17
C/O KAREN MCLELLAN 18
cc: BOLLINGER TERESA DOC-DP-G1-THA 19
*** End of Message ***

Function:
Functions(1/6): PF2=NExt 3=ENd 4=MEnu 5=Find 6=AMend 7=BWd 8=FWD pf1=help



Dan L Dierdorff
07/29/98 09:15 AM

To: Sister Rene, SOC Monroe
cc:
Subject: [redacted] visit, 7/22/98

I came in on Weds. eve. and began my usual visits to all four tiers in [redacted] unit.
When I was talking to other inmates on the tier (where [redacted] was located), I could hear him moan and talk incoherently. When I went to visit him I was suprised, as he had no clothes on. He was lying on his bed, and I said [redacted] are you OK?"
He said something I could not understand, moved quickly to the floor of his cell,lay on the floor, and acted physically and mentally upset. In retrospect, I would say he looked like a man with a high fever. I don't think he knew I was visiting him. This was the first time in numerous visits that [redacted] and I were unable to talk to each other.
I asked [redacted] if he wanted me to pray about anything. He did not answer, so I prayed that God would give him peace. When I left that tier I casually said to a woman officer that [redacted] was really out of it tonite, and did not have a stitch of clothing on. I did not ask an officer to check on him, nor did I believe that he was in a life threatening situation.
Sister, I am available to talk to someone at SOC or to speak to the family.

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: R.N. BOLLENGER DATE: 080598

FROM: C/O T. BENDA SUBJECT: DEATH I/M [redacted]

ON 080598 AT ABOUT 245 P.M. R.N. BOLLENGER REQUESTED THE FOLLOWING MEMO.

ON OR ABOUT 07-22-98 AT ABOUT 930 P.M. WHILE PERFORMING THE INSTITUTIONAL COUNT, I SAW I/M [redacted] LAYING DOWN ON HIS CELL FLOOR. I ASKED HIM IF HE WAS FEALING "OK". HE SAID "YES, I'M A LITTLE HOT I TOOK A SHOWER, I'M OK".

OFFICER T. BENDA.

DOC 02-110 (3/91) BW-1

On 7/23/98 a code was called indicating I/M was nonresponsive to
taff. Upon my arrival a code team was assembled and we entered the cell
nd secured the I/M. While attempting to initiate a member to place
e I/M into restraints, the officer stated the I/M was cold and stiff. I
dered medical staff into the cell and, after examining the I/M,
edical staff's staff stated the I/M was deceased. The Monroe Police
partment and Snohomish County Medical Examiner were contacted VIA
11. Snohomish County Medical Examiner departed SOC at 0503
ith the deceased I/M. Monroe Police Department Officer departed SOC
t 0608. Cell [redacted] is secured and will remain secured until released
ck to the State by Monroe Police Department.

Larry

LT Conner

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

DATE: 7-23-98

TO: Lt Conner

SUBJECT: I/M [redacted]

FROM: C/O Brown C

I Arrived on [redacted] unit Approxmately At 0047 to relieve C/O Taylor RN Cave Arrived At 0050 with meds for I/M [redacted] And I/M [redacted] I Escorted the Nurse to Tier 3 to cell # [redacted] I/M [redacted] didn respond, we Moved to cell [redacted] I/M [redacted] gave him his meds And returned to [redacted] I/M [redacted] cell. The Nurse called out his NAME no response I banged on the door, No response, I then Informed [redacted] unit booth to contact the shift Sgt. RN Todd came on the Tier to see if he could get some type of Response by using wet sock and water, no Response, Sgt Milan on unit Approxmately 0105, Sgt Milan spoke with the Nurse's And went And called Lt. Conner, Lt Conner Arrived on [redacted] unit spoke with Sgt Milan and the Nurse, C/O Taylor And I got protective gear to Enter the cell. I/M [redacted] has A record of Assaulting staff. We were to go in cuff him And the Nurse would check him out. By orders of Sgt Milan. C/O Taylor And I Entered the cell with the Mat it was placed on the back of I/M [redacted] covering his back and Arms to Imobilize him C/O Taylor took his right Arm to cuff him C/O Taylor said his

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Lt CONNORS DATE: 7-23-98

FROM: C/O BROWN C SUBJECT: I/M [redacted]

hand was cold and Stiff. At this Time the Mat was removed of I/M [redacted] RN Todd said That he had to be turned on his back to check for a heart beat. RN Todd was at the upper torso C/O Taylor In the middle and I was at the Leg and thigh we Turned him over and placed him on his back where RN Todd Listened for A Heartbeat And did not have a heart beat, At this time the Medical Examiner and Monroe Police Dept. was call. The Area was then concealed as a crime scene, and no one was Allowed In that area until Monroe Police Dept. Arrived Guard was posted C/O Brown. Medical Examiner and Monroe Police Arrived and took control of the Area.

TO: DEHAVEN BARRY DOC-DP-G1-BD3 ? JUL-98 05:29:24
SPECIAL OFFNDR CTR
16730 FERRY ROAD
MONROE WA 98272-0000

FROM: DEHAVEN BARRY DOC-DP-G1-BD3 23-JUL-98 05:14:54
SPECIAL OFFNDR CTR
16730 FERRY ROAD
MONROE WA 98272-0000

SUBJECT: I/M [redacted] DOC-DP-G1-BD3/MA#

/TO CONNER LARRY DOC-DP-G1-LC3 OK
/FROM DEHAVEN BARRY DOC-DP-G1-BD3 OK
/DATE THURSDAY 23-JUL-98 AT 5:23AM OK
/SUBJECT I/M [redacted] OK

AT APPROX 0047 HOURS I RECEIVED A CALL FROM C/O JIM SMITH ASKING WHERE THE SGT. WAS HE INFORMED ME THAT INMATE [redacted] HAD NOT APPEARED TO MOVE SINCE THEY CAME ON SHIFT.

I CONTACTED THE SGT. AND HE WENT TO THE UNIT. ALONG WITH RN 2 LEA ANN CAVE I THEN CONTACTED LT. CONNER OVER AT TRCC AND ADVISED HIM THAT WE HAD A POSSIBLE SITUATION AT SOC. HE ADVISED ME TO KEEP HIM POSTED.

SHORTLY THERE AFTER LT. CONNER RETURNED AND LT. CONNER SGT. MILAN. C/O'S BROWN. NETHERTON. TAYLOR AND RN 2'S RICHARD TODD AND LEA ANN CAVE WENT TO ENTER THE CELL TO CHECK ON INMATE [redacted]

C/O SMITH NOTIFIED ME AT 0127 HOURS THAT THEY WERE ENTERING THE CELL. AT APPROX 0130 I WAS NOTIFIED BY C/O SMITH THAT IT APPEARED AS IF THE INMATE WAS DECEASED. AT 0134 LT. CONNER NOTIFIED ME THAT THE INMATE WAS DECEASED. AT 0134 SNO PAC 911 OPERATOR 195 WAS CONTACTED BY ME AND ADVISED THAT WE HAD AN INMATE THAT WAS DECEASED AND WE NEEDED MONROE POLICE AND THE SNO CO. MEDICAL EXAMINER.

AT 0150 POLICE OFFICER MARTINEZ ARRIVED ON SITE. AT 0200 AN INFORMAL COUNT WAS CONDUCTED PER POLICY. ALL INMATES ACCOUNTED FOR CLEARING AT 0209.

AT THIS TIME C/O NETHERTON RELIEVED ME OF MAIN CONTROL DUTIES AND I ASSISTED LT. CONNER IN GATHERING INFORMATION ON THE INMATE AND COMMUNICATING WITH THE DUTY OFFICER AND OTHER REQUIRED STAFF. I WAS SENT TO THE UNIT WITH THE MEDICAL EXAMINER AND STOOD BY AWAITING FURTHER INSTRUCTIONS.

I ESCORTED THE POLICE TO THE UNIT TO INTERVIEW INMATES AND OFF THE UNIT. THIS ENDED MY PARTICIPATION IN THIS EMERGENCY SITUATION.

C/O BARRY DEHAVEN

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* * END OF MESSAGE * * PRINTED ON 23-JUL-98 AT 05:29:29 MA#

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
SPECIAL OFFENDER CENTER
P.O. BOX 514 -PARK PLACE - MONROE, WASHINGTON 98272 - 0514

TO: Lt. Conner, Larry DATE: 07/23/98

FROM: Sgt. Milan, Tony SUBJECT: I/M [redacted] -Unit / [redacted]

At or about 0055hrs I received a call from C/O Smith that the nurse was coming up to the Unit to see I/M [redacted] do-to [redacted] having not moved at all on our shift and he was being unresponsive.
At 0105hrs I arrived on the Unit and RN Todd stated that [redacted] seemed to be breathing, but was unresponsive. RN Todd, C/O Brown and C/O Taylor were trying to get [redacted] to response to them calling to him and they also tried throwing socks and water at him. Still he was unresponsive. I asked if he was asleep and breathing, RN Todd stated that he ([redacted] appeared to be breathing and asleep. I recommended that we let him sleep, but would call the Lt. to get the okay to open the Cell. Lt. Conner stated that he was on his way back to SOC and to wait for him to arrive. When the Lt. did arrive the Video Camera and Mat were brought up to the Unit and A Entry Debriefing was done.
At 0127hrs Lt. Conner attempted to get I/M [redacted] to response to Staff, No Response was received from [redacted]. So I gave the order to open [redacted], C/O Brown and C/O Taylor with myself entered the cell. The mat was placed on [redacted] at which time [redacted] did not move. [redacted] was ordered by C/O Taylor to place his arms behind his back, No response by [redacted] C/O Taylor took [redacted] by the right arm and tried to place it behind his back, but the arm would not move that easily so. Lt Conner had RN Todd come in and check [redacted] out. At which time RN Todd stated that I/M [redacted] was Deceased and that at this time CPR and any kind of First Aid would not help. At 0133hrs RN Todd stated that [redacted] was Deceased. At 0145hrs [redacted] cell was closed as a Crime scene by Lt. Conner.
At 0150hrs the Monroe Police Dept. Officer C. Martinez on grounds and at 0222hrs he was on A-Unit to view the crime scene.
At 0325hrs Snohomish County Coroner D. Selove MD arrived and was taken to the crime scene.
At 0403hrs I/M [redacted] was removed from his cell by the Snohomish County Coroner and at 0407hrs the cell was closed for investigation.
At 0422hrs I/M [redacted] was removed from the Unit.
At 0503hrs I/M [redacted] was removed from SOC grounds by the Snohomish County Coroner.

Staff Involved:

Lt. Conner, L.	Shift Lt.
Sgt. Milan, T.	Shift Sgt.
C/O Dehaven, B.	Main Control
C/O Brown, C.	Mat / RM
C/O Taylor, M.	Mat / Unit Staff
C/O Smith, J.	Unit Staff
C/O Netherton, S.	Camera Operator
RN Todd, R.	Medical Staff
RN Cave, L.	Medical Staff

End of Report:

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Shift Lt.

DATE: 7-23-98

FROM: C/O Michael Taylor

SUBJECT: I/M [redacted]

at approx 10:34 pm on 7-22-98 C/O J. Smith and RN Caves went up to give I/M [redacted] his meds. they tryed to wake him up but could not. they took that as a refusal.

At my 12:15 am tier I/M [redacted] was laying in the same position he had been since my 11:15 pm tier. He appeared to be breathing.

At C/O's Smith 12:45 am tier he noticed that I/M [redacted] was still laying in the same position. C/O Smith then came to the booth and called RN Caves and asked her if she could check on I/M [redacted] At that time C/O Brown relieved me for my break.

I came back on unit a approx 1:05 am with Sgt Milan and RN Todd. At that time RN Todd asked me to get her some socks. RN Todd then tryed calling I/M [redacted] name and knocking on his cell door it did not bring anying response from I/M [redacted] at this time RN Todd rolled the socks into small balls and threw them at I/M [redacted] trying to get a response. RN Todd tryed a water bottle with water unit still no response. At that time Lt Conners had C/O's Brown and my self go in the cell with the Hatt because of I/M [redacted] past aggersive Behavior toward staff.

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Shift Lt

DATE: 7-23-98

FROM: C/O Michael Taylor

SUBJECT: I/m [redacted]

C/o's Brown and my self entered the cell with sgt milan and rn todd as backup. we placed the matt on I/m [redacted] back he did not move at that time I took I/m [redacted] right hand to aply hand cuffs on him when I went to move his hand it was stiff and cold. when I moved it I felt something pop. Lt conners asked if I/m was resisting I said no. that he was cold and stiff at that time rn todd checked I/m [redacted] and had C/O Brown sgt milan and my self turn I/m [redacted] over. I then left the cell with Lt conners and went to the shift office were I started calling staff. I first notified LINDA willenberg at 1^{34} AM. She had me call Assoc Supt Carol Grandmontange at 1^{36} AM I then call OCO. Duty officer margo. Jensen at 1^{56} AM. Then PhD tom foley at 2^{02} AM. Left message. then notified S.S. Renee. kittelson at 2^{07} AM. C/O Dehaven called PhD Edward Goldenberg at 2^{25} AM.

We went back to unit with MPD officer ~~[illegible]~~ ~~[illegible]~~ Covato Martinez and ME Chames. and MD Daniel Selover. and this concludes my participation in this situation.

C/O [signature]

DOC 02-110 (3/91)

recycled paper

CHASE RIVELAND
SECRETARY

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Teresa Bollinger RN III

DATE: 7/23/98

FROM: G Wagner RN II

SUBJECT: [redacted]

At approx 6^{40}p on 7/22/98, C/O K. McClellan called the infirmary to report I/M [redacted] was complaining of shortness of breath. I asked how his speech sounded and she said fine. I told her we were doing medlines and as I/M [redacted] had complained several times in the past about how he couldn't breath in his cell - he said he needed to go out and get some fresh air, I assumed it was the heat and stuffiness of his cell. I told the C/O a cool shower might be helpful and if he continued to complain to please call me back. I also informed the other PM nurse Mike Kalina as he was going up to the unit to do the lockdown meds and he would be seeing him. Since I heard nothing further from the unit, I assumed the situation had been resolved.

G Wagner RN II

INTRODUCTION

The Employee Handbook is designed to acquaint you with the Department of Corrections and state employment. Guidelines and job-related information are given to assist you in the performance of your assigned duties. It is intended as a supplement to departmental directives, state laws, Merit System Rules and facility or office procedures. If you need further information or clarification, you should contact your supervisor or personnel representative. They can provide you with answers or refer you to the location of the specific rules or source documents.

DEPARTMENT OBJECTIVES

In May of 1981, the Washington State Legislature established the Department of Corrections, separating it from the Department of Social and Health Services.

The department's mission is to promote public safety by providing facilities and services to evaluate, control, and redirect the behavior of adult felony offenders committed to our jurisdiction by the courts. In carrying out our mission, the department cooperates with other state criminal justice systems and endeavors to assure that offenders charged to our care are prepared for release and reintegration into the community.

The department's main objectives are to:

- Ensure safety for the public, staff and offenders;
- Punish the offender for violating the law, generally through the denial of liberty;
- Treat all offenders and staff fairly and equitably;
- Reflect in the system the values of the community by avoiding idleness, adopting the work ethic, providing opportunities for self-improvement, providing tangible rewards for accomplishments, and sharing the obligation of the community;
- Effectively and efficiently manage resources;

Attachment 2

- Provide for restitution;
- Be accountable to the citizens of the state;
- Meet the national standards appropriate to the State of Washington.

CODE OF ETHICS

High moral and ethical standards among correctional employees are essential for the success of the department's programs. The Department of Corrections subscribes to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service.

DEPARTMENT EXPECTATIONS

As a new employee of the department, you will have many things to learn, not the least of which will be the expectations of your supervisor, your co-workers, and the agency as a whole. To assist you with this responsibility, following is a list of some departmental expectations for your study. Familiarize yourself with the list so that you may understand and fulfill the duties of your position.

As a representative of the Department of Corrections, you will be expected to:

- Positively represent Washington State government to everyone you meet. You are our best public relations agent;
- Dress appropriately for your job classification and duties. Clothing may not have mottos, logos, or advertisements that may be offensive or in conflict with the goals of the Department;
- Wear issued uniforms only as authorized;
- Be a good citizen, obey laws while on and off-duty. Your conduct off duty may reflect on your fitness for duty;
- Treat fellow staff with dignity and respect;
- Be impartial, understanding and respectful to offenders;
- Serve each offender with appropriate concern for their welfare and with no purpose of personal gain;

Attachment 2

Gloria M Wagner
Employee Name (Please Print)

ACKNOWLEDGEMENT OF RECEIPT OF DOC EMPLOYEE HANDBOOK

I acknowledge receipt of the June 1993 Washington State Department of Corrections Employee Handbook and agree to become familiar with and have a thorough knowledge and understanding of the contents.

Gloria M Wagner
Employee Signature

14/24/93
Date

Original - Personnel File

Attachment 3

FORM S.F. 570 Rev 1/85

STATE OF WASHINGTON
CLASSIFICATION QUESTIONNAIRE
(POSITION DESCR...)

PER-943

SHADED AREAS ARE COMPLETED BY DEPARTMENT OF PERSONNEL

Field	Value
1. AGENCY NAME	Department of Corrections
2. POSITION NO.	HB 36
EMPLOYEE'S NAME (Last, First, Initial)	DAVIS, Tamara J.
PHONE NO.	794-2236
4. SUBMITTED BY	☐ AGENCY ☐ EMPLOYEE
5. POSITION ACTION NO	
DIVISION/INSTITUTION/SECTION/UNIT	DOP/SOC/Infirmary
MAIL STOP	NM-84
7. SUBMITTED FOR	☒ UPDATE ☐ REALLOCATION ☐ ESTABLISHMENT ☐ OTHER
IMMEDIATE SUPERVISOR'S NAME	Fran Bartley
PHONE NO.	794-2236
IMMEDIATE SUPERVISOR'S CLASS TITLE	Registered Nurse 3
PRESENT CLASS TITLE	Registered Nurse 2
CLASS CODE	5632
PROPOSED CLASS TITLE	
CLASS CODE	
WORKING TITLE (if different than class title)	RNC
CLASS TITLE	Registered Nurse 2
CLASS CODE	5632
EMPLOYMENT With Dept. YEARS / MONTHS	16 / 0
WITH PRESENT DUTIES YEARS / MONTHS	10 / 7
12. HRS. OF WORK	40 hrs./wk.
15. EFFECTIVE DATE	
16. WORK WEEK DESIGNATION	
17. PAY RANGE	
LOCATION OF EMPLOYMENT	Special Offender Center, Monroe, WA
18. AUDITED BY	
19. DATE	
REVIEWED BY	[signature]
22. DATE	10/24/91

% OF TIME/ ☐ DAY ☐ WK ☐ MO. ☐ YR

23. EMPLOYEE'S STATEMENT OF DUTIES

READ INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS SECTION.
LIST THOSE DUTIES FIRST WHICH OCCUPY MOST OF YOUR TIME. UNDERLINE YOUR MOST RESPONSIBLE DUTY.

Under the supervision of the RN 3, the RN 2 provides comprehensive nursing care services in the clinical setting of the Special Offender Center, a 108-bed adult correctional facility providing intensive therapeutic community services to mentally ill offenders.

40% Accurately set up, adminster, and record all medications, such as major tranquilizers, neuroleptics, anti-parkinsonian meds, antibiotics, and anti-convulsant medications, as well as others as ordered.

10% Set up, distribute, and record all decanoate meds, maintaining the tracking method and document any side effects.

10% Assist psychiatrist with med reviews on units. Complete all orders and relay to pharmacy. Assist P.A.s when needed. Participate in case management on all units.

10% Enter computer data for upcoming psychiatric appointments. Order batch reports.

10% Provide ongoing nursing treatment and emergency treatment as necessary.

5% Clear inmates for food service and keep accurate documentation.

5% Obtain scheduled and emergency EKGs. Assist P.A. with sick call and minor surgery.

5% Provides for the safety, security, and sanitation of supplies, equipment, and the Infirmary area.

5% Maintains professional nursing care integrity as it applies to appearance, behavior, demeanor, and delivery of services. Performs other work as required.

OCT 2_ 1991

Attachment 4

1163

(attach additional sheets if necessary)

ORIGINAL COPY FOR THE ... | COPY FOR AGENCY HEADQUARTERS | COPY FOR FIELD OFFICE | COPY FOR EMPLOYEE | COPY FOR DIRECT MAIL TO THE ...

(3) The license holder shall sign a waiver allowing the program to release information to the disciplining authority if the licensee does not comply with the requirements of this section or is unable to practice with reasonable skill or safety. The substance abuse program shall report to the disciplining authority any license holder who fails to comply with the requirements of this section or the program or who, in the opinion of the program, is unable to practice with reasonable skill or safety. License holders shall report to the disciplining authority if they fail to comply with this section or do not complete the program's requirements. License holders may, upon the agreement of the program and disciplining authority, reenter the program if they have previously failed to comply with this section.

(4) The treatment and pretreatment records of license holders referred to or voluntarily participating in approved programs shall be confidential, shall be exempt from RCW 42.17.250 through 42.17.450, and shall not be subject to discovery by subpoena or admissible as evidence except for monitoring records reported to the disciplining authority for cause as defined in subsection (3) of this section. Monitoring records relating to license holders referred to the program by the disciplining authority or relating to license holders reported to the disciplining authority by the program for cause, shall be released to the disciplining authority at the request of the disciplining authority. Records held by the disciplining authority under this section shall be exempt from RCW 42.17.250 through 42.17.450 and shall not be subject to discovery by subpoena except by the license holder.

(5) "Substance abuse," as used in this section, means the impairment, as determined by the disciplining authority, of a license holder's professional services by an addiction to, a dependency on, or the use of alcohol, legend drugs, or controlled substances.

(6) This section does not affect an employer's right or ability to make employment-related decisions regarding a license holder. This section does not restrict the authority of the disciplining authority to take disciplinary action for any other unprofessional conduct.

(7) A person who, in good faith, reports information or takes action in connection with this section is immune from civil liability for reporting information or taking the action.

(a) The immunity from civil liability provided by this section shall be liberally construed to accomplish the purposes of this section and the persons entitled to immunity shall include:

(i) An approved monitoring treatment program;

(ii) The professional association operating the program;

(iii) Members, employees, or agents of the program or association;

(iv) Persons reporting a license holder as being impaired or providing information about the license holder's impairment; and

(v) Professionals supervising or monitoring the course of the impaired license holder's treatment or rehabilitation.

(b) The immunity provided in this section is in addition to any other immunity provided by law. [1993 c 367 § 3; 1991 c 3 § 270; 1988 c 247 § 2.]

Legislative intent—1988 c 247: "Existing law does not provide for a program for rehabilitation of health professionals whose competency may be impaired due to the abuse of alcohol and other drugs.

It is the intent of the legislature that the disciplining authorities seek ways to identify and support the rehabilitation of health professionals whose practice or competency may be impaired due to the abuse of drugs or alcohol. The legislature intends that such health professionals be treated so that they can return to or continue to practice their profession in a way which safeguards the public. The legislature specifically intends that the disciplining authorities establish an alternative program to the traditional administrative proceedings against such health professionals." [1988 c 247 § 1.]

RCW 18.130.180 Unprofessional conduct. The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers or documents;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

Attachment 5

(ii) Medical and surgical nursing.

(iii) Parent/child nursing with only an assisting role in the care of clients during labor and delivery and those with complications.

(iv) Geriatric nursing.

(v) Mental health nursing.

(vi) All nursing courses shall include components of restorative, rehabilitative and supportive care.

(vii) Laboratory and clinical practice in the functions of the practical nurse, including but not limited to, administration of medications, common medical surgical techniques and related client teaching.

(viii) Concepts of client care management.

FOR REGISTERED NURSE PROGRAMS:

(a) Instruction in the physical and biological sciences and shall include content drawn from the areas of anatomy and physiology, physics, chemistry, microbiology, pharmacology and nutrition, which may be integrated, combined, or presented as separate courses.

(b) Instruction in the social and behavioral sciences and shall include content drawn from the areas of communications, psychology, sociology and anthropology, which may be integrated, combined, or presented as separate courses.

(c) Theory and clinical experiences in the areas of medical nursing, surgical nursing, obstetric nursing, nursing of children and psychiatric nursing, which may be integrated, combined, or presented as separate courses. Baccalaureate programs also shall include theory and clinical experiences in community health nursing.

(d) History, trends, and legal and ethical issues pertaining to the nursing profession, which may be integrated, combined, or presented as separate courses. Baccalaureate programs shall include study of research principles.

(e) Opportunities for the student to learn assessment of needs, planning, implementation, and evaluation of nursing care for diverse individuals and groups. Baccalaureate programs shall include the study and practice of leadership.

(f) Clinical experiences in the care of persons at each stage of the human life cycle. These experiences shall include opportunities for the student to learn and have direct involvement in, responsibility and accountability for nursing care in the areas of acute and chronic illnesses, promotion and maintenance of wellness. The emphasis placed on these areas, the scope encompassed, and other allied experiences offered shall be in keeping with the purpose, philosophy, and objectives of the program.

(g) Opportunities for the student to participate in multidisciplinary health care.

[Statutory Authority: RCW 18.79.110. 95-21-072, § 246-840-575, filed 10/16/95, effective 11/16/95.]

WAC 246-840-700 Standards of nursing conduct or practice. The purpose of defining standards of nursing conduct or practice through WAC 246-840-700 and 246-840-710 is to identify responsibilities of the nurse in health care settings and as provided in the Nursing Practice Act, chapter 18.79 RCW. Violation of these standards may be grounds for disciplinary action pursuant to chapter 18.130 RCW. Each individual, upon entering the practice of nursing, assumes a measure of responsibility and public trust and the corresponding obligation to adhere to the standards of nursing practice. The nurse shall be responsible and accountable for the quality of nursing care given to clients. This responsibility cannot be avoided by accepting the orders or directions of another person. The standards of nursing conduct or practice include, but are not limited to the following:

FOR REGISTERED NURSES:

(1) Nursing process:

(a) The registered nurse shall collect pertinent objective and subjective data regarding the health status of the client.

(b) The registered nurse shall plan and implement nursing care which will assist the client to maintain or return to a state of health or will support a dignified death.

(c) The registered nurse shall communicate significant changes in the client's status to appropriate members of the health care team. This communication shall take place in a time period consistent with the client's need for care.

(d) The registered nurse shall document, on essential client records, the nursing care given and the client's response to that care.

(2) Delegation and supervision: The registered nurse shall be accountable for the safety of clients receiving nursing service by:

(a) Delegating selected nursing functions to others in accordance with their education, credentials, and demonstrated competence.

(b) Supervising others to whom he/she has delegated nursing functions.

(3) Other responsibilities:

(a) The registered nurse shall have knowledge and understanding of the laws and rules regulating nursing and shall function within the legal scope of nursing practice.

(b) The registered nurse shall be responsible and accountable for practice based on and limited to the scope of her/his education, demonstrated competence, and nursing experience.

(c) The registered nurse shall obtain instruction, supervision, and consultation as necessary before implementing new or unfamiliar techniques or practices.

(d) The registered nurse shall be responsible for maintaining current knowledge in his/her field of practice.

(e) The registered nurse shall conduct nursing practice without discrimination.

(f) The registered nurse shall respect the client's right to privacy by protecting confidential information.

(g) The registered nurse shall report unsafe nursing acts and practices, and illegal acts as defined in WAC 246-840-730.

FOR PRACTICAL NURSES:

(4) The licensed practical nurse, functioning under the direction and supervision of other licensed health care professionals as provided in RCW 18.79.060, shall be responsible and accountable for his or her own nursing judgments, actions and competence.

(5) The licensed practical nurse shall practice practical nursing in the state of Washington only with a current Washington license.

(6) The licensed practical nurse shall not permit his or her license to be used by another person for any purpose.

Attachment 6

(7) The licensed practical nurse shall have knowledge of the statutes and rules governing licensed practical nurse practice and shall function within the legal scope of licensed practical nurse practice.

(8) The licensed practical nurse shall not aid, abet or assist any other person in violating or circumventing the laws or rules pertaining to the conduct and practice of licensed practical nursing.

(9) The licensed practical nurse shall not disclose the contents of any licensing examination or solicit, accept or compile information regarding the contents of any examination before, during or after its administration.

(10) The licensed practical nurse shall delegate activities only to persons who are competent and qualified to undertake and perform the delegated activities, and shall not delegate to unlicensed persons those functions that are to be performed only by licensed nurses.

(11) The licensed practical nurse, in delegating functions, shall supervise the persons to whom the functions have been delegated.

(12) The licensed practical nurse shall act to safeguard clients from unsafe practices or conditions, abusive acts, and neglect.

(13) The licensed practical nurse shall report unsafe acts and practices, unsafe practice conditions, and illegal acts to the appropriate supervisory personnel or to the appropriate state disciplinary board or commission.

(14) The licensed practical nurse shall respect the client's privacy by protecting confidential information, unless required by law to disclose such information.

(15) The licensed practical nurse shall make accurate, intelligible entries into records required by law, employment or customary practice of nursing, and shall not falsify, destroy, alter or knowingly make incorrect or unintelligible entries into client's records or employer or employee records.

(16) The licensed practical nurse shall not sign any record attesting to the wastage of controlled substances unless the wastage was personally witnessed.

(17) The licensed practical nurse shall observe and record the conditions of a client, and report significant changes to appropriate persons.

(18) The licensed practical nurse may withhold or modify client care which has been authorized by an appropriate health care provider, only after receiving directions from an appropriate person, unless in a life threatening situation.

(19) The licensed practical nurse shall leave a nursing assignment only after properly reporting to and notifying appropriate persons and shall not abandon clients.

(20) The licensed practical nurse shall not misrepresent his or her education and ability to perform nursing procedures safely.

(21) The licensed practical nurse shall respect the property of the client and employer and shall not take equipment, materials, property or drugs for his or her own use or benefit nor shall the licensed practical nurse solicit or borrow money, materials or property from clients.

(22) The licensed practical nurse shall not obtain, possess, distribute or administer legend drugs or controlled substances to any person, including self, except as directed by a person authorized by law to prescribe drugs.

(23) The licensed practical nurse shall not practice nursing while affected by alcohol or drugs, or by a mental, physical or emotional condition to the extent that there is an undue risk that he or she, as a licensed practical nurse, would cause harm to him or herself or other persons.

(24) It is inconsistent for a licensed practical nurse to perform functions below the minimum standards of competency as expressed in WAC 246-840-715.

[Statutory Authority: Chapter 18.79 RCW. 97-13-100, § 246-840-700, filed 6/18/97, effective 7/19/97.]

WAC 246-840-705 Functions of a licensed practical nurse. A licensed practical nurse is one who has met the requirements of the Washington state Nurse Practice Act, chapter 18.79 RCW. The licensed practical nurse recognizes and is able to meet the basic needs of the client, and gives nursing care under the direction and supervision of the registered nurse or licensed physician to clients in routine nursing situations. In more complex situations the licensed practical nurse functions as an assistant to the registered nurse and carries out selected aspects of the designated nursing regimen.

A routine nursing situation is one that is relatively free of scientific complexity. The clinical and behavioral state of the client is relatively stable and requires abilities based upon a comparatively fixed and limited body of knowledge.

In complex situations, the licensed practical nurse facilitates client care by meeting specific nursing requirements to assist the registered nurse in the performance of nursing care.

The functions of the licensed practical nurse makes practical nursing a distinct occupation within the profession of nursing. The licensed practical nurse has specific roles in nursing in direct relation to the length, scope and depth of his or her formal education and experience. In the basic program of practical nursing education, the emphasis is on direct client care.

With additional preparation, through continuing education and practice, the licensed practical nurse prepares to assume progressively more complex nursing responsibilities.

[Statutory Authority: Chapter 18.79 RCW. 97-13-100, § 246-840-705, filed 6/18/97, effective 7/19/97.]

WAC 246-840-710 Violations of standards of nursing conduct or practice. The following will serve as a guideline for the nurse as to the acts, practices, or omissions that are inconsistent with generally accepted standards of nursing conduct or practice. Such conduct or practice may be grounds for action with regard to the license to practice nursing pursuant to chapter 18.79 RCW and the Uniform Disciplinary Act, chapter 18.130 RCW. Such conduct or practice includes, but is not limited to the following:

(1) Failure to adhere to the standards enumerated in WAC 246-840-700(1) which may include:

(a) Failing to assess and evaluate a client's status or failing to institute nursing intervention as required by the client's condition.

(b) Willfully or repeatedly failing to report or document a client's symptoms, responses, progress, medication, or other nursing care accurately and/or intelligibly.

Attachment 7

(c) Willfully or repeatedly failing to make entries, altering entries, destroying entries, making incorrect or illegible entries and/or making false entries in records pertaining to the giving of medication, treatments, or other nursing care.

(d) Willfully or repeatedly failing to administer medications and/or treatments in accordance with policy and procedure.

(e) Willfully or repeatedly failing to follow the policy and procedure for the wastage of medications where the nurse is employed or working.

(f) Willfully causing or contributing to physical or emotional abuse to the client.

(2) Failure to adhere to the standards enumerated in WAC 246-840-700(2) which may include:

(a) Delegating nursing care function or responsibilities to a person who the nurse knows or has reason to know lacks the ability or knowledge to perform the function or responsibility, or delegating to unlicensed persons those functions or responsibilities the nurse knows or has reason to know are to be performed only by licensed persons. This section should not be construed as prohibiting delegation to family members and other caregivers exempted by RCW 18.79.040(3), 18.79.050, 18.79.060 or 18.79.240.

(b) Failure to supervise those to whom nursing activities have been delegated. Such supervision shall be adequate to prevent an unreasonable risk of harm to clients.

(3) Failure to adhere to the standards enumerated in WAC 246-840-700(3) which may include:

(a) Performing or attempting to perform nursing techniques and/or procedures for which the nurse lacks the appropriate knowledge, experience, and education and/or failing to obtain instruction, supervision and/or consultation for client safety.

(b) Violating the confidentiality of information or knowledge concerning the client, except where required by law or for the protection of the client.

(c) Writing prescriptions for drugs unless authorized to do so by the board.

(4) Other violations:

(a) Appropriating for personal use medication, supplies, equipment, or personal items of the client, agency, or institution.

(b) Practicing nursing while impaired by any mental, physical and/or emotional condition to the extent that the person may be unable to practice with reasonable skill and safety.

(c) Willfully abandoning clients by leaving a nursing assignment without transferring responsibilities to appropriate personnel or caregiver when continued nursing care is required by the condition of the client(s).

(d) Practicing nursing while impaired by alcohol and/or drugs.

(e) Conviction of a crime involving physical abuse or sexual abuse relating to the practice of nursing.

[Statutory Authority: Chapter 18.79 RCW. 97-13-100, § 246-840-710, filed 6/18/97, effective 7/19/97.]

WAC 246-840-715 Standards/competencies. Minimum standards of competency expected of beginning licensed practical nurses include the following:

(1) **Standard I** - The practical nurse assists in implementing the nursing process. The nursing process is defined as a systematic approach to nursing care which has the goal of facilitating an optimal level of functioning for the client, recognizing cultural and religious diversity.

The components of the nursing process are assessing, planning, implementing and evaluating. Written and verbal communication is essential to the nursing process.

Competencies:

(a) Assessment - Makes observations, gathers data and assists in identification of needs and problems relevant to the client.

(i) Makes basic observations of clients' safety and comfort needs.

(ii) Identifies physical discomfort and environmental threats to client safety.

(iii) Identifies basic physiological, emotional, sociological, cultural, economic, and spiritual needs.

(iv) Collects specific data as directed.

(v) Identifies major deviation from normal.

(vi) Selects data from established sources relevant to client's needs or problems.

(vii) Collaborates in organizing data.

(viii) Assists in formulating the list of clients' needs or problems.

(ix) Identifies major short-term and long-term needs of clients.

(b) Planning - Contributes to the development of approaches to meet the needs of clients and families.

(i) Develops client care plans, utilizing a standardized nursing care plan.

(ii) Assists in setting priorities for nursing care.

(iii) Participates in client care conferences.

(c) Implementation - Carries out planned approaches to client care.

(i) Carries out nursing actions developed in care plan to ensure safe and effective nursing care.

(ii) Performs common therapeutic nursing techniques.

(iii) Administers medications safely and accurately, within institutional policies and procedures, and with knowledge of the medication being administered.

(d) Evaluation - Utilizing a standard plan for nursing care, appraises the effectiveness of client care.

(i) Collaborates in data collection relevant to outcome of care.

(ii) Assists in comparing outcome of care to formulated objective.

(iii) Assists with adjustments in care.

(iv) Reports outcome of care given.

(2) **Standard II.** The practical nurse uses communication skills effectively in order to function as a member of the nursing team. Communication is defined as a process by which information is exchanged between individuals through a common system of symbols, signs, or behaviors that serves as both a means of gathering information and of influencing the behavior and feelings of others.

Competencies:

Applies beginning skills in verbal, nonverbal and written communication, recognizing and respecting cultural diversity and respecting the spiritual beliefs of individual clients.

(a) Uses common medical terminology and abbreviations.

evaluate the performance of the nursing assistant, including direct observation of the skill and ability of the nursing assistant to perform the delegated nursing task. The nurse must also reevaluate the patient's condition, the care provided to the patient, the capability of the nursing assistant, the outcome of the task, and any problems. Frequency of supervision is at the discretion of the registered nurse to ensure safe and effective services are provided. Reevaluation and documentation must occur at least every sixty days.

(2) A registered nurse may assume delegating responsibilities from the delegating registered nurse for the delegation process, provided the registered nurse assuming responsibility knows the patient through their assessment, the skills of the nursing assistant, and the plan of care. This may include a reevaluation of the patient by the nurse assuming responsibility for delegation. The nurse assuming the responsibility for delegation from another nurse is accountable and responsible for the delegated task. The nurse must document the following in the patient's record:

(a) The reason and justification for another nurse assuming responsibility for the delegation;

(b) The nurse assuming responsibility must agree, in writing, to perform the supervision; and

(c) That the nursing assistant and patient have been informed of this change.

[Statutory Authority: Chapter 18.79 RCW. 96-05-060, § 246-840-950, filed 2/19/96, effective 3/21/96.]

WAC 246-840-960 Accountability, liability, and coercion. (1) The registered nurse and nursing assistant are accountable for their own individual actions in the delegation process. The delegated task becomes the responsibility of the person to whom it is delegated but the registered nurse retains overall accountability for the nursing care of the patient, including nursing assessment, evaluation, and assuring documentation is completed.

(2) Nurses acting within the protocols of their delegation authority shall be immune from liability for any action performed in the course of their delegation duties.

(3) Nursing assistants following written delegation instructions from registered nurses for delegated tasks shall be immune from liability.

(4) The nursing care quality assurance commission shall take no disciplinary action against nurses following delegation protocols appropriately.

(5) Complaints regarding delegation of specific nursing tasks may be reported to the aging and adult services administration of the department of social and health services or via a toll-free telephone number.

(6) All complaints specifically related to nurse-delegation shall be referred to the nursing care quality assurance commission.

(7) No certified community residential program for the developmentally disabled, licensed adult family home, or licensed boarding home contracting to provide assisted living services may discriminate or retaliate in any manner against a person because the person made a complaint or cooperated in the investigation of a complaint.

(8) No person may coerce a nurse into compromising patient safety by requiring the nurse to delegate if the nurse determines it is inappropriate to do so. Nurses shall not be subject to any employer reprisal or disciplinary action by the Washington nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.

(9) Nursing assistants shall not be subject to any employer reprisal or disciplinary action for refusing to accept delegation of a nursing task.

[Statutory Authority: Chapter 18.79 RCW. 96-05-060, § 246-840-960, filed 2/19/96, effective 3/21/96.]

WAC 246-840-970 Rescinding delegation. (1) The registered nurse may rescind delegation of the nursing task based on the following circumstances which may include, but are not limited to:

(a) When the nurse believes patient safety is being compromised;

(b) When the patient's condition is no longer stable and predictable;

(c) When the frequency of staff turnover makes delegation impractical to continue in the setting;

(d) When there is a change in the nursing assistant's willingness or competency to do the task;

(e) When the task is not being performed correctly; or

(f) When the patient or authorized representative requests that the delegation be rescinded.

(2) In the event delegation is rescinded, the delegating registered nurse assumes responsibility for performing the task or initiating and participating in developing an alternative plan to ensure the continuity for the provision of the task.

(3) The delegating registered nurse must document the reason for rescinding delegation of the task and the plan for ensuring continuity of the task.

[Statutory Authority: Chapter 18.79 RCW. 96-05-060, § 246-840-970, filed 2/19/96, effective 3/21/96.]

WAC 246-840-980 Evaluation of nurse delegation. The nurse must participate in recordkeeping as required by the secretary of health to facilitate evaluation.

[Statutory Authority: Chapter 18.79 RCW. 96-05-060, § 246-840-980, filed 2/19/96, effective 3/21/96.]

WAC 246-840-990 Fees and renewal cycle. (1) Licenses for practical nurse and registered nurse must be renewed every year on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2.

(2) Licenses for advanced registered nurse must be renewed every two years on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2.

(3) The following nonrefundable fees shall be charged by the health professions quality assurance division of the department of health. Persons who hold an RN and an LPN license shall be charged separate fees for each license. Persons who are licensed as an advanced registered nurse practitioner in more than one specialty will be charged a fee for each specialty:

Attachment 8

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
OFFICE OF CORRECTIONAL OPERATIONS
TWIN RIVERS CORRECTIONAL CENTER / SPECIAL OFFENDER CENTER
PO BOX 514 • Monroe, Washington 98272-0514 • (360) 794-2200
FAX (360) 794-2314

September 24, 1998

TO: Gloria Wagner, Registered Nurse 2

FROM: Teresa Bollinger, Registered Nurse 3

Regarding: Memo of Counseling

An incident occurred during the 4:00 p.m. med line on 8/31/98 in which you dispensed medication to I/M [redacted] and then failed to immediately chart this fact, as required by law and as further directed by Ella Ray Sigmund in a memo to RN's dated 8/13/98. By your signature on Ms. Sigmund's memo, you acknowledged that you were aware of the directive prior to the occurrence of this 8/31/98 incident.

I sent you an e-mail on 9/12/98 to refresh your memory relative to the content of Ms. Sigmund's 8/13/98 directive.

By your failure to adhere to lawfully mandated and management reinforced prescribed procedure in the process of medication distribution, you were directly responsible for the overdose of medication received by I/M [redacted] on the evening of 8/31/98. Such neglect of duty at the least caused considerable discomfort for I/M [redacted] and if you persist in such practice, could prèsent a future situation of life-threatening proportion.

I am now advising you that any future disregard of Ms. Sigmund's 8/13/98 directive regarding medication charting procedures will result in further corrective/disciplinary action up to and including dismissal from your employment with the Department of Corrections.

cc: Personnel file

TB:ap

Attachment 9

I was present on May 18, 19 and 20, 1998; when RN3 Teresa Bollinger stated she gave a verbal directive regarding inmate complaints.
I do not recall hearing the alleged verbal directive stating nurses will physically assess any inmate complaining of a physical abnormality.

Name	Date
Stephanie Atchison	10-13-98
Michael Valesin RN 2	10/13/98
Leann Cave RN-2	10/14/98
Richard Elliott RN2	10-23-98
Gloria Wagner RN 2	10-29-98

I WAS NOT PRESENT ON MAY 18, 19, 20, 1998; WHEN TERESA BOLLINGER, THEN ACTING TEMPORARY RN3, GAVE A VERBAL DIRECTIVE REGARDING INMATE COMPLAINTS. I DO NOT RECALL HEARING THE ALLEGED VERBAL DIRECTIVE STATING NURSES WILL PHYSICALLY ASSESS ANY INMATE COMPLAINING OF A PHYSICAL ABNORMALITY.

[signature] RN II 10/27/98

11-18-98

To Whom it May Concern:

I was working at the Special Offenders Center on May 18, 19 and 20, 1998. I may have been present at the noon-time nursing report on May 18 and 19 but was not present on May 20. I do not recall hearing or hearing about an alleged verbal directive from Teresa Bellinger RN3 to nurses, on or about the above dates, stating "Nurses will assess any inmate complaining of a physical abnormality."

Linda Fluke ARNP CHCS II

*** CONFIDENTIAL ***

DEPARTMENT OF CORRECTIONS

DISCIPLINARY ACTION AUTHORIZATION

Gloria Wagner
Employee's Name

2/4/99
Date Received at Headquarters

RN 2
Employee's Job Classification

SOC
Employee's Job Location

Chris Graham
Assigned Personnel Officer/Phone #

RECOMMENDED ACTION:

Reduction in Pay: RIP 5% x 6 months / $
(Percentage/Length) (Total $ Amount)

Demotion to: ______
(Job Classification)

Suspension: ______ / $
(Length) (Total $ Loss)

Dismissal: ______
(Effective)

______
Date completed form faxed to PO

The attached disciplinary action has been reviewed as noted below. "This information is provided under the attorney/client relationship and invokes that privilege. It should be considered CONFIDENTIAL in nature."

Initials/Title	Date	Approve	Disapprove	Comments
HR Administrator	4-20 DC	✓		
AAG	4-20	✓		
Appropriate Deputy Secretary	4-23			
DOC Secretary	K 2?			

Please hand deliver to all reviewers and return to Leslie Carrigg, HR, 8th Floor, upon completion.

*** CONFIDENTIAL ***

DEPARTMENT OF CORRECTIONS

DISCIPLINARY ACTION AUTHORIZATION

Gloria Wagner
Employee's Name

2/4/99 Date Received at Headquarters	**RECOMMENDED ACTION:**
RN 2 Employee's Job Classification	Reduction in Pay: ____ / $ ____ (Percentage/Length) (Total $ Amount)
SOC Employee's Job Location	Demotion to: ____ (Job Classification)
Chris Graham Assigned Personnel Officer/Phone #	Suspension: ____ / $ ____ (Length) (Total $ Loss)
	Dismissal: Susp f/by dismissal (Effective)
	4-5-99 Date completed form faxed to PO

The attached disciplinary action has been reviewed as noted below. "This information is provided under the attorney/client relationship and invokes that privilege. It should be considered CONFIDENTIAL in nature."

Initials/Title	Date	Approve	Disapprove	Comments
HR Administrator [initials] (2nd review)	3/2/99	→		Elisabeth + others — the first letter (behind the fax page) is the revised letter modified after further info gathering. I have [illegible]
AAG M[illegible]	3/9/99		✓	[redacted]
Appropriate Deputy Secretary	4/2/99		✓	Return to [illegible] for develop of [illegible] action alt.
DOC Secretary [initials]	4/5/99		✓	

Please hand deliver to all reviewers and return to Leslie Carrigg, HR, 8th Floor, upon completion.

LV✓

I attached all the materials associated with this submittal, including the first routing sheet which includes Mike's comments. As I challenged myself to look at this with a "fresh eye" after much discussion & revision has gone on, I now feel some concern that it appears we have not had a method of ensuring nursing standards stated in the WAC's are carried out. It does not appear that there are internal procedures clearly set forth or expectations clarified. Even the meetings ~~that~~ when the supervisor felt sure she was communicating the expectation that complaints be assessed, apparently did not communicate the message. (statements from staff are on the ...) It would seem a key question for us will be whether we can defer to the nursing standards in the WAC's as a basis for our action. It is my understanding that the Nursing Board has taken no action, and commonly takes months before follow up.

WPS: [redacted]

Revised letter

DRAFT

Date

PERSONAL AND CONFIDENTIAL DELIVERY

Gloria Wagner

Ms. Wagner:

This is official notification of your suspension without pay from your position as a Registered Nurse 2 with the Department of Corrections at the Special Offender Unit of Monroe Correctional Complex from __date__ to __date__ to be followed by your immediate dismissal at the end of your regularly scheduled shift on __date.

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06 Revised Code of Washington, and the Merit System Rules, Title 356 Washington Administrative Code (WAC) Section 356-34-010 (1) (a) Neglect of duty, (h) Gross misconduct, (i) Willful violation of the published employing agency or department of personnel rules or regulations and 356-34-040, **Dismissal - Notification**, and 356-34-050, **Suspension - Followed by Dismissal**.

Specifically, you neglected your duty, committed an act of gross misconduct and willfully violated published agency rules, when, on 7/22/98, you failed to meet the basic standards of nursing care in physically assessing a medical complaint by Inmate [redacted] and you also failed to document his medical complaint in the infirmary log, as well as, Inmate [redacted] medical file.

The evidence indicates that you received a call in the infirmary at approximately 6:10 PM on 7/22/98 from Karen McLellan, Correctional

Officer 2 on unit, that Inmate was complaining that he was having trouble getting air. You in turn asked C/O McLellan if Inmate was having a problem speaking, to which C/O McLellan responded, "no". You then stated to C/O McLellan that you were starting medication lines, that this was a usual complaint from Inmate that his cell was probably hot and stuffy, and told C/O McLellan to have Inmate take a cool shower to help him feel better. You also told C/O McLellan, "if he continues to complain, call me back." You continued with medication lines and heard no more from the unit. As you finished medication lines, you informed RN 2 Mike Kalina of C/O McLellan's call regarding Inmate Without physically assessing Inmate complaint and as you had heard nothing more from the unit staff regarding Inmate complaint, you and RN 2 Kalina decided it was not an emergent situation and RN 2 Kalina agreed to check on Inmate at lockdown medication line, which was at approximately 8:30 PM. When RN2 Kalina checked on Inmate he was observed to be asleep and snoring. There was no indication that RN2 Kalina communicated with Inmate to check his physical status or with unit staff regarding any further complaints that Inmate may have made.

At approximately 10:34 PM on 7/22/98, which was after your shift and you were no longer in the institution, C/O 2 James Smith contacted the infirmary and asked RN 2 Leann Cave to check on Inmate C/O Smith further reported to RN 2 Cave that Inmate had not changed positions in approximately ninety minutes and that his feet appeared pale. RN 2 Cave indicated that she was unaware of any complaint from Inmate as there had been no documentation of any complaint from him in the infirmary log nor in Inmate medical record.

During the Administrative Comments investigation of this incident, you indicated to Ella Ray Sigmund, CMHPM and Acting Associate Superintendent, that Inmate had made similar complaints in the past and ~~that those complaints were~~ not always documented. It ~~should be noted~~ that Inmate died in his cell that ~~evening.~~

An Employee Conduct Report initiated on 8/3/98 describing this incident in greater detail is attached (Attachment #1) hereto and incorporated herein.

Inmate complaint of having difficulty getting air is significant to his documented physical problem of which all medical staff, including yourself, were aware. The knowledge of this medical significance is information you should have responded to.

The Department of Corrections Employee Handbook states, in part, under **Department Objectives,** on pages 1 and 2:

The department's main objectives are to:

- **Ensure safety for...offenders;** (emphasis added)

- **Treat all offenders...fairly and equitably;** (emphasis added)

- **Meet the national standards appropriate to the State of Washington** (emphasis added)

and also states, in part, under **Code of Ethics** on page 2:

> **High moral and ethical standards among correctional employees are essential for the success of the department's programs. The Department of Corrections subscribes to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service.** (emphasis added)

and further states, in part, under **Department Expectations,** on page 2:

> As a representative of the Department of Corrections, you will be expected to:
>
> - **Serve each offender with appropriate concern for their welfare...** (emphasis added)

On 11/24/93, you acknowledged receipt of the June 1993 Employee Handbook, further agreeing to become familiar with and have a thorough knowledge and understanding of its contents. Copies of pages 1 and 2 of the 1993 Employee Handbook (Attachment #2), and your acknowledgment of its receipt (Attachment #3) are attached hereto and incorporated herein.

The classification questionnaire (CQ) for your RN 2 position, HB36, which outlines its duties states, in part, under "Employee's Statement of Duties":

> **Provide ongoing nursing treatment and emergency treatment as necessary.** (emphasis added)
>
> **Maintains professional nursing care integrity as it applies to...delivery of service.** (emphasis added)

A copy of the CQ for your position, HB36, is attached (Attachment #4) hereto and incorporated herein.

RCW 18.130, **Regulation of Health Professions - Uniform Disciplinary Act,** states, in part, under RCW 18.130.180, **Unprofessional conduct,** subparagraph 4:

> The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:
>
> (4) **Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed.** (emphasis added)

A copy of RCW 18.130.180 (4) is attached (Attachment #5), hereto and incorporated herein.

WAC 246-840, **Practical and Registered Nursing,** states, in part, under WAC 246-840-700, **Standards of nursing conduct or practice**:

> **...Each individual, upon entering the practice of nursing, assumes a measure of responsibility and public trust and the corresponding obligation to adhere to the standards of nursing practice. The nurse shall be responsible and accountable for the quality of nursing care given to clients. The standards of nursing conduct or practice include, but are not limited to the following:**
>
> **FOR REGISTERED NURSES:**
>
> **(1) Nursing process:**
>
> **(a) The registered nurse shall collect pertinent objective and subjective data regarding the health status of the client.**
>
> **(c) The registered nurse shall communicate significant changes in the client's status to appropriate members of the health care team. This communication shall take place in a time period consistent with the client's need for care.**

> **(d) The registered nurse shall document, on essential client records, the nursing care given and the client's response to that care.**
>
> **(3) Other responsibilities:**
>
> **(a) The registered nurse shall have knowledge and understanding of the laws and rules regulating nursing and shall function within the legal scope of nursing practice.** (emphasis added)

A copy of WAC 246-840-700, **Standards of nursing conduct or practice: FOR REGISTERED NURSES**, is attached (Attachment #6) hereto and incorporated herein.

WAC 246-840, **Practical and Registered Nursing,** states, in part, under WAC 246-840-710, **Violations of standards or nursing conduct or practice:**

> **The following will serve as a guideline for the nurse as to the acts, practices or omissions that are inconsistent with generally accepted standards of nursing conduct or practice...Such conduct or practice includes, but is not limited to the following:**
>
> **(1) Failure to adhere to the standards enumerated in WAC 246-840-700(1) which may include:**
>
> **(a) Failing to assess and evaluate a client's status or failing to institute nursing intervention as required by the client's condition.**
>
> **(b) Willfully or repeatedly failing to report or document a client's symptoms, responses, progress, medication, or other nursing care accurately and/or intelligibly.**
>
> **(c) Willfully or repeatedly failing to make entries, altering entries, destroying entries, making incorrect or illegible entries and/or making false entries in records pertaining to the giving of medication, treatments, or other nursing care.** (emphasis added)

A copy of WAC 246-840-710, **Violations of standards of nursing or practice**, is attached (Attachment #7) hereto and incorporated herein.

WAC 246-840, **Practical and Registered Nursing**, states, in part, under WAC 246-840-960, **Accountability, liability, and coercion,** subparagraph 1:

> **(1) The registered nurse and nursing assistant are accountable for their own individual actions in the delegation process. The delegated task becomes the responsibility of the person to whom it is delegated but the registered nurse retains overall accountability for the nursing care of the patient, including nursing assessment, evaluation, and assuring documentation is completed.** (emphasis added)

A copy of WAC 246-840-960, **Accountability, liability, and coercion**, is attached (Attachment #8) hereto and incorporated herein.

You were aware, or should have been aware of the foregoing provisions of RCW 18.13.180 and WAC's 246-840-700, 246-840-710, and 246-840-960, as evidenced by the fact that you have been a licensed Registered Nurse within the State of Washington since gaining employment with the Department of Corrections on 9/21/87.

As an employee and Registered Nurse 2 with the Department of Corrections at the Special Offender Unit of Monroe Correctional Complex, you have a duty and obligation to:

1. Adhere to its policies and procedures, which are designed to ensure the efficient and effective management of the Department's programs;
2. Ensure the safety for offenders; to treat all offenders fairly and equitably; and to meet the national standards appropriate to the State of Washington;
3. Ensure the high moral and ethical standards the department expects of its employees to ensure the success of its programs;
4. Perform your duties in a professional, competent and compassionate manner;
5. Meet the expectations of the agency as a whole.
6. Serve each offender with appropriate concern for their welfare; and

7. Meet the department's expectations that you would meet the laws and regulations of the State of Washington regarding nursing care and the standards of nursing conduct or practice, required for licensure as a registered nurse, which includes: the accountability for the quality of nursing care given to a client; and the gathering and documentation of pertinent data regarding the health status of the client in essential medical records.

Inmate ██ complaint of having difficulty getting air is significant to his documented overall medical condition, which all medical staff, including yourself, were aware or should have been aware. Given his overall medical condition, there was, according to Dr. Jonas, WSRU Contract Physician, who I had review this incident, medical significance to his complaint, which you should have responded to. Even though you indicated during the course of the investigation of this incident that Inmate ██ had made numerous medical complaints of a similar nature, it was noted in a review of his medical chart that those "similar" complaints had not been charted.

Additionally, while you relied on the observation of a correctional officer that he was able to speak, it should be noted that correctional officers are not medical staff and are not qualified nor are they expected to conduct medical assessments of inmates. Also, while you did not hear back from unit correctional staff of any further complaints from Inmate ██ you took no affirmative action after completing medication lines to ascertain his physical status in person or by calling unit staff to check on him. Instead you waited until approximately 8:30 PM to have Inmate ██ checked on by RN 2 Kalina.

Finally, even though you had received an indication from correctional staff of Inmate ██ physical complaint, you failed to appropriately document that complaint in either the infirmary log or his medical chart.

By your behavior in this incident, you have clearly demonstrated:

1. A neglect of your duty and obligation to meet the reasonable expectations of the Department that you would adhere to its policies and procedures; that you would ensure for the safety of its inmates and treat all offenders fairly and equitably; to meet the national standards appropriate to the State of Washington; that you would perform your duties in a professional, competent and compassionate manner, serving each offender with appropriate concern for their welfare; and that you would meet the laws and regulations of the State of Washington regarding nursing care and

the standards of nursing conduct or practice required for your licensure as a registered nurse. These charges are based on your behavior of failing to appropriately provide a physical assessment of Inmate [redacted] after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate [redacted] was complaining that he was having trouble getting air; and your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM.

2. A neglect of your duty to meet the reasonable expectations of the Department that you would obey all laws while on duty, which included the laws and regulations of the State of Washington regarding nursing care and the standards of nursing conduct or practice required for your licensure as a registered nurse, to include: accountability for the quality of nursing care given to a client; and the collection and documentation of pertinent data regarding the health status of the client in essential medical records. These charges are based on your failure to document his medical complaint in the infirmary log and Inmate [redacted] medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate [redacted] later that evening. During the Administrative Comments meeting with Ms. Sigmund, you also indicated that you did not document in his medical file any of the numerous similar complaints that he had made about his difficulty getting air and that his complaints were many and delusional in nature and that you did not document them as well.

3. A neglect of your duty to meet the reasonable expectations outlined in your Registered Nurse 2 position's Classification Questionnaire, HB36, to provide ongoing nursing treatment and emergency treatment as necessary; and to maintain professional nursing care integrity as it applies to delivery of service. These charges are based on your behavior of failing to appropriately provide a physical assessment of Inmate [redacted] after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate [redacted] was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate [redacted] medical chart. This lack of documentation failed to provide the next shift

nurse with necessary information needed to properly assess Inmate ■ later that evening.

4. A willful violation of the Department of Corrections Employee Handbook by your failure to: assist the department in meeting its objective of ensuring the efficient and effective management of its programs, the safety of its offenders, that all offenders would be treated fairly and equitably, and that the national standards appropriate to the State of Washington would be met; meet the moral and ethical standards of the department that you would perform your Registered Nurse 2 duties in a professional and competent manner; meet the expectations of the department that you would obey all laws while on duty, which includes the laws and regulations of the State of Washington regarding nursing care and the standards of nursing conduct or practice required for your licensure as registered nurse; and to serve each offender with appropriate concern for their welfare. These charges are based on your behavior of failing to appropriately provide a physical assessment of Inmate ■ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate ■ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate ■ medical chart. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate ■ later that evening.

5. Gross misconduct by your blatant and flagrant disregard for the stated objectives and ethics of the Department of Corrections to ensure the safety of offenders; to treat all offenders fairly and equitably; to meet the national standards appropriate to the State of Washington; and to subscribe to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service, all of which adversely impacts the Depararment's ability to carry out its mission and functions. These charges are based on your behavior of failing to appropriately provide a physical assessment of Inmate ■ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate ■ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or

calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate [redacted] medical chart. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate [redacted] later that evening.

In reviewing your personnel file I find:

1. A Memo of Counseling dated 9/24/98, from your supervisor, RN 3 Bollinger, which addressed your behavior of 8/31/98, dispensing medication to Inmate [redacted], and failing to immediately chart that information, as required by law and as further directed by Ella Ray Sigmund, CMHPM in a memo to RN's dated 8/13/98. By your failure to do so, you were directly responsible for an overdose of medication received by Inmate [redacted] (Attachment #9)

A copy of the foregoing document from your personnel file is attached (Attachment #9) hereto and incorporated herein.

On 11/24/98, I met with you at a pre-termination meeting. Also present was Mike Wilson, Business Agent, Teamsters Local #313, and your employee representative; Mark Anderson, Attorney, Teamsters Local #313; Dinnie Burnham, Teamster Local #313 Shop Steward; Bob Riordan, Human Resource Manager, Monroe Correctional Complex (MCC); Linda Gilstrap, Personnel Officer at the Special Offender Unit (SOU); and Chris Graham, newly appointed Personnel Officer at the Special Offender Unit, as an observer. The purpose of the meeting was to give you the opportunity to present me with any information that you wanted me to consider prior to my making a decision.

At the meeting, Mr. Wilson indicated that six out of the seven registered nurses at SOU had indicated that they had not received the verbal directive from RN 3 Bollinger to physically assess any inmate who complained of any physical abnormality at the meetings on 5/18, 5/19, and 5/20/98. He additionally indicated that 7/22/98 was the hottest day of the year and that your decision not to physically assess Inmate [redacted] complaint of not getting air was based to an extent on that fact. Mr. Wilson also indicated that Inmate [redacted] had been at SOU for four years and had many similar complaints, which when physically assessed, were determined to be medically unfounded. Mr. Wilson also indicated that later in the evening of 7/22/98, CO Benda reported that Inmate [redacted] was lying on the floor and when asked if he was okay, Inmate [redacted] responded "Yes, I'm a little hot...I took a shower, I'm OK."

(handwritten margin note:) We don't indicate in the letter that this instruction was given

Finally, Mr. Wilson presented a magazine article that spoke to the physical aspect of dehydration of patients who were on psychotropic drugs.

Mr. Wilson went on to indicate that there was no reason for you to document Inmate [redacted] complaint, as when RN 2 Mike Kalina checked on Inmate [redacted] at 8:30PM, Inmate [redacted] reported that he was OK. Mr. Wilson stated that physical complaints are only documented when the inmate is not okay. He further indicated that if you had received more complaints from Inmate [redacted] you would have gone to physically assess him, but, since you hadn't received any and RN2 Kalina had reported that Inmate [redacted] was okay, there wasn't a need to physically assess him.

In response to Mr. Riordan's indication that physical assessment and medical charting of Inmate [redacted] physical complaints were essential to the attending physician in formulating medical history and follow-up and were required by nursing practice and standards of nursing practice, Mr. Anderson indicated that you had not violated nursing practices or laws as RN2 Kalina was the one who assessed Inmate [redacted] discussed his report to you that the Inmate had said he was okay, and it should have been RN2 Kalina who should have documented/charted that assessment.

Ms. Burnham indicated that the manner in which you responded to Inmate [redacted] complaint through Correctional Officer McLellan, i.e., phone triage, was a standard practice throughout Monroe Correctional Complex.

Finally, Mr. Wilson indicated that you had worked within Monroe Correctional Complex at the Washington State Reformatory and SOU for the past 11 years, had no previous corrective/disciplinary actions noted in your personnel record, and, in fact, your performance evaluations were above average. Accordingly, he asked that the misconduct be withdrawn.

With respect to the foregoing issues/information presented to me at our meeting, the following is provided:

1. Issue: Six out of seven registered nurses at SOU indicated that they had not received the verbal directive from RN 3 Bollinger to physically assess any inmate who complained of any physical abnormality at meetings on 5/18, 5/19, and 5/20/98.

   Mr. Wilson indicated that he could get signed statements from the six of the seven RN's he spoke with (which included you and RN 2 Kalina) to support his claim. Mr. Wilson subsequently provided copies of three memorandums signed by you and four other RN2's

indicating that they were present on the dates of the meetings, but did not recall hearing the verbal directive from RN 3 Bollinger to physically assess any inmate complaining of a physical abnormality; another memorandum signed by Linda Fluke, Corrections Health Care Specialist 2, that indicated that she may have been at the meetings on 5/18 and 19, but, not on 5/20, and did not recall hearing or hearing about the directive from RN 3 Bollinger; and a memorandum from RN 2 Roy Darnell, that indicated that while he was not at the meetings, he did not recall hearing about the alleged directive from RN 3 Bollinger.

Based on the foregoing, I am making a finding of no misconduct. relative to the allegation that you failed to follow the verbal directive from RN 3 Bollinger to physically assess an inmate any time they complained of a physical abnormality.

Copies of the foregoing memorandums submitted regarding this issue are attached (Attachment #10) hereto and incorporated herein.

2. Issue: Many similar complaints from Inmate [redacted] which when physically assessed, were determined to be medically unfounded.

It is interesting to note that, while on the one hand Mr. Wilson made the indication that six of seven registered nurses indicated that they had not received Ms. Bollinger's verbal directive to physically assess inmate complaints, on the other hand he made this statement regarding previous "similar" physical complaints made by Inmate [redacted] It should be noted here, that when I had medical staff review Inmate [redacted] medical file for a one year period, documentation revealed that he was seen, on average, 1-2 times per month by nursing staff; at least one time per month by a Correctional Health Care Specialist; and only one entry documenting a medical encounter by nursing staff while he was on his living unit. It is apparent to me from this statement, that if nursing staff **had been physically assessing Inmate [redacted] medical complaints**, they were not appropriately documenting/charting those complaints in his medical file, which as previously indicated, would not meet WAC 246-840-700, **Standards of Nursing Conduct or Practice**.

Additionally, in speaking with Ms. Sigmund regarding mentally ill inmates, which is the reason for Inmate [redacted] being treated at SOU,

she reiterated to me that those inmates oftentimes have difficulty in verbalizing/communicating the exact nature of their medical complaints, and, accordingly, that is the very reason that their physical complaints should always be medically assessed.

3. Issue: There was no reason for you to document Inmate [redacted] complaint, as when RN 2 Kalina checked on him at 8:30PM, Inmate [redacted] indicated he was okay; Mr. Wilson's further indication that physical complaints are only documented when the inmate is not okay; and that, according to Mr. Wilson, should you have received more complaints from Inmate [redacted] you would have gone to physically assess him.

   Neither Mr. Wilson nor I are medical professionals. Accordingly, I spoke with Dr. Jonas, WSRU contract physician, who in turn indicated to me, that, in his opinion, Inmates [redacted] physical complaint **was of medical significance** to him and that, **given Inmate [redacted] overall medical condition, such a complaint should not only have been documented, but, physically assessed, as well.**

4. Issue: Phone triage being a standard practice throughout Monroe Correctional Complex.

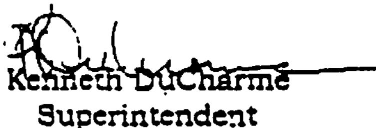
   While phone triage may be appropriate in non-emergent situations, i.e., a cold, headache, toothache, severe ankle pain from an ankle injury, etc., as I indicated to Ms. Burnham during our meeting, it has always been my expectation, during my tenure as Superintendent of the Washington State Reformatory, that nursing staff would physically assess inmate physical complaints that could be potentially life-threatening. As I indicated to you in Issue #4, it was the medical opinion of Dr. Jonas, that given the overall medical condition of Inmate [redacted], his physical complaint of not being able to "get air", was of medical significance, should have been physically assessed, then, documented. Accordingly, phone triage in this incident demonstrated poor nursing judgment on your part, a failure of you to meet acceptable standards of nursing care expected of a licensed registered nurse, and was an inappropriate response to his physical complaint.

In conclusion and full consideration of the foregoing, I have determined to dismiss you from your position as a Registered Nurse 2 with the Department

of Corrections at Monroe Correctional Complex as indicated in paragraph one of this letter.

Under the provisions of Washington Codes 358-20-010 and 040, you have the right to appeal this action to the Personnel Appeals Board, 2828 Capitol Boulevard, Olympia, Washington, 98504, within thirty (30) days from the effective date stated in paragraph one of this letter.

The Merit System rules (WACS), Department of Corrections' policies, Monroe Correctional Complex-Special Offender Center Field Instructions and the Collective Bargaining Agreement are available for your review upon request.



Kenneth DuCharme
Superintendent

KDC:cg
Attachments

cc: Dave Savage, Deputy Secretary, OCO
Eldon Vail, Assistant Deputy Secretary, OCO
Phil Stanley, NW Regional Administrator
Jennie Adkins, Human Resources Administrator, OAS
Linda Dalton, Senior Assistant Attorney General
Cheryl Landers, NW Region Human Resource Manager
Bob Riordan, MCC Human Resource Manager
Personnel File

cc: Reg Hamm

***** CONFIDENTIAL *****

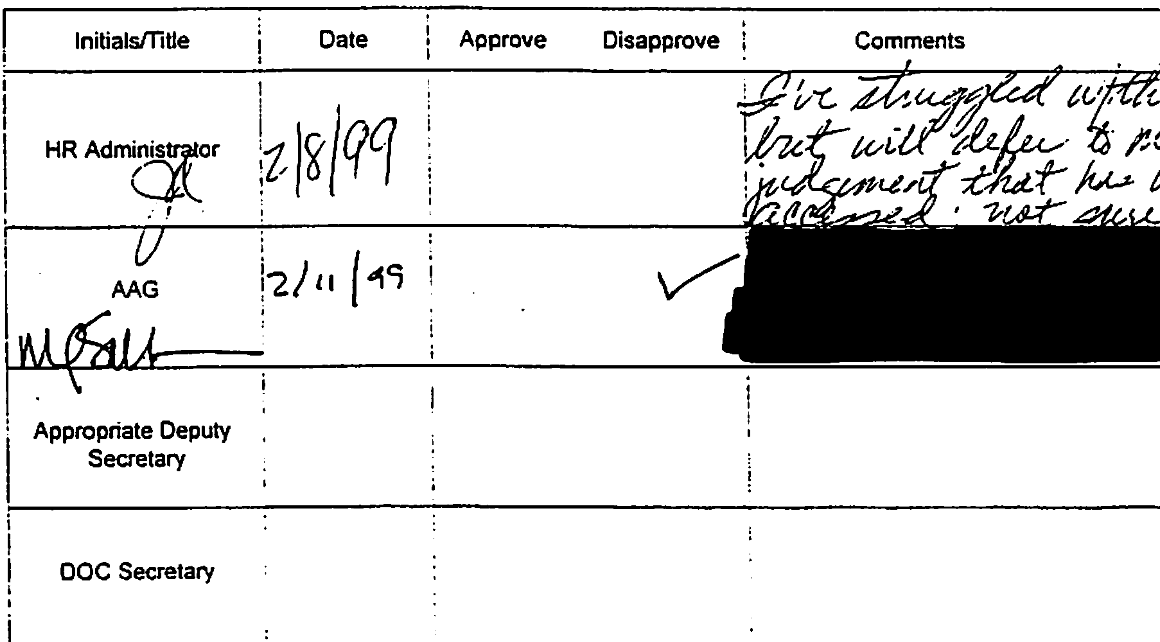
DEPARTMENT OF CORRECTIONS
DISCIPLINARY ACTION AUTHORIZATION

RECEIVED
FEB 0 9 1999
OFFICE OF THE ATTORNEY GENERAL
LABOR & PERSONNEL DIVISION

Gloria Wagner
Employee's Name

2/4/99 Date Received at Headquarters	**RECOMMENDED ACTION:**
RN 2 Employee's Job Classification	Reduction in Pay: / $ (Percentage/Length) (Total $ Amount)
SOC Employee's Job Location	Demotion to: (Job Classification)
Chris Graham Assigned Personnel Officer/Phone #	Suspension: / $ (Length) (Total $ Loss)
	Dismissal: Susp f/by dismissal (Effective)
	Date completed form faxed to PO

The attached disciplinary action has been reviewed as noted below. "This information is provided under the attorney/client relationship and invokes that privilege. It should be considered CONFIDENTIAL in nature."



Initials/Title	Date	Approve	Disapprove	Comments
HR Administrator [initials]	2/8/99			I've struggled with this but will defer to medical judgement that he been accessed; not sure the [redacted]
AAG [signature]	2/11/99		✓	[redacted]
Appropriate Deputy Secretary				
DOC Secretary				

Please hand deliver to all reviewers and return to Leslie Carrigg, HR, 8th Floor, upon completion.

With respect to the foregoing issues/information presented to me at our meeting, the following is provided:

1. Issue: Six out of seven registered nurses at SOU indicated that they had not received the verbal directive from RN 3 Bollinger to physically assess any inmate who complained of any physical abnormality at meetings on 5/18, 5/19, and 5/20/98.

   Mr. Wilson indicated that he could get signed statements from the six of the seven RN's he spoke with (which included you and RN 2 Kalina) to support his claim. However, he never produced those statements at our meeting, nor at any subsequent meetings I had with him concerning you. Additionally, in speaking with RN 3 Bollinger, she emphatically recalls presenting that directive from Ms. Sigmund at meetings on the dates indicated. She further recalled writing a note on a copy of the email from Ms. Sigmund that the directive had been presented to all nursing staff, which Ms. Sigmund informed me, she recalls receiving and reviewing.

2. Issue: Many similar complaints from Inmate [redacted] which when physically assessed, were determined to be medically unfounded.

   It is interesting to note that, while on the one hand Mr. Wilson made the indication that six of seven registered nurses indicated that they had not received Ms. Bollinger's verbal directive to physically assess inmate complaints, on the other hand he made this statement regarding previous "similar" physical complaints made by Inmate [redacted] It should be noted here, that when I had medical staff review Inmate [redacted] medical file for a one year period, documentation revealed that he was seen, on average, 1-2 times per month by nursing staff; at least one time per month by a Correctional Health Care Specialist; and only one entry documenting a medical encounter by nursing staff while he was on his living unit. It is apparent to me from this statement, that if nursing staff **had been physically assessing Inmate [redacted] medical complaints**, they were not appropriately documenting/charting those complaints in his medical file, which as previously indicated, would not meet WAC 246-840-700, **Standards of Nursing Conduct or Practice.**

   Additionally, in speaking with Ms. Sigmund regarding mentally ill inmates, which is the reason for Inmate [redacted] being treated at SOU, she reiterated to me that those inmates oftentimes have difficulty in verbalizing/communicating the exact nature of their medical complaints, and, accordingly, that is the very reason that their physical complaints should always be medically assessed.

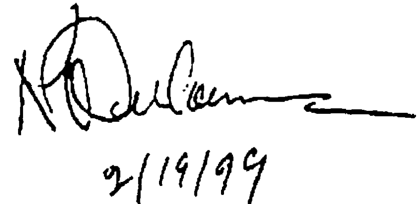
3. Issue: There was no reason for you to document Inmate [redacted] complaint, as when RN 2 Kalina checked on him at 8:30PM, Inmate [redacted] indicated he was

okay; Mr. Wilson's further indication that physical complaints are only documented when the inmate is not okay; and that, according to Mr. Wilson, should you have received more complaints from Inmate you would have gone to physically assess him.

Neither Mr. Wilson nor I are medical professionals. Accordingly, I spoke with Dr. Jonas, WSRU contract physician, who in turn indicated to me, that, in his opinion, Inmates physical complaint **was of medical significance** to him and that, **given Inmate overall medical condition, such a complaint should not only have been documented, but, physically assessed, as well.**

4. Issue: Phone triage being a standard practice throughout Monroe Correctional Complex.

While phone triage may be appropriate in non-emergent situations, i.e., a cold, headache, toothache, severe ankle pain from an ankle injury, etc., as I indicated to Ms. Burnham during our meeting, it has always been my expectation, during my tenure as Superintendent of the Washington State Reformatory, that nursing staff would physically assess inmate physical complaints that could be potentially life-threatening. As I indicated to you in Issue #4, it was the medical opinion of Dr. Jonas, that given the overall medical condition of Inmate his physical complaint of not being able to "get air", was of medical significance, should have been physically assessed, then, documented. Accordingly, phone triage in this incident demonstrated poor nursing judgment on your part, a failure of you to meet acceptable standards of nursing care expected of a licensed registered nurse, and was an inappropriate response to his physical complaint.



2/19/99

original letter

DRAFT

Date

PERSONAL AND CONFIDENTIAL DELIVERY

Gloria Wagner

Ms. Wagner:

This is official notification of your suspension without pay from your position as a Registered Nurse 2 with the Department of Corrections at the Special Offender Unit of Monroe Correctional Complex from _date_ to _date_ to be followed by your immediate dismissal at the end of your regularly scheduled shift on _date.

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06 Revised Code of Washington, and the Merit System Rules, Title 356 Washington Administrative Code (WAC) Section 356-34-010 (1) (a) Neglect of duty, (d) Insubordination, (h) Gross misconduct, (i) Willful violation of the published employing agency or department of personnel rules or regulations and 356-34-040, **Dismissal - Notification,** and 356-34-050, **Suspension - Followed by Dismissal.**

Specifically, you neglected your duty, were insubordinate, committed an act of gross misconduct and willfully violated published agency rules, when, on 7/22/98, you failed to provide a physical assessment of Inmate and you also failed to document his medical complaint in the infirmary log, as well as, Inmate medical file.

The evidence indicates that you received a call in the infirmary at approximately 6:10 PM on 7/22/98 from Karen McLellan, Correctional Officer 2 on unit, that Inmate S was complaining that he was having

trouble getting air. You in turn asked C/O McLellan if Inmate ■ was having a problem speaking, to which C/O McLellan responded, "no". You then stated to C/O McLellan that you were starting medication lines, that this was a usual complaint from Inmate ■ that his cell was probably hot and stuffy, and told C/O McLellan to have Inmate ■ take a cool shower to help him feel better. You also told C/O McLellan, "if he continues to complain, call me back." You continued with medication lines and heard no more from the unit. As you finished medication lines, you informed RN 2 Mike Kalina of C/O McLellan's call regarding Inmate ■ You and RN 2 Kalina decided it was not an emergent situation and RN 2 Kalina agreed to check on Inmate ■ at lockdown medication line, which was at approximately 8:30 PM. At that time, Inmate ■ was snoring and there was no verbal communication between RN 2 Kalina and Inmate ■

At approximately 10:34 PM on 7/22/98, C/O 2 James Smith contacted the infirmary and asked RN 2 Leann Cave to check on Inmate ■ C/O Smith further reported to RN 2 Cave that Inmate ■ had not changed positions in approximately ninety minutes and that his feet appeared pale. RN 2 Cave indicated that she was unaware of any complaint from Inmate ■ as there had been no documentation of that complaint.

During the Administrative Comments investigation of this incident, you indicated to Ella Ray Sigmund, CMHPM and Acting Associate Superintendent, that Inmate ■ had made similar complaints in the past and that they were not always documented. It should be noted that Inmate ■ died in his cell that evening.

An Employee Conduct Report initiated on 8/3/98 describing this incident in greater detail is attached (Attachment #1) hereto and incorporated herein.

On May 18, 19 and 20, 1998, you were present in the infirmary when RN 3 Teresa Bollinger, your supervisor, gave a verbal directive to all RN 2's that they were to physically assess any inmate who complained of any physical abnormality. This directive was based on a memo provided by Ella Ray Sigmund, CMHPM.

Inmate ■ complaint of having difficulty getting air is significant to his documented physical problem of which all medical staff, including yourself, were aware. The knowledge of this medical significance is information you should have responded to.

The Department of Corrections Employee Handbook states, in part, under **Department Objectives,** on pages 1 and 2:

The department's main objectives are to:

- **Ensure safety for...offenders;** (emphasis added)

- **Treat all offenders...fairly and equitably;** (emphasis added)

- **Meet the national standards appropriate to the State of Washington** (emphasis added)

and also states, in part, under **Code of Ethics** on page 2:

> **High moral and ethical standards among correctional employees are essential for the success of the department's programs. The Department of Corrections subscribes to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service.** (emphasis added)

and further states, in part, under **Department Expectations,** on page 2:

> As a...employee of the department, **you will have many things to learn, not the least of which will be the expectations of your supervisor....and agency as a whole**...(emphasis added)
>
> As a representative of the Department of Corrections, you will be expected to:
>
> - **Be a good citizen, obey all laws while on** and off **duty...**(emphasis added)
>
> - **Serve each offender with appropriate concern for their welfare and with no purpose of personal gain.** (emphasis added)

On 11/24/93, you acknowledged receipt of the June 1993 Employee Handbook, further agreeing to become familiar with and have a thorough knowledge and understanding of its contents. Copies of pages 1 and 2 of the 1993 Employee Handbook (Attachment #2), and your acknowledgment of its receipt (Attachment #3) are attached hereto and incorporated herein.

The classification questionnaire (CQ) for your RN 2 position, HB36, which outlines its duties states, in part, under "Employee's Statement of Duties":

> **Provide ongoing nursing treatment and emergency treatment as necessary**. (emphasis added)
>
> **Maintains professional nursing care integrity as it applies to...delivery of service.** (emphasis added)

A copy of the CQ for your position, HB36, is attached (Attachment #4) hereto and incorporated herein.

RCW 18.130, **Regulation of Health Professions - Uniform Disciplinary Act,** states, in part, under RCW 18.130.180, **Unprofessional conduct,** subparagraph 4:

> The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:
>
> (4) **Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed.** (emphasis added)

A copy of RCW 18.130.180 (4) is attached (Attachment #5), hereto and incorporated herein.

WAC 246-840, **Practical and Registered Nursing,** states, in part, under WAC 246-840-700, **Standards of nursing conduct or practice:**

> **...Each individual, upon entering the practice of nursing, assumes a measure of responsibility and public trust and the corresponding obligation to adhere to the standards of nursing practice. The nurse shall be responsible and accountable for the quality of nursing care given to clients. The standards of nursing conduct or practice include, but are not limited to the following:**
>
> **FOR REGISTERED NURSES:**
>
> **(1) Nursing process:**
>
> **(a) The registered nurse shall collect pertinent objective and subjective data regarding the health status of the client.**
>
> **(c) The registered nurse shall communicate significant changes in the client's status to appropriate members of**

the health care team. This communication shall take place in a time period consistent with the client's need for care.

(d) The registered nurse shall document, on essential client records, the nursing care given and the client's response to that care.

(3) Other responsibilities:

(a) The registered nurse shall have knowledge and understanding of the laws and rules regulating nursing and shall function within the legal scope of nursing practice. (emphasis added)

A copy of WAC 246-840-700, **Standards of nursing conduct or practice: FOR REGISTERED NURSES**, is attached (Attachment #6) hereto and incorporated herein.

WAC 246-840, **Practical and Registered Nursing,** states, in part, under WAC 246-840-710, **Violations of standards or nursing conduct or practice:**

The following will serve as a guideline for the nurse as to the acts, practices or omissions that are inconsistent with generally accepted standards of nursing conduct or practice...Such conduct or practice includes, but is not limited to the following:

(1) Failure to adhere to the standards enumerated in WAC 246-840-700(1) which may include:

(a) Failing to assess and evaluate a client's status or failing to institute nursing intervention as required by the client's condition.

(b) Willfully or repeatedly failing to report or document a client's symptoms, responses, progress, medication, or other nursing care accurately and/or intelligibly.

(c) Willfully or repeatedly failing to make entries, altering entries, destroying entries, making incorrect or illegible entries and/or making false entries in records pertaining to the giving of medication, treatments, or other nursing care. (emphasis added)

A copy of WAC 246-840-710, **Violations of standards of nursing or practice,** is attached (Attachment #7) hereto and incorporated herein.

WAC 246-840, **Practical and Registered Nursing,** states, in part, under WAC 246-840-960, **Accountability, liability, and coercion,** subparagraph 1:

> **(1) The registered nurse and nursing assistant are accountable for their own individual actions in the delegation process. The delegated task becomes the responsibility of the person to whom it is delegated but the registered nurse retains overall accountability for the nursing care of the patient, including nursing assessment, evaluation, and assuring documentation is completed.** (emphasis added)

A copy of WAC 246-840-960, **Accountability, liability, and coercion,** is attached (Attachment #8) hereto and incorporated herein.

You were aware, or should have been aware of the foregoing provisions of RCW 18.13.180 and WAC's 246-840-700, 246-840-710, and 246-840-960, as evidenced by the fact that you have been a licensed Registered Nurse within the State of Washington since gaining employment with the Department of Corrections on 9/21/87.

As an employee and Registered Nurse 2 with the Department of Corrections at the Special Offender Unit of Monroe Correctional Complex, you have a duty and obligation to:

1. Adhere to its policies and procedures, which are designed to ensure the efficient and effective management of the Department's programs;

2. Ensure the safety for offenders; to treat all offenders fairly and equitably; and to meet the national standards appropriate to the State of Washington;

3. Ensure the high moral and ethical standards the department expects of its employees to ensure the success of its programs;

4. Perform your duties in a professional, competent and compassionate manner;

5. Meet the expectations of your supervisor and the agency as a whole.

6. Serve each offender with appropriate concern for their welfare; and

7. Meet the department's expectations that you would meet the laws and regulations of the State of Washington regarding nursing care and the standards of nursing conduct or practice, required for licensure as a registered nurse, which includes: the accountability for the quality of nursing care given to a client; and the gathering and documentation of pertinent data regarding the health status of the client in essential medical records.

By your behavior in this incident, you have clearly demonstrated:

1. A neglect of your duty and obligation to meet the reasonable expectations of the Department that you would adhere to its policies and procedures; that you would ensure for the safety of its inmates and treat all offenders fairly and equitably; to meet the national standards appropriate to the State of Washington; that you would perform your duties in a professional, competent and compassionate manner, serving each offender with appropriate concern for their welfare; and that you would meet the laws and regulations of the State of Washington regarding nursing care and the standards of nursing conduct or practice required for your licensure as a registered nurse. These charges are based on your behavior of failing to appropriately provide a physical assessment of Inmate ██ after receiving a call from a correctional officer who said Inmate ██ was complaining that he was having trouble getting air. After asking the correctional officer if the inmate was having a problem speaking and being told "no", you told the correctional officer that you were starting medication lines, that this was a usual complaint from Inmate ██ that his cell was probably hot and stuffy, and that the inmate should take a cool shower to make him feel better. You told the correctional officer "if he continues to complain, call me back." You then continued with the medication lines.

2. A neglect of your duty to meet the reasonable expectations of the Department that you would obey all laws while on duty, which included the laws and regulations of the State of Washington regarding nursing care and the standards of nursing conduct or practice required for your licensure as a registered nurse, to

include: accountability for the quality of nursing care given to a client; and the collection and documentation of pertinent data regarding the health status of the client in essential medical records. These charges are based on your failure to document his medical complaint in the infirmary log and Inmate [redacted] medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate [redacted] later that evening. During the Administrative Comments meeting with Ms. Sigmund, you also indicated that you did not document in his medical file any of the numerous similar complaints that he had made about his difficulty getting air and that his complaints were many and delusional in nature and that you did not document them as well.

3. Insubordination by your failure to follow your supervisor's verbal directive on May 18, 19, and 20, 1998 at the noontime nursing meeting, that all RN's were to physically assess any inmate who complained of any physical abnormality. These charges are based on your failure to document his medical complaint in the infirmary log and Inmate [redacted] medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate [redacted] later that evening.

4. A willful violation of the Department of Corrections Employee Handbook by your failure to: assist the department in meeting its objective of ensuring the efficient and effective management of its programs, the safety of its offenders, that all offenders would be treated fairly and equitably, and that the national standards appropriate to the State of Washington would be met; meet the moral and ethical standards of the department that you would perform your Registered Nurse 2 duties in a professional and competent manner; meet the expectations of the department that you would obey all laws while on duty, which includes the laws and regulations of the State of Washington regarding nursing care and the standards of nursing conduct or practice required for your licensure as registered nurse; and to serve each offender with appropriate concern for their welfare. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate [redacted] after receiving a call from a correctional officer who said Inmate [redacted] was complaining that he was having trouble getting air; and your failure to document his medical complaint in the infirmary log and Inmate [redacted] medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate [redacted] later that evening.

5. A willful violation of the duties of your Registered Nurse 2 position's Classification Questionnaire, HB36, to provide ongoing nursing treatment and emergency treatment as necessary; and to maintain professional nursing care integrity as it applies to...delivery of service. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate [redacted] after receiving a call from a correctional officer who said Inmate [redacted] was complaining that he was having trouble getting air; and your failure to document his medical complaint in the infirmary log and Inmate [redacted] medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate [redacted] later that evening.

7. Gross misconduct by your blatant and flagrant disregard for the stated objectives and ethics of the Department of Corrections to ensure the safety of offenders; to treat all offenders fairly and equitably; to meet the national standards appropriate to the State of Washington; and to subscribe to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service, all of which adversely impacts its ability to carry out its mission and functions. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate [redacted] after receiving a call from a correctional officer who said Inmate [redacted] was complaining that he was having trouble getting air and your failure to document Inmate [redacted] medical complaint in the infirmary log and Inmate [redacted] medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate [redacted] later that evening.

In reviewing your personnel file I find:

1. A Memo of Counseling dated 9/24/98, from your supervisor, RN 3 Bollinger, which addressed your behavior of 8/31/98, dispensing medication to Inmate [redacted], and failing to immediately chart that information, as required by law and as further directed by Ella Ray Sigmund, CMHPM in a memo to RN's dated 8/13/98. By your failure to do so, you were directly responsible for an overdose of medication received by Inmate [redacted]

A copy of the foregoing document from your personnel file is attached (Attachment #9) hereto and incorporated herein.

On 11/24/98, I met with you at a pre-termination meeting. Also present was Mike Wilson, Business Agent, Teamsters Local #313, and your employee representative; Mark Anderson, Attorney, Teamsters Local #313; Dinnie Burnham, Teamster Local #313 Shop Steward; Bob Riordan, Human Resource Manager, Monroe Correctional Complex (MCC); Linda Gilstrap, Personnel Officer at the Special Offender Unit (SOU); and Chris Graham, newly appointed Personnel Officer at the Special Offender Unit, as an observer. The purpose of the meeting was to give you the opportunity to present me with any information that you wanted me to consider prior to my making a decision.

At the meeting, Mr. Wilson indicated that six out of the seven registered nurses at SOU had indicated that they had not received the verbal directive from RN 3 Bollinger to physically assess any inmate who complained of any physical abnormality at the meetings on 5/18, 5/19, and 5/20/98. He additionally indicated that 7/22/98 was the hottest day of the year and that your decision not to physically assess Inmate [redacted] complaint of not getting air was based to an extent on that fact. Mr. Wilson also indicated that Inmate [redacted] had been at SOU for four years and had many similar complaints, which when physically assessed, were determined to be medically unfounded. Mr. Wilson also indicated that later in the evening of 7/22/98, CO Benda reported that Inmate [redacted] was lying on the floor and when asked if he was okay, Inmate [redacted] responded "Yes, I'm a little hot...I took a shower, I'm OK." Finally, Mr. Wilson presented a magazine article that spoke to the physical aspect of dehydration of patients who were on psychotropic drugs.

not checked

Mr. Wilson went on to indicate that there was no reason for you to document Inmate [redacted] complaint, as when RN 2 Mike Kalina checked on Inmate [redacted] at 8:30PM, Inmate [redacted] reported that he was OK. Mr. Wilson stated that physical complaints are only documented when the inmate is not okay. He further indicated that if you had received more complaints from Inmate [redacted] you would have gone to physically assess him, but, since you hadn't received any and RN2 Kalina had reported that Inmate [redacted] was okay, there wasn't a need to physically assess him.

In response to Mr. Riordan's indication that physical assessment and medical charting of Inmate [redacted] physical complaints were essential to the attending physician in formulating medical history and follow-up and were required by nursing practice and standards of nursing practice, Mr. Anderson indicated that you had not violated nursing practices or laws as RN2 Kalina was the one who assessed Inmate [redacted] discussed his report to you that the Inmate had said he was okay, and it should have been RN2 Kalina who should have documented/charted that assessment.

Ms. Burnham indicated that the manner in which you responded to Inmate ███ complaint through Correctional Officer McLellan, i.e., phone triage, was a standard practice throughout Monroe Correctional Complex.

Finally, Mr. Wilson indicated that you had worked within Monroe Correctional Complex at the Washington State Reformatory and SOU for the past 11 years, had no previous corrective/disciplinary actions noted in your personnel record, and, in fact, your performance evaluations were above average. Accordingly, he asked that the misconduct be withdrawn.

In conclusion and full consideration of the foregoing, I have determined to ~~dismiss you from~~ your position as a Registered Nurse 2 with the Department ~~of Corrections~~ at Monroe Correctional Complex as indicated in paragraph one of this letter.

first Susp w/o Pay

Under the provisions of Washington Codes 358-20-010 and 040, you have the right to appeal this action to the Personnel Appeals Board, 2828 Capitol Boulevard, Olympia, Washington, 98504, within thirty (30) days from the effective date stated in paragraph one of this letter.

The Merit System rules (WACS), Department of Corrections' policies, Monroe Correctional Complex-Special Offender Center Field Instructions and the Collective Bargaining Agreement are available for your review upon request.

Kenneth DuCharme
Superintendent

KDC:cg
Attachments

cc: Dave Savage, Deputy Secretary, OCO
Eldon Vail, Assistant Deputy Secretary, OCO
Phil Stanley, NW Regional Administrator
Jennie Adkins, Human Resources Administrator, OAS
Linda Dalton, Senior Assistant Attorney General
Cheryl Landers, NW Region Human Resource Manager
Bob Riordan, MCC Human Resource Manager
Personnel File

Jennie - Please excuse the delay in processing this letter of discipline. The superintendent has vacillated back and forth in deciding if Ms. Wagner should be terminated or heavily reduced in salary and reassigned to TRCC. He has met with the union on numerous occasions, the last meeting being on 1/22. He decided at that time to terminate Ms. Wagner.

Chris Graham

E/5/5 off
3rd shift
12 noon - 10 pm

*** CONFIDENTIAL ***

DEPARTMENT OF CORRECTIONS

DISCIPLINARY ACTION AUTHORIZATION

RECEIVED
APR 2 1999
OFFICE OF THE ATTORNEY GENERAL
LABOR & PERSONNEL DIVISION

Gloria Wagner
Employee's Name

2/4/99
Date Received at Headquarters

RN 2
Employee's Job Classification

SOC
Employee's Job Location

Chris Graham
Assigned Personnel Officer/Phone #

RECOMMENDED ACTION:

Reduction in Pay: RIP 5% x 6 months / $
(Percentage/Length) (Total $ Amount)

Demotion to:
(Job Classification)

Suspension: / $
(Length) (Total $ Loss)

Dismissal:
(Effective)

4-28-99
Date completed form faxed to PO

The attached disciplinary action has been reviewed as noted below. "This information is provided under the attorney/client relationship and invokes that privilege. It should be considered CONFIDENTIAL in nature."

Initials/Title	Date	Approve	Disapprove	Comments
HR Administrator	4-20	✓		
AAG	4/21/99	✓		
Appropriate Deputy Secretary	4/27/99	✓		
DOC Secretary	4/28/99	✓		

Please hand deliver to all reviewers and return to Leslie Carrigg, HR, 8th Floor, upon completion.

LV

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
OFFICE OF CORRECTIONAL OPERATIONS
MONROE CORRECTIONAL COMPLEX - SPECIAL OFFENDER UNIT
PO BOX 514 • Monroe, Washington 98272-0514

May 6, 1999

PERSONAL AND CONFIDENTIAL DELIVERY

Gloria Wagner

Ms. Wagner:

This is official notification that you will be reduced in salary within your present classification as a Registered Nurse 2 with the Department of Corrections at the Special Offender Unit of Monroe Correctional Complex, Range 45N, Step P, $3801 per month, to Step N, $3617 per month, effective May 24, 1999 to November 24, 1999 inclusive.

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06 Revised Code of Washington, and the Merit System Rules, Title 356 Washington Administrative Code (WAC) Section 356-34-010 (1) (a) Neglect of duty, (h) Gross misconduct, (i) Willful violation of the published employing agency or department of personnel rules or regulations and 356-34-020, **Reduction in Salary - Demotion - Procedures.**

Specifically, you neglected your duty, committed an act of gross misconduct and willfully violated published agency rules, when, on 7/22/98, you failed to provide a physical assessment of Inmate , and you also failed to document his medical complaint in the infirmary log, as well as, Inmate medical file.

The evidence indicates that you received a call in the infirmary at approximately 6:10 PM on 7/22/98 from Karen McLellan, Correctional Officer 2 on unit, that Inmate was complaining that he was having trouble getting air. You in turn asked C/O McLellan if Inmate was having a problem speaking, to which C/O McLellan responded, "no". You then stated to C/O McLellan that you were starting medication lines, that this was a usual complaint from Inmate that his cell was probably hot and stuffy, and told C/O McLellan to have Inmate take a cool shower to help him feel better. You also told C/O McLellan, "If he continues to complain, call me back." You continued with medication lines and heard no more from

stuffy, and told C/O McLellan to have Inmate ▮ take a cool shower to help him feel better. You also told C/O McLellan, "if he continues to complain, call me back." You continued with medication lines and heard no more from the unit. As you finished medication lines, you informed RN 2 Mike Kalina of C/O McLellan's call regarding Inmate ▮. Without physically assessing Inmate ▮ complaint and as you had heard nothing more from the unit staff regarding Inmate ▮ complaint, you and RN 2 Kalina decided it was not an emergent situation and RN 2 Kalina agreed to check on Inmate ▮ at lockdown medication line, which was at approximately 8:30 PM. When RN2 Kalina checked on Inmate ▮ he was observed to be asleep and snoring. There was no indication that RN2 Kalina communicated with Inmate ▮ to check his physical status or with unit staff regarding any further complaints that Inmate ▮ may have made.

At approximately 10:34 PM on 7/22/98, which was after your shift and you were no longer in the institution, C/O 2 James Smith contacted the infirmary and asked RN 2 Leann Cave to check on Inmate ▮. C/O Smith further reported to RN 2 Cave that Inmate ▮ had not changed positions in approximately ninety minutes and that his feet appeared pale. RN 2 Cave indicated that she was unaware of any complaint from Inmate ▮ as there had been no documentation of any complaint from him in the infirmary log nor in Inmate ▮ medical record. It should be noted that Inmate ▮ died in his cell that evening.

During the Administrative Comments investigation of this incident, you indicated to Ella Ray Sigmund, CMHPM and Acting Associate Superintendent, that Inmate ▮ had made similar complaints in the past and that they were not always documented.

An Employee Conduct Report initiated on 8/3/98 describing this incident in greater detail is attached (Attachment #1) hereto and incorporated herein.

Inmate ▮ complaint of having difficulty getting air was significant to his documented physical problem of which all medical staff, including yourself, were aware. The knowledge of this medical significance is information you should have responded to.

The Department of Corrections Employee Handbook states, in part, under **Department Objectives**, on pages 1 and 2:

> The department's main objectives are to:
>
> - **Ensure safety for...offenders;** (emphasis added)

- **Treat all offenders...fairly and equitably;** (emphasis added)

- **Meet the national standards appropriate to the State of Washington** (emphasis added)

and also states, in part, under **Code of Ethics** on page 2:

> **High moral and ethical standards among correctional employees are essential for the success of the department's programs. The Department of Corrections subscribes to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service.** (emphasis added)

and further states, in part, under **Department Expectations,** on page 2:

> As a representative of the Department of Corrections, you will be expected to:
>
> - **Serve each offender with appropriate concern for their welfare...**(emphasis added)

On 11/24/93, you acknowledged receipt of the June 1993 Employee Handbook, further agreeing to become familiar with and have a thorough knowledge and understanding of its contents. Copies of pages 1 and 2 of the 1993 Employee Handbook (Attachment #2), and your acknowledgment of its receipt (Attachment #3) are attached hereto and incorporated herein.

The classification questionnaire (CQ) for your RN 2 position, HB36, which outlines its duties states, in part, under "Employee's Statement of Duties":

> **Provide ongoing nursing treatment and emergency treatment as necessary**. (emphasis added)
>
> **Maintains professional nursing care integrity as it applies to...delivery of service.** (emphasis added)

A copy of the CQ for your position, HB36, is attached (Attachment #4) hereto and incorporated herein.

As an employee and Registered Nurse 2 with the Department of Corrections at the Special Offender Unit of Monroe Correctional Complex, you have a

duty and obligation to:

1. Adhere to its policies and procedures, which are designed to ensure the efficient and effective management of the Department's programs;

2. Ensure the safety for offenders; to treat all offenders fairly and equitably; and to meet the national standards appropriate to the State of Washington;

3. Ensure the high moral and ethical standards the department expects of its employees to ensure the success of its programs;

4. Perform your duties in a professional, competent and compassionate manner;

5. Meet the expectations of the agency as a whole; and

6. Serve each offender with appropriate concern for their welfare.

Inmate [redacted] complaint of having difficulty getting air is significant to his documented overall medical condition, which all medical staff, including yourself, were aware or should have been aware. Given his overall medical condition, there was, according to Dr. Jonas, WSRU Contract Physician, who I had review this incident, medical significance to his complaint, which you should have responded to. Even though you indicated during the course of the investigation of this incident that Inmate [redacted] had made numerous medical complaints of a similar nature, it was noted in a review of his medical chart that those "similar" complaints had not been charted.

Additionally, while you relied on the observation of a correctional officer that he was able to speak, it should be noted that correctional officers are not medical staff and are not qualified nor are they expected to conduct medical assessments of inmates. Also, while you did not hear back from unit correctional staff of any further complaints from Inmate [redacted] you took no affirmative action after completing medication lines to ascertain his physical status in person or by calling unit staff to check on him. Instead, you waited until approximately 8:30 PM to have Inmate [redacted] checked on by RN2 Kalina. Finally, even though you had received an indication from correctional staff of Inmate [redacted] physical complaint, you failed to appropriately document that complaint in either the infirmary log or his medical chart.

By your behavior in this incident, you have clearly demonstrated:

1. A neglect of your duty and obligation to meet the reasonable expectations of the Department that you would adhere to its policies and procedures; that you would ensure for the safety of its inmates and treat all offenders fairly and equitably; to meet the national standards appropriate to the State of Washington; and that you would perform your duties in a professional, competent and compassionate manner, serving each offender with appropriate concern for their welfare. These charges are based on your behavior of failing to appropriately provide a physical assessment of Inmate █ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate █ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate █ medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate █ later that evening. During the Administrative Comments meeting with Ms. Sigmund, you also indicated that you did not document in his medical file any of the numerous similar complaints that he had made about his difficulty getting air and that his complaints were many and delusional in nature and that you did not document them as well.

2. A neglect of your duty to meet the reasonable expectations outlined in your Registered Nurse 2 position's Classification Questionnaire, HB36, to provide ongoing nursing treatment and emergency treatment as necessary; and to maintain professional nursing care integrity as it applies to delivery of service. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate █ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate █ was complaining that he was having trouble getting air; and your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate █ medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate █ later that evening.

3. A willful violation of the Department of Corrections Employee Handbook by your failure to: assist the department in meeting its objective of ensuring the efficient and effective management of its programs; to ensure the safety of its offenders and to treat all offenders fairly and equitably; meet the national standards appropriate to the State of Washington; meet the moral and ethical standards of the department that you would perform your Registered Nurse 2 duties in a professional and competent manner; and to serve each offender with appropriate concern for their welfare. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate █ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate █ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate █ medical chart. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate █ later that evening.

4. Gross misconduct by your blatant and flagrant disregard for the stated objectives and ethics of the Department of Corrections to ensure the safety of offenders; to treat all offenders fairly and equitably; to meet the national standards appropriate to the State of Washington; and to subscribe to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service, all of which adversely impacts the Department's ability to carry out its mission and functions. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate █ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate █ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate █ medical chart. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate █ later that evening.

In reviewing your personnel file I find:

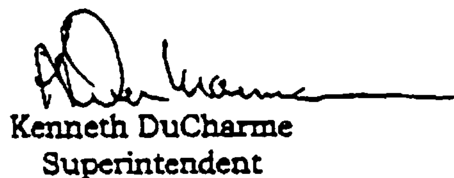
1. A Memo of Counseling dated 9/24/98, from your supervisor, RN 3 Bollinger, which addressed your behavior of 8/31/98, dispensing medication to Inmate [redacted] and failing to immediately chart that information, as required by law and as further directed by Ella Ray Sigmund, CMHPM in a memo to RN's dated 8/13/98. By your failure to do so, you were directly responsible for an overdose of medication received by Inmate [redacted]

A copy of the foregoing document from your personnel file is attached (Attachment #5) hereto and incorporated herein.

In conclusion and full consideration of the foregoing, I have determined to reduce your salary as a Registered Nurse 2 as indicated in paragraph one of this letter.

Under the provisions of Washington Codes 358-20-010 and 040, you have the right to appeal this action to the Personnel Appeals Board, 2828 Capitol Boulevard, Olympia, Washington, 98504, within thirty (30) days from the effective date stated in paragraph one of this letter.

The Merit System rules (WACS), Department of Corrections' policies, Monroe Correctional Complex-Special Offender Center Field Instructions and the Collective Bargaining Agreement are available for your review upon request.



Kenneth DuCharme
Superintendent

KD:cg
Attachments

cc: Dave Savage, Deputy Secretary, OCO
Eldon Vail, Assistant Deputy Secretary, OCO
Phil Stanley, NW Regional Administrator
Jennie Adkins, Human Resources Administrator, OAS
Linda Dalton, Senior Assistant Attorney General
Cheryl Landers, NW Region Human Resource Manager
Bob Riordan, MCC Human Resource Manager
Personnel File

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
OFFICE OF CORRECTIONAL OPERATIONS
MONROE CORRECTIONAL COMPLEX - SPECIAL OFFENDER UNIT
PO BOX 514 • Monroe, Washington 98272-0514

May 6, 1999

PERSONAL AND CONFIDENTIAL DELIVERY

Gloria Wagner

Ms. Wagner:

This is official notification that you will be reduced in salary within your present classification as a Registered Nurse 2 with the Department of Corrections at the Special Offender Unit of Monroe Correctional Complex, Range 45N, Step P, $3801 per month, to Step N, $3617 per month, effective May 24, 1999 to November 24, 1999 inclusive.

This disciplinary action is taken pursuant to the Civil Service Law of Washington State, Chapter 41.06 Revised Code of Washington, and the Merit System Rules, Title 356 Washington Administrative Code (WAC) Section 356-34-010 (1) (a) Neglect of duty, (h) Gross misconduct, (i) Willful violation of the published employing agency or department of personnel rules or regulations and 356-34-020, **Reduction in Salary - Demotion - Procedures.**

Specifically, you neglected your duty, committed an act of gross misconduct and willfully violated published agency rules, when, on 7/22/98, you failed to provide a physical assessment of Inmate and you also failed to document his medical complaint in the infirmary log, as well as, Inmate medical file.

The evidence indicates that you received a call in the infirmary at approximately 6:10 PM on 7/22/98 from Karen McLellan, Correctional Officer 2 on unit, that Inmate was complaining that he was having trouble getting air. You in turn asked C/O McLellan if Inmate was having a problem speaking, to which C/O McLellan responded, "no". You then stated to C/O McLellan that you were starting medication lines, that this was a usual complaint from Inmate that his cell was probably hot and stuffy, and told C/O McLellan to have Inmate take a cool shower to help him feel better. You also told C/O McLellan, "if he continues to complain, call me back." You continued with medication lines and heard no more from

stuffy, and told C/O McLellan to have Inmate ■ take a cool shower to help him feel better. You also told C/O McLellan, "if he continues to complain, call me back." You continued with medication lines and heard no more from the unit. As you finished medication lines, you informed RN 2 Mike Kalina of C/O McLellan's call regarding Inmate ■ Without physically assessing Inmate ■ complaint and as you had heard nothing more from the unit staff regarding Inmate ■ complaint, you and RN 2 Kalina decided it was not an emergent situation and RN 2 Kalina agreed to check on Inmate ■ at lockdown medication line, which was at approximately 8:30 PM. When RN2 Kalina checked on Inmate ■ he was observed to be asleep and snoring. There was no indication that RN2 Kalina communicated with Inmate ■ to check his physical status or with unit staff regarding any further complaints that Inmate ■ may have made.

At approximately 10:34 PM on 7/22/98, which was after your shift and you were no longer in the institution, C/O 2 James Smith contacted the infirmary and asked RN 2 Leann Cave to check on Inmate ■ C/O Smith further reported to RN 2 Cave that Inmate ■ had not changed positions in approximately ninety minutes and that his feet appeared pale. RN 2 Cave indicated that she was unaware of any complaint from Inmate ■ as there had been no documentation of any complaint from him in the infirmary log nor in Inmate ■ medical record. It should be noted that Inmate ■ died in his cell that evening.

During the Administrative Comments investigation of this incident, you indicated to Ella Ray Sigmund, CMHPM and Acting Associate Superintendent, that Inmate ■ had made similar complaints in the past and that they were not always documented.

An Employee Conduct Report initiated on 8/3/98 describing this incident in greater detail is attached (Attachment #1) hereto and incorporated herein.

Inmate ■ complaint of having difficulty getting air was significant to his documented physical problem of which all medical staff, including yourself, were aware. The knowledge of this medical significance is information you should have responded to.

The Department of Corrections Employee Handbook states, in part, under **Department Objectives,** on pages 1 and 2:

> The department's main objectives are to:
>
> - **Ensure safety for...offenders;** (emphasis added)

- **Treat all offenders...fairly and equitably;** (emphasis added)

- **Meet the national standards appropriate to the State of Washington** (emphasis added)

and also states, in part, under **Code of Ethics** on page 2:

> **High moral and ethical standards among correctional employees are essential for the success of the department's programs. The Department of Corrections subscribes to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service.** (emphasis added)

and further states, in part, under **Department Expectations,** on page 2:

> As a representative of the Department of Corrections, you will be expected to:
>
> - **Serve each offender with appropriate concern for their welfare...**(emphasis added)

On 11/24/93, you acknowledged receipt of the June 1993 Employee Handbook, further agreeing to become familiar with and have a thorough knowledge and understanding of its contents. Copies of pages 1 and 2 of the 1993 Employee Handbook (Attachment #2), and your acknowledgment of its receipt (Attachment #3) are attached hereto and incorporated herein.

The classification questionnaire (CQ) for your RN 2 position, HB36, which outlines its duties states, in part, under "Employee's Statement of Duties":

> **Provide ongoing nursing treatment and emergency treatment as necessary.** (emphasis added)
>
> **Maintains professional nursing care integrity as it applies to...delivery of service.** (emphasis added)

A copy of the CQ for your position, HB36, is attached (Attachment #4) hereto and incorporated herein.

As an employee and Registered Nurse 2 with the Department of Corrections at the Special Offender Unit of Monroe Correctional Complex, you have a

duty and obligation to:

1. Adhere to its policies and procedures, which are designed to ensure the efficient and effective management of the Department's programs;

2. Ensure the safety for offenders; to treat all offenders fairly and equitably; and to meet the national standards appropriate to the State of Washington;

3. Ensure the high moral and ethical standards the department expects of its employees to ensure the success of its programs;

4. Perform your duties in a professional, competent and compassionate manner;

5. Meet the expectations of the agency as a whole; and

6. Serve each offender with appropriate concern for their welfare.

Inmate complaint of having difficulty getting air is significant to his documented overall medical condition, which all medical staff, including yourself, were aware or should have been aware. Given his overall medical condition, there was, according to Dr. Jonas, WSRU Contract Physician, who I had review this incident, medical significance to his complaint, which you should have responded to. Even though you indicated during the course of the investigation of this incident that Inmate had made numerous medical complaints of a similar nature, it was noted in a review of his medical chart that those "similar" complaints had not been charted.

Additionally, while you relied on the observation of a correctional officer that he was able to speak, it should be noted that correctional officers are not medical staff and are not qualified nor are they expected to conduct medical assessments of inmates. Also, while you did not hear back from unit correctional staff of any further complaints from Inmate you took no affirmative action after completing medication lines to ascertain his physical status in person or by calling unit staff to check on him. Instead, you waited until approximately 8:30 PM to have Inmate checked on by RN2 Kalina. Finally, even though you had received an indication from correctional staff of Inmate physical complaint, you failed to appropriately document that complaint in either the infirmary log or his medical chart.

By your behavior in this incident, you have clearly demonstrated:

1. A neglect of your duty and obligation to meet the reasonable expectations of the Department that you would adhere to its policies and procedures; that you would ensure for the safety of its inmates and treat all offenders fairly and equitably; to meet the national standards appropriate to the State of Washington; and that you would perform your duties in a professional, competent and compassionate manner, serving each offender with appropriate concern for their welfare. These charges are based on your behavior of failing to appropriately provide a physical assessment of Inmate ██ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate ██ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate ██ medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate ██ later that evening. During the Administrative Comments meeting with Ms. Sigmund, you also indicated that you did not document in his medical file any of the numerous similar complaints that he had made about his difficulty getting air and that his complaints were many and delusional in nature and that you did not document them as well.

2. A neglect of your duty to meet the reasonable expectations outlined in your Registered Nurse 2 position's Classification Questionnaire, HB36, to provide ongoing nursing treatment and emergency treatment as necessary; and to maintain professional nursing care integrity as it applies to delivery of service. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate ██ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate ██ was complaining that he was having trouble getting air; and your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate ██ medical file. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate ██ later that evening.

3. A willful violation of the Department of Corrections Employee Handbook by your failure to: assist the department in meeting its objective of ensuring the efficient and effective management of its programs; to ensure the safety of its offenders and to treat all offenders fairly and equitably; meet the national standards appropriate to the State of Washington; meet the moral and ethical standards of the department that you would perform your Registered Nurse 2 duties in a professional and competent manner; and to serve each offender with appropriate concern for their welfare. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate ■ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate ■ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate ■ medical chart. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate ■ later that evening.

4. Gross misconduct by your blatant and flagrant disregard for the stated objectives and ethics of the Department of Corrections to ensure the safety of offenders; to treat all offenders fairly and equitably; to meet the national standards appropriate to the State of Washington; and to subscribe to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service, all of which adversely impacts the Department's ability to carry out its mission and functions. These charges are based on your behaviors of failing to appropriately provide a physical assessment of Inmate ■ after receiving a call at 6:10 PM on 7/22/98 from a correctional officer who said Inmate ■ was complaining that he was having trouble getting air; your failure to take any affirmative action, after completing medication lines, to ascertain his physical status or calling unit staff to check on him until approximately 8:30 PM; and your failure to document his medical complaint in the infirmary log and Inmate ■ medical chart. This lack of documentation failed to provide the next shift nurse with necessary information needed to properly assess Inmate ■ later that evening.

In reviewing your personnel file I find:

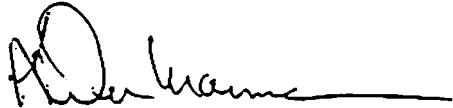
1. A Memo of Counseling dated 9/24/98, from your supervisor, RN 3 Bollinger, which addressed your behavior of 8/31/98, dispensing medication to Inmate █ #█ and failing to immediately chart that information, as required by law and as further directed by Ella Ray Sigmund, CMHPM in a memo to RN's dated 8/13/98. By your failure to do so, you were directly responsible for an overdose of medication received by Inmate █

A copy of the foregoing document from your personnel file is attached (Attachment #5) hereto and incorporated herein.

In conclusion and full consideration of the foregoing, I have determined to reduce your salary as a Registered Nurse 2 as indicated in paragraph one of this letter.

Under the provisions of Washington Codes 358-20-010 and 040, you have the right to appeal this action to the Personnel Appeals Board, 2828 Capitol Boulevard, Olympia, Washington, 98504, within thirty (30) days from the effective date stated in paragraph one of this letter.

The Merit System rules (WACS), Department of Corrections' policies, Monroe Correctional Complex-Special Offender Center Field Instructions and the Collective Bargaining Agreement are available for your review upon request.



Kenneth DuCharme
Superintendent

KD:cg
Attachments

cc: Dave Savage, Deputy Secretary, OCO
Eldon Vail, Assistant Deputy Secretary, OCO
Phil Stanley, NW Regional Administrator
Jennie Adkins, Human Resources Administrator, OAS
Linda Dalton, Senior Assistant Attorney General
Cheryl Landers, NW Region Human Resource Manager
Bob Riordan, MCC Human Resource Manager
Personnel File

DEPARTMENT OF CORRECTIONS

EMPL /EE CONDUCT REPORT

THIS FORM TO BE USED IN COMPLIANCE WITH POLICY DIRECTIVE NO. 857.005

INSTRUCTIONS AND TIME LIMITS:

1. The person making the report shall provide a clear description of the incident under "Description of Incident" and, with any witness(es) or person(s) having knowledge, shall sign in the space provided and submit to the supervisor of the involved employee within fourteen (14) calendar days after the date of discovery of an employee's alleged misconduct.
2. The form shall be submitted to the employee involved who shall complete the "Employee's Statement" and return the report to his/her supervisor within seven (7) calendar days following the date of receipt.
3. The appropriate supervisor shall review the facts of the incident, complete the "Supervisor's Report" and submit the report to the Office Head within seven (7) calendar days following the date of receipt.
4. The Office Head or designated representative shall review and within thirty (30) calendar days following the date of receipt determine whether misconduct has occurred. This shall be reported under "Administrative Comments" and shared with the employee. When the supervisor and Office Head are the same person, the supervisor's supervisor shall complete the Administrative Comments.

EMPLOYEE INVOLVED	ORGANIZATIONAL UNIT		
Gloria Wagner	MCC - Special Offender Center		
POSITION TITLE	**DATE OF INCIDENT**	**TIME OF INCIDENT**	
RN 2	7/22/98	6:10 PM	☐ AM ☐ PM

DESCRIPTION OF INCIDENT:

ON 7/22/98 AT APPROXIMATELY 6:10 PM, YOU WERE NOTIFIED BY CO KAREN MCLELLAN THAT INMATE [redacted] WAS COMPLAINING THAT HE "WAS HAVING TROUBLE GETTING AIR." YOU INSTRUCTED CO MCLELLAN TO HAVE INMATE [redacted] TAKE A COLD SHOWER

IN A MEMO YOU PREPARED TO RN3 TERESA BOLLINGER, YOU INDICATED THAT "INMATE [redacted]S HAD COMPLAINED SEVERAL TIMES IN THE PAST ABOUT HOW HE COULDN'T BREATHE IN HIS CELL" AND THAT AS YOU "ASSUMED IT WAS THE HEAT AND STUFFINESS IN HIS CELL" YOU TOLD CO MCLELLAN "A COOL SHOWER MIGHT BE HELPFUL." AS YOU WERE DOING MED LINES, YOU CHOSE NOT TO GO SEE INMATE [redacted] ON THE UNIT, INFORMING RN2 MIKE KALINA OF INMATE [redacted] COMPLAINT AND FOR HIM TO CHECK ON HIM WHEN HE DID UNIT LOCKDOWN MEDS.

ON 5/18/19/20 1998, YOU WERE PRESENT WHEN RN3 BOLLINGER GAVE A VERBAL DIRECTIVE TO ALL RN2'S PRESENT THAT THEY WERE TO PHYSICALLY ASSESS ANY INMATE WHO COMPLAINED OF ANY PHYSICAL ABNORMALITY.

INITIATED BY:

NAME (PLEASE PRINT)	POSITION TITLE	SIGNATURE	DATE
Teresa Bollinger	RNC-3	Teresa Bollinger RNC-3	8/3/[illegible]

WITNESS(ES):

NAME	POSITION TITLE	SIGNATURE	DATE

DOC 3-30 (REV. 3-85) -294-

Attachment 1

August 10, 1998

On 7/22/98 at approximately 6:10 PM, C/O Karen McLellen called the infirmary and informed me I/M [redacted] was complaining that he was "having trouble getting air". I asked "Is he having problems speaking?" she said "No". I told her I was just starting med lines, that this was a usual complaint from him, that his cell was probably hot and stuffy. I told C/O McKellen that a cool shower would probably help him feel better. I also said "If he continues to complain call me back". I then did med lines and heard no more from the unit.

As soon as we finished med-lines, I informed Mike Kalina, RN II of C/O McKellan's call. We decided it was not emergent and M. Kalina, RN II agreed to check on him at lockdown med-line since he was doing that side anyway. At 8pm as we were leaving to do lockdown medications, I reminded M. Kalina, RN II to check on I/M [redacted] He said he would. After checking with staff on the unit and listening to I/M [redacted] usual snoring, he noticed nothing amiss and returned to the infirmary.

I/M [redacted] had no history of respiratory or cardiac problems. He was very somatic and often times delusional. He would frequently say, "I can't breathe in this cell, could you talk to someone and see if I can go outside and get some fresh air." He was never in any acute respiratory distress, his speech normal and clear, so I would give him reassurance and apologize for having no control over his lock down status.

The incident was not ignored. Because of his history of many somatic complaints, we did not feel it was emergent and since we received no call back from the unit, we thought that the situation had resolved. It is common practice to assess I/M's, especially those on lockdown status on the unit at lockdown med lines.

Gloria M Wagner RN

Gloria M. Wagner, RN II

cc: Mike Wilson
Teamster Business Associate
Local 313

Employee Conduct Report: Gloria Wagner, RN 2
September 21, 1998

Administrative Comments:

On August 3, 1998, you were issued an Employee Conduct Report (ECR) by Teresa Bollinger, RN 3. It is alleged misconduct occurred by you on the evening of July 22, 1998, when you failed to respond to provide a physical assessment on offender [redacted] after receiving a call in the infirmary at 6:10 PM from Karen Mclellan, Correctional Officer on [redacted] Unit. It was later that same evening [redacted] died in his cell on [redacted] Unit.

Findings of this Review:

According to RN 3 Teresa Bollinger, on the dates of May 18, 19, and 20, 1998, you were present when she gave a directive to all RN 2's that they were to physically assess any inmate who complained of any physical abnormality. This directive was based on a memo directive this writer sent to Mrs. Bollinger. You report not being aware of this directive on July 22, 1998.

You assumed [redacted] was complaining about his difficulty getting air because it was a hot night and instructed CO Mclellan to have [redacted] take a cold shower and to call back if his problems persisted. Although by your own report and the report of others this was a common complaint of [redacted] CO Mclellan did not call back.

You were in the middle of doing med lines when you received the call from CO Mclellan.

You did not document this call in the infirmary log or [redacted] medical file. Nor had you documented in his medical file any of the numerous similar complaints that he had about his difficulty getting air. You state [redacted] complaints were many and often delusional in nature and that you do not document them always. You acknowledge knowing that if nurses do not document offender's complaints in their medical files and if offenders do not make the same complaints to their treating physicians, then they will not have this information.

You verbally reported [redacted] complaint to RN 2 Mike Kalina who looked in on [redacted] at approximately 8:30 PM to find him snoring as he slept. There was no verbal communication at this time between [redacted] and Mr. Kalina.

CO Taylor observed [redacted] lying on the floor naked about 9:30 PM. According to Mr. Taylor's report, at that time [redacted] indicated he felt better after taking a shower.

[redacted] was a difficult offender to assess for medical problems because he complained often about a number of medical problems, some of which could be verified

as not real and he was delusional (his belief system was idiosyncratic and often could not be verified).

According to Dr. Jonas, M.D., [redacted] treating physician, the aforementioned complaint of having difficulty getting air is significant to his documented physical problem of which all medical staff, including yourself, were aware. The knowledge of this medical significance should be information commonly known among nurses, according to Dr. Jonas. You state knowing the problem becomes a medical concern at the time s/he becomes neumoniatic.

Persons prescribed psychotropic medications are more susceptible to the effects of heat than are the general population. You indicate not having knowledge of this on the date of July 22, 1998.

You recently became certified as a psychiatric nurse and the above information was not included in the material you read for the exam you took to become certified.

You state you or any of the other nurses would never deliberately harm an inmate.

Conclusion: This reviewer finds misconduct for failing to respond to an offender complaining of having a medical problem (who later died), for the following reasons:

1. A CO is not a medically trained person therefore s/he relies on the medical expertise s/he cannot be relied on to provide a medical assessment of an offender 's physical complaints, nor should s/he be placed in the position to assume legal liability for having done so.

2. Although it was stated in Ms. Lareau's investigative report at the time RN 3 Bollinger verbally gave the physical assessment directive, included was not a time frame for meeting with the offender after receiving a complaint, [redacted] was not physically assessed at any time during the evening of July 22, 1998.

3. The fact that it was an unusually hot evening is all the more reason why RN 2 Wagner should have been more concerned for the welfare of [redacted] Her assumption he was having a minor reaction to the heat should have been confirmed or not by a physical assessment .

4. The fact that [redacted] repeatedly made the same complaint about having difficulty getting air should have raised a red flag to Ms. Wagner to (1.) do a physical assessment and (2) document this complaint in his medical chart for the treating physician to further assess. And to provide recorded information to nurses working the following shifts. As this information was not documented in any location, the fact [redacted] complained of having a physical problem did not get passed on to the next shift of nurses. RN 2 Cave reports she did not know of this complaint when she was called to look in on [redacted] at 10:34 PM, by CO Smith.

5. Although you were in the middle of doing med lines, you could have requested that correctional officers bring [redacted] to the infirmary for assessment while holding off on having the next group of offenders sent to med line.

Additonal Comments:

In addition to this writer's findings of misconduct for failure to respond to an offender's physical complaint, your failure to document in [redacted] medical file what according to Dr. Jonas, M.D. is pertinent medical information is also reason for misconduct. This lack of documentation failed to provide RN 2 Cave with necessary information she needed to properly assess [redacted] later that evening.

Ella Ray Sigmund, Office Head

Ella Ray Sigmund
Acting Associate Superintendent / CMHPM
9-18-98

CHASE RIVELAND
Secretary

pac et

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
SPECIAL OFFENDER CENTER
P.O. Box 514 - Park Place • Monroe, Washington 98272-0514

9/9/98

TO: Gloria Wagner

FROM: Ray Sigmund
Acting Associate Superintendent

SUBJECT: ADMINISTRATIVE MEETING

I am scheduling a meeting with you on 9/10/98 at 2:30 p.m. in my office to discuss the Employee Conduct Report initiated by your supervisor. Attached please find copies of the following documents:

- Employee Conduct Report
- Employee Rights Pursuant to Article 8.2 of Institutions CBA

The purpose of this meeting is to give you an opportunity to explain your account of the incident prior to my making a decision as to whether or not misconduct occurred.

You are entitled to have an employee representative present at this meeting. No copies have been sent to your representative. If you choose to have an employee representative present, it is your responsibility to forward these documents to him/her yourself.

BB

Att: (2)

cc: Linda Gilstrap, Personnel

Chronological Description of Incident

C/O McLellan was unit Booth Officer on Shift III, July 22 1998. It was a very hot night and the air conditioners were not working well. C/O McLellan said that was acting normally during her shift and not yelling that night. At approximately 1810 activated the cell intercom by yelling that he was having trouble getting air. C/O McLellan replied to that she would notify the infirmary, and said that she sent an officer to check on him (I did not corroborate this.) C/O McLellan said that had enough breath to activate the intercom, which took a fairly loud noise to activate. C/O McLellan said that this was the only time that she knew of on this shift which complained or activated the intercom. She said that was known to have many complaints, but could not recall exactly if he had complained of trouble getting his air, or indeed any of his specific complaints, in the past. C/O McLellan said that there was nothing in presentation which was unusual or which alarmed her. She also said that the nurses had always been very attentive to and had always evaluated his complaints in a timely fashion. For her part, she said, she always relayed the inmates' complaints to medical without delay.

That night, RN2 Wagner was conducting medication lines when she received the call from Unit Booth C/O McLellan, stating that was complaining of having trouble getting air. RN2 Wagner asked C/O McLellan if was having problems speaking, and was told that he was not. Since it was such a hot night, RN2 Wagner thought perhaps the heat was bothering and suggested to C/O McLellan that a cool shower might help. RN2 Wagner further asked C/O McLellan to call her back if had any more problems; C/O McLellan's memo did corroborate this. RN2 Wagner said that she did not hear back from the unit, and so assumed was feeling better.

RN2 Wagner said that she completely trusted C/O McLellan and the rest of the unit staff to follow through with and let her know if he was having further problems. She (and several other nurses- Atchison, Cooper-Schmidt, and Kalina) said that complaint of having trouble getting enough air was a frequent complaint for him, that he was never in any respiratory distress when evaluated for this complaint, and that he frequently included the request to go outside and get some fresh air, saying that he could not get enough air in his cell. RN2 Wagner said that she had no reason to believe - either from past medical history or the presentation of his complaint that night - that was in any danger or that this was different in any way from previous similar complaints.

At about 1830-1845, after finishing the dinner medication lines, RN2 Wagner told Mike Kalina, RN2, about complaint and her conversation with C/O McLellan. The Shift III nurses split up their nursing duties, and that evening it was the responsibility of Mike Kalina RN2 to respond to non-emergency complaints on Unit. They decided that since this was a frequent complaint and hitherto without objective findings for

and since they had not heard back from the unit, RN2 Kalina would check on [redacted] at the 2000 medication rounds.

C/O McLellan stated that one of the officers who saw [redacted] about this time said that he was puffing a little, but nothing out the ordinary for him. [redacted] did take a cool shower, and the officers could hear him "whooping and hollering" in the shower (which did not, as RN2 Kalina later pointed out, indicate respiratory distress.)

Mike Kalina, RN2, and an officer checked on [redacted] at about 2030. RN2 Kalina said that [redacted] was asleep and snoring quite loudly (this was corroborated by C/O McLellan's 7/23 memo) as was his habit. [redacted] respirations at that time were even and regular and he appeared, when seen through the cell window, to be merely asleep and in no distress. Attempts made to awaken [redacted] by calling and knocking were of no avail. RN2 Kalina said that since these medications were voluntary medications, and [redacted] was known to sleep through this medication pass (despite the noise of the calling and knocking) nothing seemed out of the ordinary.

At some time between 1800 and 2200 (the exact time has not been determined) a religious volunteer (Dan Dierdorff) visited [redacted] He thought that [redacted] was "really out of it" that night. He was unable to communicate with [redacted] for the first time in "numerous visits." The volunteer said that he did not think [redacted] was in a life threatening situation and so did not ask an officer to check on him. In retrospect, however, he said [redacted] "looked like a man with a high fever."

C/O Benda checked on [redacted] about 2130 and [redacted] was lying on the cell floor. (Immediately after [redacted] death I asked several people who knew [redacted] if lying on the floor and/or being naked was unusual for him. No one thought it was very out of the ordinary for him. This was before my investigation and I do not remember who or when I asked, though.) C/O Benda asked [redacted] if he was feeling OK and according to C/O Benda, [redacted] replied "Yes, I'm a little hot, I took a shower, I'm OK."

I did not think it appropriate to interview, nor to include any information from a "declaration" written by SOC Inmate Sean Morin #912839. This is the inmate who could be heard yelling on the videotape of the entry of [redacted] cell the night he died. The point of Mr. Morin's letter is to debunk and expose actions and inactions by the nursing and custody staff. This memo is included in the packet of memos.

Nursing Interviews

RN3 Bollinger wrote the ECR. She alleges that RN2 Wagner chose not to go see [redacted] on the unit when C/O McLellan relayed [redacted] complaint. RN3 Bollinger stated that on May 18, 19, and 20, 1998 she announced at the noontime nursing meeting that all nurses were to physically assess any inmate who complained of any physical abnormality. Her concern is that RN2 Wagner neglected her duty by failing to physically assess [redacted] at the time of his complaint.

In my interview with RN3 Bollinger on 8/24, she stated that she had informed the nurses that they must bring down to the clinic and physically assess all patient complaints of potentially severe problems such as chest pain, shortness of breath, severe abdominal pain, etc. RN3 Bollinger says that she did not state a timeframe within which these problems were to be assessed, nor put her directive in writing, nor have the nurses sign that they had received this directive. RN3 Bollinger estimated that the SOC nursing staff receives 10-20 notifications of physical problems each week, not all of them severe. Further, when asked if she thought that the nurses should assess the 20th instance of a particular complaint by a particular patient like the 1st, she replied "yes."

I asked RN3 Bollinger what her thoughts were on the nurses performing "telephone triage" of patient complaints, that is, trying to ascertain over the telephone which complaints were significant enough to warrant physical assessment. While stating that the nurses have to use their clinical judgment to ascertain which problems are significant enough to warrant the patient being brought down to the clinic and assessed, she also stated that it was not the officers' job to judge what was an emergency or even to describe how the inmate appeared to them. (I happen not to agree with this last thought - the officers are trained observers and are well able to describe in layman's terms how someone looks. This is not asking the officers to make a medical judgment or call.)

Every nurse interviewed expressed the deep frustration and concern that they did not have enough time on their shifts to complete their tasks, and many thought the latter half of Shift III was the busiest and most difficult (although nights was, as well.) The general opinion was that there was no "slack" time between about 1615 and 2200; any urgency or emergency must be carefully evaluated for its significance because of the impact on the shift duties. Some examples given were: giving the "dinner" medications too late could impact the " bedtime" medications because many medications cannot be given too close together. One nurse running late could adversely impact the" bedtime" medication line for the whole institution. And many times there would be more than once special (time-consuming) problem per shift, such as an inmate requiring an involuntary shot or other medication as well as an urgency or emergency.

When asked, RN3 Bollinger stated that she had filed the ECR because RN2 Wagner had not followed the directive concerning physical assessment, and because she did not think that RN2 Wagner had used good medical judgment. RN3 Bollinger, also when asked,

stated that the reason she filed the ECR was for "someone else to investigate (the situation) and make a decision on whatever needed to be done."

In interviews with all of the seven full-time nurses at SOC, when specifically asked if they remembered RN3 Bollinger "announcing the expectation that every time an inmate voiced a physical complaint he would be visualized and assessed by a nurse," four - including RN2 Wagner - replied no, one replied no but it was standard operating procedure to do so, and two replied that they had heard her say this in the past but couldn't remember where or when.

Included in the ECR packet were DOP Policy 620.020 and TRCC Field Instruction 620.020 " Inmate Deaths." Neither of these seems applicable to this part of the situation. Also included is TRCC Field Instruction 610.020 "Inmate Health Emergencies" which states "The following conditions constitute a medical necessity for emergency transfer:....Any clinical situation that presents as life threatening or requires physician-level intervention...i.e. ...respiratory impairment..."

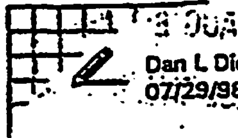
Investigative Statement

1. Appropriate communication occurred between nursing staff and custody staff. Nursing staff had asked for a "call back" if [redacted] had any further problems and a second call was neither made nor received.

2. Telephone triage is a necessary tool in this setting and must be used with accurate observations and reporting by custody staff combined with the use of good nursing judgment.

3. None of the nurses or officers who wrote memos or were interviewed about [redacted] complaint of the evening of 7/22 thought he was having respiratory impairment or that he was experiencing a life threatening problem.. [redacted] "whooped and hollered" in his cool shower that evening. RN2 Kalina assessed [redacted] sleeping (snoring) respirations as "rhythmic and regular" on his (RN2 Kalina's) 2030 follow-up of [redacted] complaint. [redacted] told C/O Benda at 2130 that he was OK. The one incongruity is in the religious volunteers' description of his visit with [redacted] but the only potentially relevant observation which the volunteer made on that was done in retrospect

4. It is unclear whether RN3 Bollinger's verbal directive to visualize and assess every inmate who complained of a severe physical abnormality reached all the staff.



Dan L Dierdorff
07/29/98 09:15 AM

To: Sister Rene, SOC Monroe
cc:
Subject: [redacted] visit, 7/22/98

I came in on Weds. eve. and began my usual visits to all four tiers in [redacted] unit.
When I was talking to other inmates on the tier (where [redacted] was located), I could hear him moan and talk incoherently. When I went to visit him I was suprised, as he had no clothes on. He was lying on his bed, and I said "[redacted] are you OK?"
He said something I could not understand, moved quickly to the floor of his cell,lay on the floor, and acted physically and mentally upset. In retrospect, I would say he looked like a man with a high fever. I don't think he knew I was visiting him. This was the first time in numerous visits that [redacted] and I were unable to talk to each other.
I asked [redacted] if he wanted me to pray about anything. He did not answer, so I prayed that God would give him peace. When I left that tier I casually said to a woman officer that [redacted] was really out of it tonite, and did not have a stitch of clothing on. I did not ask an officer to check on him, nor did I believe that he was in a life threatening situation.
Sister, I am available to talk to someone at SOC or to speak to the family.

Dan D

CHASE RIVELAND
SECRETARY

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: T. Bollinger RN 3

DATE: 7/24/98

FROM: M. Kalenic RN 2

SUBJECT: I/M [redacted]

Before administering meds on [redacted] unit at 8pm pill line, I was reminded that I/M [redacted] had complained of difficulty breathing earlier in the shift. When I arrived at I/M [redacted] cell, he appeared to be asleep and was snoring loud enough to be heard at the cell door.

Attempts were made to alert the I/M to pill line. Since it wasn't an involuntary medication he could refuse it. There was no response, and the I/M continued to appear asleep and was still snoring, so it was construed as a refusal. I/M [redacted] has done same in the past many times. — Michael Kalenic RN

EMSD INMATE [redacted] Read Mode Line: 1

To: WAGNER GLORIA)C-DP-G1-GWD 1
From: MCLELLAN KAREN DOC-DP-G1-KS6 2
Date: Thursday 23-Jul-98 at 8:53pm 3
Subject: INMATE [redacted] 4
ON 7-22-98 AT APPROXIMATELY 6:10 PM INMATE [redacted] CALLED THE [redacted] 5
UNIT BOOTH AND ASKED ME TO CALL THE INFIRMARY AND TELL THEM THAT HE WAS 6
HAVING TROUBLE GETTING AIR. I CALLED AND TALKED TO R.N. WAGNER WHO TOLD 7
ME TO HAVE INMATE [redacted] TAKE A COLD SHOWER. SHE ASKED ME TO LET HER 8
KNOW IF HE DID NOT GET BETTER. AFTER INMATE [redacted] TOOK HIS SHOWER I HAD 9
C/O TAYLOR CHECK ON HIM. HE WAS LAYING DOWN AND APPEARED TO BE KEY. 10
ABOUT A HALF HOUR LATER C/O BENDA CHECKED AND FOUND THE SAME THING. 11
DURING 8:30 MEDS. R.N. KALINA AND I WENT TO INMATE [redacted] CELL AND FOUND 12
HIM ASLEEP AND SNORING. 13
AT APPROXIMATELY 9:30 P.M. C/O BENDA WENT TO INMATE [redacted] CELL TO 14
CHECK ON HIM, HE WAS LYING ON THE FLOOR. C/O BENDA SAID ARE YOU OK? 15
INMATE [redacted] SAID "YES I'M JUST A LITTLE HOT, I TOOK A SHOWER AND AM 16
FEELING BETTER". HE THEN LEFT THE TIER. 17
C/O KAREN MCLELLAN 18
cc: BOLLINGER TERESA DOC-DP-G1-THA 19
*** End of Message ***

Function:
Functions(1/6): PF2=NExt 3=ENd 4=MEnu 5=Find 6=AMend 7=BWd 8=FWD pf1=help

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: R.N. BOLLENGER DATE: 080598

FROM: C/O T. BENDA SUBJECT: DEATH I/M [redacted]

ON 080598 AT ABOUT 245 P.M. R.N. BOLLENGER REQUESTED THE FOLLOWING MEMO.

ON OR ABOUT 07-22-98 AT ABOUT 930 P.M. WHILE PERFORMING THE INST-ITUTIONAL COUNT, I SAW I/M [redacted] LAYING DOWN ON HIS CELL FLOOR. I ASKED HIM IF HE WAS FEALING "OK". HE SAID "YES, I'M A LITTLE HOT I TOOK A SHOWER, I'M OK".

OFFICER T. BENDA

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
SPECIAL OFFENDER CENTER
P.O. BOX 514 -PARK PLACE - MONROE, WASHINGTON 98272 - 0514

TO: Lt. Conner, Larry DATE: 07/23/98

FROM: Sgt. Milan, Tony SUBJECT: I/M Unit /

At or about 0055hrs I received a call from C/O Smith that the nurse was coming up to the Unit to see I/M do to having not moved at all on our shift and he was being unresponsive.
At 0105hrs I arrived on the Unit and RN Todd stated that seemed to be breathing, but was unresponsive. RN Todd, C/O Brown and C/O Taylor were trying to get to response to them calling to him and they also tried throwing socks and water at him. Still he was unresponsive. I asked if he was asleep and breathing, RN Todd stated that he ( ) appeared to be breathing and asleep. I recommended that we let him sleep, but would call the Lt. to get the okay to open the Cell. Lt. Conner stated that he was on his way back to SOC and to wait for him to arrive. When the Lt. did arrive the Video Camera and Mat were brought up to the Unit and A Entry Debriefing was done. At 0127hrs Lt. Conner attempted to get I/M to response to Staff, No Response was received from So I gave the order to open , C/O Brown and C/O Taylor with myself entered the cell. The mat was placed on at which time did not move. was ordered by C/O Taylor to place his arms behind his back, No response by . C/O Taylor took by the right arm and tried to place it behind his back, but the arm would not move that easily so. Lt Conner had RN Todd come in and check out. At which time RN Todd stated that I/M was Deceased and that at this time CPR and any kind of First Aid would not help. At 0133hrs RN Todd stated that was Deceased. At 0145hrs cell was closed as a Crime scene by Lt. Conner.
At 0150hrs the Monroe Police Dept. Officer C. Martinez on grounds and at 0222hrs he was on A-Unit to view the crime scene.
At 0325hrs Snohomish County Coroner D. Selove MD arrived and was taken to the crime scene.
At 0403hrs I/M was removed from his cell by the Snohomish County Coroner and at 0407hrs the cell was closed for investigation.
At 0422hrs I/M was removed from the Unit.
At 0503hrs I/M was removed from SOC grounds by the Snohomish County Coroner.

Staff Involved:

Lt. Conner, L.	Shift Lt.
Sgt. Milan, T.	Shift Sgt.
C/O Dehaven, B.	Main Control
C/O Brown, C.	Mat / RM
C/O Taylor, M.	Mat / Unit Staff
C/O Smith, J.	Unit Staff
C/O Netherton, S.	Camera Operator
RN Todd, R.	Medical Staff
RN Cave, L.	Medical Staff

End of Report:

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Shift Lt.

DATE: 7-23-88

FROM: C/O Michael Taylor

SUBJECT: I/M [redacted]

at approx 10:34 pm on 7-22-88 C/O J. Smith and RN Caves went up to give I/M [redacted] his meds. they tryed to wake him up but could not. they took that as a refusal.

At my 12:15 am tier I/M [redacted] was laying in the same position he had been since my 11:15 pm tier. He appeared to be breathing.

At C/O Smith 12:45 am tier he noticed that I/M [redacted] was still laying in the same position. C/O Smith then came to the booth and called RN Caves and asked her if she could check on I/M [redacted] At that time C/O Brown releived me for my break.

I came back on unit a approx 1:05 am with Sgt Milan and RN Todd. At that time RN Todd asked me to get him some socks. RN Todd then tryed calling I/M [redacted] name and knocking on his cell door it did not bring anying response from I/M [redacted] at this time RN Todd rolled the socks into small balls and threw them at I/M [redacted] trying to get a response. RN Todd tryed a water bottle with water init still no response. At that time Lt Conners had C/O's Brown and my self go in the cell with the nett becase of I/M [redacted] past aggersive Behavior toward staff.

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Shift Lt

DATE: 7-23-98

FROM: C/O Michael Taylor

SUBJECT: I/M [redacted]

C/O's Brown and my self entered the cell with sgt Milan and RN Todd as backup. we placed the matt on I/M [redacted] back he did not move at that time I took I/M [redacted] right hand to aply hand cuffs on him when I went to move his hand it was stiff and cold. when I moved it I felt somthing pop. Lt conners asked if I/M was resisting I said no. that he was cold and stiff at that time RN Todd checked I/M [redacted] and had C/O Brown sgt milan and my self turn I/M [redacted] over. I then left the cell with Lt conners and went to the shift office were I started calling staff. I first notified Linda Willenberg at 1 34 AM. She had me call Assoc Supt Carol Grandmontange at 1 36 AM I then call OCO. Duty officer Margo. Jensen at 1 56 AM. Then PhD tom foley at 2 02 AM. left message. then notified S.S. Renee. Kittelson. at 2 07 AM. C/O Dehaven called PhD Edward Goldenberg at 2 25 AM.

We went back to unit with MPD officer ~~Tovato~~ ~~Alar~~ Covato Martines and ME Chames. and MD Daniel Senlover. and this Concludes my Participation in this Situation.

C/O [signature]

TO: DEHAVEN BARRY
SPECIAL OFFNDR CTR
16730 FERRY ROAD
MONROE WA 98272-0000

DOC-DP-G1-BD3 __-JUL-98 05:29:24

FROM: DEHAVEN BARRY
SPECIAL OFFNDR CTR
16730 FERRY ROAD
MONROE WA 98272-0000

DOC-DP-G1-BD3 23-JUL-98 05:14:54

SUBJECT: I/M [redacted] DOC-DP-G1-BD3/MA#

/TO CONNER LARRY DOC-DP-G1-LC3 OK
/FROM DEHAVEN BARRY DOC-DP-G1-BD3 OK
/DATE THURSDAY 23-JUL-98 AT 5:23AM OK
/SUBJECT I/M [redacted] # [redacted] OK

AT APPROX 0047 HOURS I RECEIVED A CALL FROM C/O JIM SMITH ASKING WHERE THE SGT. WAS HE INFORMED ME THAT INMATE [redacted] HAD NOT APPEARED TO MOVE SINCE THEY CAME ON SHIFT.

I CONTACTED THE SGT. AND HE WENT TO THE UNIT. ALONG WITH RN 2 LEA ANN CAVE I THEN CONTACTED LT. CONNER OVER AT TRCC AND ADVISED HIM THAT WE HAD A POSSIBLE SITUATION AT SOC. HE ADVISED ME TO KEEP HIM POSTED.

SHORTLY THERE AFTER LT. CONNER RETURNED AND LT. CONNER SGT. MILAN. C/O'S BROWN. NETHERTON.. TAYLOR AND RN 2'S RICHARD TODD AND LEA ANN CAVE WENT TO ENTER THE CELL TO CHECK ON INMATE [redacted].

C/O SMITH NOTIFIED ME AT 0127 HOURS THAT THEY WERE ENTERING THE CELL. AT APPROX 0130 I WAS NOTIFIED BY C/O SMITH THAT IT APPEARED AS IF THE INMATE WAS DECEASED. AT 0134 LT. CONNER NOTIFIED ME THAT THE INMATE WAS DECEASED. AT 0134 SNO PAC 911 OPERATOR 195 WAS CONTACTED BY ME AND ADVISED THAT WE HAD AN INMATE THAT WAS DECEASED AND WE NEEDED MONROE POLICE AND THE SNO CO. MEDICAL EXAMINER.

AT 0150 POLICE OFFICER MARTINEZ ARRIVED ON SITE. AT 0200 AN INFORMAL COUNT WAS CONDUCTED PER POLICY. ALL INMATES ACCOUNTED FOR CLEARING AT 0209.

AT THIS TIME C/O NETHERTON RELIEVED ME OF MAIN CONTROL DUTIES AND I ASSISTED LT. CONNER IN GATHERING INFORMATION ON THE INMATE AND COMMUNICATING WITH THE DUTY OFFICER AND OTHER REQUIRED STAFF. I WAS SENT TO THE UNIT WITH THE MEDICAL EXAMINER AND STOOD BY AWAITING FURTHER INSTRUCTIONS.

I ESCORTED THE POLICE TO THE UNIT TO INTERVIEW INMATES AND OFF THE UNIT. THIS ENDED MY PARTICIPATION IN THIS EMERGENCY SITUATION.

C/O BARRY DEHAVEN

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* * END OF MESSAGE * * PRINTED ON 23-JUL-98 AT 05:29:29 MA#

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

DATE: 7-23-98

TO: Lt Conner

SUBJECT: I/M [redacted]

FROM: C/O Brown C

I Arrived on [redacted] unit Approxmately At 0047 to relieve C/O Taylor RN Cave Arrived At 0050 with meds for I/M [redacted] And I/M [redacted] I Escorted the Nurse to Tier 3 to cell # [redacted] I/M [redacted] didn respond, we Moved to cell [redacted] I/M [redacted] gave him his meds And returned to [redacted] I/M [redacted] cell. The Nurse called out his NAME no response I banged on the door, No response, I then Informed [redacted] unit booth to contact the shift Sgt. RN Todd came on the Tier to see if he could get some type of Response by using wet sock and water, No Response, Sgt Milan on unit Approxmately 0105, Sgt Milan spoke with the Nurse's And went And called Lt. Conner. Lt Conner Arrived on [redacted] unit spoke with Sgt Milan And the Nurse. C/O Taylor And I got protective gear to Enter the cell. I/M [redacted] has A record of Assaulting staff. We were to go in cuff him And the Nurse would check him out. By orders of Sgt Milan. C/O Taylor And I Entered the cell with the Mat it was placed on the back of I/M [redacted] covering his back And Arms to Imobilize him C/O Taylor took his right Arm to cuff him C/O Taylor said his

DOC 02-110 (3/91) BW-1

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

DATE: 7-23-98

TO: Lt Connors

SUBJECT: I/M [redacted]

FROM: C/O Brown C

hand was cold and stiff. At this time the mat was removed of I/M [redacted]. RN Todd said that he had to be turned on his back to check for a heart beat. RN Todd was at the upper torso C/O Taylor in the middle and I was at the leg and thigh we turned him over and place him on his back where RN Todd listened for a heartb and did not have a heart beat, At this time the Medica Examiner and Monroe Police Dept, was call. The Area was then concealed as a crime scene, and no one was Allowed in that area until Monroe Police Dept. Arrived Guard was posted C/O Brown. Medical Examiner and Monroe Police Arrived and took control of the Area.

1299

DOC 02-110 (3/91) SW-1

CHASE RIVELAND
SECRETARY

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Watch Lieutenant DATE: 7-23-98

FROM: R. Todd RN SUBJECT: [redacted]

At approximately 0100 I received word that [redacted] Unit staff & Learie Love RN were unable to verbally elicit a response from I/m [redacted] Upon arriving on the Unit @ 0105 I also attempted to elicit a response from I/m [redacted] through verbal stimuli. After failing to do so & taking into account I/m [redacted] past history of assaultiveness towards staff I decided to try ~~th~~ the rather unorthodox method of throwing wet wadded up socks & using a spray bottle in a further attempt to gain some response from I/m [redacted]

Since these efforts also proved unsuccessful the decision was made to enter I/m [redacted] cell using three officers with a mat. Upon entering the cell I/m [redacted] was found to be cool to the touch, unresponsive to physical stimuli, & with out a radial pulse. I/m [redacted] was then log rolled onto his left side @ which point it was noted that his limbs remained in approximately the same position.

Further examination led me to conclude that I/m [redacted] had been dead for sufficient length of time as as to render any efforts @ resuscitation useless. I/m [redacted] was then rolled onto his back & the area secured

CHASE RIVELAND
SECRETARY

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Watch Lieutenant

DATE: 7-23-98

FROM: R. Todd RN

SUBJECT: [redacted]

pending the arrival of the medical examiner.
DOC Policy 620.200 (Offender deaths) was then
implemented & the proper authorities notified.
Richard Todd RN

CHASE RIVELAND
SECRETARY

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Watch Lieutenant

DATE: 7-23-98

FROM: R. Todd RN

SUBJECT: [redacted]

At approximately 0100 I received word that [redacted] Unit staff & Leanin Cove RN were unable to verbally elicit a response from I/M [redacted]. Upon arriving on the Unit @ 0105 I also attempted to elicit a response from I/M [redacted] through verbal stimuli. After failing to do so & taking into account I/M [redacted] past history of assaultiveness towards staff I decided to try ~~th~~ the rather unorthodox method of throwing wet wadded up socks & using a spray bottle in a further attempt to gain some response from I/M [redacted].

Since these efforts also proved unsuccessful the decision was made to enter I/M [redacted] cell using three officers with a mat. Upon entering the cell I/M [redacted] was found to be cool to the touch, unresponsive to physical stimuli, & with out a radial pulse. I/M [redacted] was then log rolled onto his left side @ which point it was noted that his limbs remained in approximately the same position.

Further examination led me to conclude that I/M [redacted] had been dead for sufficient length of time as as to render any efforts @ resuscitation useless. I/M [redacted] was then rolled onto his back & the area secured

CHASE RIVELAND
SECRETARY

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Watch Lieutenant

DATE: 7-23-98

FROM: R. Todd RN

SUBJECT: [redacted]

pending the arrival of the medical examiner.
DOC Policy 620.200 (Offender deaths) was then
implemented & the proper authorities notified
Richard Todd RN

CHASE RIVELAND
SECRETARY

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Teresa Bollinger RN III DATE: 7/23/98

FROM: G Wagner RN II SUBJECT: [redacted]

At approx 6[15]p on 7/22/98, C/O K. McClellan called the infirmary to report I/M [redacted] was complaining of shortness of breath. I asked how his speech sounded and she said fine. I told her we were doing medlines and as I/M [redacted] had complained several times in the past about how he couldn't breath in his cell - he said he needed to go out and get some fresh air, I assumed it was the heat and stuffiness of his cell. I told the C/O a cool shower might be helpful and if he continued to complain to please call me back. I also informed the other PM nurse Mike Kalina as he was going up to the unit to do the lockdown meds and he would be seeing him. Since I heard nothing further from the unit, I assumed the situation had been resolved.

G Wagner RN II

CHASE RIVELAND
SECRETARY

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Shift Lt/Sgt.

DATE: 7-23-98

FROM: L. Cave RN

SUBJECT: IM [redacted]

At Approx. 10:30 pm this evening C.O. J. Smith accompanied me to IM [redacted] cell where IM. appeared to be sleeping. in the past occasionally IM. [redacted] wouldn't Awaken for meds. Both the C.O. & I noted that I.M. [redacted] Appeared to be breating and was laying in a prone position. On the Approx. 1245 Am tier check IM [redacted] position was unchanged and C.O. Smith called the infirmary. At Approx. 1255 the staff & I tried to Awaken I.M. [redacted] by approx 1:05 am the Sgt. RN Todd where on the unit & more vigorous efforts where made with physical Stimuli. Due to I.M. [redacted] history of Assaultive behavior, Sufficient Staff was gathered to enter cell. Upon Cell entry RN Todd Assessed I.M. [redacted] and determained he had been dead for Sometime & CPR would be of no use.

L. Cave RN

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS

MEMORANDUM

TO: Lt. Conners

DATE: 7-23-98

FROM: C/O S. Netherton

SUBJECT: Death of I/M [redacted]

On 7-23-98 at approx. 1:15 AM I was requested to report to [redacted] Unit with the camera from the shift office, when I arrived on the unit I ran the camera, recording the incident of discovering the death of this I/m.

C/O S Netherton

1244

DOC 02-110 (REV. 6/97)

recycled paper

On 7/23/98 a code was called indicating I/M was nonresponsive to staff. Upon my arrival a code team was assembled and we entered the cell and secured the I/M. While attempting to initiate a member to place the I/M into restraints, the officer stated the I/M was cold and stiff. I ordered medical staff into the cell and, after examining the I/M, medical staff's staff stated the I/M was deceased. The Monroe Police Department and Snohomish County Medical Examiner were contacted VIA 911. Snohomish County Medical Examiner departed SOC at 0503 with the deceased I/M. Monroe Police Department Officer departed SOC at 0608. Cell [redacted] is secured and will remain secured until released back to the State by Monroe Police Department.

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

MEMORANDUM

TO: Lt. Connors

DATE: 7-23-98

FROM: C/O Jim Smith, Booth Officer

SUBJECT: Inmate

DOC#

At approx. 10:34 pm on 7-22-98, RN Caves + I went to Inmate cell ( ) to offer him his nightly meds. Inmate appeared to be sleeping. We tried waking him up by calling his name + knocking on his door. He did not respond + we took this as a med. refusal. At that time, it appeared to me that inmate was breathing. At my 12:45 am. Tier √, I saw that inmate was laying in the same position. He still appeared to be breathing but I was concerned that he hadn't moved + his feet looked pale.

When I got back to the unit booth, I called RN Caves + informed her that another inmate was requesting a PRN. I asked her if she would check on Inmate when she came up to the Unit. I told her that he appeared to be sleeping but that I was concerned that he hadn't moved since she saw him at 10:34 pm. I told her also that his feet looked pale. I called Sgt. Milan at approx. 12:55 am. + informed him of the situation + that the nurse was going to check on him. He said to keep him informed.

(cont. on page 2)

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

TO: Lt. Connors DATE: 7-23-98

FROM: c/o Jim Smith, Booth Officer SUBJECT: Continued from Page 1

cont.)

RN Caves arrived on Unit at approx. 12:56am, and along with c/o Brown, went to [redacted] cell + tried to wake him up. They could not. c/o Brown called to me in the booth and told me to call the Sgt. I called Sgt. Milan + told him that we could not wake up inmate [redacted] + that RN Caves was requesting him to come to the Unit. Sgt. Milan + RN Todd arrived on Unit at 1:05 am. Lt. Connors arrived on Unit at 1:17 am. c/o Netherton arrived on Unit at 1:22 am.

I opened cell 303 at approx 1:27 am. Lt. Connors ordered it opened. M/C was ntfd.

The cell was entered by c/o's Taylor + Brown, Sgt. Milan and RN Todd. A short time later I heard RN Todd say that Inmate [redacted] was dead. I ntfd. Main Control. At approx. 1:35 am. Lt. Connors declared cell [redacted] a crime scene. He left the unit with c/o Taylor at approx. 1:35 am. At approx. 1:46 am. Sgt. Milan ordered c/o's Brown + Netherton to Secure cell [redacted]

DOC 02-110 (3/91) SW-1

INTRODUCTION

The Employee Handbook is designed to acquaint you with the Department of Corrections and state employment. Guidelines and job-related information are given to assist you in the performance of your assigned duties. It is intended as a supplement to departmental directives, state laws, Merit System Rules and facility or office procedures. If you need further information or clarification, you should contact your supervisor or personnel representative. They can provide you with answers or refer you to the location of the specific rules or source documents.

DEPARTMENT OBJECTIVES

In May of 1981, the Washington State Legislature established the Department of Corrections, separating it from the Department of Social and Health Services.

The department's mission is to promote public safety by providing facilities and services to evaluate, control, and redirect the behavior of adult felony offenders committed to our jurisdiction by the courts. In carrying out our mission, the department cooperates with other state criminal justice systems and endeavors to assure that offenders charged to our care are prepared for release and reintegration into the community.

The department's main objectives are to:

- Ensure safety for the public, staff and offenders;
- Punish the offender for violating the law, generally through the denial of liberty;
- Treat all offenders and staff fairly and equitably;
- Reflect in the system the values of the community by avoiding idleness, adopting the work ethic, providing opportunities for self-improvement, providing tangible rewards for accomplishments, and sharing the obligation of the community;
- Effectively and efficiently manage resources;

Attachment 2

- Provide for restitution;
- Be accountable to the citizens of the state;
- Meet the national standards appropriate to the State of Washington.

CODE OF ETHICS

High moral and ethical standards among correctional employees are essential for the success of the department's programs. The Department of Corrections subscribes to a code of unfailing honesty, respect for dignity and individuality of human beings, and a commitment to professional and compassionate service.

DEPARTMENT EXPECTATIONS

As a new employee of the department, you will have many things to learn, not the least of which will be the expectations of your supervisor, your co-workers, and the agency as a whole. To assist you with this responsibility, following is a list of some departmental expectations for your study. Familiarize yourself with the list so that you may understand and fulfill the duties of your position.

As a representative of the Department of Corrections, you will be expected to:

- Positively represent Washington State government to everyone you meet. You are our best public relations agent;
- Dress appropriately for your job classification and duties. Clothing may not have mottos, logos, or advertisements that may be offensive or in conflict with the goals of the Department;
- Wear issued uniforms only as authorized;
- Be a good citizen, obey laws while on and off-duty. Your conduct off duty may reflect on your fitness for duty;
- Treat fellow staff with dignity and respect;
- Be impartial, understanding and respectful to offenders;
- Serve each offender with appropriate concern for their welfare and with no purpose of personal gain;

Gloria M Wagner

Employee Name (Please Print)

ACKNOWLEDGEMENT OF RECEIPT OF DOC EMPLOYEE HANDBOOK

I acknowledge receipt of the June 1993 Washington State Department of Corrections Employee Handbook and agree to become familiar with and have a thorough knowledge and understanding of the contents.

Gloria M Wagner ______________________ 12/24/93

Employee Signature Date

Original - Personnel File

Attachment 3

S.F. 570 (Rev. 11/80)

CLASSIFICATION QUESTIONNAIRE
(POSITION DESCRIPTION)

PER-9

SHADED AREAS ARE COMPLETED BY DEPARTMENT OF PERSONNEL

Field	Value
1. Agency Name	Department of Corrections
2. Position No.	HB 36
3. Employee's Name (Last, First, Initial)	DAVIS, Tamara J.
Phone No.	794-2236
4. Submitted By	☐ Agency ☐ Employee
5. Position Action No.	
6. Division/Institution/Section/Unit	DOP/SOC/Infirmary
Mail Stop	NM-84
7. Submitted For	☒ Update ☐ Reallocation ☐ Establishment ☐ Other
8. Immediate Supervisor's Name	Fran Bartley
Phone No.	794-2236
Immediate Supervisor's Class Title	Registered Nurse 3
9. Present Class Title	Registered Nurse 2
Class Code	5632
Proposed Class Title	
Class Code	
10. Working Title (if different than class title)	RNC
Class Title	Registered Nurse 2
Class Code	563[illegible]
11. Employment, With Dept. Years / Months	16 / 0
With Present Duties Years / Months	10 / 7
12. Hrs. of Work	40 hrs./wk.
13. Location of Employment	Special Offender Center, Monroe, WA
21. Date	10/24/91

22. % of Time: ☐ Day ☐ Wk ☒ Mo. ☐ Yr

23. EMPLOYEE'S STATEMENT OF DUTIES

READ INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS SECTION.

LIST THOSE DUTIES FIRST WHICH OCCUPY MOST OF YOUR TIME. UNDERLINE YOUR MOST RESPONSIBLE DUTY.

Under the supervision of the RN 3, the RN 2 provides comprehensive nursing care services in the clinical setting of the Special Offender Center, a 108-bed adult correctional facility providing intensive therapeutic community services to mentally ill offenders.

%	Duty
40%	Accurately set up, adminster, and record all medications, such as major tranquilizers, neuroleptics, anti-parkinsonian meds, antibiotics, and anti-convulsant medications, as well as others as ordered.
10%	Set up, distribute, and record all decanoate meds, maintaining the tracking method and document any side effects.
10%	Assist psychiatrist with med reviews on units. Complete all orders and relay to pharmacy. Assist P.A.s when needed. Participate in case management on all units.
10%	Enter computer data for upcoming psychiatric appointments. Order batch reports.
10%	Provide ongoing nursing treatment and emergency treatment as necessary.
5%	Clear inmates for food service and keep accurate documentation.
5%	Obtain scheduled and emergency EKGs. Assist P.A. with sick call and minor surgery.
5%	Provides for the safety, security, and sanitation of supplies, equipment, and the Infirmary area.
5%	Maintains professional nursing care integrity as it applies to appearance, behavior, demeanor, and delivery of services. Performs other work as required.

OCT 2[illegible] 1991

Attachment 4

1251

(attach additional sheets if necessary)

☐ —ORIGINAL COPY FOR THE ☐ —COPY FOR AGENCY HEADQUARTERS ☐ —COPY FOR FIELD OFFICE ☐ —COPY FOR EMPLOYEE ☐ —COPY FOR DIRECT MAIL TO THE

EMPLOYEE'S STATEMENT (CONT.)

24. EMPLOYEES WITHIN THE AGENCY WHOSE DUTIES ARE THE SAME

	Name	Classification Title	Working Title
A.	Meredith Gjovig	RN	2
B.			
C.			

25. UNITS SUPERVISED (if applicable), NO. OF EMPLOYEES IN EACH, ALSO ATTACH 8½" x 11" ORGANIZATION CHART

N/A

26. SUBORDINATE EMPLOYEES REPORTING DIRECTLY TO THIS POSITION—HIGHEST PAY RANGE FIRST.

	Name or Number	Classification Title	Working Title
A.	N/A		
B.			
C.			
D.			

E. (Number) ADDITIONAL EMPLOYEES REPORTING DIRECTLY TO THIS POSITION.

27. OFFICE MACHINES, EQUIPMENT, TOOLS, MOTOR VEHICLES, ETC. OPERATED ON JOB, PERCENT OF TIME

Copier, Autoclave, Equipment common to nursing care services, motor vehicle.

28. ADDITIONAL COMPENSATION (ROOM, BOARD, LAUNDRY, CLOTHING, ETC.) RECEIVED IN ADDITION TO CASH SALARY

N/A

I CERTIFY THAT THE STATEMENTS CONTAINED HEREIN ARE MY OWN AND ARE ACCURATE AND COMPLETE.

29. SIGNATURE OF EMPLOYEE [signature]

30. DATE 10/21/91

IMMEDIATE SUPERVISOR'S STATEMENT

31. [X] AGREE [ ] DISAGREE WITH EMPLOYEE'S STATEMENTS. EXPLAIN (Attach Additional Sheets, if Needed)

32. [X] AGREE [ ] DISAGREE WITH EMPLOYEE'S STATEMENT AS TO MOST RESPONSIBLE DUTY (ITEM 23.). EXPLAIN.

33. SUPERVISION REQUIRED BY POSITION

[ ] CLOSE, DETAILED [X] SPOT CHECK BASIS ONLY [ ] LITTLE—EMPLOYEE RESPONSIBLE FOR DEVISING OWN WORK METHODS [ ] OTHER EXPLAIN ITEM CHECKED

34. EDUCATION REQUIRED BY POSITION

[ ] LESS THAN HIGH SCHOOL [ ] HIGH SCHOOL GRADUATION [ ] SOME COLLEGE NO. OF YEARS REQ'D. [X] COLLEGE GRADUATION [ ] GRADUATE STUDY DEGREE (KIND)

MAJOR

Graduation from an accredited School of Professional Nursing.

35. EXPERIENCE REQUIRED BY POSITION (KIND AND LENGTH OF TIME)

One year professional nursing experience. Bachelor's degree involving major study in nursing may substituted for general nursing experience, but not for psychiatric nursing experience.

36. SPECIAL KNOWLEDGE, SKILLS, LANGUAGE, LICENSE, CERTIFICATE, ETC REQUIRED BY POSITION.

Valid WA State License to practice as a registered nurse; ~~two years psychiatric nursing experies required.~~ GW

37. SIGNATURE OF IMMEDIATE SUPERVISOR [signature] RN 3

38. TITLE Registered Nurse 3

39. DATE 10-14-91

DEPARTMENT HEAD'S STATEMENT

40. COMMENTS AS TO ACCURACY AND COMPLETENESS OF STATEMENTS BY EMPLOYEE AND IMMEDIATE SUPERVISOR. (Attach Additional Sheets if Necessary)

41. [X] AGREE [ ] DISAGREE WITH STATEMENTS IN ITEMS 34, 35, AND 36. COMMENT

1252

42. SIGNATURE OF DEPARTMENT HEAD OR DESIGNEE [signature]

43. TITLE Health Care Manager

44. DATE 10/17/91

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
OFFICE OF CORRECTIONAL OPERATIONS
TWIN RIVERS CORRECTIONAL CENTER / SPECIAL OFFENDER CENTER
PO BOX 514 • Monroe, Washington 98272-0514 • (360) 794-2200
FAX (360) 794-2314

September 24, 1998

TO: Gloria Wagner, Registered Nurse 2

FROM: Teresa Bollinger, Registered Nurse 3

Regarding: Memo of Counseling

An incident occurred during the 4:00 p.m. med line on 8/31/98 in which you dispensed medication to I/M[redacted] and then failed to immediately chart this fact, as required by law and as further directed by Ella Ray Sigmund in a memo to RN's dated 8/13/98. By your signature on Ms. Sigmund's memo, you acknowledged that you were aware of the directive prior to the occurrence of this 8/31/98 incident.

I sent you an e-mail on 9/12/98 to refresh your memory relative to the content of Ms. Sigmund's 8/13/98 directive.

By your failure to adhere to lawfully mandated and management reinforced prescribed procedure in the process of medication distribution, you were directly responsible for the overdose of medication received by I/M[redacted] on the evening of 8/31/98. Such neglect of duty at the least caused considerable discomfort for I/M[redacted] and if you persist in such practice, could present a future situation of life-threatening proportion.

I am now advising you that any future disregard of Ms. Sigmund's 8/13/98 directive regarding medication charting procedures will result in further corrective/disciplinary action up to and including dismissal from your employment with the Department of Corrections.

cc: Personnel file

TB:ap

Attachment 51253