BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

Dorothy Stithem
Appellant,

vs.

DOC
Respondent.

Case No. DISM-96-0020

STIPULATION AND ORDER FOR RETURN OF EXHIBITS AND/OR DEPOSITIONS

It is hereby stipulated that when the Order in the above-entitled action becomes final, or upon the Order becoming final after an appeal, or upon the filing of a Dismissal, the Board may return or destroy all exhibits in the above-entitled matter to the party introducing said exhibits.

Dorothy Stithem KW
Appellant/Representative for Appellant

Return ✓ Destroy ____

Representative for Respondent

Return ✓ Destroy ____

Michael Sellars

IT IS SO ORDERED:

DATED this 26th day of September, 1997.

Howard N. Jorgen
CHAIR, Personnel Appeals Board

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

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

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

March 27, 1998

CERTIFIED Z-351-965-742

Dorothy Stithem
29020 1st Avenue S #21
Des Moines, WA 98198

RE: Dorothy Stithem v. Department of Corrections, Dismissal Appeal,
Case No. DISM-96-0020

Dear Ms. Stithem:

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 March 27, 1998.

Sincerely,

Don Bennett
Executive Secretary

DB:lh
Enclosure

cc: Michael Sellars, AAG
Jennie Adkins, DOC

BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

DOROTHY STITHEM, Appellant, v. DEPARTMENT OF CORRECTIONS, Respondent.	Case No. DISM-96-0020 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF THE BOARD

I. INTRODUCTION

1.1 **Hearing.** This appeal came on for hearing before the Personnel Appeals Board, HOWARD N. JORGENSON, Vice Chair, and ROGER F. SANFORD, Member. The hearing was held in the Superintendent's Conference Room at the Washington State Reformatory in Monroe, Washington, on March 12, 1998. JUDITH MERCHANT, Chair, did not participate in the hearing or in the decision in this matter.

1.2 **Appearances.** Appellant Dorothy Stithem was present and represented herself *pro se*. Respondent Department of Corrections was represented by Michael P. Sellars, Assistant Attorney General.

1.3 **Nature of Appeal.** This is an appeal from a disciplinary sanction of dismissal for neglect of duty and gross misconduct for Appellant allegedly failing to provide basic emergency assistance to an inmate and failing to properly log the incident in the inmate's medical record.

1.4 **Citations Discussed.** WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983); McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987); Rainwater v.

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504
(360) 586-1481

School for the Deaf, PAB No. D89-004 (1989); Holladay v. Dep't of Veteran's Affairs, PAB No. D91-084 (1992).

II. FINDINGS OF FACT

2.1 Appellant Dorothy Stithem was a Registered Nurse 2 and a permanent employee of Respondent Department of Corrections (DOC) at the Washington State Reformatory (WSR) in Monroe, Washington. Appellant and Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder, Titles 356 and 358 WAC. Appellant filed a timely appeal with the Personnel Appeals Board on February 26, 1996.

2.2 By letter dated January 31, 1996, Appellant was dismissed from her position, effective February 15, 1996, for neglect of duty and gross misconduct. The letter states in part:

> Specifically, you neglected your duty and committed acts of gross misconduct in that on September 25, 1995, you failed to provide basic emergency assistance to an inmate and subsequently failed to properly log this incident in the inmate's medical record. At approximately 2:00 a.m., Officer Rimestad telephoned you and said that inmate Mattson, #724795, had requested medical assistance as the inmate was experiencing chest pains. You were also advised that the inmate believed that he was having a heart attack and that the nitroglycerin pills he was taking had not relieved his pain. Not being convinced of Officer Rimestad's call for immediate attention, you requested to speak to yet another officer, dwindling away more precious time.
>
> Officer Munoz came on the telephone and reiterated that the inmate was indeed having chest pains. Officer Munoz relayed to you that this incident was a medical emergency. Instead of immediately responding to the unit, you replied to the officer that you did not want to go down to the unit if the inmate was just having heartburn. After Officer Munoz renewed his appeal that the incident was an emergency, you finally responded to the officer's request and arrived at the unit at approximately 2:05 a.m. without reviewing the inmate's chart which would have revealed evidence that the inmate had a history of hypertension. However, even though you were notified of the inmate's symptoms, you arrived at the unit without ANY medical equipment such as the emergency box, wheelchair or oxygen equipment. You acted improperly and were negligent by failing to take a full physical assessment of the inmate and merely read a radial pulse. You frittered more time away and asked the inmate if he was certain that he was not having heartburn. Additionally, you were

negligent in leaving the inmate with the officers while you departed the unit to return to the hospital, 3rd floor. Instead, you should have remained with the inmate while the officers transported the inmate to the hospital floor.

Basic/standard nursing practices dictate that whenever a patient is complaining of or experiencing chest pains, that you immediately respond with the emergency/oxygen equipment. As a Registered and experienced nurse, you should have known that chest pains may be a symptom of: 1) cardiac; 2) pulmonary; or 3) chest wall problems and must be treated as such.

Fortunately, upon the inmate's arrival to the hospital floor, Registered Nurse Kelly May, whom you asked to assist you with the EKG, was prepared and immediately took charge of the situation. Registered Nurse May immediately started oxygen and took the inmate's vital signs and performed an EKG. You were told to then call the Physician Assistant, M. Semerad, who was "on call" and was told by her to review the inmate's chart because inmate Mattson had a history of cardiac problems. PA Semerad stated that you were having difficulty locating the cardiac history in the chart and you became somewhat flustered and repeatedly stated, "I can't find it, I can't find it." You failed to properly review and read the inmate's chart so that you could give or relay to the consulting medical professional essential and dynamic medical information on the inmate. Registered Nurse May, who had taken full charge, with minimal assistance from you, called "911" in order that the inmate be transported to Providence General Hospital in Everett. The inmate was ultimately treated for a triple bypass operation that very morning.

Furthermore, you neglected your duty and committed other acts of gross misconduct when you failed to chart this incident in the inmate's medical history chart. When you were instructed on September 28, 1995, to chart this incident, you failed to properly note that your comments were a "late entry" as required.

. . . .

(Exh. R-1).

2.3 Officer Scott Rimestad has been a Correctional Officer at the Washington State Reformatory for 2 1/2 years. On September 25, 1995, he was working the graveyard shift. He received a call from the Section 3A control booth informing him that an inmate was having chest pains. Officer Rimestad called the third floor hospital and told Appellant that an inmate was having chest pains. Appellant asked him who the inmate was, what the inmate's condition was, how long he had been

experiencing the chest pains, and where the inmate was located. Appellant indicated to Officer Rimestad that she wanted him to assess the inmate's condition and then call her back. Appellant also asked Officer Rimestad how long he had worked in Section 3A. Appellant then asked to talk to any other officer who was present and Officer Rimestad gave the telephone to Officer Munoz. Officer Rimestad testified that after about 10 minutes, Appellant arrived at the unit. However, even though Officer Rimestad testified that he told Appellant that the inmate was having chest pains, Appellant did not have the emergency equipment with her when she arrived to attend to the inmate. Appellant asked the inmate several questions and observed his condition. She then told the officers to transport the inmate to the third floor hospital. Officer Rimestad testified that although he did not use the term medical emergency when told Appellant that the inmate was having chest pains, the intent of his call was to get her to respond to the situation as soon as possible. (Testimony of Officer Scott Rimestad).

2.4 On September 25, 1995, Officer Frank Munoz was asked by the control booth to go to the Section 3A annex and assist with a problem with an inmate. When Officer Munoz arrived, Officer Rimestad was on the telephone with Appellant and was telling her that an inmate wanted to see a nurse. Appellant had indicated to Officer Rimestad that she wanted to talk to another officer so Officer Rimestad gave the telephone to Officer Munoz. Office Munoz testified that he told Appellant that the inmate was having chest pains and that someone needed to come to the unit. Appellant told him that she did not want to come to the unit if the inmate was just having heartburn. Officer Munoz testified that when he and Officer Rimestad returned to the inmate, the inmate was sitting on the edge of his bunk, his complexion was ashen and pale gray, he was holding his chest and he was having a hard time breathing. The inmate indicated that he had taken three to four nitroglycerin tablets. After about five to severn minutes, Appellant arrived at the unit, however, she did not have the emergency equipment with her. Appellant talked to the inmate and then instructed

the officers to transport the inmate to the thrid floor hospital while she returned to the hospital and prepared for the inmate's arrival. Officer Munoz testified that he has experience dealing with medical emergencies and that under normal circumstances, the nurse would bring oxygen and an emergency kit when responding to a situation involving an inmate with chest pains. In addition, the nurse would stay with the inmate during the transport. After Appellant left to return to the third floor, the officers transported the inmate. The inmate was unable to move to a wheelchair, and therefore, in the interest of saving time, the officers carried the inmate up the stairs to the third floor hospital. When they arrived at the hospital, Nurse Kelly May opened the door for them. Nurse May took one look at the inmate and said to call "911." (Testimony of Officer Frank Munoz).

2.5 Registered Nurse 2 Kelly May testified that on September 25, 1995, she was working in the fourth floor hospital area. She stated that fourth floor nurses do not to respond to medical emergencies but that third floor nurses are responsible for triaging inmates when a medical situation occurs. Nurse May stated that for medical emergencies, the response time should be less than five minutes. She testified that on September 25, Appellant called and asked her to assist her with administering an EKG on an inmate. Nurse May testified that when she arrived to assist Appellant, Appellant was reading the EKG machine manual and asked her, in reference to the EKG machine, "How do you run this thing?" When the inmate arrived, he was being carried by the officers, he was not on oxygen, his vitals had not been taken, and nitroglycerin had not been administered. Nurse May testified that at the very minimum, Appellant should have put the inmate on oxygen and taken his vitals. Nurse May knew that the inmate had experienced previous problems, that he had failed an exercise tolerance test, and that he needed to be given something to help him relax. Nurse May told Appellant to call the Physician Assistant and have her order valium for the inmate. Nurse May testified that the inmate's complexion was blue-gray, he was sweating, and he was experiencing pain in the middle of his chest radiating to his left arm. Nurse May further testified

that she took control of the situation and that Appellant did all of things she asked her to do. However, when Nurse May was conducting the EKG, she thought that Appellant was calling the medics as Nurse May had instructed her to do. Appellant had not heard her give this instruction, so Nurse May called the medics herself. In addition, Nurse May testified that Appellant did not appear to know where to locate information in the inmate's medical records. Nurse May further testified that she logged the September 25 incident in the inmate's medical record. (Testimony of Nurse Kelly May).

2.6 Norma Gray, Health Care Manager 2, investigated the Employee Conduct Report. Ms. Gray found that Appellant's "actions during this incident were both unsafe and unprofessional." (Exh. R-1, Att. 2). Ms. Gray testified that Officer Rimestad told Appellant that the inmate was experiencing chest pains. Ms. Gray stated that an inmate with chest pains constitutes a medical emergency and that Appellant should have responded appropriately. Ms. Gray further testified that Appellant had been instructed to complete training in how to operate the EKG machine, but that even though Appellant indicated that she had completed the training, she had not. (Testimony of Norma Gray).

2.7 Mike Williams, Associate Superintendent of Custody, conducted the administrative hearing on the Employee Conduct Report. In his Administrative Comments, Mr. Williams stated that

> ". . . I am convinced that RN Stithem fell short of her obligation to provide professional and complete patient care in this instance, because of the following: (1) She had to be convinced by CO Munoz to come to the unit, by telling her that the inmate was complaining of serious chest pains (and she should not rely on any officer to determine the serious need for medical assistance. (2) She failed to review the inmate's chart, which obtained evidence that the inmate had a history of cardiac problems. (3) When she arrived in the unit, she had not brought oxygen or the emergency kit with her for her initial assessment and treatment of the inmate. She should have made a medical assessment when she saw the inmate and, upon determining the need for an EKG, called the other RN and asked that she make the necessary preparations while she (Stithem) stayed with the inmate. (4) She left the inmate with two officers and went back to the hospital when she knew five

> nitroglycerin tablets had not helped the inmate and he was feeling pain starting to progress down his arm. (5) She was not able to read pertinent information, upon request on the telephone, to the consulting PA. (6) she was not able to run an EKG, which is a duty she should have received training in, or requested training in. (7) She failed to indicate in her chart entry that it was a "late entry." I agree with HCM Gray that RN Stithem's actions, and inactions, in this incident constitute misconduct. I recommend that appropriate corrective/disciplinary action be taken.

(Exh. R-1, Att. 2).

2.8 Appellant testified that the third floor clinic is very busy. She testified that Officer Rimestad did not tell her that there was a medical emergency or that the inmate was having chest pains. At the time, she believed the inmate asking for the nurse was an inmate she had previously treated with Malox for indigestion. When she realized that Officer Rimestad did not know who the inmate was, she asked to speak to another officer. Appellant testified that Officer Munoz told her that an inmate wanted to see a nurse, not that the inmate was having chest pains. (Testimony of Appellant). However, in her February 23, 1998, sworn declaration, Appellant states on page six that Officer "Munoz told [her] that it was Inmate Mattson and that he complained of chest pains." (Exh. A-1).

2.9 When Appellant arrived at the inmate's cell, the inmate was sitting on his bed. The inmate told her that he had chest pains but that he had not told the officers. Appellant determined that the inmate's pulse was strong and steady and that his complexion was ashen-gray, which she felt was the inmate's normal color. (Testimony of Appellant).

2.10 Appellant determined that the inmate should be checked with the EKG machine and instructed the officers to transport to the inmate to the third floor hospital by wheelchair. Although Appellant had participated in training on the EKG machine, she had never used it on a patient. Because she knew that Nurse May had cardiac experience, Appellant asked for her assistance. By the time that the inmate arrived in the third floor hospital, Appellant stated that the inmate looked

entirely different and that his condition had escalated. When the inmate arrived, Appellant was on the telephone with the Physician Assistant. Nurse May started the EKG machine and put the inmate on oxygen. (Exh. A-1). Appellant admits that Nurse May took charge of the situation, but Appellant testified that although she was lacking confidence, she probably could have done what was required. Appellant further testified that when she was talking to the Physician Assistant, she looked through the recent entries in the inmate's chart and found the Physician Assistant's orders for tests on the inmate. However, the results of the tests were not in the chart so Appellant was unable to provide that information to the Physician Assistant as requested. Appellant stated that the results of the tests were not put in the inmate's chart until October 5, 1995. (Testimony of Appellant).

2.11 After the Physician Assistant ordered the inmate to be sent to the hospital by "911," Appellant copied the inmate's records and the assisted the medics in getting the inmate ready to leave. (Exh. A-1).

2.12 Appellant testified that the WSR had over 600 inmates at the time of this incident and that she was unfamiliar with inmate Mattson. (Testimony of Appellant).

2.13 Appellant further testified that when Nurse May said she would chart the incident in the inmate's record, Appellant agreed. Appellant then charted the incident in the inmate's record on September 28, 1995, after her supervisor told her to do so. However, in her February 23, 1998 sworn declaration, Appellant states on page 13 that "Several weeks later . . . . My supervisor then told me to prepare a chart entry which I did." (Exh. A-1). Appellant admits that although she thought that she had, she did not note her chart entry as a late entry. (Testimony of Appellant).

2.14 Kenneth DuCharme is the Superintendent of WSR and is Appellant's appointing authority. Mr. DuCharme agreed with the results of the administrative hearing and felt that misconduct had occurred. He determined that Appellant had neglected her duty by her reluctance to respond to the incident after being asked to do so by the officers, by failing to take the emergency kit with her to the incident, by conducting only a cursory check of the inmate, by not staying with the inmate during the transport, by being unable to operate the EKG machine, by failing to note her entry in the inmate's record as a late entry, and by failing to provide the requisite standard of care for the inmate. Mr. DuCharme felt that Appellant's conduct demonstrated a series of gross errors in judgment that could have had a catastrophic result and caused a great liability for the institution. Mr. DuCharme testified that termination was the appropriate action in light of these gross errors. (Testimony of Kenneth DuCharme).

III. ARGUMENTS OF THE PARTIES

3.1 Respondent argues that Appellant made a series of serious errors in judgment in a situation in which time was of the essence. Appellant failed to respond to the situation in a timely manner and when she finally did respond, she failed to utilize the tools that were available for her to use. Respondent asserts that it cannot risk having medical staff providing an unacceptable level of care to inmates. Therefore, Respondent asks that the termination be upheld.

3.2 Appellant argues that a medical emergency was never declared by the officers and that the officers never told her that the inmate was having chest pains. Appellant contends that the officers' inappropriate transport of the inmate, after she had instructed them to use a wheelchair, caused the inmate's condition to worsen and created a medical emergency. Appellant asserts that if anyone had told her there was a medical emergency or a "man down," she would have responded appropriately and would have utilized the emergency kit. Appellant argues that the evidence and testimony in this

case contains many untruths, and that in her opinion, she handled the situation in an appropriate and timely manner.

IV. CONCLUSIONS OF LAW

4.1 The Personnel Appeals Board has jurisdiction over the parties hereto and the subject matter herein.

4.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting the charges upon which the action was initiated by proving by a preponderance of the credible evidence that Appellant committed the offenses set forth in the disciplinary letter and that the sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983).

4.3 Neglect of duty is established when it is shown that an employee has a duty to his or her employer and that he or she failed to act in a manner consistent with that duty. McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987).

4.4 Gross misconduct is flagrant misbehavior which adversely affects the agency's ability to carry out its functions. Rainwater v. School for the Deaf, PAB No. D89-004 (1989).

4.5 In determining whether a sanction imposed is appropriate, consideration must be given to the facts and circumstances including the seriousness and circumstances of the offense. The penalty should not be disturbed unless it is too severe. The sanction imposed should be sufficient to prevent recurrence, to deter others from similar misconduct, and to maintain the integrity of the program. An action does not necessarily fail if one charge is not sustained unless the entire action depends on the unproven charge. Holladay v. Dep't of Veteran's Affairs, PAB No. D91-084 (1992).

4.6 Respondent has met its burden of proof that Appellant neglected her duty and committed acts of gross misconduct. Appellant received a call for medical assistance for an inmate who was experiencing chest pains. Correctional officers are not medical staff and are not qualified to conduct medical assessments on inmates. Rather than asking the officers to assess the condition of the inmate, it is Appellant's duty to respond immediately and use her medical knowledge, skills and the appropriate equipment to assess the inmate herself. Appellant failed to respond and assess the inmate appropriately. In addition, Appellant, by her own admission, was not confident with her ability to use the EKG machine on a patient. Furthermore, Appellant failed to properly chart information in the inmate's medical record. Appellant neglected her duty in a situation which, given the serious nature of her actions and inactions, could have resulted in an extremely negative impact on the inmate and the institution.

4.7 Under the facts and the seriousness of the circumstances of this case, we conclude that Respondent has proven that the disciplinary sanction of dismissal is warranted, and the appeal should be denied

V. ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of Dorothy Stithem is denied.

DATED this 17th day of March, 1998.

WASHINGTON STATE PERSONNEL APPEALS BOARD

Howard N. Jorgenson, Vice Chair

Roger F. Sanford, Member

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504
(360) 586-1481

I, M. Louise Akramoff, certify that on February 26, 1998, I mailed a copy of this document, postage prepaid, to all parties or their counsel of record. I certify under penalty of perjury, under the laws of the State of Washington, that the foregoing is true and correct.

M. Louise Akramoff /pls

BEFORE THE PERSONNEL APPEALS BOARD
STATE OF WASHINGTON

DOROTHY STITHEM, Appellant, v. DEPARTMENT OF CORRECTIONS, Respondent.	NO. DISM-96-0020 EXHIBIT AND WITNESS LIST

COMES NOW the Respondent, State of Washington Department of Corrections, and hereby designates the following witnesses and exhibits that may be used in the Respondent's case in chief:

WITNESS LIST

1. Scott Reimstad
2. Frank Munoz
3. Kelly May
4. Richard Allis
5. Marty Semerad
6. Norma Gray
7. Michael Williams
8. Kenneth DuCharme

EXHIBIT LIST

R-1 Disciplinary Letter, dated January 31, 1996, plus following attachments:
a) Memo from Norma Gray to Annette Belden, dated June 15, 1995.
b) Employee Conduct Report, dated September 18, 1995. (18 pages).

ATTORNEY GENERAL OF WASHINGTON
Labor & Personnel Division
905 Plum St. SE, Bldg. 3
PO Box 40145
Olympia, WA 98504-0145
(360) 664-4167

R-2 Memo from Kelly May to Annette Belden and Norma Gray dated September 25, 1995.

R-3 Memo from Officer Munoz to Watch 1 Shift Lieutenant/Sergeant.

R-4 Memo to Norma Gray for c/o R. Allis, dated September 23, 1995.

DATED this 26 day of February, 1998.

CHRISTINE O. GREGOIRE
Attorney General

MICHAEL P. SELLARS
WSBA #21331
Assistant Attorney General

ATTORNEY GENERAL OF WASHINGTON
Labor & Personnel Division
905 Plum St. SE, Bldg. 3
PO Box 40145
Olympia, WA 98504-0145
(360) 664-4167

BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

DOROTHY STITHEM, Appellant, vs. DEPARTMENT OF CORRECTIONS, Respondent.	Case No. DISM-96-0020 NOTICE OF SCHEDULING

Notice is hereby given of scheduling the hearing on the appeal before the Personnel Appeals Board. The hearing will be held at the Washington State Reformatory, Monroe, Washington, on **Thursday, March 12, 1998, beginning at 9:30 a.m.**

The parties shall arrive at the hearing location thirty (30) minutes before the hearing time for the purpose of exchanging copies of, and when possible, stipulating to exhibits. The parties shall bring six (6) copies of the premarked exhibits which they intend to offer into evidence. Whenever possible, the parties should exchange witness lists prior to the day set for the hearing.

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

DATED this 11th day of December, 1997.

WASHINGTON STATE PERSONNEL APPEALS BOARD

Teresa Parsons

Teresa Parsons, Hearings Coordinator
(360) 664-0479

cc: Dorothy Stithem, Appellant Z-351-965-605
Michael P. Sellars, AAG
Jennie Adkins, DOC

Personnel Appeals Boar
2828 Capitol Boulevar
Olympia, Washington 9850

Appellant served by both certified and regular mail.

WASHINGTON STATE

PERSONNEL APPEALS BOARD

APPEAL STATUS REPORT

(To be completed by Mediators)

Date: November 3, 1997

Appeal Name: Stithem v Dept of Corrections

Appeal Number: PAB Case No DISM-96-0020

The status of the above-captioned appeal is as follows:

- ☐ The appeal was settled and a copy of the withdrawal order is attached.
- ☐ The appeal was settled and the parties are going to withdraw.
- ☐ Appellant called to advise that he/she would withdraw.
- ☐ The appeal has been settled but final paperwork has not been completed. _____ should be contacted by _____, 19___ to be sure that the withdrawal is forthcoming.
- ☒ The appeal was not settled in mediation. ~~The case should now be set for pre-hearing conference and hearing by the board.~~ Hearing set: March 12, 1998
- ☐ The mediation case has not been scheduled, and the case is being returned to the Board for re-assignment.

Other _____

_____

_____

_____

Jennifer Woods — 11-3-97

Mediator's Signature — Date

JENNIFER WOODS
Attorney at Law
715 North 193rd Place
Seattle, WA 98133
(206) 546-9081

November 3, 1997

Dorothy Stithem
29020 1st Avenue S., #21
Des Moines, WA 98198

Michael P. Sellars
Assistant Attorney General
P.O. Box 40145
Olympia, WA 98504-0145

Re: Stithem v. Dept. of Corrections
PAB Case No. DISM-96-0020

Dear Ms. Stithem and Mr. Sellars:

Enclosed please find the Pre-Hearing Statement in the above referenced appeal. This statement outlines the hearing date and other important dates leading up to the hearing.

I urge Ms. Stithem to seek the advice of legal counsel if these cut off dates and the appeals procedure are confusing.

Very truly yours,

/S/

Jennifer Woods

cc: Personnel Appeals Board

PRE-HEARING STATEMENT

Stithem v. Dept. of Corrections
PAB Case No. DISM-96-0020

The pre-hearing dates were set by means of an October 23, 1997 letter of proposed dates to Appellant and counsel for Respondent and follow up telephone conversations with Appellant and counsel for Respondent confirming the acceptability of these dates. The representatives of the parties are: Dorothy Stithem, pro se; Michael P. Sellars, Assistant Attorney General, for the Respondent; and, Jennifer Woods, Mediator, for the Personnel Appeals Board.

The following stipulations were made by the parties:

1. The hearing in this matter shall be held **March 12, 1998** beginning at **9:30 a.m.** at the Washington State Reformatory, Monroe, Washington.

2. Discovery in this matter shall be served and filed so that it can be responded to no later than February 12, 1998.

3. Appellant and counsel for Respondent shall exchange witness and exhibit lists, with a copy to the Executive Secretary, Personnel Appeals Board, no later than February 26, 1998.

4. Appellant and counsel for Respondent shall exchange pre-hearing briefs, if any, with a copy to the Executive Secretary, Personnel Appeals Board, no later than March 5, 1998.

5. Appellant and counsel for Respondent shall participate in a pre-hearing telephone conference with the Executive Secretary, Personnel Appeals Board, **9:00 a.m. March 9, 1998.** The telephone conference call will be initiated by the Executive Secretary and will be used to explore possible stipulations concerning witnesses, exhibits, and the statement of the issue to be presented to the Board.

Any objections or corrections must be filed with the Executive Secretary within 20 days of the date of this statement and shall, at the same time, be served upon each of the participants named above. This statement becomes part of the official record of the proceedings, and the stipulations are binding on the parties, unless this statement is modified for good cause.

Dated: November 3, 1997

PERSONNEL APPEALS BOARD

By: Jennifer Woods
Jennifer Woods

JENNIFER WOODS
Attorney at Law
715 North 193rd Place
Seattle, WA 98133
(206) 546-9081

October 23, 1997

Dorothy Stithem
29020 1st Avenue S., #21
Des Moines, WA 98198

Michael P. Sellars
Assistant Attorney General
P.O. Box 40145
Olympia, WA 98504-0145

Re: Stithem v. Dept. of Corrections
PAB Case No. DISM-96-0020

Dear Ms. Stithem and Mr. Sellars:

My understanding is that Ms. Stithem is now representing herself in this matter. If this is not the case, please let me know as soon as possible.

The hearing before the Personnel Appeals Board in this appeal is scheduled for **March 12, 1998** beginning at **9:30 a.m.** and will be held at the Washington State Reformatory, Monroe, Washington.

I suggest the following pre-hearing dates:

Discovery cut-off which is the date by which all discovery must be served and filed with thirty days to respond included: February 12, 1998.

Exchange of witness and exhibit lists: February 26, 1998.

Exchange of optional pre-hearing briefs: March 5, 1998.

Pre-hearing telephone conference with the Personnel Appeals Board Executive Secretary: March 9, 1998.

If these cut-off dates are acceptable, I will finalize them in an Order. Please let me know if these work for you. If I don't hear from you in a week or so, I will call you.

Thank you for your efforts at mediation.

Very truly yours,

Jennifer Woods

cc: Kenneth Latsch

JENNIFER WOODS
Attorney at Law
715 North 193rd Place
Seattle, WA 98133
(206) 546-9081

August 13, 1997

Dorothy Stithem
29020 1st Avenue S. #21
Des Moines, WA 98198

Michael P. Sellars
Assistant Attorney General
P.O. Box 40145
Olympia, WA 98504-0145

Re: Stithem v. Dept. of Corrections
PAB Case No. DISM-96-0020

Dear Ms. Stithem and Mr. Sellars:

The mediation in the above referenced appeal is scheduled for **August 26, 1997** beginning at **10:00 a.m.** and will be held at the Department of Social and Health Services, 840 North Broadway, Building A, Room 101, Everett, Washington.

The purpose of the meeting is to try to resolve Ms. Stithem's appeal informally so that the need for a hearing before the Personnel Appeals Board is not necessary. My understanding is that Ms. Stithem may be attending the mediation without her attorney, John Arthur.

I look forward to our meeting on the 26th and hope that we can find a resolution to this appeal.

Very truly yours,

Jennifer Woods

cc: John Arthur, Atty
Kenneth Latsch, PAB

JENNIFER WOODS
Attorney at Law
715 North 193rd Place
Seattle, WA 98133
(206) 546-9081

April 14, 1997

Michael P. Sellars
Assistant Attorney General
P.O. Box 40145
Olympia, WA 98504-0145

Dorothy Stithem
29020 1st Avenue South #21
Federal Way, WA 98003

Re: Stithem v. Dept. of Corrections
PAB Case No. DISM-96-0020

Dear Mr. Sellars and Ms. Stithem:

I have been assigned to act as mediator in this matter. As such, my role is to schedule a meeting to try to resolve this appeal informally without the need for a hearing before the Personnel Appeals Board.

My understanding is that Mr. Sellars, who represents DOC is available for this meeting May 23, 1997 and that he is checking with the appointing authority concerning his availability.

It appears that the WPEA is not representing Ms. Stithem in this appeal. Ms. Stithem, you are welcome to appear at the mediation on your own or be assisted by counsel at that meeting, but it is up to you to retain an attorney if that is what you want.

Please call me at the above referenced number to let me know whether the May 23, 1997 date for mediation will work for you. Leave a message if I am not there. If the May 23, 1997 date will not work, please include in your message some alternative dates so that I can get this matter scheduled.

Very truly yours,

Jennifer Woods

cc: Kenneth Latsch

CERTIFICATE OF SERVICE

I certify that I served a copy of this document on all parties or their counsel of record on 09/24/96 as follows:

X US Mail Postage Prepaid — Stithem/Cunningham/McLaughlin
__ ABC/Legal Messenger
__ State Campus Delivery
__ Hand delivered by
__ to

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Dated: September 24, 1996 at Olympia, WA

Diana M Beatty

RECEIVED
SEP 1996
PERSONNEL APPEALS BOARD

BEFORE THE PERSONNEL APPEALS BOARD
STATE OF WASHINGTON

DOROTHY STITHEM, Appellant, v. DEPARTMENT OF CORRECTIONS, Respondent.	NO. DISM-96-0020 NOTICE OF WITHDRAWAL AND SUBSTITUTION OF COUNSEL

TO: KENNETH LATSCH, Executive Secretary, Personnel Appeals Board;
AND TO: DOROTHY STITHEM, Appellant, Pro se.

NOTICE IS HEREBY GIVEN that VALERIE B. PETRIE, Assistant Attorney General, does hereby withdraw as attorney for Respondent, Department of Corrections, in the above-entitled action, and that MICHAEL P. SELLARS, Assistant Attorney General, is hereby substituted as the attorney for said Respondent. It is requested that any and all further pleadings herein be served upon the undersigned attorney at the Office of the Attorney General at the address given below.

DATED this 25 day of September, 1996.

CHRISTINE O. GREGOIRE
Attorney General

MICHAEL P. SELLARS
WSBA #21331
Assistant Attorney General

ATTORNEY GENERAL OF WASHINGTON
Labor & Personnel Division
905 Plum St. SE, Bldg. 3
PO Box 40145
Olympia, WA 98504-0145
(360) 664-4167

WPEA

The Washington Public Employees Association • 1-800-544-WPEA

Headquarters • 124 10th Ave SW
Olympia WA 98501 • (360) 943-1121
FAX (360) 357-7627
Toll Free (800) 544-9732

Monroe Office • 20014 Hwy 2-E • Unit C
Monroe WA 98272 • (360) 794-0733
FAX (360) 794-6986
Toll Free (800) 794-9732

Walla Walla Office • 401 W Main • Suite B
Walla Walla WA 99362 • (509) 529-8632
FAX (509) 525-5487
Toll Free (800) 529-9732

June 5, 1996

Kenneth Latsch, Executive Secretary
WA State Personnel Appeals Board
PO Box 40911
Olympia WA 98504-0911

Re: Dorothy Stithem Vs. DOC, Termination Appeal, DISM-96-0020

Dear Mr. Latsch:

This letter confirms that WPEA will not be representing the above-named employee in this appeal. Further correspondence on this issue can be directed to the employee at their home address: 29020 1st Avenue S, Federal Way, WA 98003.

Thank you for attending to this issue.

Sincerely yours,

Katherine E. Cunningham by fax

Katherine E. Cunningham
WPEA-DOC Program Director
(sv/2kathy96/latc065/06-05-96)

cc: Dorothy Stithem
Mark Lyon, WPEA General Counsel
Diane Leigh, Manager Human Resources

CERTIFICATE OF SERVICE

I certify that I served a copy of this document on all parties or their counsel of record on March 13, 1996 as follows:

X US Mail Postage Prepaid — Dorothy Stithem; Katherine E. Cunningham, WPEA

__ ABC/Legal Messenger

__ State Campus Delivery

__ Hand delivered by

to

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Dated: March 13, 1996 at Olympia, WA.

Sharon J. Kozar

RECEIVED

MAR 14 1996

PERSONNEL APPEALS BOARD

BEFORE THE PERSONNEL APPEALS BOARD
STATE OF WASHINGTON

DOROTHY STITHEM, Appellant, v. DEPARTMENT OF CORRECTIONS, Respondent.	NO. DISM-96-0020 NOTICE OF APPEARANCE

TO: KENNETH LATSCH, Executive Secretary, Personnel Appeals Board;
DOROTHY STITHEM, Appellant;
KATHERINE E. CUNNINGHAM, Washington Public Employees Association.

PLEASE TAKE NOTICE that the Respondent, Department of Corrections, without waiving objection as to the sufficiency of service of process or jurisdiction of this Board, does hereby enter its appearance in the above-entitled action, by and through its attorneys, CHRISTINE O. GREGOIRE, Attorney General, and VALERIE B. PETRIE, Assistant Attorney General, and requests that all further pleadings herein be served upon said Respondent at the Office of the Attorney General at the address given below.

DATED this 13 day of March, 1996.

CHRISTINE O. GREGOIRE
Attorney General

Valerie B. Petrie

VALERIE B. PETRIE
Assistant Attorney General
WSBA No. 21126
Attorney for Respondent

ATTORNEY GENERAL OF WASHINGTON
Labor & Personnel Division
905 Plum Street SE, Bldg. 3
PO BOX 40145
Olympia, WA 98504-0145
(360) 664-4167

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

STATE OF WASHINGTON
PERSONNEL APPEALS BOARD

(360) 586-1481
FAX (360) 753-0139

March 1, 1996

Ms. Katherine E. Cunningham
Washington Public Employees Association
20014 Hwy. 2-E #C
Monroe, WA 98272

RE: Dorothy Stithem v. Department of Corrections, Dismissal Appeal,
Case No. DISM-96-0020

Dear Ms. Cunningham:

This letter is to acknowledge receipt of the above entitled appeal by the Personnel Appeals Board on February 26, 1996.

Sincerely,

Kenneth J. Latsch
Executive Secretary

KJL:tmp
cc: Dorothy Stithem
Linda A. Dalton, AAG
Jennie Adkins, PO

WPEA

The Washington Public Employees Association • 1-800-544-WPEA

Headquarters • 124 10th Ave SW
Olympia WA 98501 • (360) 943-1121
FAX (360) 357-7627
Toll Free (800) 544-9732

Monroe Office • 20014 Hwy 2-E • Unit C
Monroe WA 98272 • (360) 794-0733
FAX (360) 794-6986
Toll Free (800) 794-9732

Walla Walla Office • 401 W Main • Suite B
Walla Walla WA 99362 • (509) 529-8632
FAX (509) 525-5487
Toll Free (800) 529-9732

February 22, 1996

Kenneth Latsch, Executive Secretary
WA State Personnel Appeals Board
P O Box 40911
Olympia WA 98504-0911

Re: DOC-WSR Termination, D. Stithem, RN

Dear Mr. Latsch:

Enclosed is the appeal and materials, filed on behalf of the above-named employee. Please contact me directly if there is further information required.

Sincerely yours,

Katherine E. Cunningham

Katherine E. Cunningham
Employee Relations Specialist
(sv/1kathy96/latsc222/02-22-96)

cc: D. Stithem
Phil Archibald, WPEA-WSR President
Rick Hall, WPEA-DOC Program Director

APPEAL FORM

DISM-96-0020

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

This form will help you provide necessary information to the Personnel Appeals Board when you file an appeal. You are not required to use this form; however, appeals must be filed in accordance with the requirement as set forth in Chapter 358-20 WAC.

If the space on the form is insufficient or if you wish to provide additional information, you may attach additional pages.

RECEIVE

PRINT OR TYPE - SIGN ON PAGE 2

FEB 2 6 1996

PERSONNEL
APPEALS B

PART I. APPELLANT IDENTIFICATION

NAME: Dorothy Stithem
(Last name, first name, middle initial)

HOME ADDRESS: 29020 1st Avenue S #21
(Number and street)
Federal Way, WA 98003
(City, state and ZIP code)

PHONE NUMBERS: (Include area code)
WORK: (360) 794-2600
HOME: (206) 946-5807

EMPLOYING AGENCY OR INSTITUTION: DOC-WSR

AGENCY OR INSTITUTION THAT TOOK ACTION YOU ARE APPEALING: WSR

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

Katherine E. Cunningham, Employee Relations Specialist
WPEA 20014 Highway 2-E, Unit C 1 (800) 544-9732 #202 voicemail
Monroe, WA 98272 Monroe Office (360) 794-0733

An appellant may authorize a representative to act on his/her behalf. The Board must be notified of any change in representation.

PART III. TYPE OF APPEAL

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

__X__ a. Disciplinary: (check applicable action(s).
__X__ Dismissal, _____Suspension, _____Demotion, _____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 : UCTION-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?_____

Katherine E. Cunningham 2-21-96

SIGNATURE OF APPELLANT OR REPRESENTATIVE DATE SIGNED

CHASE RIVELAND
Secretary

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
WASHINGTON STATE REFORMATORY
P.O. Box 777 • Monroe, Washington 98272-0777

January 31, 1996

PERSONAL DELIVERY

Dorothy Stithem
29020 1st Avenue S., #21
Federal Way, WA 98003

Ms. Stithem:

This is official notification of your dismissal effective the end of your scheduled shift on February 15, 1996, from your position as a Registered Nurse 2 with the Department of Corrections, Washington State Reformatory.

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 Section 356-34-010 (1-a) Neglect of Duty, 1-h) Gross misconduct, and 356-34-040 Dismissal - Notification.

Specifically, you neglected your duty and committed acts of gross misconduct in that on September 25, 1995, you failed to provide basic emergency assistance to an inmate and subsequently failed to properly log this incident in the inmate's medical record. At approximately 2:00 a.m., Officer Rimestad telephoned you and said that inmate Mattson, #724795, had requested medical assistance as the inmate was experiencing chest pains. You were also advised that the inmate believed that he was having a heart attack and that the nitroglycerin pills he was taking had not relieved his pain. Not being convinced of Officer Rimestad's call for immediate attention, you requested to speak to yet another officer, dwindling away more precious time.

Officer Munoz came on the telephone and reiterated that the inmate was indeed having chest pains. Officer Munoz relayed to you that this incident was a medical emergency. Instead of immediately responding to the unit, you replied to the officer that you did not want to go down to the unit if the inmate was just having heartburn. After Officer Munoz renewed his appeal that the incident was an emergency, you finally responded to the officer's request and arrived at the unit at approximately 2:05 a.m. without reviewing the inmate's chart which would have revealed evidence that the inmate had a history of hypertension. However, even though you were notified of the inmate's symptoms, you arrived at the unit without ANY medical equipment such as the emergency box, wheelchair or oxygen equipment. You acted improperly and were negligent by failing to take a full physical assessment of the inmate and merely read a radial pulse. You frittered more time away and asked the inmate if he was certain that he was not having heartburn. Additionally, you were negligent in leaving the inmate with the officers while you departed the unit to return to the hospital, 3rd floor. Instead, you should have remained with the

inmate while the officers transported the inmate to the hospital floor.

Basic/standard nursing practices dictate that whenever a patient is complaining of or experiencing chest pains, that you immediately respond with the emergency/oxygen equipment. As a Registered and experienced nurse, you should have known that chest pains may be a symptom of: 1) cardiac; 2) pulmonary; or 3) chest wall problems and must be treated as such.

Fortunately, upon the inmate's arrival to the hospital floor, Registered Nurse Kelly May, whom you asked to assist you with the EKG, was prepared and immediately took charge of the situation. Registered Nurse May immediately started oxygen and took the inmate's vital signs and performed an EKG. You were told to then call the Physician Assistant, M. Semerad, who was "on call" and was told by her to review the inmate's chart because inmate Mattson had a history of cardiac problems. PA Semerad stated that you were having difficulty locating the cardiac history in the chart and you became somewhat flustered and repeatedly stated, "I can't find it, I can't find it." You failed to properly review and read the inmate's chart so that you could give or relay to the consulting medical professional essential and dynamic medical information on the inmate. Registered Nurse May, who had taken full charge, with minimal assistance from you, called "911" in order that the inmate be transported to Providence General Hospital in Everett. The inmate was ultimately treated for a triple bypass operation that very morning.

Furthermore, you neglected your duty and committed other acts of gross misconduct when you failed to chart this incident in the inmate's medical history chart. When you were instructed on September 28, 1995, to chart this incident, you failed to properly note that your comments were a "late entry" as required.

On December 6, 1995, a pre-termination meeting was held to further discuss this incident and the recommendation that your employment be terminated. I provided you until December 11, 1995, to provide me with any mitigating reasons not brought to my attention which might affect my final decision concerning your employment. I have not received any written statement.

In addition, in reviewing your personnel file, I find a memorandum dated June 15, 1995, from Norma Gray, Health Care Manager, to Annette Belden, your supervisor, which documents your unsafe and unacceptable nursing practices.

Copies of the June 15, 1995, memorandum and the Employee Conduct Report which describes this incident in more detail are attached and incorporated herein (attachments 1 & 2)

Your failure to:

1) immediately respond to an inmate known to have a hypertensive history;

2) review the inmate's chart in order to obtain pertinent medical information;

3) promptly/swiftly respond with all necessary/basic medical emergency equipment;

4) take all of the inmate's vital signs;

5) accompany the inmate during his transport in a wheelchair to the hospital floor;

6) operate the EKG machine, and

7) properly denote a "late entry" into the inmate's chart

are considered acts inconsistent with acceptable medical/nursing practices, gross misconduct and neglect of duty.

Your acts of gross misconduct and neglect of duty in this case could have resulted in the inmate's death due to your poor standards of practice, mistreatment and lack of medical attention. Your failure to properly respond to a medical emergency with even the minimal medical emergency paraphernalia and subsequently failing to promptly chart this incident of a cardiac patient are acts which are inconsistent with good nursing practices and cannot be tolerated. Your late entry into the inmate's medical chart without the proper "late entry" notation is also conduct contrary to minimum nursing practices. Your actions are considered very serious and are detrimental to the good order, discipline and safety of the institution. In addition, you have exposed the Department to potential liability because of your failure to act and respond to an inmate known to have had a cardiac history. Therefore, considering the seriousness and the potential consequences of your actions, I have no alternative but to terminate your employment with the Department of Corrections.

Under the provisions of the Washington Administrative Code 358-20-010 and 040, you have the right to appeal this action to the Personnel Appeals Board. Your appeal must be filed in writing to the Office of the Executive Secretary, Personnel Appeals Board, 2828 Capitol Boulevard, Olympia, WA 98504, within thirty (30) days after the effective date stated in paragraph one of this letter or you have the right to file a grievance under the provisions of Article 10 of the Collective Bargaining Agreement between the Department of Corrections and the Washington Public Employee Association.

Kenneth DuCharme, Superintendent
Washington State Reformatory

KD:jm

cc: Eldon Vail, Assistant Director Division of Prisons
Jennie Adkins, Director, Division of Human Resources
Linda Dalton, Sr. Assistant Attorney General
Cheryl Landers, Northwest Area Personnel Manager
L. Nani McLaughlin, Personnel Supervisor
Personnel File

CHASE RIVELAND
Secretary

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

MEMORANDUM

TO: Annette Belden, RN 3

DATE: 6/15/95

FROM: Norma L. Gray, HCM 2

SUBJECT: Dorothy Stithem, RN 2

It was brought to my attention today that Dorothy Stithem, RN 2 has been prepouring narcotics, putting them in unmarked paper fluted cups, and then placing them in an unmarked drawer in the medcart. This is an unsafe and unacceptable practice.

It was also brought to my attention that she has been doing lab draws and working with IV lines without using gloves. In one incident she assisted in securing the IV line on an HIV positive patient without the use of gloves. According to OSHA, WISHA, and the Department of Health the institution could be fined $5,000.00 dollars per nurse if this practice were reported to the Department of Health.

Please discuss these two issues with Dorothy and prepare a letter of counseling outlining the proper technique she should be using. I will review the letter of counseling on Tuesday, June 20th, 1995 prior to you issuing it to her.

cc: K. DuCharme, Superintendent
Annette Belden personnel file
~~Dorothy Stithem personnel file~~
file

NLG/cm

ATTACHMENT # _____

PAGE _____ OF _____

DOC 2-110 (11/89)

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		
Dorothy Stithem, RN 2	WSR/Health Services		
POSITION TITLE	DATE OF INCIDENT	TIME OF INCIDENT	
RN,2	9/25/95	2	[X] AM [ ] PM

DESCRIPTION OF INCIDENT:

On 9/25/95 at approximately 2 AM inmate Mattson #724793 on 3A declared a medical emergency for chest pain. You arrived on 3A at approximately 2:05 AM without O2 and the emergency box. You remained for approximately 2 minutes on 3A and requested the inmate be taken to the clinic. Mr. Mattson #724793, quickly deteriorated with increased pain, shortness of breath and cyanosis. You asked Kelly May, RN 2, to assist you. She stated she had to take charge of the situation. The inmate was transported via 911 to the hospital. You did not chart your initial encounter and assessment of the patient.

INITIATED BY:

NAME (PLEASE PRINT)	POSITION TITLE	SIGNATURE	DATE
Annette Belden	RN III	Annette Belden RN III	9/28/95

WITNESS(ES):

NAME	POSITION TITLE	SIGNATURE	DATE
Kelly May	RN II	ATTACHMENT # 2	9-28-95
Sgt R Kornegay	Sgt		

03-30 (REV 3-85) -264

DATE DELIVERED TO EMPLOYEE Annette Bolden BY Oct 3 1995

EMPLOYEE'S STATEMENT:

See attached

Signature of Employee: Dorothy F Stithem Date: 10-6-95

SUPERVISOR'S REPORT: DATE RECEIVED BY SUPERVISOR 10/9/95 BY: Annette Bolden

See attached Supervisory Response

Signature & Title of Supervisor: M L Grayston Date: 10/16/95

ADMINISTRATIVE COMMENTS: DATE RECEIVED BY OFFICE HEAD [signature] BY: 10-16-95

On 11/14/95, I met with Dorothy Stithem and her representative, Ann Lindsey; HRA M. Doyle and PO L.N. McLaughlin were also present. Ms. Stithem stated that she initially thought the inmate in 3A might have been an inmate she had seen several days before to whom she had given Maalox. She stated that she did not look at the chart for this inmate because she thought she should go to the unit to assess him and getting the chart first would have taken a longer amount of time. She said she took the inmate's pulse and it seemed fine and, after speaking

(Continued on page AC-2)

Signature of Office Head: [signature] Date: 11-14-95

ATTACHMENT # 2

PAGE 2 OF 2 16

DISTRIBUTION
ORIGINAL—EMPLOYEE'S PERSONNEL FILE
ONE COPY—EMPLOYEE

BACK 294

CHASE RIVELAND
Secretary

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

MEMORANDUM

TO: Annette Belden RN III DATE: 9/28/95

FROM: Dorothy Stuteen RN II SUBJECT: Memo as requested /phone

On 9/25/95 @ appx 2[10] A I received a call on 3rd floor Clinic from the C/O on 3A stating that I/M Mattson was requesting to see the nurse. I immediately ran up to 4th floor to take the Pharmacy keys to the 4th floor nurse. They were both busy @ pts, but as soon as I could locate one of them I went directly to 3A where I was met at the upper level door by the officer who had called. He escorted me to I/M. Mattsons cell. Mattson did not acknowledge our presence, so I asked him what I could do for him. His response was "I've been having left chest pain since about 1A & now its beginning to go down my left arm". He then added that in that time he had taken 5 nitro gl. tabs S.L & much relief. I asked why he had waited so long to call & he replied that another I/M had made enough noise to have wakened him & that he thought he was just "mad about that" & if he took enough nitro the pain would go away.

DOC 2-110 (11/89)

ATTACHMENT # 2
PAGE 5 OF 18

CHASE RIVELAND
Secretary

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

MEMORANDUM

TO:

DATE:

FROM:

SUBJECT:

He was pale but not diaphoretic. His radial pulse was regular @ 84. Because of his apparent discomfort I felt he should be evaluated on 3rd floor C Dr, an EKG, PA orders & possibly a trip out to the Hosp. By this time another C/O was present and I asked them to bring the pt to 3rd floor A.S.A.P. Pt agreed & them he could sit in a W/C. The officers stated they would call the Sgt's office & have R+R bring a W/C stat & to get advice as to the fastest route up via elevator.

I returned to 3rd floor to get ready & immed called Kelly May on 4th floor to monitor me on the EKG since I knew she was experienced in ICU and I had just done an EKG for approx 3 yrs & was probably lucky.

She stated she wasn't busy & agreed to come.

I then called PA Leonard, the PA on call, to ask for an order to send pt out if need be. She asked me to read the last several pages of notes ~~plus the last consult report~~ for background

ATTACHMENT # 2
EX. 4
PAGE 4 OF 18

CHASE RIVELAND
Secretary

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

MEMORANDUM

TO: DATE:

FROM: SUBJECT:

During this time Kelly arrived & shortly the pt also arrived, having been transported by 2 men Corry. The 2 later told me they decided on that rather than the more time consuming elevator route. Since I was on the phone c Marty I was comfortable c Kelly starting the EKG. She put pt on O2 & got VS for Marty which I relayed to her. Kelly then requested nitro, so I ran back up to 4th to retrieve the Pharmacy keys, back down, called Tower 1, entered Pharmacy got the nitro & returned to pt. By this time both phones were ringing & the Sgt was present c questions. I ans phones & Sgt & then Kelly requested I go to 4th floor to get a Valium 5. I got the Valium from 4th & asked Jeannette if she was OK - she replied fine so I returned to the pt. Kelly then requested copies of the last 4 PER pages, current med cards & most recent consult report from prev. Resp trig for evaluation

ATTACHMENT # 2

PAGE 5 OF 18

DOC 2-110 (11/89)

CHASE RIVELAND
Secretary

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

MEMORANDUM

TO: DATE:

FROM: SUBJECT:

I finished making the copies just as the medics arrived & announced a couple more phone calls. I was assisting the medics in getting pt ready to leave when Kelly requested another Valium 5 mg. Again I called Tower 1, entered Pharmacy & returned w Valium, which pt took willingly. By this time (possibly from the level of excitement & tension in the room) the pt was shaking & anxious, but he stated he did feel much better. Kelly filled out the new Consult form & the paperwork was ready to go as was the pt.

I appreciated Kelly's help because of her previous ICU skills & experience.

The patient had responded well & I felt we had done our "teamwork" best to get him to the Hospital ASAP.

DOC 2-110 (11/89)

CHASE RIVELAND
Secretary

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

MEMORANDUM

TO: DATE:

FROM: SUBJECT:

After the left @ 3A I continued & my reg nights work & Kelly returned to 4th floor & my heart-felt thanks.

P.S. I feel there are situations (like this one) which may require reevaluation & some policy to facilitate medical procedure If this is possible I hope someone experienced from medical can have some input to.

ATTACHMENT # 2

PAGE 7 OF 18

SUPERVISORY RESPONSE

ECR - Dorothy Stithem, RN 2

Staff persons C/O R. Allis, C/O Munoz, C/O C. Reed, Sgt. R. Kornegay, Marty Semerad, PAC, as well as yourself were interviewed as a result of this ECR. Officer Munoz states he heard Officer Reimstadt on the phone talking to you stating there was a medical emergency with inmate Mattson #724793 having chest pain. Officer Munoz said there was hesitation on your part to respond to 3A Unit and he again repeated that inmate Mattson was having chest pains. You did respond at approximately 2:05 am without any medical equipment, such as the emergency box, wheelchair, or oxygen. The only assessment done by you in the inmate's cell was to take a radial pulse and to tell the officers to bring inmate Mattson to the 3rd floor. You left Officer Reimstadt and Officer Munoz with the patient and returned to the 3rd floor. On returning to the 3rd floor you called Kelly May, RN 2 and requested assistance to perform a EKG on inmate Mattson. She immediately upon arrival of the inmate started oxygen and took vital signs. RN May states she and PAC Semerad who was on call,told you 911 would have to be called. PA Semerad states when she received the call from you that you had little or no information to report on inmate Mattson. PA Semerad states she told you to look in the chart because Mattson had a history of cardiac problems. PA Semerad also stated you were having difficulty locating the cardiac history in inmate Matsons chart and became somewhat flustered and repeatedly stated "I can't find it, I can't find it". Inmate Mattson was transported to Providence General Hospital in Everett. RN May states she then finished charting on inmate Mattson and returned to the 4th floor. The incident was reported to RN 3 Annette Belden. When she checked inmate Mattson's chart she noted you had not charted regarding this incident. You were instructed by RN 3 Belden on 9/28/95 to make a late entry notation in inmate Mattsons medical record. A copy of your note which is dated 9/25/95 at 3 am does not indicate this was a late entry nor does it give a thorough description of the incident. Your actions during this incident were both unsafe and unprofessional.

NLG/cm

10/16/95

ATTACHMENT # 2

PAGE 9 OF 18

with him in the unit, she found that he had taken five "nitros" in the previous short while and that seemed to do no good. He began complaining of pain going down his arm and, at that point, she decided he should be taken to the third floor of the hospital where an EKG and treatment could be started. She believed that the officers carrying the inmate up the stairs might well have caused him more pain and anxiety than bringing him up more slowly in a wheelchair. She stated that she had only done two EKGs before, which is why she asked RN May to come down from the fourth floor and run the EKG. She believed that, once RN May had taken charge (she had ER experience), it was her role to assist RN May. She stated that it was difficult for her to find the last consult (during her telephone conversation with the PA on duty) because that consult was not in the chart. Basically, RN Stithem believed the situation was handled well and that appropriate treatment was given. Regarding the late entry in the chart, RN Stithem said that, since RN May's entry was quite detailed and covered the incident well, she herself did not write much; she indicated that she failed to write "late entry" in the charting.

After reviewing the charting, reading the memo from RN May dated 9/25/95, the memo from CO Reed of 9/26/95, the memo from CO Munoz of 9/25/95, the memo from Sgt. Kornegay of 9/25/95, the memo from CO Allis regarding inmate Morton 906181 of 9/23/95, the memo of RN Stithem of 9/28/95, and the Supervisor's Report of HCM N. Gray dated 10/16/95, I am convinced that RN Stithem fell short of her obligation to provide professional and complete patient care in this instance, because of the following: (1) She had to be convinced by CO Munoz to come to the unit, by telling her that the inmate was complaining of serious chest pains (and she should not rely on any officer to determine the serious need for medical assistance. (2) She failed to review the inmate's chart, which obtained evidence that the inmate had a history of cardiac problems. (3) When she arrived in the unit, she had not brought oxygen or the emergency kit with her for her initial assessment and treatment of the inmate. She should have made a medical assessment when she saw the inmate and, upon determining the need for an EKG, called the other RN and asked that she make the necessary preparations while she (Stithem) stayed with the inmate. (4) She left the inmate with two officers and went back to the hospital when she knew five nitroglycerin tablets had not helped the inmate and he was feeling pain starting to progress down his arm. (5) She was not able to read pertinent information, upon request on the telephone, to the consulting PA. (6) She was not able to run an EKG, which is a duty she should have received training in, or requested training in. (7) She failed to indicate in her chart entry that it was a "late entry." I agree with HCM Gray that RN Stithem's actions, and inactions, in this incident constitute misconduct. I recommend that appropriate corrective/disciplinary action be taken.

STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

MEMORANDUM

TO: Annette & Norma DATE: 4-25-95 3:00 Am

FROM: Kelly SUBJECT: Man down Chest Pain
3A - Mattson 724793

I was working on the 4th Floor ē Jeanette @ 2:20 AM when Dorothy called to say she had just come back from a man down for chest pain & needed my help with the EKG. I went downstairs & she was reading the EKG book. I asked her where the patient was - she said the officers were bringing him up. I wondered why she left a patient in cardiac pain with the officers on 3A & she on the 3rd floor. I assumed though, that the pt was on a gurney ē O2.

I heard a loud voice at stairway yelling to open door - 2:25 Am c/o Reed & c/o Muñoz were carrying patient up 3 flights of stairs from 3A. I asked why - they said Dorothy did not bring any equipment with her - I asked her & she said there was "no wheelchair" I felt alarmed (as I am previous ICU nurse) pt was gray, diaphoretic - NO O2 10/10 stated CP. Pt was very nervous, very tremulous/shivering stating his pain had "never been this bad". I told Dorothy to call Marty immediately that we needed to send him to Hospital via medics & 911.

I ~~pt~~ put on O2 mask 7L, vital signs taken, EKG done - on arrival BP 80/40 p50 CP 10/10 - I thought pt. was going to code since he stated his pain had been continuous since 1:10 Am & took 6 or 7 NTG SL ~~5~~ Relief. He called for man down help @ 2:00 Am (per pt) & did not arrive until 2:25. Pt was stabilized on 10/10 CP → 4/10 CP ē O2 NTG SL & Valium 10 mg po - I spoke to PA, called 911, spoke ē medics - told Dorothy to photocopy chart & get Valium for me, which was total assistance I received from her. When I would ask her where material copied for medics was she did not know. I would have liked more proactive assistance - it seemed as though I had to take over in this situation. I was off of floor from 2:25 - 3:15 Am & at this time Jeanette stated she needed assistance.

The patient also apologized to Dorothy in front of me for mad at her when he told her the had chest pain & she said What, what, what?

MATTSON, GERALD 3-28-46 724793

DATE 9/18/95 | TIME 9:00 Am | FACILITY WSR | UNIT 3A-64 | ALLERGIES

F/u on patient on chest pain that [illegible] Tdl + then angioplasty (balloon) was tried at the distal (R) coronary but failed so he's being tried on medical management - he states that he does get this chest pain still most sx. in the morning wake up + also on going upstairs but not on flat areas

* Also was schedule for a refraction but unfortunately was in the hosp at that time.

P- Advice to get in touch c counsellor + will discuss [illegible] for no stairs

PLAN RX

P/s. re-schedule c optometrist for refraction -

[illegible signature]

DATE 9-25 | TIME 2:25 Am | FACILITY WSR | UNIT 3A-66 | ALLERGIES NKA

S/o 49 y/o c ⊕ family Hx CP + ⊕ treadmill (only 6 min) c CP) 3 wks ago.

Pt states starting 1:10 Am - CP midsternum radiating (L) arm. Pt stated he took 6 NTG prior to calling for assistance @ 2:20 Am. Pt here 2:25 10/10 CP. EKG shows widened complex Q wave + wide QRS ST↑. O2 immediately 7L mask - CP 8/10 ↓ PA told we need to send pt 911 ~~[illegible]~~ Providence Colby campus. Pt shaking tremendously - difficulty getting EKG extreme nervousness. 2:35 Am 6/10 CP NTG + SL

2:45 CP 4/10 - still midsternal radiating (L) arm 911 here .. ON EKG cont ~~[illegible]~~

3:00 Am Paramedic inserted line en route pt transferred to Providence Hosp everett Colby cardiac in ALS 911 amb. in stable cond. A+O X3, color pink W+D - no longer pale + diaphoretic CP 4/10 pt states feeling improved. A. Cardiac insufficiency CP P. To ccu Kraynak

PLAN RX

c CP

Valium 10mg po now to Sesulad

Kraynak (VAL 10 po 2:30 P)

2:25 80/42 p50 10/10 cp

2:30 100/50 p63 8/10 cp

2:35 110/61 p84 6/10 cp

2:45 110/50 p52 4/10 cp

NTG + SL

MATTSON, GERALD 3-28-46 724793

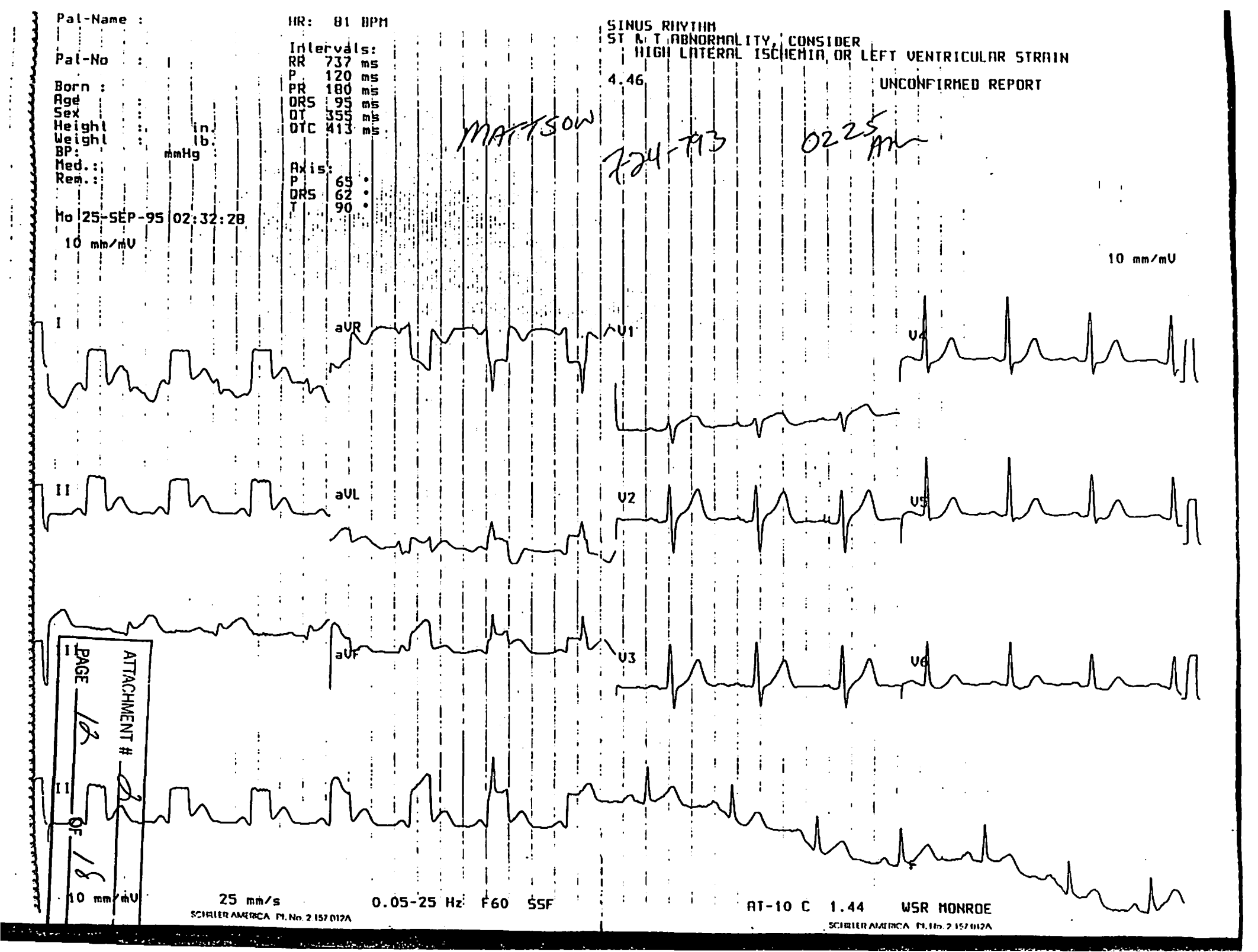
DATE | TIME | FACILITY | UNIT | ALLERGIES

PLAN RX

MATTSON, GERALD 3-28-46 724793

ATTACHMENT # 2

DOC 13-435 (REV. 8/94)


Pal-Name :
Pal-No :
Born :
Age :
Sex :
Height : in
Weight : lb
BP: mmHg
Med.:
Rem.:
Mo 25-SEP-95 02:32:28
10 mm/mV
HR: 81 BPM
Intervals:
RR 737 ms
P 120 ms
PR 180 ms
QRS 95 ms
QT 355 ms
QTC 413 ms
Axis:
P 65 °
QRS 62 °
T 90 °
SINUS RHYTHM
ST & T ABNORMALITY, CONSIDER
HIGH LATERAL ISCHEMIA OR LEFT VENTRICULAR STRAIN
4.46
UNCONFIRMED REPORT
MATTSON
724-713
0225 PM
10 mm/mV
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
II
ATTACHMENT # 2
PAGE 13 OF 16
10 mm/mV
25 mm/s
0.05-25 Hz F60 SSF
SCHILLER AMERICA PI. No. 2 157 012A
AT-10 C 1.44 WSR MONROE
SCHILLER AMERICA PI. No. 2 157 012A

CHASE RIVELAND
Secretary

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
WASHINGTON STATE REFORMATORY
P.O. Box [illegible] • Monroe, Washington 98272-0777

TO: WATCH 1 LIEUTENANT/ SERGEANT DATE: 09-26-95

FROM: OFFICER REED, C. (W-1) SUBJECT: INMATE MATTSON #724793

At approximately 2:13 a.m., on 09-25-95, I arrive with a wheelchair at cell 3A66. Inmate Mattson, #724793 was sitting on his bunk and holding his chest with both hands.

Officer Munoz stated that RN Stithem had been to the cell, had spoke with Inmate Mattson, and had then left to return to the 3rd. floor hospital.

Inmate Mattson was not able to stand, so he was lifted into the wheelchair by Officer Munoz and I.

When we arrived at the entrance of the upper Segregation area (adjacent the block 3 control booth) I felt that due to Inmate Mattson's shortness of breath and severe chest pains, that there was not enough time to safely transport Inmate Mattson via the block 3 elevator. Officer Munoz and I carried Inmate Mattson to the 3rd. floor hospital via the block 3 stairwell. We were met at the door by RN May, who immediately administered Oxygen to Inmate Mattson.

RN May stated to me that Inmate Mattson would require treatment at an outside hospital. At that time, approximately 2:15 a.m., I notified Lieutenant Ahlstedt of the pending outside hospital trip, and then left the 3rd. floor hospital, as ordered by Lieutenant Ahlstedt.

9-26-95

ATTACHMENT # 2
PAGE 13 OF 18

CHASE RIVELAND
Secretary

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
WASHINGTON STATE REFORMATORY
P.O. Box 777 • Monroe, Washington 98272-0777

TO: WATCH 1 SHIFT LIEUTENANT/ SERGEANT DATE: 09-25-95

FROM: OFFICER MUNOZ (W1) SUBJECT: INMATE MATTSON #724793

On 09-25-95, at approximately 2:00 a.m., I went to block 3 for formal count. As I entered Block 3, Officer Cook asked me to assist Officer Reimstadt in 3A Unit who is new Intermittent Officer. As I entered 3A, Officer Reimstadt was on the phone talking to Nurse Stithem regarding a medical emergency with Inmate Mattson # 724793, who was having chest pains. Nurse Stithem asked to talk to another Officer so Officer Reimstadt handed me the phone. I told Nurse Stithem that Inmate Mattson was declaring a medical emergency because he was having chest pains. Nurse Stithem stated that she didn't want to respond and find out that Inmate Mattson was only having heartburn. Nurse Stithem then stated that she would come down and check on the Inmate after I repeated that Inmate Mattson was having chest pains.

Officer Reimstadt and I then proceeded to 3A66. RN Stithem arrived at approximately 2:05a.m., without any medical equipment and spoke to Inmate Mattson. Inmate Mattson stated that he was having severe chest pains. Inmate Mattson repeated several times that they were severe chest pains. RN Stithim stated that she was going back to the 3rd floor hospital to get things ready, and that I was to bring Inmate Mattson to the 3rd floor hospital. RN Stithem then left Officer Reimstadt and myself with Inmate Mattson. At approximately 2:08 a.m., I requested that Officer Cook to call for a wheelchair.

Officer Reed arrived at approximately 2:13a.m., with a wheelchair. Inmate Mattson was lifted into the wheelchair because he was unable to stand.

Inmate Mattson was carried up the block 3 stairs to the 3rd floor hospital, where he was immediately met by RN May and given Oxygen. RN May stated that 911 needed to be notified.

At approximately 2:40 a.m., I left the 3rd floor hospital and returned to the shift office, in compliance of orders by Sergeant Kornegay.

EXHIBIT # 2
PAGE 14 OF 18

9-26-95

CHASE RIVELAND
Secretary

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
WASHINGTON STATE REFORMATORY
P.O. Box 777 • Monroe, Washington 98272-0777

SEP 1995
WASHINGTON STATE REFORMATORY
HEALTH SERVICES

TO: Capt. Evans

9-25-95

FROM: Sgt. R. Kornegay

Re: Mattson # 724793

At approximately 2:00am, 9-25-95, I recieved a radio call indicating there was an emergency in the 3-A unit, I called the cage, and was told by C.O. Cook, Mattson # 724793 was declaring a medical emergency due to chest pains. Cook said C.O. Munoz was on the scene, the nurse had been notified, but a wheelchair was needed to transport the inmate to the infirmary. I called C.O. Reed back from night patrol, and instructed him to take a wheel chair to 3-A, asap. R.N. Stithem arrived at approximately 2:05am, and requested we transport the inmate to the infirmary. According to C.O. Munoz, R.N. Stithem returned to the infirmary at approximately 2:07am, stating she would get things ready for the inmate. Up to this point, we received no indication this was a life or death situation. C.O. Reed arrived a few minutes later. He and C.O. Munoz assessed the situation, the inmate indicated he had taken 6 or 7 nitro pills with no relief, and he was in severe pain. C.O.'s Reed & Munoz took the initiative and decided Mattson needed immediate care. Rather than take the elevator, they physically carried Mattson up the back stairs to the infirmary. They sensed time was of the essence. I was told by R.N. May, their quick thinking saved Mattson's life. When I arrived for work today, R.N. May told me Mattson had a massive heart attack, and without Reed & Munoz taking the action they did, Mattson would not have survived. I believe Reed & Munoz should be commended for their accurate assessment of the situation, and the action they took. I would also like to request a gurney, and a wheelchair be placed in 3-A to save time in an emergency situation.

cc; Norma Gray
Kelly May

ATTACHMENT # 2
PAGE 15 OF 18

AMOS E REED
Secretary

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS

RECEIVED
SEP 2 9 1995
WASHINGTON STATE DEPARTMENT OF
HEALTH SERVICES UNIT

MEMORANDUM

TO: Norma Gray

DATE: 09-23-95

FROM: C/O R. Allis

SUBJECT: Inmate Morton #906181
3A-63, Medical Emergency

At approximately 1:12 A.M., on 09-23-95, inmate Morton, #906181 complained to the unit officer of chest pains declaring a medical Emergency. C/O Helmer notified the shift office and nurse D. Stithem. I responded to 3A unit to escort nurse Stithem to 3A-63.

At approximately 1:25 A.M. nurse Stithem arrived in 3A to assess I/M Morton. Nurse Stithem arrived without a stethoscope, blood pressure cuff, emergency kit, or oxygen. On medical emergency responses these items have been standard in the past.

Upon initial contact with I/M Morton, nurse Stithem appoligized for the time lapse because she had to take the Pharmacy keys up to the 4th floor. I/M Morton proceded to explain the nature of his complaint to nurse Stithem and she assessed the problem as indigestion. Nurse Stithem did say that there was no indication of heart problems on I/M Morton's medical records. Nurse Stithem again reiterated that it was probabaly only indigestion and checked I/M Morton's pulse.

Nurse Stithem told I/M Morton that he should take some Malox for his indegestion but if his pains persisted to notify the unit officer and she would come back.

This was the extent of this incident. This memo is for your information to deal with as you desire.

C/O R. Allis/ Watch I

R. Allis

ATTACHMENT # 2
PAGE 16 OF 18

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
MEMORANDUM

RECEIVED
OCT 0 4 1995
WASHINGTON STATE REFORMATORY
HEALTH SERVICES UNIT

CHASE RIVELAND
SECRETARY

DATE: 10-8-95

TO: Annette Felden RN III
Norma Gray HCM II

SUBJECT:

FROM: Kelly Mayfield

This note (copy enclosed) is not dated properly nor is late entry written. I was filing pt's op note today + noticed this entry. When pt was admitted 9-30-95 I read his chart at 11:00 Pm. The enclosed chart entry was not there then. It was also not there when I left 9-25-95 6 AM.

Kelly may RN

add Note: On the ECR I signed (annette asked me to sign as a witness regarding this (Thurs Oct 5th) I believe it stated that no note was written by this nurse.)

DOC 2-109 (11-89)

ATTACHMENT # 2
PAGE 17 OF 18

MATTSON, GERALD 3-28-46
724793

DATE	TIME	FACILITY	UNIT	ALLERGIES
9/25	3.	WSR	3A·66	NKA

PLAN RX

At approx [illegible] pt requested to see nurse when I arrived he stated he had left chest pain now beginning to go to left arm; that he had taken 5 [illegible] nitros ͞s relief. Also stated he had been angry re being woken by another IM @ 1A & thought the pain would go away ͞c the nitro. Color pale, no diaphoresis, Pres @ 84 radial. Brought to 3rd floor for EKG + O2, valium & nitro as noted above. Sent to Prov Everett per 9H [illegible] PA Semerad ͞c pain [illegible] + VSS @ 3 A. Conversing normally & no [illegible] [illegible] & nervous [illegible]

[signature] RN

DOC 13-435 (REV. 8/94)

PRIMARY ENCOUNTER REPORT

ATTACHMENT # 2

PAGE 18 OF 18