HEARING OFFICER, CAREER SERVICE BOARD
CITY AND COUNTY OF DENVER, COLORADO
Appeal No. A024-17

DECISION REVERSING 10-DAY SUSPENSION

JAMES JOHNSON, Appellant,

v.

DEPARTMENT OF SAFETY, DENVER SHERIFF'S DEPARTMENT,
and the City and County of Denver, a municipal corporation, Agency.

I. INTRODUCTION

The Appellant, Captain James Johnson, appeals his ten-day suspension from the Denver Sheriff's Department (Agency) assessed on April 19, 2017, for alleged violations of specified Career Service Rules and Agency regulations. A hearing concerning this appeal was conducted by Bruce A. Plotkin, Hearing Officer, on August 28 and 29, 2017. The Agency was represented by Assistant City Attorneys Shelby Felton and John Sauer, while the Appellant was represented by Daniel Foster, Esq. and Mallory Revel, Esq. of the law firm Foster Graham Milstein & Calisher, LLP. Agency's exhibits 1-34, and Appellant's exhibits A, B, D, I, Q, S, T, W, AA-CC, and EE-II were admitted. Civilian Review Administrator Shannon Elwell testified for the Agency. Appellant testified on his own behalf, and also presented the following witnesses: Deputy Smajo Civic, RN Monica Bisgard, RN Ashlee Allison, former Capt. Jeff Wood, and Sgt. Keri Adcock

II. ISSUES

The following issues were presented for appeal:

A. whether the Appellant violated any of the following Career Service Rules: 16-60 A; or 16-60 L., via Denver Sheriff's Department Rules and Regulations (RR) 1100.8.

B. if the Appellant violated one or more of the aforementioned Career Service Rules, whether the Agency's decision to suspend him for 10 days conformed to the purposes of discipline under CSR 16-20.

III. FINDINGS

James Johnson, has been an officer in the Denver Sheriff's Department for 24 years. His primary job duties, as are pertinent here, are "to provide safety and security for the community by ensuring care and custody of detainees by operating safe, secure, efficient and humane facilities that adhere to federal state and local laws." [Exh. 34]. At the time of the incident underlying this appeal, Johnson had been a Captain for less than two months and was the Watch Commander at Denver's downtown jail, known in the Agency as the Downtown Detention Center (DDC), meaning he was the highest-ranking officer overseeing that facility. In that capacity, Johnson was also responsible for the safety and security of inmates, being alert to and addressing current and potential issues affecting the DDC and, as is particularly pertinent here, responding to and overseeing actions by subordinate officers during critical incidents. [Exh. 33].

Housing unit 4D at the DDC is known as a special management unit. Dangerous and mentally impaired inmates there require the highest level of monitoring and care.

On November 11, 2015, 4D inmate Michael Marshall, after refusing his psychotropic medicine for several days, became unstable, tearing at his food, cramming it in his mouth, tearing up trash, smearing his feces, and pulling foam from his mattress. To the deputies who were instructing him to clean up his cell, Marshall appeared to be unable to comprehend them. He was allowed out of his cell in order for his cell to be cleaned, but aggressively approached another inmate and was unresponsive to deputies' instructions.

Deputies escorted Marshall to the nearby sally port where he could remain separated from other inmates while the deputies had his cell cleaned. They also placed a request for Marshall to be reclassified so that he would be moved to a "camera cell" where he could be more effectively monitored, and so that emergency medication, "e-meds," could be forcibly administered to address his symptoms.

While the reclassification was being processed, Marshall began pacing the sally port, strewing trash from a blanket he had carried with him from his cell. He refused multiple instructions to return to the bench and remain seated. He tried several times to walk past deputies toward the inmate common area. A deputy pushed Marshall in the chest to prevent him from leaving the sally port towards the corridor, and Marshall fell backward and down along a wall. At that point, other deputies who had been summoned and had been observing from just outside the sally port, entered to assist with controlling Marshall as he fell to the floor.[1] Five deputies had difficulty controlling Marshall on the floor, and one of them called for additional officer assistance.

Johnson heard the call for officer assistance and arrived shortly after. Johnson positioned himself on the wall opposite the door to the sally port, just inside of which five deputies were on the floor attempting to control Marshall, and just outside of which two sergeants were observing and engaging with the deputies. Marshall continued to kick and tried to stand up. Leg restraints were applied, but Marshall continued to struggle and resist all attempts to calm him down and to control him. [Exh. 2-6].

About one minute after Johnson's arrival, deputies began to control Marshall, and assisted him to a sitting position, but he suddenly became limp and unresponsive. [Exh. 1-5; Exh. 1-38; Exh. R-6; Exh. 32 at 18:35:42]. The deputies lowered him. Marshall vomited. Johnson approached the sally port to observe, and immediately ordered Sergeant Adcock to call for a medical emergency, even though a call had been placed before he arrived.[2] [Johnson testimony; Adcock testimony, Adcock cross-exam; Exh. 32 at 18:36:10]. Nursing staff began to arrive within 30 seconds after that call. In compliance with the Watch Commander Post Orders, Johnson returned to his prior position on the far wall, as two sergeants remained just outside the sally port, observing the deputies. [Exh. 32 at 18:36:12; see also Exh. 33].

As five nurses arrived, Marshall regained consciousness and immediately struggled again. Deputies again held Marshall down by his limbs, shoulder blade area and pelvis.

Registered Nurse Ashlee Allison took Marshall's vital signs which appeared to be stable. She checked his lungs and determined he had bronchial spasms, which she described as tightness as occurs during hard exercise or as a result of struggle or vomiting. Concerned about

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[1] The Agency deemed all deputies' reactions up to this point to be "reasonable, necessary and legitimate." [*see* Exh. 2 n. 4; Exh. 2-5].

[2] Johnson was aware of the earlier call but determined, under the circumstances, that the situation required more urgency. [Exh. 8-10].

possible aspiration of vomit, she asked the deputies to relieve any pressure on Marshall's back and when she looked up they had complied and were restraining Marshall only by his limbs. [Exh 2-8]. During that time, Johnson remained in the hallway outside the sally port, occasionally engaging in conversation with officers in the hallway, but otherwise observing in the direction of the sergeants who remained just outside the sally port observing their deputies.

Head Charge Nurse Monica Bisgard wrote down the vital signs as Allison called them out and asked Allison to return Marshall to an upright position and place him in a wheelchair in anticipation of taking his vital signs more effectively and to wheel him to the medical unit, but the officers, who were still trying to control Marshall, balked at placing him in an unrestrained wheelchair based on his combativeness and their concern for the safety of all present.

Sgt. Adcock called for a restraint chair. Before moving Marshall to the restraint chair, deputies placed a spit hood over his mouth to prevent Marshall from biting or excreting vomit onto responders. [Exh. 2-10].

While deputies secured the restraint chair and pulled it into the adjacent corridor, Marshall became unresponsive again. Allison used her stethoscope to listen to Marshall's heart, heard two beats then nothing. Deputies immediately removed the spit hood, removed the restraints and laid the unresponsive Marshall on the floor, where a deputy began performing CPR. Johnson ordered Sergeant Adcock to call for an ambulance and then left to begin making notifications as required by his post orders.

Johnson knew he was required as Watch Commander to make notifications under the current emergency circumstances. Since he was new to the position of Captain and Watch Commander, he retrieved the Agency's policy book to make sure he complied with his duties. He filled out a Substantial Risk of Death Form; assigned a scribe to take detailed notes of the incident; instructed deputies to secure Marshall's cell; alerted his Chief; had Denver Health Medical Center alerted to Marshall's arrival; and filled out an in-custody risk of death form, all in conformance with pertinent written protocols. After Marshall was taken out by the EMTs, Johnson continued to focus on notifications, securing the scene for the Denver Police Department, and notifying the peer support unit, also in compliance with protocol. [Exh. 2-14; Exh. R-8; Johnson testimony].

A contemplation of discipline meeting was held on March 31, 2017, which Johnson attended with his attorney, Daniel Foster. On April 19, 2017, the Agency served its notice of suspension on Johnson, signed by the decision-maker, Civil Review Administrator Shannon Elwell, [Exhibit 27]. The appeal followed timely on April 19, 2017.

IV. ANALYSIS

A. Jurisdiction and Review

Jurisdiction is proper under CSR 19-20, as the direct appeal of a suspension. I am required to conduct a *de novo* review, meaning to consider all the evidence as though no previous action had been taken. Turner v. Rossmiller, 532 P.2d 751 (Colo. App. 1975).

B. Burden and Standard of Proof

The Agency retains the burden of persuasion throughout the case to prove the Appellant violated one or more cited sections of the Career Service Rules, and to prove the degree of discipline complied with CSR 16-20. The standard by which the Agency must prove each violation is by a preponderance of the evidence.

C. Career Service Rule Violations

1. CSR 16-60 A. Neglect of Duty

Elwell failed to specify what duties Johnson failed to satisfy, other than his Captain classification and his temporary role as Watch Commander, both addressed under CSR 16-60 L., below. [*See* In re Gale, CSA 2-15, 5 (11/23/15), *aff'd* In re Gale, CSB 2-15 (7/21/16); *see also* In re Mitchell, CSB 57-13, 3 (11/7/14)]. Accordingly, no violation of this rule is found. [*See* In re Hernandez & Garegnani, CSA 25-17 & 26-17 (11/3/17)]

2. CSR 16-60 L. Failure to observe written departmental or agency regulations, policies or rules.

As it pertains to:

Denver Sheriff Departmental Rules and Regulations
RR 1100.8 – Failure to Supervise
Supervisors are required to fulfill all obligations, duties and responsibilities of their rank.

In its notice of discipline, the Agency claimed Appellant's conduct failed to satisfy two duties: Deputy Captain Class Specifications and Watch Commander Duties under Post Order TD001.1D.

Deputy Sheriff Captain Class Specifications

Elwell identified three sections of the Deputy Sheriff Captain Class Specifications she believed Johnson violated:

1. Provide work instruction and assistance to employees with different or unusual assignments.

In the notice of discipline, Elwell found Johnson was passive and lackadaisical. She specified Johnson (a) observed the incident from the corridor; (b) engaged in light conversation with subordinates; and (c) should have engaged with responding staff and more actively managed and supervised the scene, all deemed by Elwell to violate this section of his Captain Class Specification duties.

(a) Observed from corridor.

From Johnson's position on the wall, directly across from his subordinate sergeants Adcock and Moore, Johnson could view their actions and hear them, except when he turned away briefly. [Exh. 32]. Next, as seen in the video, Johnson approached closely to view the incident at three critical times. [*Id*.]. Former Captain Jeff Wood testified, credibly and without rebuttal, that Johnson's position was proper for a Captain in this situation because it allowed him to see the incident, supervise his sergeants, and also to stay out of the way of staff and equipment. [Wood testimony; *see also* re Wood's credibility, below]. Wood also noted when Johnson's view became blocked, he moved to have a better view. [Id.] The video also showed Johnson moving closer to observe as deputies and nursing staff began taking Marshall out of the restraint chair, and backing out of the way in anticipation of medical staff's arrival. [Exh. 32 at 18:51:45]. Those were not actions of an inattentive supervisor.

(b) Engaged in light conversation with subordinates.

In the notice of discipline, and at hearing, Elwell appeared to fault Johnson for engaging in light conversation with Sergeants. Elwell believed Johnson was discussing either unrelated events with Sergeants, or making light of the situation, based on his momentary smile or laugh. Johnson testified his interactions with Sergeants were related to the underlying incident, including calling for a medical emergency, calling for an ambulance, and how and when to follow protocol for an emerging critical incident. [Johnson testimony; Exh. R; Exh. 10-14; 10-23]. With a silent video, Johnson's denial, denial by the sergeants present, and no other evidence to affirm Elwell's assumptions, they remain unproven, or, to the extent seen on the recording, lack a significant connection to a rule violation.

(c) Failed to engage with responding staff

Elwell also denounced Johnson's failure to monitor and communicate with responding staff during the critical incident with Marshall. She cited the broadly-worded "provide work instruction and assist[ance to] employees with difficult and/or unusual assignments" from the classification specifications for the position of captain. [Exh. 34-2]. I infer "responding staff" includes deputies, sergeants, and nursing staff.

The Captain Class Specification states as follows.

Deputy Sheriff Captain (Career Service Authority Classification Specifications)

General Statement of Class Duties: Performs second level supervisor protective services work directing subordinate supervisors on an assigned shift and/or in a specialized unit in the Denver Sheriff Department.

[Exh. 34-1] [emphasis added].

Insofar as the notice of discipline asserted Johnson failed to communicate directly with deputies during a critical incident as a basis for discipline, that assertion lacks foundation based on the statement of duties, above. Moreover, Johnson logically testified that, had he directly involved himself in deputies' activities and choices, he would have been inappropriately usurping the role of his sergeants. [Johnson testimony; *see also* Wood testimony]. The chain of command structure in the Agency requires a separation of oversight, so that if Johnson saw the deputies engaging in improper restraint of Marshall, he would have directed his Sergeants to address it. [Johnson testimony; *see also* Wood testimony].

Other evidence supports that conclusion. Deputy Civic was one of the deputies who restrained Marshall. Civic testified deputies usually do not have conversations with supervisors during a critical incident, and that having a supervisor yelling directions would not have helped. Other officers who were present similarly found Johnson's level of communication was appropriate. [Exh. 1-29; Exh. 9-19; 9-55; Exh. 10-23; Adcock testimony].

The Agency failed to establish that Johnson failed to communicate, or inadequately communicated, with deputies. Next, insofar as the Agency claimed Johnson failed to communicate adequately with sergeants on scene, the following evidence was persuasive.

- Sergeants Adcock and Moore were present for the entire incident, Sergeants Newtown and Sergeant Petrie also arrived on scene. Sergeants Adcock and Moore actively managed the scene, while Newtown called for a restraint chair. Adcock, following Johnson's instruction, called for a medical emergency; and Moore ordered inmate

Marshall to stop resisting, while also monitoring the situation. [Exh. U-19-20; Exh. 10; Exh. 1]. None of the sergeants was disciplined for their actions.

- Sgt. Adcock's IA statement and testimony affirmed Johnson interacted appropriately with officers on scene, [Adcock testimony; Exh. 1-38, 42]

- in his IA interview, Sgt. Newtown affirmed Johnson managed the scene appropriately. [Exh. 10-22, 10-23].

- Former Captain Jeffery Wood's testimony was persuasive.[3] His shift overlapped that of Johnson at the time of the incident. He was the same rank and standing as Johnson, a Captain who was also a Watch Commander; and Wood was with the DSD for 32 years, 17 of which were as Captain and frequent Watch Commander. Wood had managed "thousands" of critical incidents. [Exh. FF-8]. His experience and familiarity with Johnson's duties made Wood distinctly qualified to opine as to Johnson's performance of the duties of the Captain (and performance of the Watch Commander position as described below).

Wood was on duty at the time of the incident and arrived at the scene when he overheard the call for officer assistance, but stepped away for a meeting when he saw Johnson had control of the incident. He returned when the call went out for a medical emergency. He observed Johnson's performance of his duties both times. He also witnessed the deputies and nurses controlling and assisting Marshall.

During his IA interview, Wood reviewed the entire video recording of the incident, after which he affirmed Johnson was "absolutely" performing his duties properly. He stated a captain's duty is to monitor the sergeants and not intervene with their direct supervision of deputies unless excessive force is used. "The Sergeant should handle the incident…you should let them do their job…the Sergeant would have to be grossly mishandling the incident [for me to take over the scene." [Wood testimony]. He stated, and I find it logical, that a captain is the on-scene "big picture person" who needs to step back to view the entire scene. Wood recalled Johnson conferred with Sgt. Adcock. He also recalled when Johnson's view was blocked, he changed position to retain his view of the incident, which, to Wood, indicated Johnson was fulfilling his duties as supervisor. [Wood testimony]. Having viewed the recording of the incident, Wood stated he would have made sure a medical emergency was called, that he would assign a scribe, and would have called for an ambulance. [Exh. FF-15, 16]. Johnson did all of that.

The video evidence confirms that, at times, Johnson remained at the far wall of the corridor, opposite the sally port door, and at times he maneuvered around other officers to have a closer view, conferred with Sergeants Adcock and Newtown, and gave directions to Adcock. [Exh. 32 at 18:36:10]. In view of the video evidence, testimony from officers who were present, and Wood's testimony, I conclude Johnson gave, contrary to Elwell's conclusion, a proper amount of guidance and direction to responding staff under his duties, and did not have unduly "limited communication" with responding staff. In addition, as stated above, none of the sergeants were disciplined for failure to supervise, which could have been some indication that Johnson failed to supervise his sergeants.

The same evidence contradicts the separate claim that Johnson "took a passive role in managing the incident" and should have "interacted with the deputies in a more active way…"

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[3] The Agency alleged Wood was not credible because he had been under investigation for excessive use of force and dishonesty, however the investigation was never completed and no findings entered, making the allegations a nullity. It was apparent Wood was not particularly fond of the Agency at the time of his retirement; however, his expertise in the duties of a Captain and Watch Commander were unassailed, and aside from the Agency's attempt to discredit Wood' general credibility, it offered no rebuttal to Wood' statements regarding the proper role for a Captain and Watch Commander during a critical incident.

First, this claim presumes Johnson was tasked with a responsibility to be involved in a hands-on manner. The evidence, above, indicates it is the on-scene sergeants who had that responsibility and that Johnson fulfilled his obligation to observe whether the sergeants were properly monitoring their charges. As was stated above, Elwell had no issue with the conduct of any of the sergeants. Second, as stated above, it is the sergeants, and not Johnson's role to interact with the deputies on scene. That Johnson may not have been aware Marshall vomited now it occurred, as denounced by Elwell, is not a failing of the Captain or Watch Commander position. That immediate observation also falls within the purview of the sergeants' duties. As Johnson and Wood testified, that extent of observation would have required Johnson to insert himself into a very crowded scene and thereby interfered with deputies and nurses alike. Such interference could have opened Johnson to criticism for interfering with the same responders he was charged with overseeing. [Johnson testimony; Wood testimony].

Next, as regards the allegations concerning Johnson's interaction with responding medical staff, Elwell's allegations were highly subjective as to what extent Johnson "should have communicated with medical staff;" "manag[ed] the situation;" or "appl[ied] supervisory principles and practices," since no particular authority was cited, I reject the inferred offer to impute any.

During a medical emergency, as this clearly was, the most senior officer on site – Johnson - is responsible for the safety of the inmate, nurses, and the officers equally. The senior-most nurse on site is responsible for the medical side of the emergency. If the two responsibilities conflict, the safety of the nurses and officers take precedence over the medical emergency of the inmate. This is true logically as well as officially. [Exh. II at 4001.00].[4] Wood's testimony was equally persuasive. He stated medical and security functions are separate and security concerns override medical.

Also regarding Johnson's interactions with medical staff, Elwell claimed Johnson failed <u>to</u> ascertain the extent of the medical emergency, i.e. that Marshall vomited, and therefore failed to interact with medical staff regarding that development. That conclusion is contrary to the evidence. Almost immediately after Johnson arrived, and Marshall became unconscious, Johnson approached, looked in, and immediately ordered a medical emergency call. [Johnson testimony; Adcock testimony; Exh. 24-13]. Johnson also asked whether Marshall's chest was rising and falling, instructed the call for an ambulance, and made all required emergency notifications. [DO 4002.00]. Johnson did not consider carrying Marshall to the medical unit or consider alternate modes to transport him there, as suggested by Elwell, since he learned nurses were waiting for e-meds to arrive, [Exh. 24-14], which would be administered there in the corridor, following which Marshall would be transported directly to the hospital.

In summary, testimony from those present, the video evidence, and testimony from former Captain Wood rebut Elwell's claim that Johnson failed to communicate or inadequately communicated with staff in violation of DO 1100.8. Elwell's criticism of Johnson's "lackadaisical" appearance is just that: a matter of appearance, and not substantively in violation of authority.

[4] Since an inmate who is lashing out during a medical emergency could well inflict harm on those trying to help him, it is the duty of the officers to protect not only themselves, but the medical staff who are attempting to assist the inmate. It follows that the duty to protect responders could require – even at the risk of aspiration - holding down the head of an inmate who is vomiting if responders are in danger of even an unintentional assault. Moreover, it seems evident such an inmate may need to be restrained in order to administer emergency medication.

2. Formulate tactical approaches to pending medical crises

In her 2nd claim related to the Captain Class Specifications, Elwell found Johnson failed to formulate a tactical approach to potential crisis situations, which derived from his duties as a Captain. [Exh. 34].

The reference to "formulating tactical approaches to potential crisis situations" does not apply, as this was not a potential crisis, but an actual critical incident for which there were protocols and which Johnson applied as found below.

3. Apply problem-solving techniques

The third violation of the Captain Class Specifications alleged by Elwell was that Johnson failed to "apply problem-solving techniques to the incident, including a failure to identify the problem, exercise sound reasoning, provide alternative solutions, and distinguish between relevant and not relevant information."

This reference derives from the minimum qualifications for a Captain [Exh. 34-3]. I assume the Agency would not have qualified Captain Johnson for his current rank, awarded less than two months earlier, had he not demonstrated these minimum qualification. Stated another way, these qualities are prerequisite to apply for the rank of Captain, not a performance standard after the rank is attained. As such, this prerequisite fails to provide an enforceable standard of conduct.

Watch Commander Duties

Insofar as the Agency's claims related to Johnson's duties as a Watch Commander, it is helpful to begin with the only pertinent language in the Watch Commander Post Order that relates to this appeal.

DENVER SHERIFF DEPARTMENT
WATCH COMMANDER
POST ORDER TD001.1D

Critical and Other Incidents

Watch Commanders are expected to respond to critical incident alarms, and to manage and document the incident(s) according to all Post Orders, Department Orders, and Policies. Watch Commanders shall complete a cover letter report in TAG on all critical incidents.

Details of incidents involving serious injury, serious illness, or death shall be reported promptly to the Major of Operations, who will coordinate notifications to appropriate individuals, including notifying the next of kin.

[Exh. 33-4].

The only direct reference to the duties of a watch commander In the Agency's notice of discipline claimed "[a]s a Watch Commander, Captain Johnson was responsible for, among other things, ensuring the safety and security of the inmates in the DDC, and being alerted to and addressing current or potential issues affecting the same." That language does not derive from the Watch Commander Post Order, which is silent as to those duties. The only other basis for "duties" allegedly violated by Johnson derive from the specifications under the classification

of Captain which was addressed above, and were fulfilled by Johnson. No evidence addressed whether Johnson "reported promptly to the Major of Operations," thus, to the extent it was a claim, it remained unproven.

Other duties related to the Watch Commander post

During cross examination, Elwell supposed the incident was most likely a Type 1, Type 2, or Type 3 Incident under DO 4002.00 Emergency Classifications, which state as follows.

> **Type 1 – Critical incidents that are natural or manmade events, or any other occurrence of unusual or severe nature which causes or threatens to cause the loss of life or injury to persons and/or severe property damage. Such situations cannot be safely controlled by the use of personnel on duty without great risk of serious injury. In Type 1 incidents, it is the responsibility of the ranking supervisor on scene to assess the situation and decide what actions will be taken.**

Elwell testified this classification is most appropriately used for natural disasters or prison riots, and therefore I find this subsection inapplicable based on the Agency's evidence.

> **Type 2 – Major actions which place the lives and safety of staff, or others in serious danger and cannot be safely controlled by the use of personnel on duty. In Type 2 incidents, it is the responsibility of the ranking supervisor on scene to assess the situation and decide what actions will be taken.**

Elwell testified this classification is also most appropriately used for a fire or riot, not a medical emergency involving a single inmate. Based on this representation, I find this subsection inapplicable.

> **Type 3 – Actions that cause a serious stoppage or disruption to routine operations. Such situations can be safely handled by personnel on duty along with outside assistance such as local law enforcement, paramedics, and/or fire department.**

Elwell stated Type 3 is most likely the correct classification for Marshall's situation, as it was handled by in-house medical staff and required only a paramedic from outside. Under 4002.00, the required protocol for the Watch Commander under this emergency classification includes seven actions.

1. **Notify Control Center Personnel immediately.**
2. **Respond to the affected area if possible and gather information about the incident.**
3. **Remove members of the public and non-essential personnel from the immediate area.**
4. **Assign a scribe, as necessary.**
5. **Contain the threat and establish a secure perimeter.**
6. **Call additional staff within the facility to maintain control, if necessary.**
7. **The necessary outside agency shall be contacted.**

Johnson testified, and Elwell affirmed, that Johnson accomplished each of these requirements during the incident. Because Johnson followed the only applicable section of Watch Commander duties pertinent to this incident, he did not fail to meet the requirements of his Watch Commander duties, and no violation was proven thereunder. Consequently, no violation of CSR 16-60 L. was proven.

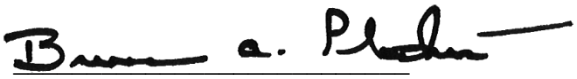
The Agency failed to prove Johnson violated any of the rules or orders alleged in its notice of discipline. The failure to prove any violation requires a reversal of discipline.

Had the Agency proven any violation, Johnson's experience as Captain of less than two months, this being his first critical incident, his detailed compliance with emergency protocols during the critical incident, and his highly positive work history likely would have required a significantly mitigated penalty, rather than the presumptive level assessed by Elwell.

V. ORDER

The Agency's 10-day suspension of Captain Johnson's employment, beginning May 7, 2017 to May 16, 2017, is reversed, and back pay and benefits shall be restored accordingly.

DONE November 6, 2017.



Bruce A. Plotkin
Hearing Officer
Career Service Board

NOTICE OF RIGHT TO FILE PETITION FOR REVIEW

You may petition the Career Service Board for review of this decision, in accordance with the requirements of CSR § 19-60 et seq., within fifteen calendar days after the date of mailing of the Hearing Officer's decision, as stated in the decision's certificate of delivery. See Career Service Rules at www.denvergov.org/csa. **All petitions for review must be filed with the:**

Career Service Board
c/o OHR Executive Director's Office
201 W. Colfax Avenue, Dept. 412, 4th Floor
Denver, CO 80202
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Career Service Hearing Office
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AND opposing parties or their representatives, if any.