SUMMARY
November 4, 2021

2021COA135

No. 19CA2041, *Johnson v. CSA* — Municipal Law — City and County of Denver — Charter of the City and County of Denver — Career Service Board — Career Service Rules — Code of Conduct and Discipline

The Career Service Personnel System established by Denver's City Charter authorizes the Career Service Authority Board (Board) to promulgate the Denver Career Service Rules (CSR) specifying the grounds for discipline and the disciplinary process for City and County of Denver employees. A division of the court of appeals interprets the CSR governing the Board's review of a hearing officer's decision. The majority concludes that the Board has authority to (1) come to a different ultimate conclusion of law based on the same existing facts without running afoul of CSR 21-21(D) (insufficient evidence) and (2) reverse a hearing officer's decision that would establish precedent beyond the existing appeal under

CSR 21-21(C) (policy-setting precedent). Under the CSR, either singularly or in combination, the division affirms the Board's reversal of the hearing officer's decision.

The dissent concludes that the Board reversibly erred by misconstruing the hearing officer's evidentiary factual findings as ultimate facts that the Board could set aside. The dissent also directs attention to the need for clarity in the distinction between evidentiary facts and ultimate facts. *See Lawley v. Dep't of Higher Educ.*, 36 P.3d 1239, 1245 (Colo. 2001) (recognizing that the distinction between evidentiary facts and ultimate conclusions of fact is not always clear).

COLORADO COURT OF APPEALS **2021COA135**

Court of Appeals No. 19CA2041
City and County of Denver District Court No. 19CV31002
Honorable Michael A. Martinez, Judge

James Johnson,

Plaintiff-Appellant,

v.

Department of Safety for the City and County of Denver, Colorado,

Defendant-Appellee.

ORDER AFFIRMED

Division III
Opinion by JUDGE JOHNSON
Freyre, J., concurs
Furman, J., dissents

Announced November 4, 2021

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Kristin M. Bronson, City Attorney, Shelby A. Felton, Assistant City Attorney, Denver, Colorado, for Defendant-Appellee

¶ 1 As part of the Career Service Personnel System established by Denver's City Charter, the Career Service Authority Board of the City and County of Denver (Board) is authorized to promulgate rules to enforce and oversee the merit-based personnel system. Denver City Charter § 9.1.1. Part of the Career Service Rules (CSR), CSR 16 "titled 'Code of Conduct and Discipline,' specifies the rules, grounds for discipline, and disciplinary process for City and County of Denver employees." *Roybal v. City & Cnty. of Denver*, 2019 COA 8, ¶ 16.

¶ 2 This case requires us to examine the CSR in the context of a disciplinary proceeding of Captain James Johnson (Captain Johnson), who was the watch commander at the Denver Downtown Detention Center (Detention Center) when a use of force incident occurred that ultimately resulted in the death of an inmate. The Department of Safety for the City and County of Denver brought an action against Captain Johnson in which the civilian review administrator of that agency initially determined that he neglected his duties when he failed to supervise the incident. Although a hearing officer reversed the initial decision, on review, the Board

reversed the hearing officer and suspended Captain Johnson for ten days.

¶ 3 As part of our review of the CSR, we look specifically at the rules that govern the Board's review of a hearing officer's decision. The Board is authorized to reverse a hearing officer's decision based on any one of the following:

> (B) Erroneous interpretation of applicable authority: The Board may reverse a decision based on an erroneous interpretation of any applicable legal authority. A Hearing Officer's interpretation of applicable legal authority is subject to de novo review.
>
> (C) Policy-setting precedent: The Hearing Officer's decision is of a precedential nature involving policy considerations that may have effect beyond the appeal at hand.
>
> (D) Insufficient evidence: The Hearing Officer's decision is not supported by the evidence. The Board may only reverse a decision on this ground if the Hearing Officer's decision is clearly erroneous.

CSR 21-21(B)-(D). Other divisions of this court have analyzed these rules to review Board decisions. *See, e.g.*, *Khelik v. City & Cnty. of Denver*, 2016 COA 55, ¶¶ 23-26. But this case highlights the Board's authority to (1) come to a different ultimate conclusion of law based on the same existing facts without running afoul of CSR

21-21(D) (insufficient evidence) and (2) reverse a hearing officer's decision that would establish precedent beyond the existing appeal under CSR 21-21(C) (policy-setting precedent). Under the CSR, above-mentioned rules, we affirm the Board's reversal of the hearing officer's decision.

I. Background

¶ 4 On November 11, 2015, Captain Johnson was the on-duty watch commander at the Detention Center. This meant he was the highest ranking officer overseeing the Detention Center. At that time, Captain Johnson had held that position for less than two months.

¶ 5 That evening, an inmate at the Detention Center was involved in an incident with several deputies from the Denver Sheriff's Department. The inmate had refused his psychotropic medications for several days and had become unstable. The inmate was "tearing at his food, cramming it in his mouth, tearing up trash, smearing his feces, and pulling foam from his mattress." As a result of these actions, the deputies removed the inmate and placed him in a sally port (holding cell) to wait while his cell was cleaned. The inmate became agitated and tried to leave the sally port, which resulted in

a physical altercation with the deputies. During the altercation, the inmate was pushed in the chest and fell backward along a wall to the ground. The deputies then called for additional assistance.

¶ 6 Some of the subsequent events were captured on surveillance video without audio. The camera view was of the hallway outside of the particular sally port where the inmate had been housed.

¶ 7 The surveillance video shows Captain Johnson arriving at the scene along with five other deputies responding to the call for assistance. He positioned himself on the wall opposite the door to the sally port. Captain Johnson remained leaning on the wall for the majority of the incident, but, at times, walked off camera into another room.

¶ 8 After Captain Johnson arrived, off camera the inmate continued to resist the deputies within the sally port. The deputies eventually controlled the inmate and placed him in a sitting position. At this point, the inmate vomited and became limp and unresponsive. Captain Johnson then ordered a sergeant to call for a medical emergency.

¶ 9 Nurses arrived to attend to the inmate, who remained off camera in the sally port. The inmate regained consciousness and

started struggling again. One of the deputies restrained the inmate's ankles with "pain compliance devices," which again caused the inmate to stop resisting. Two of the nurses saw the inmate vomit again, and one of them asked a deputy to relax his hold on the inmate's neck out of concern that the inmate would accidentally breathe fluid into his lungs. One of the nurses then requested that the inmate be evaluated for breath sounds, which revealed that the inmate was experiencing a bronchial spasm.

¶ 10 A sergeant called for a restraint chair to be brought in so that the inmate could sit upright while also remaining under control. The inmate was placed in the chair, a spit hood was placed over the inmate's mouth to prevent him from biting or vomiting, and a nurse detected a heartbeat, which then stopped. At this point, the inmate became visible on the video, as he was rolled out of the sally port into the hallway in the restraint chair. When the inmate became nonresponsive again, the deputies removed him from the restraint chair onto the floor of the hallway, they removed the spit hood, and two deputies performed CPR. Shortly thereafter, Captain Johnson ordered that the paramedics be called. The inmate was taken to the hospital where he died nine days later.

¶ 11 In April 2017, after reviewing the November 11, 2015, incident at the Detention Center, the Denver Department of Safety's Civilian Review Administrator Shannon Elwell (the Administrator) suspended Captain Johnson without pay for ten days for violations of CSR 16-28(A) (neglect of duty); and CSR 16-28(R) (failure to observe written departmental or agency regulations, policies, or rules). The latter rule violation pertained to failure to supervise under Denver Sheriff's Department, *Revised Rules and Regulations, in Discipline Handbook: Conduct Principles and Disciplinary Guidelines* app. F, 1100.8 (updated Oct. 1, 2021), https://perma.cc/LN6S-PUBU (Regulation 1100.8).[1] Regulation 1100.8 provides that "[s]upervisors are required to fulfill all obligations, duties and responsibilities of their rank."

[1] We refer to the latest version of the rules and regulations, as the relevant language pertinent to this appeal has not changed. We note, however, that the versions of the Career Service Rules in effect from 2013 to 2016 were renumbered, with language from some rules consolidated. The parties do not dispute, and our reading of the rules confirms, that the substance of the language did not change. *Compare* City and County of Denver, *Career Service Rules* 16-28(A), (R) (updated June 22, 2018), *with* City and County of Denver, *Career Service Rules* 16-60(A), (B), (L) (updated Jan. 7, 2013).

¶ 12 Captain Johnson appealed the Administrator's determination to the Career Service Authority (CSA) Hearing Office. A hearing officer conducted a two-day hearing, where Captain Johnson — through counsel —presented evidence and testimony from various personnel involved in the incident. The hearing officer reversed Johnson's ten-day suspension, finding that his alleged violations of CSR 16-28(A) and 16-28(R) and Regulation 1100.8 were not supported by a preponderance of the evidence.

¶ 13 The City of Denver appealed to the Board, claiming that the hearing officer erroneously interpreted the rules, set improper policy precedent, and relied on insufficient evidence. The Board reversed, agreeing with the City's arguments. Ultimately, the Board concluded that Captain Johnson did "virtually nothing during a crisis situation" and that he "committed the rules violations as charged."

¶ 14 Captain Johnson timely appealed the Board's decision to the Denver District Court pursuant to C.R.C.P. 106(a)(4). The district court affirmed the Board's decision.

¶ 15 On appeal, Captain Johnson contends the Board erred because it (1) substituted its own findings of fact when it overturned

the decision of the hearing officer; (2) abused its discretion when it overturned the decision of the hearing officer by dismissing the testimony of retired Captain Jeff Wood; and (3) determined he violated CSR 16 based on an incorrect interpretation of the rule.

II. Standard of Review

¶ 16 C.R.C.P. 106(a)(4) authorizes a district court to review the decision made by "any governmental body or officer or any lower judicial body exercising judicial or quasi-judicial functions." We review the agency's decision de novo. *Roybal*, ¶ 9. Consequently, we review the decision of the administrative body itself, and not that of the district court. *Id.* We will affirm the administrative body's decision unless "the governmental entity exceeded its jurisdiction or abused its discretion, which occurs if the body misapplied the law or no competent evidence supports its decision." *Whitelaw v. Denver City Council*, 2017 COA 47, ¶ 8; *see also* C.R.C.P. 106(a)(4).

¶ 17 The lack of competent evidence "means that the governmental body's decision is 'so devoid of evidentiary support that it can only be explained as an arbitrary and capricious exercise of authority.'" *Canyon Area Residents for the Env't v. Bd. of Cnty. Comm'rs*, 172

P.3d 905, 907 (Colo. App. 2006) (quoting *Bd. of Cnty. Comm'rs v. O'Dell*, 920 P.2d 48, 50 (Colo. 1996)).

¶ 18 Competent evidence is the same as substantial evidence. *City of Colorado Springs v. Givan*, 897 P.2d 753, 756 (Colo. 1995). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* (quoting *Colo. Mun. League v. Mountain States Tel.*, 759 P.2d 40, 44 (Colo. 1988)).

¶ 19 "[A]dministrative proceedings are accorded a presumption of validity and all reasonable doubts as to the correctness of administrative rulings must be resolved in favor of the agency." *Van Sickle v. Boyes*, 797 P.2d 1267, 1272 (Colo. 1990). We will not weigh the evidence or substitute our judgment for that of the administrative body. *Kruse v. Town of Castle Rock*, 192 P.3d 591, 601 (Colo. App. 2008).

III. Substitution of Findings

¶ 20 Captain Johnson contends that the Board improperly engaged in its own factfinding. We disagree.

A. Applicable Law

¶ 21 The Board's review of a hearing officer's decision is limited by CSR 21. As relevant here, "[t]he Board may only reverse a decision [for insufficient evidence] if the Hearing Officer's decision is clearly erroneous." CSR 21-21(D). In referring specifically to the hearing officer's "decision," CSR 21-21(D) authorizes the Board to review the hearing officer's ultimate conclusions of fact, rather than just evidentiary findings of fact.

¶ 22 Generally, "evidentiary facts are the detailed factual or historical findings upon which a legal determination rests." *State Bd. of Med. Exam'rs v. McCroskey*, 880 P.2d 1188, 1193 (Colo. 1994). "When conflicting testimony is presented in an administrative hearing, the credibility of witnesses and the weight to be given their testimony are decisions within the province of the agency." *Colo. Div. of Revenue v. Lounsbury*, 743 P.2d 23, 26 (Colo. 1987). Evidentiary findings are binding on the administrative body if they are supported by substantial evidence or, as in this case, are not clearly erroneous. CSR 21-21(D); *see also Nixon v. City & Cnty. of Denver*, 2014 COA 172, ¶ 21.

¶ 23 Conversely, "findings of ultimate fact involve a conclusion of law, or at least a mixed question of law and fact, and settle the rights and liabilities of the parties." *McCroskey*, 880 P.2d at 1193; *see also Nixon*, ¶ 22 (An ultimate conclusion of fact "may be, and usually is, mixed with ideas of law or policy, and has been characterized as a conclusion of law, or at least a determination of a mixed question of law and fact."). A reviewing agency is not bound by a hearing officer's ultimate conclusions of fact. *See Nixon*, ¶¶ 19-24; *see also Woods v. City & Cnty. of Denver*, 122 P.3d 1050, 1053 (Colo. App. 2005).

¶ 24 Although evidentiary findings of fact and ultimate conclusions of fact are terms of art borrowed from the Colorado Administrative Procedure Act, *see* § 24-4-105(15)(b), C.R.S. 2021, we agree with other divisions of this court that have concluded there is no reason why these standards of review are not equally applicable to review an administrative decision under C.R.C.P. 106(a)(4). *See Nixon*, ¶¶ 19-23; *Woods*, 122 P.3d at 1053; *Vukovich v. Civ. Serv. Comm'n*, 832 P.2d 1126, 1128 (Colo. App. 1992).

B. Analysis

¶ 25 Captain Johnson argues that the Board improperly conducted factual findings in three areas involving whether he (1) improperly supervised his staff by formulating a tactical plan; (2) was aware that an initial medical emergency call had been made; and (3) interacted with his sergeants and medical staff in the sally port.

1. Lack of Supervision — Failure to Formulate a Tactical Plan

¶ 26 Captain Johnson contends that the Board's finding that he failed to supervise his staff is a finding of fact, not an ultimate conclusion of law. But the district court properly reasoned that, "[c]ontrary to [Captain Johnson's] assertion, the issue of whether [his] conduct during the incident was sufficient to satisfy his duties as Captain is not a factual finding to which the Board is necessarily bound, but rather is an ultimate finding over which the Board can exercise discretion."

¶ 27 The Board determined that "the record of this case demonstrated that [Captain Johnson] was not able to articulate a tactical approach, or any type of plan whatsoever, which addressed the exigent circumstances presented by the situation at hand." The Board then added that

> the record reflects that [Captain Johnson] did not know what his subordinates had planned, but that he had made incorrect assumptions about what the plan was (having failed to communicate with any subordinate regarding any plan or course of action), and he failed to provide a plan or direct any course of action to those dealing directly with the emergency.

The Board merely reached a different ultimate conclusion of fact from the same underlying evidentiary facts. *See Khelik*, ¶ 13 ("An action by an administrative agency is not arbitrary or an abuse of discretion when the reasonableness of the agency's action is open to a fair difference of opinion, or when there is room for more than one opinion."). The Board reviewed the evidence and had a difference of opinion with the hearing officer. In the Board's opinion, Captain Johnson "did virtually nothing during a crisis situation."

¶ 28 To be sure, the Administrator could have testified at the hearing in more detail about what actions, in her view, Captain Johnson *should* have performed differently to satisfy the performance standards for captain. For instance, the Administrator was equivocal when asked where Captain Johnson should have stood, and how he should have more effectively managed the incident. But the Board's opinion is supported by competent

evidence in the record aside from the Administrator's testimony. *Whitelaw*, ¶ 8. Indeed, the Board accepted the evidentiary findings that Captain Johnson was present, called for a medical emergency, and, at times, moved closer to the sally port to observe. Nonetheless, the Board ultimately determined, with record support, that Captain Johnson's presence in the sally port hallway during the medical emergency was insufficient; he should have taken a more active role in the events and should have articulated a clear response plan for his subordinates.

¶ 29 For example, there was inconsistent testimony regarding the existence of a plan to treat the inmate after he stopped struggling. Some of the officers thought that they would walk the inmate out of the sally port to the medical clinic to administer the psychotic medications, while the nurses intended to administer the medications where the inmate was located. And yet, Captain Johnson thought the plan was to place the inmate in a restraint chair to take him to the medical clinic. Some of the officers — including Captain Johnson himself — were unaware of the inmate's breathing difficulties, and Captain Johnson was unaware of the

medical staff's initial assessment of the inmate, or that the inmate had vomited a second time.

¶ 30 Likewise, there was evidence that, although Captain Johnson was present and monitoring radio channels, he could not see within the sally port himself to supervise his staff. Indeed, the nurses were concerned that the inmate would accidentally breathe fluid into his lungs after vomiting a second time, so they directed Deputy Bret Garegnani (Deputy Garegnani) to relax his hold on the inmate and requested that someone check the inmate's breathing. But the officers were unaware of the request to keep pressure off the inmate's back, as some officers claimed they did not hear or recall what the nurses had said. If the sergeants did not know or hear what was being directed by the nurses, it was equally true that Captain Johnson did not know either. Thus, there was competent evidence in the record supporting the Board's conclusion that Johnson's mere presence and radio communication were insufficient to formulate an overall plan for the incident.

¶ 31 In support of its conclusion that the Board engaged in factfinding, the dissent points to the fact that Denver Sheriff's Department classifies a medical situation with an inmate as a "Type

3" situation, which did not require Captain Johnson to be physically involved in a manner to overstep the actions of the medical staff or his sergeants. Instead, he "articulated his tactical approach" by being present in the affected area, listening to radio communications, directing that a medical emergency be called, ruling out options, and summoning the ambulance once it was determined the inmate was not breathing. *Infra*, ¶ 161. But based on the discrepancies in the testimony, as highlighted above, we are unpersuaded that the Board engaged in factfinding in reaching its ultimate conclusion that Captain Johnson failed to supervise his staff.

2. Emergency Call

¶ 32 Captain Johnson claims the Board engaged in factfinding about his purported lack of knowledge that a prior emergency call had been made. Captain Johnson points to the hearing officer's footnote saying that he was aware of the prior call based on his testimony, as well as testimony of other personnel, such as Sergeant Keri Adcock (Sergeant Adcock), who testified Captain Johnson's presence at the scene may have "sped things up." True, the Board did not explain why it deviated from the hearing officer's

factual finding on this point. But Sergeant Adcock did not testify specifically as to Captain Johnson's knowledge of the prior emergency call and apparently was unaware that Deputy Garegnani admitted to making the initial call. Thus, there was no corroborating testimony from other witnesses who actually either saw Captain Johnson make the prior emergency call or knew that he was aware of the call. And there is support in the record indicating that Deputy Garegnani made the initial emergency call, and that Captain Johnson was unaware of that call. Thus, given the totality of the circumstances as evidenced in the record, Captain Johnson's knowledge of the prior call was not essential to the Board's ultimate conclusions.

¶ 33 The Board determined that by standing by the sally port and failing to provide leadership, Captain Johnson failed to develop and communicate a plan, and made incorrect assumptions about what his subordinates had planned. Even assuming the Board relied on Captain Johnson's lack of awareness of the initial medical emergency call, we still cannot say that the Board engaged in factfinding or set aside the facts of the hearing officer under CSR 21-21(D) in reaching its ultimate conclusion of law.

3. Interactions with Staff in the Sally Port

¶ 34 Captain Johnson contends that contrary to the Board's factual finding, he interacted with personnel in the sally port. While the surveillance video did show that Captain Johnson was present in the hallway of the sally port, there is no indication that Captain Johnson *physically* interacted with anyone in or entered the sally port itself. Even though Captain Johnson claims he interacted with staff or could hear the activity over the radio and moved closer to the sally port, the fact remains he stayed outside so he could have missed crucial information from personal observation of the unfolding events. His claim that he heard what was occurring on the radio was also belied by the inconsistent testimony of what certain personnel knew or did not know during the incident, as discussed above. And given that much of the events leading up to the inmate's placement in the restraint chair and later need for CPR occurred in the sally port off camera, the Board's factual conclusion that "[Captain Johnson] never left his position along the wall until the situation was, for all intents and purposes, over" is not clearly erroneous.

¶ 35 Thus, the Board's decision was supported by competent evidence and will not be disturbed. CSR 21-21(D).

IV. Retired Captain Jeff Wood's Testimony

¶ 36 Captain Johnson argues that the Board erred when it dismissed the testimony of retired Captain Jeff Wood (Captain Wood). We disagree.

A. Applicable Law

¶ 37 CRE 701 provides that lay witness testimony

> is limited to those opinions or inferences which are (a) rationally based on the perception of the witness, (b) helpful to a clear understanding of the witness' testimony or the determination of a fact in issue, and (c) not based on scientific, technical, or other specialized knowledge within the scope of Rule 702.

Additionally, CRE 704 provides that "[t]estimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact."

¶ 38 The rules of evidence are not applied as strictly in administrative hearings. CSR 19-50(A) ("The Hearing Officer shall conduct the hearing in as informal a manner as is consistent with a fair, efficient, and speedy presentation of the appeal. Whether and

how the Colorado Rules of Evidence shall be applied lies within the discretion of the Hearing Officer."). Regardless, expert witnesses may not testify as to ultimate conclusions of law. *Specht v. Jensen*, 853 F.2d 805 (10th Cir. 1988); *see also Quintana v. City of Westminster*, 8 P.3d 527, 530 (Colo. App. 2000) ("[A]n expert may not usurp the function of the court by expressing an opinion of the applicable law or legal standards.").

B. Analysis

¶ 39 The Board acted within its discretion to reject retired Captain Wood's testimony on the basis that (1) he was not present for the entire incident and (2) his testimony was improper policy-setting precedent.

¶ 40 Captain Wood, another captain whose shift overlapped briefly with Captain Johnson's at the time of the incident, testified extensively at the hearing about his observations of Captain Johnson's conduct. The hearing officer found retired Captain Wood to be credible, determining that he was the same rank as Captain Johnson, had been a captain for seventeen of his thirty-two years at the Denver Sheriff's Department, and had managed "thousands" of critical incidents. Captain Wood testified that Captain Johnson's

"position [in the sally port hallway] 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." He also testified that a captain's job is not to intervene with his sergeants unless excessive force is used.

¶ 41 The Board agreed with the factual finding that retired Captain Wood was not present for the entire incident. Captain Wood testified he was at the scene for "maybe a minute or two." He acknowledged that all he witnessed was "the officers and nurses giving assistance to [the inmate]." Consequently, the Board discounted much of Captain Wood's testimony on grounds that he was not privy to the entire agency investigation, including "interviews and statements made by witnesses who had actual first-hand knowledge of the incident." The Board was entitled to reject retired Captain Wood's testimony under CSR 21-21(D) on grounds that he lacked personal knowledge of the entire incident.

¶ 42 The Board also determined that some of Captain Wood's testimony — i.e., whether Captain Johnson acted appropriately during the incident — was improper, as it "set improper precedent in accepting the expert witness testimony of that of the [civilian

review administrator]." The Board determined that "[t]he agency is entitled to set performance standards and expectations," and that the hearing officer's reliance on Captain Wood's testimony that Captain Johnson acted appropriately "permitted former Captain Wood to usurp the authority of the Agency."

¶ 43 When the Board discounted Captain Wood's testimony, it had the authority to overrule a hearing officer's decision on grounds that the decision "is of a precedential nature involving policy considerations that may have effect beyond the appeal at hand." CSR 21-21(C). Although not noted in the CSR explicitly, we view this provision to contemplate something akin to de novo review, as it allows the Board to consider broader policy implications beyond the particular appeal. Indeed, the plain language of the rule itself states that the Board may set aside a hearing officer's decision "involving policy considerations that may have *effect beyond the appeal at hand*." *Id.* (emphasis added). We review de novo the interpretation of administrative rules similar to statutes, *Winter v. Indus. Claim Appeals Off.*, 2013 COA 126, ¶ 9, and give words their plain and ordinary meanings, *id.* at ¶ 8.

¶ 44 We note that policymaking by an agency is generally considered a quasi-legislative function that is associated with rulemaking, which "does not involve the application of the policy to any specific person." *Colo. Ground Water Comm'n v. Eagle Peak Farms, Ltd.*, 919 P.2d 212, 217 (Colo. 1996). In contrast, quasi-judicial action concerns the "determination of the rights, duties, or obligations of specific individuals on the basis of the application of presently existing legal standards or policy considerations to past or present facts developed at a hearing conducted for the purpose of resolving the particular interests in question." *Id.* (quoting *Cherry Hills Resort Dev. Co. v. City of Cherry Hills Village*, 757 P.2d 622, 625 (Colo. 1988)). "What distinguishes legislation from adjudication is that the former affects the rights of individuals in the abstract and must be applied in a further proceeding before the legal position of any particular individual will be definitively touched by it; while adjudication operates concretely upon individuals in their individual capacity." *Id.* (quoting 2 Kenneth C. Davis & Richard J. Pierce, *Administrative Law Treatise* § 6.1 at 228 (1927)).

¶ 45 While policymaking within a quasi-judicial action is unusual, we take no position on the validity of CSR 21-21(C), as Captain Johnson does not challenge the substance of the rule in this appeal. *See Moody v. People*, 159 P.3d 611, 614 (Colo. 2007) (we do not address issues not raised below). Moreover, we do not perceive the Board engaged in policymaking per se when it rejected Captain Wood's testimony. Captain Wood effectively testified as an expert witness even though he was not qualified as one. *See People v. Stewart*, 55 P.3d 107, 124 (Colo. 2002) (when testimony is based on specialized training or education a police officer must be properly qualified as an expert). Even assuming that the rules of evidence are not applied as strictly in administrative hearings, it is well established that an expert witness — properly endorsed or not — may not testify as to an ultimate conclusion of law. *Quintana*, 8 P.3d at 530.

¶ 46 Here, on at least two occasions, Captain Wood testified as to the ultimate conclusion. First, during an interview with an officer from the Denver Sheriff's Department Internal Affairs, Captain Wood stated that "[e]verybody acted appropriately and they did exactly what they were supposed to do." Captain Wood also

testified that Captain Johnson acted appropriately because "[h]e was watching the sergeant. He was watching the officers. He was watching the medical staff. He could see everything that was going on. He never left and stayed throughout."

¶ 47 Captain Wood's statements included his opinions as to whether Captain Johnson had satisfied the CSR professional performance standards. Because an expert witness — in an administrative proceeding or otherwise — is not authorized to testify to an ultimate conclusion of law, it was not improper for the Board to reject those portions of Captain Wood's testimony. *See id.*; *see also Nixon*, ¶ 25 (An administrative agency must review the evidentiary findings of fact and "make its own ultimate conclusions of fact."); *Steamboat Springs Rental & Leasing, Inc. v. City & Cnty. of Denver*, 15 P.3d 785, 786 (Colo. App. 2000) ("An appellate court may affirm a correct judgment based on reasoning different from that relied on by the trial court.").

¶ 48 Thus, the Board did not abuse its discretion by discounting the overwhelming majority of Captain Wood's testimony.

V. Board's Construction of CSR 16

¶ 49 Finally, Captain Johnson argues that the Board's construction of CSR 16 was improper because his actions did not rise to the level of a violation. We disagree.

A. Applicable Law

¶ 50 "Under the charter of the City and County of Denver, it is the [Career Service Board] which both promulgates and administers the Career Service Authority Rules and whose interpretation is therefore entitled to deference." *Roybal*, ¶ 13 (quoting *Ross v. Denver Dep't of Health & Hosps.*, 883 P.2d 516, 519 (Colo. App. 1994)); *see also Regents of the Univ. of Colo. v. City & Cnty. of Denver*, 929 P.2d 58, 61 (Colo. App. 1996) (an agency's interpretation of a rule will be accepted if it has a reasonable basis in law and is warranted by the record). Police department regulations in particular "are entitled to considerable deference because of the State's substantial interest in creating and maintaining an efficient police organization." *Puzick v. City of Colorado Springs*, 680 P.2d 1283, 1286 (Colo. App. 1983).

B. Analysis

¶ 51 CSR 16's purpose statement provides employees with "clear expectations for their conduct." More specifically, that rule outlines "the . . . grounds for discipline, and disciplinary process for City and County of Denver employees." *Roybal*, ¶ 16. Captain Johnson's suspension resulted from his violations of CSR 16-28(A) (neglect of duty); and CSR 16-28(R) (failure to observe written departmental or agency regulations, policies, or rules). The Department of Safety then used the Career Service Authority Classification Specifications to identify the specific duties Captain Johnson failed to perform during the incident as captain; those duties included "provid[ing] work instruction and assist[ance to] employees with difficult and/or unusual assignments" and "formulat[ing] tactical approaches to potential crisis situations[.]" Denver Office of Human Resources, *Deputy Sheriff Captain – CU1056* at 1 (Mar. 1, 2019), https://perma.cc/6UQX-E79P.

¶ 52 The hearing officer found that the reference to "potential crisis situations" in the standard was inapplicable because the incident in question was an "actual critical incident." Instead, the hearing officer determined that such a standard merely represented the

minimum qualifications to attain the rank of captain. The Board disagreed, finding that such a construction of the standard would be "absurd."

¶ 53 The Board stated that there would be "no value in having a job requirement requiring the formulation of tactics for crisis situations . . . only for that requirement to disappear precisely at the time when an actual crisis occurs." The Department of Safety highlighted that Captain Johnson's duties included the application of effective problem solving techniques by identifying and analyzing problems, using sound reasoning to arrive at conclusions, finding alternative solutions to complex problems, and distinguishing between relevant and irrelevant information to make logical judgments. As a result, the Board concluded that Captain Johnson failed to meet the requirements of these duties during the incident, and the hearing officer incorrectly interpreted the job duties. It reasoned that "[r]ank may have its privileges, but it also carries with it responsibilities; and being the ranking officer at a crisis situation required [Captain Johnson] to act like the ranking officer on scene." We are unpersuaded that the Board's interpretation of its employee standards was unreasonable or contrary to law, and

thus the Board had authority under CSR 21-21(B) to come up with and adopt its own interpretation.

¶ 54 Consequently, we, like the district court, agree that the Board's interpretation of its personnel rules was not erroneous. *Regents*, 929 P.2d at 62.

VI. Conclusion

¶ 55 The district court's order is affirmed.

JUDGE FREYRE concurs.

JUDGE FURMAN dissents.

JUDGE FURMAN, dissenting.

¶ 56 The Denver Sheriff's Department (Agency) imposed a ten-day suspension without pay on Captain James Johnson for violating Denver Career Service Rules (CSR) 16-28(R) (failure to supervise) and 16-28(A) (neglect of duty) based on an incident where deputies restrained an inmate at the Denver Downtown Detention Center (Detention Center). During the restraint, sergeants monitored and supervised the deputies. Captain Johnson observed the incident and supervised the sergeants.

¶ 57 The Agency suspended Captain Johnson because it concluded that he either failed to communicate or inadequately communicated with staff.

¶ 58 Captain Johnson appealed the Agency's suspension.

¶ 59 After a hearing on Captain Johnson's appeal, the Hearing Officer found that "testimony from those present, the video evidence, and testimony from former Captain Wood rebut . . . [the] claim that Johnson failed to communicate or inadequately communicated with staff." The Hearing Officer then concluded that 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."

¶ 60 After reviewing the transcripts of the hearing, the Board reversed. It found, among other things, that the Hearing Officer erred by relying on the testimony of the now retired Captain Wood and that Captain Johnson "did virtually nothing" during the incident.

¶ 61 The majority affirms because, in its view, the Board has broad discretion to make "ultimate" findings. Because I conclude the Board engaged in improper evidentiary factfinding before it made its ultimate findings, I respectfully dissent.

¶ 62 I also write separately to encourage our supreme court, should it accept this case on certiorari review, to clarify the important standards of review applicable to "ultimate" findings by agencies. *See, e.g.*, *Lawley v. Dep't of Higher Educ.*, 36 P.3d 1239, 1245 (Colo. 2001) (noting that the distinction between evidentiary facts and ultimate conclusions of fact is not always clear).

I. The Hearing Officer

¶ 63 Because the Hearing Officer relied on a retired captain's testimony and made credibility findings about the evidence, I first

address the CSR that defines standards of review applicable to a Hearing Officer.

A. The Hearing Officer's Standards of Review

¶ 64 CSR 19-43(C)(1) addresses the extent to which a Hearing Officer may rely on expert opinions.

> It is within the Hearing Officer's discretion whether to allow expert testimony in a particular appeal. If the Hearing Officer does allow expert testimony, and certifies a witness as an expert on a particular subject matter, the Hearing Officer may give the expert testimony any weight it is due or no weight as appropriate.

¶ 65 CSR 19-55 addresses the burden of proof in a case involving disciplinary appeals. "Disciplinary appeals are reviewed de novo and the department or agency has the burden of proof by a preponderance of the evidence to establish that the appellant engaged in the misconduct as alleged in the Notice of Discipline and the discipline imposed was within a reasonable range of alternatives." CSR 19-55(A).

B. The Hearing Officer's Findings About the Incident

¶ 66 At Captain Johnson's appeal hearing, Civilian Review Administrator Shannon Elwell testified for the Agency. (She was

not present when the restraint happened.) Captain Johnson testified on his own behalf, and presented these witnesses: Deputy Civic, Sergeant Adcock, retired Captain Wood, Nurse Bisgard, and Nurse Allison.

¶ 67 After the hearing, the Hearing Officer made extensive findings. I summarize these findings here.

¶ 68 The incident that gave rise to Captain Johnson's suspension was undeniably tragic. After this incident, an inmate died from aspiration at a local hospital.

¶ 69 Captain Johnson was the watch commander at the Detention Center. In this capacity, the Hearing Officer found that he was "responsible for the safety and security of inmates," and "responding to and overseeing actions by subordinate officers during critical incidents." He had been in this position for less than two months.

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

¶ 71 One day an inmate on unit 4D, "after refusing his psychotropic medicine for several days, became unstable, tearing at

his food, cramming it in his mouth, tearing up trash, . . . and pulling foam from his mattress." Deputies instructed this inmate to clean up his cell, but he "appeared to be unable to comprehend them."

¶ 72 Deputies permitted the inmate to go out of his cell so they could clean it up. But this inmate "aggressively approached another inmate and was unresponsive to deputies' instructions."

¶ 73 Deputies then escorted the inmate to a nearby sally port "where he could remain separated from other inmates while the deputies had his cell cleaned." The deputies also placed a request for the inmate to be "reclassified so that he would be moved to a 'camera cell' where he could be more effectively monitored, and so that emergency medications . . . could be forcibly administered to address his symptoms."

¶ 74 "While the reclassification was being processed," the inmate "began pacing" and "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." One deputy pushed the inmate "in the chest to prevent him from leaving the sally port

towards the corridor," and the inmate "fell backward and along a wall." Other deputies who had been summoned and "had been observing from just outside the sally port, entered to assist with" controlling the inmate as he fell to the floor. Five deputies had difficulty controlling the inmate on the floor, "and one of them called for additional officer assistance." (The Agency determined all the deputies' reactions up to this point were "reasonable, necessary, and legitimate.")

¶ 75 Captain 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" the inmate, who "continued to kick and tried to stand up." The deputies applied leg restraints, but the inmate "continued to struggle and resist all attempts to calm him down and to control him."

¶ 76 Only one minute after Captain Johnson arrived, "deputies began to control" the inmate "and assisted him to a sitting position," but the inmate "suddenly became limp and unresponsive." "The deputies lowered him." The inmate vomited. Captain Johnson "immediately ordered Sergeant Adcock to call for a

medical emergency, even though a call had been placed before he arrived." Johnson "was aware of the earlier call but determined, under the circumstances, that the situation required more urgency."

¶ 77 "Nursing staff began to arrive within 30 seconds after that call." Captain Johnson "returned to his prior position on the far wall, as two sergeants remained just outside the sally port, observing the deputies."

¶ 78 "As five nurses arrived," the inmate "regained consciousness and immediately struggled again. Deputies again held" the inmate "down by his limbs, shoulder blade area and pelvis."

¶ 79 Nurse Allison took the inmate'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 possible aspiration of vomit, she asked the deputies to relieve any pressure" on the inmate's back "and when she looked up they had complied and were restraining" the inmate only by his limbs. Captain 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."

¶ 80 Nurse Bisgard, who was the nurse in charge, "wrote down the vital signs" as Nurse Allison called them out and asked Allison to return the inmate "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" the inmate, "balked at placing him in an unrestrained wheelchair based on his combativeness and their concern for the safety of all present."

¶ 81 Sergeant Adcock "called for a restraint chair." Before moving the inmate "to the restraint chair, deputies placed a spit hood over his mouth" to prevent the inmate "from biting or excreting vomit onto responders."

¶ 82 "While deputies secured the restraint chair and pulled it into the adjacent corridor," the inmate "became unresponsive again." Nurse Allison "used her stethoscope to listen" to the inmate's heart and "heard two beats then nothing. Deputies immediately removed the spit hood, removed the restraints and laid the unresponsive" inmate "on the floor, where a deputy began performing CPR."

Captain Johnson asked whether the inmate's "chest was rising and falling," and "ordered Sergeant Adcock to call for an ambulance."

¶ 83 Captain Johnson "knew he was required as Watch Commander to make notifications under the current emergency circumstances." Because he was new to the position, "he retrieved the Agency's policy book to make sure he complied with his duties." He then "filled out a Substantial Risk of Death Form; assigned a scribe to take detailed notes of the incident; instructed deputies" to secure the inmate's cell; "alerted his Chief; had Denver Health Medical Center alerted" to the inmate's arrival; and "filled out an in-custody risk of death form."

C. The Hearing Officer's Findings About Captain Johnson

¶ 84 The Agency alleged Captain Johnson failed to supervise and neglected his duties in his role as captain and watch commander. The Hearing Officer made extensive findings about these allegations. I next summarize these findings.

¶ 85 The Hearing Officer found that the "Agency retains the burden of persuasion throughout the case" to prove Captain Johnson "violated one or more cited sections" of the CSR "by a preponderance of the evidence."

1. Alleged Failure to Supervise Violations

a. Captain Duties

¶ 86 In the notice of discipline, Elwell determined Captain Johnson was "passive and lackadaisical" during the incident. As for captain job duties, Elwell faulted Captain Johnson for inadequately communicating with staff by observing the incident from the corridor, engaging in unrelated conversation with sergeants, and not adequately interacting with responding subordinates and nurses. Elwell also faulted Captain Johnson for failing to formulate a tactical approach to a potential crisis situation and not applying problem-solving techniques to the incident.

¶ 87 The Hearing Officer addressed the allegations that Captain Johnson failed to adequately supervise based, in part, on the opinions of retired Captain Wood.

i. Retired Captain Wood's Opinion

¶ 88 The Hearing Officer found that retired Captain Wood "was on duty at the time of the incident and arrived at the scene when he overheard the call for officer assistance." Wood left 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" the inmate.

¶ 89 Wood opined that "a captain's duty is to monitor the sergeants and not intervene with their direct supervision of deputies unless excessive force is used." Based on this testimony, the Hearing Officer concluded that Captain Johnson should not have interacted with the deputies because "it is the on-scene sergeants who had that responsibility" and Captain Johnson "fulfilled his obligation to observe whether the sergeants were properly monitoring their charges."

¶ 90 The Hearing Officer determined that retired Captain 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 also noted that when Johnson's view became blocked, he moved to have a better view." Based on the evidence, the Hearing Officer found that Captain Johnson did not demonstrate the "actions of an inattentive supervisor."

ii. Adequately Interacted with Subordinates

¶ 91 The Hearing Officer found that "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." But the Hearing Officer did not credit Elwell's testimony. "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."

¶ 92 The Hearing Officer determined that the Agency did not establish that Johnson "failed to communicate adequately with sergeants on scene" and failed to establish that he "inadequately communicated[] with deputies." The Hearing Officer based his findings on the following evidence:

- Sergeant Adcock's statement and testimony affirmed that Captain Johnson interacted appropriately with officers on the scene;

- Sergeant Newton's interview with the Internal Affairs Bureau affirmed that Captain Johnson managed the scene appropriately; and
- retired Captain Wood's testimony, which the Hearing Officer found "persuasive."

iii. Adequately Interacted with Nurses

¶ 93 The Hearing Officer determined that Elwell's claim that Captain Johnson failed to determine the extent of the developing medical emergency and, therefore, "failed to interact with medical staff regarding that development" was "contrary to the evidence." The Hearing Officer found that "[a]lmost immediately after Johnson arrived," the inmate became unconscious. Captain Johnson "approached, looked in, and immediately ordered a medical emergency call. Johnson also asked" whether the inmate's "chest was rising and falling, instructed the call for an ambulance, and made all required emergency notifications." Captain Johnson "did not consider carrying" the inmate "to the medical unit or consider alternate modes to transport him there" "since he learned nurses were waiting for e-meds to arrive, . . . which would be administered

there in the corridor, following which" the inmate "would be transported directly to the hospital."

¶ 94 The Hearing Officer noted that Captain Johnson was "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." But the Hearing Officer did not address how or if these conflicting responsibilities impacted Captain Johnson's interaction with nurses or subordinates.

iv. The Captain Class Job Description

¶ 95 The Hearing Officer addressed whether two components of the captain class job description defined the performance standards applicable to the incident involved in this case.

¶ 96 The Hearing Officer first addressed whether Captain Johnson failed to "formulate[] tactical approaches to potential crisis situations." Denver Office of Human Resources, *Deputy Sheriff Captain – CU1056* at 1 (Mar. 1, 2019), https://perma.cc/6UQX-E79P. The Hearing Officer determined this portion of the job description did not apply because the incident was not a "potential

crisis, but an actual critical incident for which there were protocols and which Johnson applied."

¶ 97 The Hearing Officer next addressed whether Captain Johnson failed to "apply problem-solving techniques to the incident, including a failure to identify the problem, exercise sound reasoning, provide alternate solutions, and distinguish between relevant and not relevant information." *See id.* at 2. The Hearing Officer determined this portion of the job description did not apply because "these qualities are prerequisite to apply for the rank of Captain, not a performance standard after the rank is attained."

b. Watch Commander Duties

¶ 98 The Hearing Officer noted that "Watch Commanders are expected to respond to critical incident alarms, and to manage and document the incident(s) according to all Post Order, Department Orders, and Policies."

¶ 99 The Hearing Officer found that Elwell supposed the incident was most likely classified as a Type 1, Type 2, or Type 3 incident according to the regulations. But during cross-examination, Elwell admitted that a Type 1 incident is most appropriately used for natural disasters or prison riots. She also admitted that a Type 2

incident is most appropriately used for a fire or riot, not a medical emergency involving a single inmate. Elwell thus clarified that a Type 3 incident was the correct classification for this incident. The Hearing Officer determined that "the required protocol for the Watch Commander" under this type of critical incident 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.

¶ 100 The Hearing Officer determined that Captain Johnson "accomplished each of these requirements during the incident." And, because Captain Johnson "followed the only applicable section of Watch Commander duties pertinent to this type of incident, he did not fail to meet the requirements of his Watch Commander duties, and no violation was proven thereunder."

2. Alleged Neglect of Duties Violations

¶ 101 The Hearing Officer found Captain Johnson did not neglect his duties because "Elwell failed to specify what duties" Captain Johnson failed to satisfy, "other than his Captain classification and his temporary role as Watch Commander," which the Hearing Officer addressed under the alleged failure to supervise violations.

3. Summary of the Hearing Officer's Findings

¶ 102 The Hearing Officer summarized his findings that the Agency failed to meet its burden of proof. "[T]estimony 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." The Hearing Officer then concluded that the "Agency failed to prove Johnson violated any of the rules or order alleged in its notice of discipline. The failure to prove any violation requires a reversal of discipline."

II. The Board

¶ 103 The Board reversed the Hearing Officer. The Board found that the "record reflects that [Captain Johnson] did virtually nothing during a crisis situation." The Board explained that the "Agency

reasonably expected more out of a Captain," but it did not specify what else he was expected to do.

¶ 104 In footnote two, the Board sought to clarify its summary of the record. It found as follows:

> [T]he Hearing Officer determined, based on the opinions offered by other deputies, that [Captain Johnson] by doing virtually nothing, acted appropriately during the crisis situation. The Hearing Officer went so far as to conclude that had [Captain Johnson] done something, he would have been "inappropriately usurping the role of his sergeants." We do not see how this is possible. We do not see how a ranking officer at the scene of a crisis situation can improperly usurp the authority of his underlings by acting in a manner consistent with his higher rank.

¶ 105 The Board also took issue with the Hearing Officer's reliance on retired Captain Wood's testimony, explaining that the Hearing Officer erred by relying on the "opinion" of the "'expert' witness" testifying on behalf of Captain Johnson.

¶ 106 I next address the CSR that define standards of review applicable to the Board.

A. The Board's Standards of Review

¶ 107 The Board's review of a Hearing Officer's decision is limited by CSR 21-21(A)-(E). CSR 21-21(B)-(D), which apply to this case, provide as follows:

> (B) Erroneous interpretation of applicable authority: The Board may reverse a decision based on an erroneous interpretation of any applicable legal authority. A Hearing Officer's interpretation of applicable legal authority is subject to de novo review.
>
> (C) Policy-setting precedent: The Hearing Officer's decision is of a precedential nature involving policy considerations that may have effect beyond the appeal at hand.
>
> (D) Insufficient evidence: The Hearing Officer's decision is not supported by the evidence. The Board may only reverse a decision on this ground if the Hearing Officer's decision is clearly erroneous.

¶ 108 A "clearly erroneous" decision affords the highest degree of deference to the fact finder and will only be reversed if it has "no support in the record." *People in Interest of A.M. v. T.M.*, 2021 CO 14, ¶ 15 (quoting *People in Interest of A.J.L.*, 243 P.3d 244, 250 (Colo. 2010)).

B. The Board's Findings About Captain Johnson

¶ 109 I next summarize the Board's findings that Captain Johnson failed to supervise and neglected his duties in his roles as captain and watch commander.

1. Alleged Failure to Supervise Violations of Captain Duties

a. Retired Captain Wood's Opinion

¶ 110 The Board determined that the Hearing Officer "set improper precedent" by relying "on the testimony provided by former Captain . . . Wood." The Board pointed out that the Hearing Officer made a "few factual findings based on Wood's testimony as an occurrence witness." And the Board determined that to "the extent that the Hearing Officer made any critical findings based on Wood having witnessed anything first hand, those findings would, in fact, be clearly erroneous." The Board did not specify where this happened.

¶ 111 More concerning to the Board, though, was "the fact that Wood's testimony, because he was not present during the incident, was nothing more than opinion testimony." From this, the Board determined that the Hearing Officer's decision "clearly reflects that he . . . pitted the opinion of [Elwell] against the opinion of the

'expert' witness testifying on behalf of [Captain Johnson] and decided he liked the testimony of the expert better."

¶ 112 The Board ultimately determined that the Hearing Officer "has impermissibly permitted former Captain Wood to usurp the authority of the Agency [and] the Hearing Officer's decision, which allowed an opinion witness to set standard and judge performance, sets bad policy precedent and, therefore, cannot stand."

b. Adequately Interacting with Subordinates and Nurses

¶ 113 The Board reversed the Hearing Officer's finding that Captain Johnson adequately interacted with subordinates and nurses. The Board found that the "record reflects that [Captain Johnson] did virtually nothing during a crisis situation."

¶ 114 The Board also determined that the Hearing Officer misinterpreted the priority and safety of nurses and responding officers over the medical emergency of an inmate. The Board explained this policy as follows:

> It is well-settled that the care and custody of inmates are the top priorities of the Agency. While we in no way advocate for policies that unduly or foolishly place deputies in harm's way, we do not believe that the Hearing Officer was correct in his holding that saving the life of an inmate, even a struggling inmate, was

> subservient to the safety of the nurses and deputies responding to the inmate.

¶ 115 The Board attempted to clarify its explanation in an accompanying footnote:

> We do not mean to imply that an inmate's life is to be valued more highly than the life of a Deputy or a nurse and we do not mean to imply that under all circumstances, say, for example, when the life of a Deputy or nurse is in as great peril as that of an inmate, that an inmate's health and safety takes priority over the health and safety of nurses and deputies. We only hold that in this case, given the wording of the policy, and given the fact that the health of an inmate was in much greater peril than the health and safety of any nurse or deputy on the scene, the Hearing Officer's decision to interpret the policy as prioritizing the safety of the nurses and Deputies over that of the inmate was error.

¶ 116 The Board did not fault Captain Johnson for violating this policy and it did not point out how or where the Hearing Officer applied this policy.

c. The Captain Class Job Description

¶ 117 The Board determined that the captain class job description — formulating a tactical approach to a potential crisis situation — defined the duties expected of a captain. The Board then found that "had [Captain Johnson] formulated a tactical approach when

the situation first escalated it is very possible no crisis would have occurred." The Board also found that "the record of this case demonstrates" Captain Johnson "was not able to articulate a tactical approach, or any type of plan whatsoever, which addressed the exigent circumstances presented by the situation at hand."

¶ 118 The Board did not remand for the Hearing Officer to make findings about whether Captain Johnson credibly articulated a tactical approach.

2. Neglect of Duties Violation

¶ 119 The Board determined that the Hearing Officer committed reversible error in refusing to consider the neglect of duty charge. The Board reasoned that it is not "an improper piling on or stacking of charges" if Captain Johnson "receives that ten-day suspension, regardless of whether the Agency finds the misconduct violated one rule or ten rules."

III. The District Court

¶ 120 Captain Johnson then challenged the Board's decision in district court under C.R.C.P. 106(4). The court upheld the Board's decision. Captain Johnson appealed to our court.

IV. Our Review

A. Our Applicable Standards of Review

¶ 121 In an appeal of a C.R.C.P. 106(a)(4) proceeding, we sit in the same position as the district court and review the decision of the administrative body itself. *Roybal v. City & Cnty. of Denver*, 2019 COA 8, ¶ 99.

¶ 122 We will reverse the administrative body's decision if "the governmental entity exceeded its jurisdiction or abused its discretion, which occurs if the body misapplied the law or no competent evidence supports its decision." *Whitelaw v. Denver City Council*, 2017 COA 47, ¶ 8; *see* C.R.C.P. 106(a)(4).

¶ 123 The lack of competent evidence "means that the governmental body's decision is 'so devoid of evidentiary support that it can only be explained as an arbitrary and capricious exercise of authority.'" *Canyon Area Residents for the Env't v. Bd. of Cnty. Comm'rs*, 172 P.3d 905, 907 (Colo. App. 2006) (quoting *Bd. of Cnty. Comm'rs v. O'Dell*, 920 P.2d 48, 50 (Colo. 1996)).

B. The Majority's Holding

¶ 124 The majority affirms the decision of the Board, describing the Board's finding as "an ultimate finding over which the Board can exercise discretion." *Supra* ¶ 26.

¶ 125 I agree with the majority that the CSR permit the Board to make "ultimate findings." But I respectfully disagree with the majority's conclusion that the Board did not engage in improper evidentiary factfinding to reach its ultimate findings.

¶ 126 My disagreement with my colleagues is based on a straightforward question: What should Captain Johnson have done during the incident? The majority recognizes the Board's answer to this fundamental question is not clear in the Board's findings. In my view, an "ultimate finding" of fact must be made explicitly clear because it has an effect beyond the appeal at hand. But the Board did not fulfill this essential duty in this case.

C. Judicial Review of Agency Decisions

¶ 127 Terms used in judicial review of agency decisions are not always clear. As our supreme court recognized in *Lawley*, 36 P.3d at 1245, the "distinction between evidentiary facts and ultimate

conclusions of fact is not always clear." I agree. So, I will start with standard definitions of terms that guide my analysis in this case.

¶ 128 Evidence is "[s]omething (including testimony, documents, and tangible objects) that tends to prove or disprove the existence of an alleged fact." Black's Law Dictionary 697-98 (11th ed. 2019).

¶ 129 A fact in issue can be both "[a] fact that one party alleges and that the other controverts" and "[a] fact to be determined by a fact-finder." *Id.* at 736.

¶ 130 A fact in evidence is "[a] fact that a tribunal considers in reaching a conclusion; a fact that has been admitted into evidence in a trial or hearing." *Id.*

¶ 131 An evidentiary fact is "[a] fact that is necessary to the operation of an evidentiary rule or that is necessary for or leads to the determination of an ultimate fact" and "[a] fact that furnishes evidence of the existence of some other fact." *Id.* at 735-36.

¶ 132 An intermediate fact is "[a] fact that helps lead to an ultimate fact or is a necessary element to a chain of reasoning leading to a conclusion." *Id.* at 736.

¶ 133 An ultimate fact or ultimate conclusion of a fact is "[a] fact that is found by making an inference or deduction from findings of

other facts," specifically "a factual conclusion derived from intermediate facts." *Id.* at 737.

¶ 134 Applying these terms in light of our standards of review, I conclude that the Board erred in finding that Captain Johnson violated CSR 16-28(R) (failure to supervise) and 16-28(A) (neglect of duties). I reach this conclusion because, in my view, the Board misapplied the law, or its decision is not supported by the evidence, in the following areas:

- retired Captain Wood's opinion;
- Captain Johnson's interaction with subordinates and nurses;
- captain class job description;
- watch commander duties; and
- neglect of duties violations.

¶ 135 I address these areas, in turn.

1. Alleged Failure to Supervise

a. Captain Duties

i. Retired Captain Wood's Opinion

¶ 136 I conclude the Board misapplied the law governing retired Captain Wood's testimony, and its findings are devoid of evidentiary support, for five reasons.

¶ 137 First, the CSR does not give the Board discretion to weigh expert testimony. *See* CSR 19-43(C)(1) ("It is within the Hearing Officer's discretion whether to allow expert testimony . . . the Hearing Officer may give the expert testimony any weight it is due or no weight as appropriate.").

¶ 138 Second, the Board did not give proper deference to the Hearing Officer's evidentiary factfinding concerning retired Captain Wood's testimony, which the CSR requires. *See* CSR 19-55 (defining the burden of proof); CRS 21-21(D) (defining the clearly erroneous standard of review).

¶ 139 Retired Captain Wood based his testimony about the chain of command protocol on nearly thirty-three years of experience with the Denver Sheriff's Department. He achieved the rank of captain,

which he maintained for seventeen years, and served as a sergeant for nine years before being promoted to captain.

¶ 140 Wood testified that "sergeants are the first level of supervisors." He explained that during a use of force incident, "as the captain, . . . you make sure that the sergeant is supervising his deputies. And as the captain, you are more of a big-picture person, so you kind of step back and keep an eye on everything to make sure everything is being done the way it should be." Retired Captain Wood opined that "the deputies I would have to say are well trained and do what they're supposed to 95 percent of the time."

¶ 141 Captain Johnson's attorney then asked retired Captain Wood, "So, if a sergeant is on a scene and a sergeant is working with the deputies involved, do you think it's prudent to move the sergeant out of the way, take over a scene and start giving orders?"

¶ 142 Retired Captain Wood answered, "No, that's the sergeant's job and . . . if the sergeant is already there, the sergeant should handle — should handle the incident." He explained that the captain,

> needs to take a step back, as it were, so he can see everything that's going on, see what the deputies are doing, see what the sergeant is doing. And in — about the only other thing is, like for instance, if they need an ambulance,

> the captain would probably get on the radio and notify central control to notify — to contact an ambulance. But other than that, just step back and don't really take an active role in the incident itself but to make sure everybody else is doing what they're supposed to do.

¶ 143 The Hearing Officer's finding that retired Captain Wood testified "credibly and without rebuttal" is, therefore, supported by substantial evidence.

¶ 144 Third, I conclude that the Hearing Officer's decision to weigh the unrebutted testimony of an expert witness does not involve policy-setting precedent. True enough, Elwell testified that "Captain Johnson should have been engaged in the situation" and should have positioned himself "such that he could interact with the deputies, interact with medical and be able to receive information to make informed decisions as to the best course of action." But Elwell did not testify that retired Captain Wood misconstrued the chain of command protocol. And she did not offer any facts in evidence explaining why Captain Johnson should have ignored this protocol and directly involved himself in the use of force incident.

¶ 145 Thus, the record supports the Hearing Officer's findings that Captain Johnson should not have interacted with the deputies because "it is the on-scene sergeants who had that responsibility" and Captain Johnson "fulfilled his obligation to observe whether the sergeants were properly monitoring their charges." *See* CSR 19-43(C)(1); 19-55; 21-21(D).

¶ 146 Fourth, the Board does not explain how reliance on retired Captain Wood's testimony would "have effect beyond the appeal at hand." CSR 21-21(C).

¶ 147 Fifth, as noted, the Board did not specify where in the record the Hearing Officer erred by relying on retired Captain Wood's testimony as an occurrence witness.

ii. Adequately Interacting with Subordinates and Nurses

¶ 148 I conclude the Board misapplied the CSR 21-21(D) clearly erroneous standard and made evidentiary findings about Captain Johnson's interactions with subordinates and nurses that were belied by the record. I reach this conclusion because the CSR do not authorize the Board to reverse a Hearing Officer based on its own evidentiary factfinding of what the "record reflects." Rather, CSR 21-21(D) authorizes the Board to determine whether there is

support in the record. It is difficult to square the Board's findings with our supreme court's definition of deference. *See A.M.*, ¶ 15.

¶ 149 I also conclude the Board's finding is devoid of evidentiary support. Although Elwell testified "that the conversations" on the video between Captain Johnson and Sergeant Adcock "do not have anything to do with what is going on," she admitted that "there's no evidence as to what the conversations [with the sergeants] were about."

¶ 150 And the Hearing Officer heard other evidence about what these conversations were about.

¶ 151 Retired Captain Wood testified that he had reviewed the video camera footage from the sally port camera and the hallway camera and opined that Captain Johnson was not failing his duties because "he was actively involved . . . conferring with the sergeants." Retired Captain Wood pointed out that there was "one specific incident I remember where Sergeant Adcock is standing very close to the incident, watching it, and actually steps back and starts talking with Captain Johnson, basically updating him on the situation. And also, you see him conferring with other sergeants while the incident is going on."

¶ 152 Sergeant Adcock testified that Captain Johnson instructed her "to call for a code 10 ambulance" after they realized the inmate was not breathing. She explained that she was "still technically in training at the time" so she was "listening" to her supervisors about what she needed to do. She thought that "her superior captain being there giving" her direction resulted in the medical call being placed sooner than she would have placed the call.

¶ 153 Captain Johnson testified that he was aware of what was going on during the incident. He positioned himself so everyone was in front of him and he could see everything that was happening. He had his radio on so he could hear that what needed to be done was being done, including bringing the restraint chair. He testified, "I know it's being run right even though you don't see much going on . . . . I know in the checked boxes okay that's done, that's done, that's done, I can hear it over the radio." He testified that he was "answering" the sergeants and "watching the situation." He further testified that his other supervisors were looking in on the scene, and he is looking for "[a]nything that's out of the ordinary, anything that may be — need to be corrected that I could see." He instructed Sergeant Adcock "to make the medical emergency call."

After Sergeant Adcock made the call, he stepped "back out of the way" because he knew medical people would be arriving very quickly.

¶ 154 Deputy Civic testified that he and other deputies receive sixteen weeks of training to become a deputy with the Denver Sheriff's Department. He also testified that he is trained on how to handle a crisis situation where an inmate cannot breathe. This training included making "sure that the scene and the area is safe for medical staff" so they can "provide medical assistance to the inmate." He was present at the incident, recalling four sergeants and two captains also were present. He opined that

- everyone was doing their job properly based on their training and experience;
- people were communicating; and
- everything went fairly smoothly.

He also testified that he did not need anyone to tell him what to do because "everybody did as they were trained and handled the situation properly." The Board did not disagree with this conclusion.

¶ 155 During her testimony, Elwell offered suggestions about what Captain Johnson should have done. For example, she indicated that he "should have considered carrying" the inmate "down to medical." But Captain Johnson testified that was not reasonable because the inmate was "being combative" and he needed to have the medical professionals say "he's good to be transferred. We don't just swoop in there and tell medical we're going to move somebody, medical will do their assessment."

¶ 156 Elwell also thought that it would have been a "good idea" to put the inmate "on a gurney and take him down" to medical. Captain Johnson testified that that is not how inmates are transported in the Detention Center. He also testified that "the restraint chair was the proper call."

¶ 157 Captain Johnson testified that he summoned the ambulance once it was determined that the inmate's heart stopped beating.

¶ 158 The record thus supports the Hearing Officer's finding that "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."

¶ 159 The Board also characterized the Hearing Officer's determination as follows: "based on the opinions offered by other deputies, . . . [Captain Johnson], by doing virtually nothing, acted appropriately during the crisis situation." I conclude this characterization is devoid of evidentiary support. The Hearing Officer did not find that Captain Johnson did "virtually nothing," and, as shown, substantial evidence showed otherwise.

iii. The Captain Class Job Description

¶ 160 As noted, the Board determined that the Hearing Officer erred by not recognizing the captain class job description defined the duties expected of a captain. But the Board also found that "the record reflects" that Captain Johnson's "performance during the incident did not rise to the level of meeting the minimum job requirements." The Board saw "no evidence in the record" of Captain Johnson "applying problem solving techniques, attempting to find alternate solutions to the complex problems he and his subordinates were facing, or that he was sifting out relevant versus irrelevant information to make logical judgments."

¶ 161 I conclude the Board misapplied the CSR 21-21(D) clearly erroneous standard and improperly made findings about whether

Captain Johnson formed a tactical approach based on what the "record reflects." The CSR requires the Hearing Officer to engage in this type of evidentiary factfinding. *See* CSR 19-43; *Ritzert v. Bd. of Educ. of Acad. Sch. Dist. No. 20*, 2015 CO 66, ¶ 30 (concluding that evidentiary facts "detail factual and historical findings"); *see State Bd. of Med. Exam'rs v. McCroskey*, 880 P.2d 1188, 1193 (Colo. 1994); *see also Joseph v. Mieka Corp.*, 2012 COA 84.

¶ 162 I also conclude that the Board's findings are belied by the record. Captain Johnson appeared to articulate his tactical approach as follows.

- He positioned himself so everyone was in front of him and he could see everything that was happening.
- He had his radio on so he could hear that what needed to be done was being done, including bringing a restraint chair.
- He watched for anything that was "out of the ordinary" and anything that needed to be corrected.
- He instructed Sergeant Adcock "to make the medical emergency call."
- He ruled out carrying the inmate "down to medical."

- He determined that the sergeant's request for the restraint chair "was the proper call."
- He summoned the ambulance once it was determined that the inmate's heart stopped beating.

¶ 163 Retired Captain Wood's testimony confirmed this was the proper approach, and Deputy Civic testified that the deputies were extensively trained on how to handle critical incidents at the Detention Center.

¶ 164 The testimony of Captain Johnson, retired Captain Wood, and Deputy Civic are facts in evidence. But because the Hearing Officer incorrectly determined that portions of the captain class job description did not define the duties of a captain, he did not address whether Captain Johnson had credibly formed a tactical approach to the incident. I therefore would reverse the Board with directions to remand for the Hearing Officer to make additional findings or take additional evidence on whether Captain Johnson had done so. *See* C.R.C.P. 106(a)(4); *Whitelaw*, ¶ 8. These intermediate findings, because they are based on credibility, are properly the role of the Hearing Officer and not the Board. *See* CSR 21-21(D).

b. Watch Commander Duties

¶ 165 The Board did not address whether Captain Johnson violated watch commander duties. And the record does not reveal to what extent this contributed to the ten-day suspension sanction. I therefore would reverse the Board for this reason, also, particularly in a case where the Board is rightfully concerned about the policies of the Detention Center.

2. Neglect of Duties

¶ 166 I conclude that the Board's finding that Captain Johnson neglected his duties is devoid of evidentiary support. The Hearing Officer *did not* find that the Agency improperly piled on or stacked charges. Instead, the Hearing Officer found that "Elwell failed to specify what duties" Captain Johnson failed to satisfy, "other than his Captain classification and his temporary role as Watch Commander," which the Hearing Officer addressed. This goes to the burden of proof required by CSR 19-55.

¶ 167 The Board, likewise, does not indicate what duties Captain Johnson neglected. I therefore also would reverse the Board's findings that Captain Johnson neglected his duties. *See* C.R.C.P. 106(a)(4).

V. The Need for Clarity

¶ 168 As noted, our supreme court has acknowledged that "the distinction between evidentiary facts and ultimate conclusions of fact is not always clear." *Lawley*, 36 P.3d at 1245; *see also Blair v. Lovett*, 196 Colo. 118, 123-24, 582 P.2d 668, 672 (1978) (holding that the board of education is not to conduct a second full review of the evidence or to adopt new findings of fact).

¶ 169 Practitioners also have noted that "it is frequently difficult to distinguish where an evidentiary finding or finding of fact ends and an ultimate fact or conclusion of law begins." Christina Gomez, *Vexed and Perplexed: Reviewing Mixed Questions of Law and Fact on Appeal*, 47 Colo. Law. 24, 28 (Mar. 2018). Additional "clarity and consistency" in this area "would help both the courts and counsel." *Id.* at 24, 29.

¶ 170 This case provides an opportunity for our supreme court to clarify the distinction between evidentiary facts, intermediate facts, and ultimate facts, and how these terms are to be applied by Hearing Officers, the Board, and reviewing courts in this and future cases.