Dep't of Correction v. Wisher

OATH Index Nos. 591/14 & 592/14 (May 19, 2014)

Correction officers were deficient in the performance of their duties when they failed to notify their area supervisor or the facility clinic that an inmate, who was behaving irrationally, had been removed from a line of inmates who were to receive prescription medication and had not been given his medication. Penalty of 20-day suspension recommended for each officer.

NEW YORK CITY OFFICE OF ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
DEPARTMENT OF CORRECTION
Petitioner
- against -
DARREN WISHER AND VERNA BURT
Respondents

REPORT AND RECOMMENDATION

ASTRID B. GLOADE, *Administrative Law Judge*

This employee disciplinary proceeding was referred by the Department of Correction ("Department") pursuant to section 75 of the Civil Service Law. Petitioner alleges that respondents, Correction Officers Darren Wisher and Verna Burt, were deficient in the performance of their duties by failing to notify their area supervisor or the facility clinic that an inmate had not been afforded his medication (ALJ Exs. 1, 2).

At a two-day hearing, petitioner relied on documentary evidence and presented five witnesses. Respondents testified and offered documentary evidence. For the reasons set forth below, I find that the charges are sustained and recommend that each officer be suspended without pay for 20 days.

ANALYSIS

Petitioner alleges that on July 16, 2011, Officers Wisher and Burt removed inmate AR[1] from the line where he had been waiting for prescribed medication to be dispensed because he was acting irrationally. He was not given the medication for which he had been on line. AR died the morning of July 17, 2011, after a use of force incident involving other officers that allegedly occurred after he acted erratically and asked to go to the clinic (Tr. 163-64; Pet. Ex. 28). Respondents are charged with failing to notify their area supervisor or the facility clinic that the inmate had not been afforded his medication (ALJ Exs. 1, 2).

The facts in this matter are largely uncontested. AR was admitted to the Anna M. Kross Center ("AMKC") on July 14, 2011 (Pet. Ex. 5). He was examined at the clinic, where medical staff determined he had a history of heroin and alcohol abuse (Tr. 25). Dr. Chery-Cyrille is employed by Corizon Health Services, which provides medical services to inmates at Rikers Island. She examined AR on July 15, 2011, and prescribed Librium and methadone (Tr. 23, 25-29; Pet. Ex. 7).

Dr. Chery-Cyrille testified that she prescribed Librium, which she described as a tranquilizer, to treat symptoms associated with alcohol withdrawal, including anxiety, agitation, tremors, nausea, hallucinations, seizures, and altered mental status (Tr. 30-32). AR was prescribed Librium for five days in tapering doses, starting with 75 milligrams twice a day for the first day, then 50 milligrams twice per day for the second and third days, 25 milligrams twice per day for the fourth day, and 25 milligrams for the fifth day (Tr. 26; Pet. Exs. 7, 11). According to Dr. Chery-Cyrille, Librium is prescribed in initial high doses because the patient is usually agitated when it is first administered. The dosage is tapered because the patient experiences side effects if administration of the medication is stopped abruptly (Tr. 34). A missed dose would cause the patient to experience symptoms of alcohol withdrawal (Tr. 31-32).

According to Dr. Chery-Cyrille, methadone is prescribed to patients with a history of heroin abuse to decrease withdrawal symptoms such as aches, nausea, vomiting, diarrhea,

[1] Initials have been used instead of disclosing the inmate's name due to the discussion of his medical condition and records contained herein. *See* 48 RCNY § 1-49(d) (Lexis 2013); *Comm'n on Human Rights ex rel. L. D. v. Riverbay Corp.*, OATH Index No. 1300/11 at 1 n. 1 (Aug. 26, 2011), *adopted*, Comm'n Dec. & Order (Jan. 9, 2012) (complainant's name withheld where decision discussed her medical information and history); *Human Resources Admin. v. Anonymous*, OATH Index No. 1242/10 at 1-2 (May 4, 2010), *modified on penalty*, Admin/Comm'r Dec. (June 16, 2010), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 11-17-A (Apr. 29, 2011) (party's name withheld where decision discussed personal medical information, including mental health disorder).

sweating, and irritability. As with Librium, methadone is prescribed in tapering doses because abrupt cessation of the medication results in side effects (Tr. 34-35). Dr. Chery-Cyrille prescribed methadone to AR for six days: ten milligrams once per day for the first three days, then five milligrams once per day for the next three days (Tr. 35; Pet. Exs. 7, 30). Several hours after Dr. Chery-Cyrille placed that order, the dosage was changed by a different doctor who increased the dosage to 25 milligrams and the duration of the administration of methadone to 15 days (Tr. 209-10; Pet. Ex. 30). AR was assigned to the Modular 7 double detoxification ("double detox") housing area, a unit for newly admitted inmates undergoing alcohol and heroin detoxification simultaneously (Tr. 89-90, 289; Pet. Ex. 9).

Medications prescribed for detoxification are dispensed in the morning and in the evening in the double detox area. Nurse Gladys Reimers, a Corizon Health Services employee, dispensed medication to inmates in the double detox area the evening of July 16, 2011. Ms. Reimers testified about her procedure for dispensing medication in the unit. At the start of her shift she obtains a list of inmates who are to receive medication and retrieves the medication from the pharmacy before she is escorted to the unit by a correction officer. On arrival, Ms. Reimers goes to the mini clinic, located just outside the double detox dormitory area. She notifies the medication officer, who is responsible for supervising the inmates as medicine is being distributed, when she is ready to begin dispensing medication (Tr. 50, 53, 56; Pet. Exs. 2, 13-15).

The medication officer tells the inmates to line up for their medication and Ms. Reimers dispenses medication to the inmates after checking identification and verifying that the inmate is on the list to receive the medication (Tr. 50-51). Ms. Reimers first dispenses methadone to all the inmates to whom it is prescribed, then accounts for the methadone and completes paperwork regarding its distribution (Tr. 58-59, 72-73). Ms. Reimers testified that after she has dispensed methadone, she takes the vital signs of the inmates who are to receive Librium before she dispenses that medication (Tr. 50-51). Dispensing methadone and Librium to one inmate can take several hours to complete (Tr. 56, 80).

Ms. Reimers testified that if an inmate who is on her list to receive medication does not appear when the medication is dispensed, she notifies the medication officer. That officer then goes into the housing area and calls the inmate. Ms. Reimers remains inside the mini clinic area and is unaware what additional steps, if any, the medication officer takes to try to locate the inmate (Tr. 82-83). The medication officer notifies Ms. Reimers if he or she is unable to locate

the inmate and Ms. Reimers notes in her records that the inmate missed his dosage (Tr. 51, 82-83).

AR received his medication on July 15, 2011, but did not receive any of the prescribed doses on Saturday, July 16, 2011 (Pet. Ex. 11). AR missed the morning dose of Librium on July 16th because he had been removed from the double detox area and taken for X-rays when the medication was distributed (Tr. 104, 163; Pet. Exs. 11, 21). Ms. Reimers testified that her notes on the form on which administration of Librium was documented on July 16th indicate that AR missed the evening dose because he had not been produced by the Department when Librium was dispensed at 9:00 p.m. and that he was "not in area as per [the Department]" (Tr. 52; Pet. Ex. 11). Ms. Reimers acknowledged, however, that she had no specific recollection about AR or what steps, if any, were taken to locate him when he failed to appear for his medication (Tr. 62, 83-84).

Officers Wisher and Burt worked the 3:00 to 11:31 p.m. tour in the double detox unit (Tr. 245, 346). Officer Burt testified that she has been a correction officer since 2007 and has worked in the double detox area for three to four years as the B post officer. Her responsibilities include taking the inmate count, announcing services that are being provided to the inmates, feedings, and ensuring inmates are safe from harming themselves and one another (Tr. 246; Pet. Ex. 4). During medication distribution, Officer Burt is responsible for announcing which medication is being dispensed so the inmates can line up (Tr. 248). According to Officer Burt, she is not told which inmate is to receive what medicine: only the nurse and the medication officer are privy to that information (Tr. 249).

On July 16, 2011, several minutes after Officer Burt announced that the medical staff was ready to start dispensing medication and the inmates had lined up, AR started to shout that someone was trying to cut him (Tr. 256, 278; Pet. Ex. 27A at 17-19, 25). After AR identified two inmates, Officer Burt searched them, but found no weapons (Tr. 256). Officer Burt testified that she grew concerned for AR's safety in the wake of his baseless allegations about the other inmates, so she called Officer Wisher, the A post officer. She notified him that she had removed AR from the medication line (Tr. 257, 279, 282-83, 291). Officer Burt asked Officer Wisher to put AR on the bridge, an area located just outside the dormitory and mini clinic, and to notify the captain (Tr. 257, 279, 282-83; Pet. Exs. 13-20). Officer Burt did not recall notifying anyone other than Officer Wisher that she had removed AR from the medication line (Tr. 282-83).

Officer Burt testified that AR did not tell her that he had not received his medication (Tr. 259). According to Officer Burt, when inmates miss a dose of medication, they typically complain (Tr. 260). She maintained that it is the responsibility of the clinic staff or the medication officer, not that of the B post officer, to ensure that an inmate receives his or her medication (Tr. 249-50, 261-63). She further testified that she did not recall receiving notice from the medication officer that AR had not received his medication (Tr. 259). On cross-examination, Officer Burt conceded that she could have notified the nurse or medication officer inside the mini clinic that AR had been removed from the medication line. She testified that it may have "slipped [her] mind" to notify the appropriate staff because the housing area was very busy and a hostile situation between inmates demanded her attention (Tr. 290-91). Officer Burt did not have any further contact with AR after he was placed on the bridge (Tr. 257, 261). Indeed, between 6:45 p.m. and 12:15 a.m., when her tour ended, Officer Burt conducted 12 tours of the housing area, yet she did not check on AR, nor did she ask Officer Wisher about his welfare (Tr. 281-82, 287-88).

Officer Wisher has worked in the double detox unit for eight years (Tr. 298-99). On the evening of July 16, 2011, he was on duty as the A post officer (Tr. 311). As the A post officer, he was responsible for monitoring the inmate count, log books, and phones, and for informing the B post officer of activities in the housing area (Tr. 299-300; Pet. Ex. 3).

According to Officer Wisher, Officer Burt notified him that AR was claiming that other inmates were trying to cut him and acting erratically (Tr. 312). Officer Wisher testified that inmates had been called to line up for their medication before AR's erratic behavior started and that he knew that most of the inmates who lined up did so for Librium or methadone (Tr. 324-25). According to Officer Wisher, he observed Officer Burt searching the inmates as AR continued to behave irrationally (Tr. 312). Officer Burt brought AR to Officer Wisher, who placed AR on the bridge (Tr. 312).

Like Officer Burt, Officer Wisher maintained that he put AR on the bridge out of concern for AR's safety and that of the other inmates and the officers. Officer Wisher believed that had he put AR back into the housing area and AR interrupted the distribution of medication, it probably would have led to a fight and a use of force (Tr. 313-14). Officer Wisher maintained that while AR was on the bridge he spoke to him periodically and that at no time did AR tell him that he needed medication (Tr. 312-13). Officer Wisher completed a mental health form for the

inmate and notified the area supervisor, Captain Moises Walden, that AR had been placed on the bridge (Tr. 312-13, 327).

Officer Wisher testified that when Captain Walden arrived at the double detox unit he gave the mental health form to the captain (Tr. 313). Captain Walden returned the form to Officer Wisher and directed him to submit it to the clinic at the end of his tour (Tr. 313, 318). Captain Walden went to the bridge, where he spoke to AR for about 15 minutes (Tr. 313, 317). Officer Wisher testified that he witnessed the conversation between Captain Walden and AR and that AR did not tell the captain that he needed medication (Tr. 313, 317-18).

It bears mention that there are inconsistencies between Officer Wisher's statements in his Mayoral Executive Order 16 ("MEO 16") interview and his testimony in this proceeding. For example, in his MEO 16 interview he denied that Officer Burt notified him that AR was acting irrationally; instead, he claimed he observed AR acting irrationally on the medication line (Pet. Ex. 26A at 12-13). Yet, he testified in this proceeding that it was Officer Burt who notified him that AR had been acting irrationally (Tr. 312). Further, Officer Wisher stated during his MEO 16 interview that he did not see Officer Burt pat or frisk any inmates when AR started to act erratically (Pet. Ex. 26A at 42-43). Yet, in his testimony in this matter he maintained that he observed her search the inmates for weapons (Tr. 312). While nearly three years have elapsed between the incident and Officer Wisher's testimony, these inconsistences call his credibility into question.

AR remained on the bridge for three to four hours (Tr. 313-14, 337-40). Officer Wisher testified on cross-examination that he did not notify the nurse or the medication officer that AR had been removed from the housing area because if they were looking for AR, they would have contacted him or Officer Burt (Tr. 347).

Captain Walden went to the double detox area at about 10:20 p.m., and spoke to AR with the help of another inmate, who assisted with translation and helped calm AR down (Tr. 110, 140; Pet. Ex. 22). After the conversation between the captain and AR, AR and the other inmate returned to the housing area (Tr. 140). While he was somewhat evasive in his responses, Captain Walden testified that he did not discuss whether AR had received his medication with Officers Wisher and Burt (Tr. 105-06, 111, 117). Captain Walden was, however, much less equivocal

during an MEO 16 interview on February 29, 2012, when he stated that no one informed him that AR needed medication (Pet. Ex 29A at 23, 45).[2]

Captain Walden acknowledged, with seeming reluctance, that when an inmate is placed on the bridge, it is the responsibility of the officers in the housing area to ensure that the inmate is given an opportunity to receive his or her medication (Tr. 115-16, 138-39). He testified that it is not normal practice to leave an inmate on the bridge for three hours (Tr. 115).

Respondents are charged with failure to notify their area supervisor, Captain Walden, or medical staff, that AR had not received his medication. Department Rule 3.05.120 provides that correction officers "are responsible for the efficient performance of their duties and for the proper supervision of any inmates under their direction." Section 3-02(b) of the Department's Health Care Minimum Standards sets forth the obligations of Department employees to ensure inmate access to health care services. Section 3-02(b) provides that a Department employee "shall never prohibit, delay, or cause to prohibit or delay an inmate's access to care or appropriate treatment" and requires that he or she promptly notify medical staff and a uniformed supervisor if he or she "knows or has reason to believe that an inmate may be in need of health services."

Misconduct may be premised on carelessness or negligence, as well as willful or intentional conduct. *See, e.g., McGinigle v. Town of Greenburgh*, 48 N.Y.2d 949, 951 (1979); *Reisig v. Kirby*, 62 Misc. 2d 632, 635 (Sup. Ct. Suffolk Co. 1968), *aff'd*, 31 A.D.2d 1008, (2d Dep't 1969). This tribunal has held that "the degree of carelessness must be more than *de minimis*, since minor and inconsequential errors do not rise to the level of misconduct." *Dep't of Sanitation v. Nieves*, OATH Index No. 1683/07 at 2 (Sept. 19, 2007); *see also Dep't of Sanitation v. Richards*, OATH Index No. 529/06 at 3 (Feb. 3, 2006); *Dep't of Sanitation v. Frank*, OATH Index No. 465/03 at 8 (Feb. 28, 2003). Moreover, a single error may constitute negligence where the agency has a particular interest in accuracy or there is a potential for adverse consequences. *See, e.g., Dep't of Environmental Protection v. Majors*, OATH Index No.

[2] Respondents' counsel objected to the admission of Captain Walden's MEO 16 interview into evidence, on the grounds that the interview, which petitioner offered into evidence after the captain's testimony had concluded, was duplicative and irrelevant. Respondents' counsel further contended that offering the interview after Captain Walden had been excused as a witness was an effort to circumvent effective cross-examination. Petitioner maintained that the evidentiary significance of the MEO 16 interview became apparent after Captain Walden's testimony and that his statements during the interview are relevant to these proceedings (Tr. 153-56). I admitted the interview into evidence over respondents' objection and provided respondents' counsel an opportunity to review the interview and recall Captain Walden to testify at a later date (Tr. 157-58). Respondents did not seek to recall the captain.

1024/10 at 4 (Mar. 10, 2010), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 11-35-A (May 11, 2011) (respondent guilty of negligence for his failure to include his truck's breakdown on his daily log sheet since the Department had an interest in accounting for its heavy equipment for liability and repair purposes); *Richards*, OATH 529/06 at 7 (finding respondent's failure to fuel a truck was negligent as it was an important task and the failure to perform it had adverse consequences).

The evidence establishes that Officers Wisher and Burt were negligent and that their negligence constitutes misconduct. Having worked in the double detox area for an aggregate of over a decade, they were aware that the purpose of the double detox unit is to help newly admitted inmates manage the symptoms associated with alcohol and opiate withdrawal. They knew that inmates in the unit receive medication on a fixed schedule as part of the detoxification protocol. They also knew that AR was waiting on line to receive medication, which had not yet been dispensed, when they removed him from the line for acting irrationally. He remained on the bridge for over three hours, during which time medication was dispensed in the mini clinic. Given the circumstances here, respondents were careless when they failed to notify the medical staff and the area supervisor that AR had been removed from the line before medication had been dispensed.

The Department, whose primary function is the care, custody, and control of inmates, is entitled to require that its officers consider the context in which they are performing their responsibilities in order to ensure that inmates receive the appropriate level of care. *See Human Resources Admin. v. Bellamy*, OATH Index No. 1665/03 at 9 (Jan. 9, 2004), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 07-14-SA (Feb. 9, 2007) (eligibility specialist who had little or no awareness of or concern for the context in which she was processing paperwork negligently performed her duties when she denied a homeless client and his children emergency needs benefits when the agency's procedures did not require denial of those benefits). Here, the context included respondents' work in the double detox area and their knowledge that the inmate had been acting irrationally, which precipitated his removal from the medication line before medication was dispensed. To his credit, Officer Wisher completed a mental observation form for AR and tried to submit that form to the captain, but he failed to notify anyone that AR had not received his medication.

Respondents refused to accept responsibility and sought to shift the blame for AR's failure to obtain his medication to others. Officer Burt testified that inmates who do not receive their medication typically complain to the officers (Tr. 260), suggesting that it was the inmate's responsibility to alert the appropriate staff that he did not receive his medication. It is unreasonable to expect that someone in AR's condition would have the presence of mind to alert the appropriate personnel that he had missed his medication. Furthermore, the double detox area is for newly admitted inmates: it is irresponsible to presume that a newly admitted inmate is familiar with the routines of the unit so that he would know to ask the appropriate staff members for his medication. Respondents also maintained that it is the responsibility of the medication officer and the clinic staff to ensure an inmate is afforded his or her medication (Burt: Tr. 249-50, 261-63; Wisher: Tr. 309, 347-48). However, while others may have been deficient in the performance of their duties in this tragic incident, it does not relieve respondents of responsibility for their own failure to act. Finally, respondents were aware that AR had not received his medication before they removed him from the line for acting irrationally and placed him on the bridge. It was their responsibility to follow through to ensure that AR received his medication after their actions prevented him from obtaining it when it was being dispensed.

In sum, I find that the preponderance of the credible evidence establishes that Officers Wisher and Burt failed to efficiently perform their duties when they took AR off the medication line and placed him on the bridge then failed to notify the area supervisor or the medical staff that he had not received his medication.

FINDINGS AND CONCLUSIONS

1. Respondent Burt was deficient in the performance of her duties in that on July 16, 2011, she failed to notify the area supervisor or medical staff that an inmate she had removed from the medication line had not been afforded his medication.

2. Respondent Wisher was deficient in the performance of his duties in that on July 16, 2011, he failed to notify the area supervisor or medical staff that an inmate had been removed from the medication line before medication had been dispensed and had not been afforded his medication.

RECOMMENDATION

Upon making the above findings and conclusions, I obtained and reviewed abstracts of the employee performance service report (Form 22R) of Officers Wisher and Burt for purposes of recommending an appropriate penalty. Officer Wisher has been employed by the Department since November 1996 and Officer Burt has been employed since August 2007. Neither officer has any prior disciplinary history. Petitioner requested that each officer be suspended for 20 days.

This tribunal has recommended penalties in the range of eight to ten days' suspension without pay in cases where a City employee charged with the responsibility to watch over others has been negligent in performing that duty, where that employee has no relevant disciplinary history. *See, e.g., Health and Hospitals Corp. (Woodhull Medical and Mental Health Ctr.) v. Goodman*, OATH Index No. 1425/06 at 9 (Aug. 1, 2006), *adopted*, Exec. Dir. Dec. (Aug. 31, 2006) (hospital police officer with 18 years of service briefly left a patient he had arrested waiting for medical attention unattended, permitting his escape from custody when patient leapt off a gurney; eight-day suspension without pay); *Dep't of Correction v. Andrejcisk*, OATH Index No. 1537/03 at 5 (Feb. 12, 2004), *adopted*, Comm'r Dec. (June 17, 2004) (ten-day suspension without pay for correction officer with 17 years of service who was negligent in failing to check an inmate for "signs of life" and did not notice for three hours that the inmate had died; where respondent had reason to avert his gaze from inmate on rounds); *Dep't of Correction v. Maldonado*, OATH Index No. 1373/99 (Oct. 14, 1999) (ten-day suspension recommended for correction officer who negligently stepped out of an A station booth to speak with an inmate who approached without permission), *modified on penalty*, NYC Civ. Serv. Comm'n Item No. CD 00-87-M (Aug. 7, 2000) (penalty reduced to five-day suspension).

However, where the negligent conduct involves aggravating factors such as a risk to safety or security, or where the respondent had a disciplinary history, recommendations have ranged from 15 days suspension to termination of employment. *See, e.g., Admin. for Children's Services v. Matos-Miranda*, OATH Index No. 728/12 (Apr. 13, 2012), *adopted*, Comm'r Dec. (May 1, 2012) *(18-day suspension without pay imposed where* juvenile counselor left child unattended for approximately half an hour and failed to take a proper headcount of the children in her charge); *Dep't of Correction v. Davis*, OATH Index No. 141/11 (Feb. 18, 2011)

(termination of employment recommended for correction officer who switched posts without authorization and failed to conduct scheduled tours of housing area where inmate committed suicide during time when tour of housing area should have been conducted); *Dep't of Correction v. Gonzalez*, OATH Index No. 187/07 (Feb. 20, 2007), *adopted*, Comm'r Dec. (May 7, 2007) (15-day suspension imposed for inaccurate inmate count slip); *Admin. for Children's Services v. Gold*, OATH Index No. 585/05 (Apr. 13, 2005), *adopted*, Comm'r Dec. (May 11, 2005), *aff'd*, NYC Civ. Serv. Comm. Item No. CD 07-40-SA (Apr. 9, 2007) (termination of employment imposed on supervisor of group home for failing to follow agency procedures requiring that he report adolescent's two-week AWOL to police and contact family and friends; the child, who died shortly after he escaped, lay in morgue unidentified for two weeks due to negligence); *Dep't of Correction v. Grandberry*, OATH Index No. 153/01 (Feb. 9, 2001) (given correction officer's prior disciplinary record, 25-day unpaid suspension recommended for failure to be alert while on duty), *adopted*, Comm'r Dec. (Apr. 10, 2001), *modified on penalty*, NYC Civ. Serv. Comm'n Item No. CD02-56-M (June 18, 2002) (penalty reduced to 18 days' suspension without pay).

Here, Officers Burt and Wisher have unblemished disciplinary records and Officer Wisher has a lengthy tenure, having served the Department for almost 18 years. However, their negligence warrants a penalty consistent with those recommended where there have been aggravating factors. The officers were equally careless and I find that under the facts here there is no basis for imposing different penalties for the same misconduct. The Department requested 20-day suspension for each officer and I so recommend.

The failure of a responsible party to fulfill his or her obligations can have far-reaching effects. I am not required to nor do I reach any conclusion as to a causal nexus between the respondents' failure to notify the appropriate personnel that AR had not received medication when he was removed from the medication line and AR's death after a use of force involving other officers. It must be noted, however, that AR did not receive medication that was prescribed to manage symptoms of alcohol and heroin withdrawal, such as agitation, anxiety, and hallucinations, and he died after a use of force that started when he behaved erratically. In light of the significant responsibility the Department bears for the safety of inmates, it rightly requires that its officers diligently care for inmates who are in the Department's custody. This is especially true with a vulnerable inmate such as AR, who was in a unit dedicated to addressing

medical needs associated with alcohol and opiate withdrawal. Respondents failed to exercise the appropriate level of care.

Therefore, I recommend that Officer Wisher be suspended without pay for 20 days and that Officer Burt be suspended without pay for 20 days.

Astrid B. Gloade
Administrative Law Judge

May 19, 2014

SUBMITTED TO:

JOSEPH PONTE
Commissioner

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