THE DISTRICT OF COLUMBIA

BEFORE

THE OFFICE OF EMPLOYEE APPEALS

In the Matter of:	)	
	)	
EMPLOYEE[1],	)	OEA Matter No. 1601-0022-25R26
	)	
v.	)	Date of Issuance: May 26, 2026
	)	
D.C. FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT, Agency	)	MONICA DOHNJI, Esq. Senior Administrative Judge
	)	

Philip Andonian, Esq., Employee's Representative
Connor Finch, Esq., Agency's Representative

INITIAL DECISION ON REMAND

INTRODUCTION AND PROCEDURAL HISTORY

On January 31, 2025, Employee filed a Petition for Appeal with the Office of Employee Appeals ("OEA" or "Office") contesting the D.C. Fire and Emergency Medical Services Department's ("Agency" or "FEMS") decision to terminate him from his position as a Firefighter Paramedic effective January 18, 2025. OEA issued a Request for Agency's Answer to Employee's Petition for Appeal on February 3, 2025. Agency filed its Answer to Employee's Petition for Appeal on February 26, 2025.

This matter was assigned to the undersigned Senior Administrative Judge ("SAJ") on February 27, 2025. I issued an Order on March 10, 2025, Convening a Status/Prehearing Conference in this matter for April 1, 2025. Both parties were present at the scheduled conference. During the Status/Prehearing Conference, the undersigned was informed that an Adverse Action Panel Hearing was convened in this matter on August 20, 2024, August 21, 2024, and October 24, 2024. As such, OEA's review of this appeal was subject to the standard of review outlined in *Elton Pinkard v. D.C. Metropolitan Police Department,* 801 A.2d 86 (D.C. 2002).

Subsequently, on April 1, 2025, I issued a Post Status/Prehearing Conference Order, requiring the parties to submit written briefs. Agency's brief was due by May 6, 2025; Employee's brief was due by June 3, 2025; and Agency had the option to submit a sur-reply by June 17, 2025. On April 30, 2025, Agency filed a Consent Motion to Supplement and Clarify the Administrative Record. Agency timely submitted its brief on May 6, 2025. However, Employee did not submit his brief by the June 3, 2025, deadline. Accordingly, on June 9, 2025, the undersigned issued an Order for Statement of Good Cause wherein,

[1] Employee's name was removed from this decision for the purposes of publication on the Office of Employee Appeals' website.

Employee was ordered to explain his failure to respond to the April 1, 2025, Order. Employee had until June 23, 2025, to respond to the Statement of Good Cause Order. Following Employee's failure to comply with the Statement of Good Cause Order, on June 25, 2026, the undersigned issued an Initial Decision dismissing Employee's Petition for Appeal for failure to prosecute.

Employee filed a Petition for Review with the OEA Board on July 25, 2025. Thereafter, on October 28, 2025, Agency filed an Answer to Employee's Petition for Review. The OEA Board issued an Opinion and Order ("O & O") on Petition for Review on December 18, 2025, remanding this matter to the undersigned "for consideration on the merits of the case." Accordingly, on January 5, 2026, I issued an Order setting briefing schedules for the parties. Employee's brief was due by January 27, 2026, and Agency's Sur-reply was due by February 11, 2026. On January 22, 2026, Employee filed an Unopposed Motion for Modification of Briefing Schedule. The undersigned issued an Order on January 27, 2026, granting Employee's Motion and adjusted the briefing schedule. Employee's brief was now due by February 10, 2026, and Agency's Sur-reply was due by February 25, 2026. On February 10, 2026, Employee filed a second Unopposed Motion for Modification of Briefing schedule, requesting that Employee's brief submission deadline be extended to February 13, 2026, and Agency's Sur-reply submission deadline be extended to March 2, 2026. I issued an Order on February 13, 2026, granting Employee's Motion. Both parties have timely filed their respective briefs. The record is now closed.

JURISDICTION

The Office has jurisdiction in this matter pursuant to D.C. Official Code § 1-606.03 (2001).

ISSUES

1) Whether the Trial Board's decision was supported by substantial evidence;
2) Whether there was harmful procedural error;
3) Whether Agency's action was done in accordance with applicable laws or regulations.

BURDEN OF PROOF

OEA Rule § 631.1, 6-B District of Columbia Municipal Regulations ("DCMR") Ch. 600, et seq (December 27, 2021) states:

> The burden of proof for material issues of fact shall be by a preponderance of the evidence. "Preponderance of the evidence" shall mean:
>
> > the degree of relevant evidence that a reasonable person, considering the record as a whole, would accept as sufficient to find that a contested fact is more likely to be true than untrue.[2]

OEA Rule § 631.2 *id.* states:

> For appeals filed under § 604.1, the employee shall have the burden of proof as to issues of jurisdiction, including timeliness of filing. The agency shall have the burden of proof as to all other issues.

[2] OEA Rule § 699.1.

STATEMENT OF THE CHARGE(S)

According to Agency's Answer to Employee's Petition for Appeal[3], Employee's adverse action was predicated on the following charges and specifications, which are reprinted in pertinent part below:

Charge 1 Violation of D.C. Fire & Emergency Medical Services Department Order Book Article VI, § 6 (Conduct Unbecoming an Employee), which states:

> Conduct unbecoming an employee includes conduct detrimental to good discipline, conduct that would adversely affect the employee's or the agency's ability to perform effectively, or any conduct that violates public trust or law of the United States, any law, municipal ordinance, or regulation of the District of Columbia committed while on–duty or off–duty.

Further violation of D.C. Fire and Emergency Medical Services Department Bulletin No. 3 (Patient Bill of Rights), which states:

> As our patient, you have the right to expect competent and compassionate service from us.
>
> * * *
>
> You may expect:
>
> * * *
>
> 2. To receive a timely medical assessment and determination of an appropriate level of medical care.
>
> * * *
>
> 11. That all of our personnel will be polite, compassionate, considerate, empathetic, respectful, and well mannered.

Further violation of D.C. Fire and Emergency Medical Services Department Bulletin No. 0 (Mission Statement, Vision Statement and Core Values), § 2.3, which states:

> The fundamental beliefs of the District of Columbia Fire and Emergency Medical Services Department are defined in our Core Values. The Core Values guide the Department in our behavior, training and our ability to complete our mission. Our Core Values are:
>
> * * *

[3] Agency Answer at Tab 27 (February 26, 2025).

2.3.3 *Safety* — we are uncompromising in our fundamental commitment to safety for ourselves and our community; creating operational excellence.

* * *

2.3.5 *Compassion* —we respect and treat every person with dignity, empathy and equity.

This misconduct is defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII, § 2(f)(3), which states: "Any on-duty or employment-related act or omission that interferes with the efficiency or integrity of government operations, to include: Neglect of Duty." See also 16 DPM § 1603.3(f)(3) (rev. 08/27/2012); see also 16 DPM § 1605.4(e) (rev. 06/12/2019).

Specification 1

Specifically, in her Final Investigative Report (dated 02/01/2024), EMS Captain Melonie C. Barnes describes FF/P [Employee's] misconduct as follows:

CHRONOLOGICAL NARRATIVE SECTION

On or about November 8, 2023, the Office of Internal Affairs received a complaint regarding Firefighter Paramedic [Employee] and his actions while rendering patient care on the scene of a medical response at Union Station on October 30, 2023.

EMS Battalion Chief Derek Weinroth forwarded a complaint through the Medical Director regarding Firefighter Paramedic [Employee] administering a patient intramuscular (IM) Narcan through multiple layers of clothing. This complaint was forwarded to the Office of Internal Affairs for review.

* * *

INVOLVED MEMBER(S) STATEMENT(S)

On January 23, 2024, Firefighter Paramedic [Employee] reported to the Office of Internal Affairs regarding the complaint initiated by the Amtrak Police Department. [. . .]

During his interview in part, [FF/P] [Employee] related he was working on Medic 2, and they were dispatched from quarters, with Ambulance 16 to Union Station. He related that they were initially placed in service, and then requested to come to the scene for a patient with a low heart rate.

[FF/P] [Employee] stated Medic 2 arrived on the scene and parked behind Ambulance 16. [FF/P] [Employee] related when he arrived on the scene, he saw a male patient sitting in a wheelchair slumped over and an officer was holding his head. He related that he sent his partner to see what was going on while he grabbed his ALS equipment. Before he got to the patient, he suspected that it was an overdose. [FF/P] [Employee] said he took a quick

look at the patient, and he was unresponsive and wasn't really with it, altered, and had pinpoint pupils.

[FF/P] [Employee] related from there, he remembered that the patient's sleeve was rolled all the way up and he needed to give the patient vital signs, some medication, and some oxygen. [FF/P] [Employee] recalled that the ambulance said he had a heart rate of 40, so he felt the patient was not good. [FF/P] [Employee] related that the patient had a heart rate of 90, and he administered a dose of Narcan, and slightly after that, he became more responsive.

[FF/P] [Employee] related after that, he remembers bending over and talking with the patient and begging him to go to the hospital telling him he wasn't breathing.

[FF/P] [Employee] said he practically begged the patient to go to the hospital but refused. At that point, he asked the basic unit to get the refusal.

He related that the ambulance did not feel comfortable getting the refusal, so they called for an EMS Supervisor. He said the EMS Supervisor came to the scene and had a conversation with him and Ambulance 16 separately. He said he came back and told him that the basic unit should've gotten the refusal. Afterward, they went back in service.

* * *

[FF/P] [Employee] [said that] when he and his partner arrived on the scene, he remembered telling her that this patient looked kind of messed up, so as they were walking towards him, he related that he was going to go back and get his stuff. [FF/P] [Employee] related that he grabbed his monitor and all of his equipment. He said Ambulance 16 had their oxygen on the patient, so he didn't bring his. [FF/P] [Employee] related that [FF/EMT Tarkeyia] Peterson walked up to him and told him the patient was altered, and not responsive, and the basic unit said his heart rate was 40.

[Employee] related that he does not remember directing his partner to do anything, but he remembers taking a good look at the patient and he recognized he was unresponsive, or slow to respond, and had pinpoint pupils. He related that he believed that he had taken his vitals. [FF/P] [Employee] said that he performed an assessment and gave him Narcan and his left deltoid.

[FF/P] [Employee] related that he checked his blood pressure, his heart rate, his blood sugar, and his oxygen saturation. He related that the patient had a response to the Narcan after a few minutes. [FF/P] [Employee] related that he does not know if he received any Narcan before their arrival because he did not receive a report, that he did, however, he admitted to seeing citizen Narcan on the ground near the patient. [FF/P] [Employee] related that he did

not speak to the police or asked if they gave Narcan, he just went with the signs and symptoms of the unresponsive patient. [FF/P] [Employee] said he completed the [electronic Patient Care Report (ePCR)] run sheet for this call.

* * *

[FF/P] [Employee] was asked why the basic unit was expected to get the refusal when he gave the medication, and he stated that Narcan is a basic drug and the supervisor sided with him, that the primary responding unit should get the refusal.

* * *

[FF/P] [Employee was] asked if he administered the Narcan through the patient's clothing, and he related that he did not remember, but if he did, he was scared because the patient had a heart rate of 40 and was unresponsive. [FF/P] [Employee] stated that he does not remember doing such a thing, but if there was a document that said he did, it was because he was afraid.

[FF/P] [Employee] says he never administered Narcan through a person's clothing before. He related that he doesn't remember if the patient at Union Station's heart rate was 40, or if he gave it before he checked the heart rate, but he administered the medication in an emergent manner based on the signs and symptoms of an overdose.

[FF/P] [Employee] was asked if he knew the administration routes of Narcan and he related that he did. He also noted the worst thing that can happen by administering IM medication through multiple layers of clothing is infection. He was asked if infections can kill people, and he related that infection does kill people if it's left untreated. [FF/P] [Employee] was asked if he was taught to administer medication through clothing in paramedic school, and he said no.

[FF/P] [Employee] was given an opportunity to view the body–worn camera footage associated with this incident.

The body–worn camera footage shows [FF/P] [Employee] walking up to the patient and saying nothing to him or performing an assessment. He immediately stuck him in the arm and administered an IM dose of Narcan through multiple layers of clothing.

After viewing the video, [FF/P] [Employee] was asked if the video was consistent with what occurred on the scene, and he said yes. **The video revealed [FF/P] [Employee] did not check pupils or perform an assessment**. [FF/P] [Employee] related that the patient was so emergent that he gave the medication through his clothes. [FF/P] [Employee] was asked if the patient was so emergent, why didn't he administer any oxygen to him.

He had no response. [FF/P] [Employee] related that he should have administered the medication using an aseptic technique, and this practice was not consistent with what he learned in paramedic school or consistent with this agency's protocols.

FF/P [Employee's] serial failures to follow instructions and careless / negligent work habits constitute neglect of duty. Accordingly, this termination action is proposed.

Charge 2 Violation of D.C. Fire and Emergency Medical Services Department Order Book Article VI, § 4 (Arrests, Indictments, Convictions and Investigations), which states:

> When being questioned by superior officers in connection with matters relating to official business of the Fire & EMS Department, members shall respond truthfully to all questions posed during their interview. Additionally, during the course of an investigation all members shall respond truthfully to questions by any investigator or official of the Office of Internal Affairs (OIA), even if the investigator is not of a superior rank. All OIA investigators act on behalf of the Department and the Fire Chief and as such are authorized to conduct any and all activities within the scope of their duties in the furtherance of an investigation.
>
> Any member who willfully and knowingly makes untruthful statements of any kind, or who refuses, or fails to make truthful statements in a verbal or written report pertaining to his official duties as a Fire & EMS Department employee is subject to disciplinary action, including dismissal.

Further [violation] of D.C. Fire and Emergency Medical Services Department Rules and Regulations, Article VI (**General Rules of Conduct**), which states:

> **Section 8**. Members shall refrain from immoral conduct, deception; violation or evasion of law or official rule, regulation, or order; and from false statements.

This misconduct is defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII, § 2(f)(3), which states: "Any on-duty or employment-related act or omission that interferes with the efficiency or integrity of government operations, to include: Neglect of Duty." See also 16 DPM § 1603.3(f)(3) (rev. 08/27/2012); see also 16 DPM § 1605.4(e) (rev. 06/12/2019).

Specification 1 Specifically, in her Final Investigative Report (dated 02/01/2024), EMS Captain Melonie C. Barnes describes FF/P [Employee's] misconduct as follows:

FINDINGS

> During this investigation and the Administrative Interview, it was revealed that Firefighter Paramedic [Employee] was willfully misleading, contradictory, and untruthful in most of his statements to investigators. The

following are a few false and misleading statements that were made. In his interview:

[FF/P] [Employee] related when he arrived on the scene, he saw a male patient sitting in a wheelchair slumped over and an officer was holding his head. This was **FALSE**. In the BWC footage, no officer was holding the head of the patient.

[FF/P] [Employee] said he took a quick look at the patient, and he was unresponsive, wasn't really with it, altered, and had pinpoint pupils. This was **FALSE**. In the BWC, [FF/P] Ahmed never looked at the patient in the face, asked him a question, or made contact with him, until he stuck him with a syringe through his clothing.

[FF/P] [Employee] related from there, he remembered that the patient's sleeve was rolled all the way up and he needed to give the patient some medication, oxygen, and get vital signs. This was **FALSE**. In the BWC, you can see the patient's sleeve was not rolled up, nor did [FF/P] [Employee] administer oxygen to the patient.

[FF/P] [Employee] related that the ambulance did not feel comfortable getting the refusal, so they called for an EMS Supervisor. He said the EMS Supervisor came to the scene and had a conversation with him and Ambulance 16 separately. He said he came back and told him that the basic unit should've gotten the refusal. This was **FALSE**. Per Captain Drucker's interview and Special Report, he did not side with either party regarding who should get a refusal.

[FF/P] [Employee] firmly disputed ever administering IM medication through the clothing of patients until the video evidence was presented. He seemingly changed and gave an excuse that he only does this when it’s an emergency or when he doesn't have the proper equipment. [FF/P] [Employee] even goes on to say that the worst thing to happen to a patient is that they get an infection secondary to receiving an IM injection through clothing.

As a first responder practicing pre-hospital paramedicine in a 911 System, all of the responses and calls for service are emergent, and as providers, we expect to operate effectively within the agency's guidelines during emergencies, especially when you have a multitude of additional resources at your disposal.

Having what appeared to be a cavalier attitude and stating the worst that could happen to a patient who receives an IM injection through their clothing is an infection, is a direct contradiction to our agency's core values of compassion, service, and integrity. Numerous people die from infections.

> FF/P [Employee's] provision of misleading, inaccurate, and untruthful information constitutes neglect of duty. Accordingly, this termination action is proposed.

On August 20, 2024, August 21, 2024, and October 24, 2021, Employee appeared before a Fire Trial Board. Employee was represented by counsel, and he pled Not Guilty to Charge 1 and Charge 2.[4]

SUMMARY OF THE TESTIMONY[5]

On August 20, 2024, August 21, 2024, and October 24, 2024, Agency held a three (3) day Trial Board Hearing. During the hearing, testimony and evidence were presented for consideration and adjudication relative to the instant matter. The following represents what the undersigned has determined to be the most relevant facts adduced from the findings of fact, as well as the transcript (hereinafter denoted as "Tr."), generated and reproduced as part of the Trial Board Hearing.

Vol. 1 – August 20, 2024

Employee's Case-in-Chief

1) Tarkeyia Peterson ("FF/EMT Tarkeyia")– Tr. Vol. I. pgs. 29-46

Firefighter/EMT Tarkeyia Peterson works at Agency. She confirmed that she and her partner, Employee, were present at a call for an overdose at Union Station on October 30, 2023. FF/EMT Peterson noted that once they arrived at the scene, she was the first to go to the patient, and she asked the crew that was already on the scene what they had and what they needed. FF/EMT Peterson stated that she then hooked the patient to a monitor to get baseline items. She affirmed that she assessed the patient when she first encountered the patient and she relayed that information to Employee before he administered Narcan to the patient. FF/EMT Peterson cited that while she could not recall the patient's exact vitals, she informed Employee that the patient's heart rate was fine, but they had 'pinpointed pupils.' Tr. Vol. I. pgs. 29-30.

FF/EMT Peterson recalled Employee administering Narcan to the patient. She stated that she was not sure if she was paying attention when Employee was administering the Narcan because she was still tending to the patient. She noted that she did not specifically see Employee administer the Narcan. FF/EMT Peterson reiterated that she approached the patient first, took his vitals and conveyed the information to Employee. She testified that before arriving at the scene, they communicated with the crew on the scene via radio, and based on the information they received, Employee advised her before they exited the unit at the scene that he needed to retrieve more Narcan from the back of the unit. FF/EMT Peterson asserted that prior to arriving at the scene, they knew the call was for an overdose. Tr. Vol. I. pgs. 31-33. FF/EMT affirmed that both she and Employee were paramedics and that in general, she would defer to Employee's medical assessment. She stated that she did not recall reviewing the EPCR report. Tr. Vol. I. pgs. 33 –34.

Referencing Agency's Exhibit 5 (video recording), starting at timestamp 13:45:30 to 14:01:00, FF/EMT Peterson confirmed taking the patient's vital once. She asserted that she did not conduct any patient assessment prior to taking the vitals because she asked Ambulance 16 and they had conducted the assessment. She identified herself in the video recording as standing to the left with braids/locks in her hair and talking to the patient. FF/EMT Peterson stated that this was when she first laid eyes on the patient and

[4] *Id*.
[5] *Id*. at Tabs 26, 22 and 21.

she was attempting to get the patient to sit back in the wheelchair, so he didn't fall forward. She confirmed that this happened shortly after she arrived at the scene. She stated that she spoke to the FF/EMT on the scene who verified the information they had before coming on the scene. Tr. Vol. I. pgs. 35-39.

Referring to timestamp 13:49:30 to 13:50:09 in Agency's Exhibit 5, FF/EMT Peterson explained that while FF/EMT 2 can't be seen on camera, he could be heard telling FF/EMT Peterson something about the patient's heart rate. Tr. Vol. I. pg. 40. FF/EMT Peterson acknowledged that there were instances where the camera was pointing away from the patient and that it was during that period that she arrived and was informed about the patient's heart rate by FF/EMT 2. She also confirmed that she took a good look at the patient at that point. FF/EMT Peterson testified that it appeared that Employee was standing right there with them at that time. Tr. Vol. I. pgs. 41-42.

When asked what the protocol for administering Narcan was, FF/EMT Peterson testified that from an EMT standpoint, it is done intranasally. She asserted that while it is protocol to talk to the patient before administering medication in the field, in the current incident, no one talked to this patient. FF/EMT Peterson also cited that if a paramedic treats a patient, the ALS provider was responsible for getting a refusal. Tr. Vol. I. pgs. 44-45.

Agency's Case-in-Chief

2) Kevin Dauphin ("Sgt. Dauphin") – Tr. Vol. I. pgs. 46 -60

Sergeant Kevin Dauphin is a Control Sergeant employed with the Amtrak Police Department since November 2005. He stated that in this role, he supervises officers within the District of Columbia, Maryland and Virginia. Sgt. Dauphin testified that Amtrak has jurisdiction over any crimes against Amtrak, its property, or patrons while within the system. He also asserted that Amtrak has a Memorandum of Understanding ("MOU") with the D.C. Metropolitan Police Department that covers Union Station, to New York Avenue and out to the D.C. line. Tr. Vol. I. pgs. 47-48.

Sgt. Dauphin recalled the October 30, 2023, incident involving an apparent overdose patient around Union Station. He testified that he received a call about an individual who fell off his wheelchair and was blocking the entrance to the west loading dock. Sgt. Dauphin stated that he and a few other officers arrived at the scene. Tr. Vol. I. pgs. 48-49.

Sgt. Dauphin identified Agency's Exhibit 4, Bates number 22-23, as an Amtrak Police Report. He noted that he was not the author of the document. He affirmed that he reviewed the document and based on his recollection, it was an accurate representation of the October 30, 2023, incident. Sgt. Dauphin explained that when they saw the individual who fell off his wheelchair, they noticed that he was under the influence of unknown narcotic, so they contacted Agency to respond, which they did with two (2) ambulances – a regular ambulance and a paramedic unit. Tr. Vol. I. pgs. 49-51.

Sgt. Dauphin testified that both ambulance units arrived around the same time. He explained that he noticed the "ambulance driver kind of waved off the paramedic unit, because they haven't evaluated them yet, so they weren't sure exactly what was wrong." He explained that when he and the officers first arrived at the scene, Officer Mawn, who had a firefighter background, evaluated the patient and administered some Narcan before calling Agency. Sgt. Dauphin cited that when the ambulance unit arrived, they evaluated the patient and they decided that they needed the medic/EMS unit to return because either the patient's pulse or blood pressure was low. He confirmed that the medic unit returned to the scene. Tr. Vol. I. pgs. 51-52.

Sgt. Dauphin testified that the medic unit had a male and female paramedic. He explained that once the unit arrived at the scene, the female paramedic came out first, while the male paramedic then came out with an 'AED' or defibrillator pack. He cited that the male paramedic placed the 'AED' on the ground and set up a syringe. Sgt. Dauphin stated that because it was cold, the patient was wearing many layers of clothing. He testified that the male paramedic "just gave him a shot right through all of his layers of clothing." Sgt. Dauphin stated that male paramedic told the patient he looked bad, asked him a few questions and if he wanted to go to the hospital. Tr. Vol. I. pgs. 52 -53.

Sgt. Dauphin stated that he did not recall any conversation with the medic unit when they arrived, other than the fact that they were advised that one (1) dose of Narcan had been administered to the patient. He cited that the male paramedic touched the patient's body before administering the Narcan. He stated that none of the members of the medic unit spoke to the patient before administering the Narcan. Tr. Vol. I. pgs. 53-55. Sgt. Dauphin identified Agency's Exhibit 5 as Officer Mawn's Amtrak body worn camera ("BWC"). Tr. Vol. I. pgs. 55-56.

Sgt. Dauphin cited that he was not familiar with Agency's protocols for when Narcan should be administered to a patient in the field. Tr. Vol. I. pg. 59. He cited that he had never seen Narcan administered to a patient through his clothes prior to the current incident or a provider treating a patient without asking questions. Tr. Vol. I. pg. 60.

3) Melonie Barnes ("Cpt. Barnes") – Tr. Vol. I. pgs. 62-136

Captain Melonie Barnes has been employed with Agency for twenty-seven (27) years. She currently works in the Office of Internal Affairs ("OIA") as an Investigator/Record Captain. As an Investigator, her duties include the investigation of egregious misconduct or criminal activities among the Department's members. Cpt. Barnes testified that she has worked with patient care as a paramedic and EMS supervisor in the quality oversight to field paramedics. Tr. Vol. I. pgs. 62-63.

Cpt. Barnes affirmed that she was asked to investigate a potential misconduct committed by Employee. She explained that they received a complaint from the Office of the Medical Director that Employee improperly administered medication through a patient's clothing. She confirmed that after the investigation, she prepared a final investigative report on the alleged misconduct, marked as Agency's Exhibit 1. Tr. Vol. I. pgs. 64- 65.

Cpt. Barnes identified Agency's Exhibit 2 as a Special Report submitted by Captain Michale Timmins ("Cpt. Timmins") and which she received at the beginning of her investigation. Cpt. Barnes testified that after she received this Special Report, she contacted Amtrak Police to obtain a Police Incident Report and BWC footage. She identified Agency's Exhibit 4 as the Police Incident Report she received from Amtrak Police for the current incident. Cpt. Barnes identified Agency's Exhibit 5 as the BWC footage of the Amtrak Police Officer on the scene of the incident in question that she received from the Amtrak Police Department. Cpt. Barnes identified Agency's Exhibit 3 as the initial complaint they received through the Medical Director's Office regarding Employee's patient care on the day of the incident. She cited that she reviewed the documents and BWC footage as part of her investigation. Tr. Vol. I. pgs. 66-69.

Cpt. Barnes confirmed that during her investigation, she interviewed Firefighter Tu Nguyen, his partner, Firefighter Tolliver, Captain Drucker, Firefighter Peterson, and Employee. Cpt. Barnes stated that she interviewed Employee last. She asserted that she directed Captain Drucker to submit a Special Report, but she did not request that Employee submit a Special Report. Cpt. Barnes affirmed that all the interviews

were recorded. She also stated that she showed Employee the BWC footage at some point during his interview. Tr. Vol. I. pgs. 70, 72, 92-96. Cpt. Barnes stated that she showed Firefighters Tolliver and Peterson the BWC footage when they got to her office for the interview, and before she questioned them about the incident at Union Station. Tr. Vol. I. pgs. 98-100.

Cpt. Barnes identified Agency's Exhibit 8 as the recording of the administrative interview she had with Employee. She identified Agency's Exhibit 2 as the staff roster which highlights who was working on a particular day. Cpt. Barnes cited that she reviewed the staff roster to determine who was assigned to the particular units on that day. Tr. Vol. I. pgs. 76-78.

Cpt. Barnes explained that as part of her investigation, she reviewed all evidence. She stated that the "ZOLL audio recording came from the ZOLL database website." Cpt. Barnes asserted that the ZOLL audio came from Medic 2, which was the unit Employee was on. Tr. Vol. I. pgs. 78-79.

Cpt. Barnes identified Agency's Exhibit 14 as the event chronology of the incident she received from the Office of Unified Communications ("OUC"). She affirmed that she reviewed this document during her investigation. Cpt. Barnes identified Agency's Exhibit 15 as "… a document with the Office of the Medical Director that indicates each time that [Employee] administered naloxone or Narcan to a patient between a certain time period for this period." Tr. Vol. I. pgs. 79-81. Cpt. Barnes testified that Employee operated outside of FEM's protocol when he administered Narcan on October 30, 2023. Tr. Vol. I. pgs. 82.

Cpt. Barnes defined the term 'willfully misleading' to mean "that [Employee] knew what occurred and he gave me something other than what occurred until he reviewed the evidence." She noted that thereafter, Employee changed his statement. Cpt. Barnes cited that one false statement during an interview is sufficient to consider an individual to be 'willfully misleading'. Tr. Vol. I. pgs. 87-92, 130, 134. Cpt. Barnes identified the following statements made by Employee that she considered in her investigative report to be 'willfully misleading:'

> "Firefighter [Employee] relayed that when he arrived on the scene, he saw a male patient sitting in a wheelchair slumped over and that officer was holding his head. This was not in the BWC footage. No officer was holding the head of the patient." Tr. Vol. I. pg. 101.

Upon review of the BWC footage at the 3 minutes and 2 seconds (3:02) mark, Cpt. Barnes affirmed that she could see the Officer's hand in the lower left-hand corner holding onto the patient's shirt. She also affirmed that at the 15 minutes and 38 seconds mark on the BWC footage, the Officer lets go of the patient and the patient's head slumps down and forward at that moment. Cpt. Barnes confirmed that she could hear one of the officers in the BWC video footage state that the patient had been falling over since they got him. Cpt. Barnes testified that while she reviewed the video footages during the investigation, she does not necessarily review them closely. She reiterated that her finding that Employee was 'willfully misleading' was based on Employee's statement. Cpt. Barnes stated that she did not see the officer holding the patient's head up. Tr. Vol. I. pgs. 102-106.

Reading from her report, Cpt. Barnes stated that "[Employee] said he took a quick look at the patient and he was unresponsive. Wasn't really with it. Altered and had pinpoint pupils. This was both in the BWC file [but Employee] never look at the patient in the face, asked him a question or made contact with him until he stuck him with a syringe through his clothing." Tr. Vol. I. pgs. 107. Referencing the above statement, Cpt. Barnes testified that according to the BWC video footage, Employee is seen "walking up to the patient, saying nothing to them nor performing an assessment, … he literally stuck him

in the arm and administered a dose of Narcan through the multiple layers of clothing." Upon review of the BWC video footage at time stamp 1448, Cpt. Barnes confirmed that the camera is pointed away from the patient and it stays pointed away from the patient until at least time stamp 1524. Cpt. Barnes also stated that she could also not see Employee on the video footage at this point, but she identified Firefighter Peterson approaching the patient. She further stated that Employee cited during the interview that his partner approached the patient first. Tr. Vol. I. pgs. 107-110.

Reviewing the BWC video footage at timestamp 15 minutes and 45 seconds (15:45), on the very left-hand side of the screen, Cpt. Barnes testified seeing fingers which she could not identify whom they belonged to because that was her first time seeing the fingers. She stated that she could not tell if the fingers belonged to Employee. Cpt. Barnes testified that almost everyone on the scene was wearing blue gloves, including Employee. Cpt. Barnes asserted that when Employee arrived at the scene, he had a bag of what appeared to be Narcan with him. Tr. Vol. I. pgs. 110-113.

Cpt. Barnes noted that based on the BWC video footage, while Employee was standing next to the patient, both Firefighter Peterson and the other officers were asking the patient questions. Tr. Vol. I. pg. 114. Upon review of the BWC video footage time stamp 1617, Cpt. Barnes acknowledged seeing EMT Nguyen give the patient a series of squeezes around his shoulder. Cpt. Barnes testified that if a paramedic is responsible for administering medication, that paramedic is the one responsible for ensuring that the patient meets the requirements for said medication. Tr. Vol. I. pgs. 114 -116.

Following her review of the video footage in Agency's Exhibit 8, at time stamp 1005, Cpt. Barnes testified that she did not see Employee or her partner, Firefighter Peterson, having a conversation. She stated that she did not recall where Employee told her he parked the Ambulance. Cpt. Barnes confirmed that she was aware that medic units have external facing dash cameras. Tr. Vol. I. pgs. 121 – 123. When asked if she pulled the CCTV footage from the scene, Cpt. Barnes testified that "… I believe I was aware of the CCTV footage, however, when I was speaking with Amtrak Police, the timing and everything was off and there was no audio. Therefore, the Amtrak Police gave me the body-worn camera footage instead of the CCTV." Tr. Vol. I. pg. 124.

Cpt. Barnes stated that she could not recall if anyone stated during her interview that the patient did not have pinpoint pupils. Tr. Vol. I. pgs. 125. Referring to the Stipulated Exhibit 19, at page 3, Cpt. Barnes confirmed that the document stated that "left pupil pinpoint, right pupil pinpoint." Tr. Vol. I. pg. 126.

When asked about stating in her report that Employee lied about making contact with the patient prior to administering Narcan, Cpt. Barnes stated that from her recollection of the video, she did not see Employee "… make contact until the administration of the medication." She stated that she could not recall if Employee told her that he made physical contact with the patient, but she recalled being told by Employee that he assessed the patient. Tr. Vol. I. pgs. 126 – 127.

4) Marcus Drucker ("Cpt. Drucker") – Tr. Vol. I. pgs. 137-166

Captain Marcus Drucker is currently employed at Agency as an EMS Captain assigned to EMS 7. He has been in this position for approximately six (6) years, and his duties include clinical oversight of any medical incident. Cpt. Drucker asserted that he knew Employee in a professional capacity and that he was not Employee's direct supervisor. Tr. Vol. I. pgs. 137 – 138.

Cpt. Drucker recalled the October 30, 2023, incident where he was dispatched to Union Station. Cpt. Druker testified that he was requested to the scene by Ambulance 16 because they had some concerns and needed a supervisor to come to the scene. He cited that this request was made through OUC and he was dispatched to the scene due to his proximity to the Union Station. Cpt. Druker asserted that he did not recall seeing the patient when he got to the scene. Cpt. Drucker stated that he checked in with the medic unit and ambulance to hear their sides of the issue. Tr. Vol. I. pgs. 139-141.

Cpt. Drucker confirmed that he mostly spoke to Employee while at the scene and they had a cordial conversation as they tried to figure out what the issue was. Cpt. Drucker explained that before he got to the scene, he received a phone call on his work phone from Firefighter Nguyen to inform him of an issue between them and the ambulance crew. He cited that he discussed patient care with Firefighter Nguyen when he got to the scene. Cpt. Drucker testified that "So there was concern from the ambulance crew that the patient didn't receive their full assessment from the medic unit." Tr. Vol. I. pgs. 142-145.

Cpt. Drucker stated that when he first spoke with Employee, he gathered that Employee felt that this was a call that would have been under the call of Basic Life Support ("BLS"). He highlighted that Employee felt that because the patient received BLS care, the 'refusal of care' should have been handled at the BLS level. Cpt. Druker testified that when he later spoke to Firefighter Nguyen, he reiterated that "medic came over here and just sort of didn't offer the full assessment that I would expect him to and just started kind of treating the patient." He stated that Firefighter Nguyen expressed that since Advance Life Support ("ALS") treated the patient, they were responsible for any decision making at that point. Cpt. Drucker testified that he again spoke to Employee and informed him that once his unit (ALS) became involved in the assessment and the care for the patient, they were responsible moving forward. He cited that Employee understood what he said and he acknowledged that the ALS was responsible to make the call. Cpt. Drucker affirmed that Employee was professional and receptive to the guidance he provided. Cpt. Drucker asserted that he also informed Employee's Lieutenant of the incident, and he stated that that was out of character because Employee was a good employee. Tr. Vol. I. pgs. 146-153.

Cpt. Drucker testified that he was informed by the ambulance crew that when Employee arrived, he did a "shortened assessment and gives the person Narcan." He stated that Employee informed him that he did everything he was supposed to do. Cpt. Drucker affirmed that if he had been aware that Employee administered Narcan through the patient's clothing on that day, he would have referred Employee to peer review as that would have been a reasonable step. When asked if the standard was to administer drugs through clothing even in an emergency, Cpt. Drucker stated that "So if you're asking the protocol answer would be no, under no circumstances." He also explained that "I mean … there's no exception for that in protocol if that's what you're asking." And when asked if he has heard of this practice being taught at Agency, Cpt. Drucker stated that "I'm not familiar with that being taught officially in any DC Fire/EMS capacity." Cpt. Drucker also testified that "it's a nuanced decision, but I think there are instances where getting something through clothing would be appropriate…" Tr. Vol. I. pgs. 154-157, 161, 164-166.

5) David Vitberg ("Dr. Vitberg") – Tr. Vol. I. pgs. 168 -251

Doctor David Vitberg is the interim medical director for Agency and has been in this role since May 30, 2024. He also works part-time in the Emergency Department at MedStar Washington where he practices emergency medicine. Dr. Vitberg previously worked as division chief and medical director of Critical Care Medicine at Greater Baltimore Medical Center in Towson, Maryland and as the deputy medical director for Baltimore County Fire Department. Tr. Vol. I. pgs. 168-171.

Dr. Vitberg confirmed that he was familiar with Agency's pre-hospital treatment protocols. He testified that he reviews these protocols frequently when engaged in his role. Dr. Vitberg asserted that the protocols are introduced to paramedics in multiple ways, such as to the cadets and recruits during their onboarding and initial training; during continuing education; at operations meetings and via a recent general order notifying Agency's employees of an update made to the protocols. Tr. Vol. I. pgs. 172-175.

Dr. Vitberg testified that if employees are on the scene and need immediate answers regarding protocols, Agency has an application called "Handtevy" which is available on all department phones. He explained that this application provides references to all of Agency's protocols. Dr. Vitberg stated that employees can always request that an EMS supervisor respond if there's a question regarding a protocol or whether to render a treatment. He cited that if the EMS supervisor is unclear on what to do, they can always escalate through the chain of command, typically to a battalion chief of EMS and up the ladder. Dr. Vitberg explained that any time a member has a question about what to do for patient, the member could "get on a radio channel and obtain base station consultation, speak to a physician at really any of our receiving hospitals for guidance or to the particular hospital that they're transporting a patient to." He reiterated that the member could also reference the app on their phone, call their EMS supervisor via phone or via radio or request that EMS supervisor respond to the scene and/or escalate their concerns through the chain of command. Dr. Vitberg stated that all these protocols are geared towards emergency care treatment and transportation. Tr. Vol. I. pgs. 177-180.

When asked if there were exceptions to the protocols, Dr. Vitberg stated that the protocols are a guide for how treatment should be rendered. He cited that "there is not a one size fits all for every single patient in every single situation, so there may be situations in which a paramedic or an EMT has to do something extraordinary … outside of the realm of what can be described or dictated in an EMS protocol. And that just has to be documented and typically discussed within the chain of command and with the medical director after the fact." Tr. Vol. I. pgs. 180-181. Dr. Vitberg affirmed that based on the protocols, there are situations in which once ALS care is administered, the patient can be transferred to BLS care. Dr. Vitberg asserted that an intramuscular injection is an ALS intervention and based on protocol, once it is administered, a patient cannot be transferred to BLS. Tr. Vol. I. pgs. 181-185.

Referring to Exhibit 26, Policy 2.3, Dr. Vitberg explained that this is "a universal policy across every realm of healthcare be it pre-hospital or hospital or outpatient clinic that we are as healthcare providers required when possible to obtain consent from our patients before rendering care." He confirmed that consent can be obtained by talking to the patient if the patient is able and willing to communicate. Dr. Vitberg cited that the policy across healthcare is to obtain informed consent when possible before laying hands on a patient and performing an assessment or doing any sort of treatment. Tr. Vol. I. pgs. 185-188.

Dr. Vitberg identified Exhibit 27, starting at page 91 as the general assessment and universal care protocol that is supposed to be followed to bring EMTs and paramedics through the initial patient encounter. He testified that this protocol provides an organized, methodical way for Agency members across the realm of certification from EMT to paramedics of how to assess a patient comprehensively. Dr. Vitberg testified that when a paramedic arrives at a scene, they are supposed to do a scene survey and then gather information from the crew that was already on the scene, while engaging in their own independent assessment of what's going on. Dr. Vitberg stated that "a lot of times you don't have to lay hands on the patient immediately" but assessments include getting close to the patient, observing the patient, talking to the patient, often laying hands on the patient, checking their vital signs, and performing a physical. Tr. Vol. I. pgs. 188-192.

Dr. Vitberg testified that Agency uses the 'Alert, responsive to verbal stimulation, responsive to painful simulation, and unresponsive' ("AVPU") scale, as well as other protocols to assess a patient's mental status. He stated that the AVPU assessment can be completed within three (3) to four (4) seconds. Dr. Vitberg asserted that a patient's airway is assessed by "…look, listen, and feel" as they walk towards the patient. He explained that if a patient is sitting upright, holding their head up, and able to speak to them, they will often know that the patient has a patent airway. He noted that apart from that, they must examine the patient's airway to ensure it is open. Dr. Vitberg testified that they also must determine if a patient must be transported, how urgently they need to be transported, and where they need to be transported to. Tr. Vol. I. pgs. 192- 199.

Dr. Vitberg explained that if a patient can communicate, the chief complaint and history may come from the patient. But if it is obvious that the patient is impaired and unable to communicate, that would be their chief complaint. Dr. Vitberg provided an explanation of the primary and secondary assessments and what is included in these assessments such as vital signs, how they are performed and their impact on a patient's health. Tr. Vol. I. pgs. 200-215. Dr. Vitberg asserted that if a patient is obviously intoxicated with opioid and has significant respiratory depression, it would be more appropriate to prioritize the administration of Narcan/naloxone before testing their blood glucose levels. He explained that they did parallel processes with one (1) EMT or paramedic on one hand checking a fingerstick while the other gets the Narcan out and squirts it up the patient's nose. Dr. Vitberg explained that if there was an overwhelming concern for opioid intoxication and the patient has significant respiratory compromise, there should be no delay in administering the Narcan. Tr. Vol. I. pgs. 215-216.

Dr. Vitberg identified Employee's Exhibit 15 as Agency's "treatment protocol for overdose poisoning 9.1." He affirmed that two (2) of the following three (3) indicators must be present for naloxone to administered to the patient: (1) pinpoint pupils, (2) a Glasgow Coma Score of less than 13, and (3) respiratory depression. Dr. Vitberg explained that "[a] Glasgow Coma Score is a score that ranges between 3 to 15 and includes an assessment of the eyes, the patient's ability to speak, and the patient's ability to move; E, V, M. And assigns a number to each of those categories, the lowest number... that patient can get when they're dead is 3. The highest when they're fully alert is 15 and is a general description of their level of neurologic function, alertness. Typically Glasgow Coma Scales are most appropriate when used in the categorization of trauma patients but have been used in the medical realm to help describe or categorize patients with a depressed mental state." Tr. Vol. I. pgs. 216-218, 242-245.

Dr. Vitberg testified that "Respiratory depression involves … look, listen, and feel. Looking at the patient … measuring their respiratory rate. Looking or feeling for the adequacy of chest rise and fall. Listening to their lung sounds to see if air is moving. Popping on a pulse oximeter and seeing what their pulse oximetry reading looks like. Listening to see if they have any snoring i.e. is their mouth closed or is their tongue slid back in their throat obstructing their airway? Inspecting the airway to see if there's any foreign bodies?" Dr. Vitberg asserted that this is a multifactorial assessment which can be done by observing the patient. He cited that they must be in the patient's face when making this assessment. Tr. Vol. I. pgs. 218-220.

Dr. Vitberg testified that Exhibit 29 on page 106, Protocol 14.5.3 – IM ("Intramuscular") Administration (ALS, EMT) provides an eight (8) point guide instructing Agency's ALS members on how to give an intramuscular injection. When asked if it was important to remove clothing from the injection site, Dr. Vitberg testified that "Yeah. You want to … both common sense and according to this protocol, you need to expose the area. We should be wiping the area … So you want to make sure you perform the procedure in a standard cleanly sterile manner. So cleanse the site with alcohol. And in order to do that, you

have to expose the site typically at the deltoid or over the thigh." He affirmed that they have to be able to visualize the muscle. Dr. Vitberg explained that "You want to make sure that your needle is actually going where you think it's going, at a 90 degree angle into the muscle bed. It's an intramuscular injection, so typically most of us that do this … will kind of grasp or bunch up the muscle and ensure that the needle goes 90 degrees into the muscular bed." He stated that this procedure is typically performed by paramedics. Dr. Vitberg testified that it is important to cleanse the injection site to avoid pushing bacteria or other contaminants on the skin surface through the skin into the muscle. He also cited that "in worst case scenario, if the tip of the needle where we're giving the injection ends up in a vessel, [it could] introduce bacteria or contaminants on the skin into the vascular space with the potential to create a bloodstream infection and make a patient septic." Tr. Vol. I. pgs. 220 -225.

Dr. Vitberg asserted that Exhibit 30 outlines all the various routes by which naloxone can be administered. He noted that paramedics have the discretion to administer naloxone via intranasal, intramuscular or IV injection after engaging in critical and clinical decision-making. Dr. Vitberg cited that Naloxone and Narcan are used interchangeably. He stated that Naloxone is the generic name and Narcan is the brand name. Tr. Vol. I. pgs. 225-227.

Referring to the sequence chart on Exhibit 17, Dr. Vitberg testified that only one (1) of the three (3) items required by protocol was present before the Narcan was administered at 9:50:58 in the instant matter involving Employee. He asserted that in a perfect world, at least two (2) of the three (3) items must be present before a paramedic administers Narcan. Dr. Vitberg also stated that "I understand the reality of how these things work. A lot of our processes… occur in parallel. People are collecting information, collecting vital signs while performing interventions and assessment. I'm also very aware that medical records don't always reflect what actually happened, that the sequence may be off by a minute or two." Tr. Vol. I. pgs. 227-233, 246. Dr. Vitberg confirmed that while Agency's protocols are important, they are not necessarily one-size-fits-all in the field. Tr Vol. I. pgs. 245.

Upon review of the video recording in Exhibit 5, at the timestamp 13:50:50, Dr. Vitberg was asked if he saw any sort of assessment done prior to the Narcan being administered that was within the meaning of the protocols by the person who administered the needle. Dr. Vitberg responded that "So it looks like there's a woman in our uniform with gloves on and a blue shirt and red lettering to the left of what looks like the police officer, who was interacting very purposefully kind of with the patient, talking to him along with the police officer. The patient seemed to be nodding his head. I think he said Ricardo or something of that effect. And then it looked like the EMT or our provider on the right with the radio also kind of stimulated him a little bit. I think at the very beginning of the video, I saw one of our members in a red jacket. I don't know if it's anybody in this room, but in a red jacket, almost kind of touch the patient's left side before approaching the patient with the injection." Tr. Vol. I. pgs. 233-235.

When asked if the injection was administered consistent with the protocols, Dr. Vitberg responded with "[a]bsolutely not." He testified that "It looked like the person performing the injection had kind of one hand on the syringe and needle, pushed it through layers of clothing. It looked like the patient was in a jacket. I don't really know where that needle landed. It looked like it probably went into the patient by his grimace and kind of reaction, temporarily related to all of that sequence, but not compatible with our protocols." Tr. Vol. I. pgs. 235-236, 252.

After reviewing the video from timestamp 13:46:26 to 14:50:55, Dr. Vitberg testified that the patient appeared to be responding to the female EMS and that the male provider with the radio strap on appeared to have conducted a comprehensive assessment which included a blood glucose at one point. Dr.

Vitberg stated that he couldn't hear any of the communication that was happening. He noted that the patient did not look distressed other than his head leaning forward a little bit periodically. Tr. Vol. I. pgs. 236-237.

Dr. Vitberg was asked if after reviewing the video footage, he thought that Employee had enough information before administering the Narcan, to which he responded that he did not know what happened in the other video frames. He stated that he did not know if there was any communication between the other two (2) to three (3) members on the video and Employee. Dr. Vitberg explained that if he showed up as a paramedic to a scene, he would put a lot of faith in what he's told by his colleagues on the scene regarding what was going on and what needed to be done next. He noted that while his ability to analyze the video footage was limited, from what he observed, Employee did not do much in the way of an assessment other than touching the patient's left arm and administering the injection. Dr. Vitberg explained that a reasonable paramedic in a similar situation would have laid eyes on the patient and perform some assessments while listening to the handoff from the other crew that had been on the scene before doing anything. Tr. Vol. I. pgs. 237 – 241. He emphasized that they rely heavily on communications between each other on every scene to which they report. Dr. Vitberg acknowledged that the requirement to perform an assessment on the scene is not so much an individual requirement as a requirement that the team perform together. He cited that he would trust and verify. Tr. Vol. I. pgs. 246-248.

Dr. Vitberg confirmed that sometimes there are emergencies where it's appropriate to interrupt the assessment to intervene and then continue the assessment after the intervention. He affirmed that this would be based on the paramedic's judgment. Dr. Vitberg testified that "Protocols are the guide rails within which our EMTs and paramedics operate, but with the imperative for all members, regardless of level of training, to also engage in some critical decision-making as they navigate through those protocols and treat our patients." He affirmed that if the patient is somewhat responsive, protocol should be followed. Tr. Vol. I. pgs. 249-251.

Vol. II – August 21, 2024

Employee's Case-in-Chief

6) Employee - Tr. Vol. II. pgs. 5-156

Employee has been a Firefighter/Paramedic with Agency for approximately three (3) years. He was assigned to Engine Company 26. He is currently detailed to fleet maintenance at the apparatus division. Prior to working at Agency, Employee worked as a paramedic in Fairfax County. Employee received his paramedic license in 2020 from Virginia. Tr. Vol. II. pgs. 5 – 7. He confirmed that they are taught how to administer injections, including intramuscular injections in paramedic school. Employee confirmed that they were taught the importance of visualizing the muscle before administering an injection as well as the importance of cleaning the injection site. He confirmed that he knew how to do a proper intramuscular injection before he became a certified paramedic. Employee asserted that part of his job at Agency was to administer injections to patients that need it. Tr. Vol. II. pgs. 68-72.

Employee acknowledged that as of October 30, 2023, he had been working as a paramedic for approximately three (3) years and that he was partnered with FF/EMT Peterson on that day as the passenger on the medic unit. Employee described Exhibit 1 as the dispatch for Medic 2, Ambulance 16, for an unconscious overdose at Union Station and that civilian Narcan had been administered. Employee recognized Firefighter Nguyen's voice in the recording as he placed Medic 2 in service. Employee asserted that he took this to mean that they were no longer needed and that they could go back to being available for

other runs. Employee stated that a few seconds later, Ambulance 16 requested that Medic 2 return to the scene. He explained that it was not normal for them to get called back, so he thought that something was wrong with the patient. Employee confirmed that he could see the patient from the medic unit when they got to the scene and that the patient was slumped over and unconscious. He noted that the patient was in a wheelchair with an officer holding him up and he was surrounded by other officers and the ambulance crew. Tr. Vol. II. pgs. 8-12, 73-74, 77-78, 81-85.

Employee testified that he went to the back of the medic unit to retrieve his ALS gear and met up with his partner who was with the patient. He stated that while he was getting his gear, he saw his partner standing in front of the patient, and checking the patient, while talking to the ambulance crew. Employee cited that he and his partner then had a conversation about what was going on and his partner informed him that the patient had pinpoint eyes and his heart rate was 42 as recounted by the ambulance crew. Employee stated that this conversation is not captured in the video footage because he was off the screen when the BWC was on. He also testified that before he appeared in the video footage, he had brought his equipment, set it down, put on his gloves and stood next to the police officer. Employee explained that his assessment of the patient started from the moment they were dispatched to the scene, canceled and dispatched again and continued until he visualized the patient at the scene. Tr. Vol. II. pgs. 13-14, 85-88, 90-91.

According to Employee, the current protocol for administering Narcan states that "you need to have two out of three criteria. You need to have pinpoint pupils, you need to have a GCS of 13 or altered mentation, and you need to have respiratory depression." He stated that a GCS score of less than 13 was required. Employee asserted that the patient had a GCS of less than 13 and pinpoint pupils. He also stated that he was concerned about the patient's heart rate of 42 as he feared that the patient might be heading towards cardiac arrest, so he quickly grabbed Narcan from his equipment and injected the patient with Narcan. He noted that he did not talk to the patient before administering Narcan. Employee testified that he relied on information relayed to him that the patient had pinpoint pupils and altered mentation. He explained that at that point he had gathered enough information to ascertain that the patient met the requirements for an opiate overdose, which allowed him to give Narcan. Employee admitted that he administered the Narcan through the patient's clothing. He acknowledged that this action was not consistent with Agency's protocol. Employee however explained that "It was my understanding that you can go through clothing for specific scenarios where it was the best interest of the patient… Now, I know that it was very wrong." He testified that the patient's GCS went up to 15 after he administered the Narcan. Tr. Vol. II. pgs. 14 -17, 88-89, 92-93, 98-102, 130. Employee asserted that after administering Narcan to the patient, they placed the patient on a monitor, and he continued his assessment to figure out what was wrong with the patient. Tr. Vol. II. pgs. 19-20, 26, 108-110.

Employee identified Stipulated Exhibit 25, from page 84 as Agency's transfer of care policy and he affirmed that he was familiar with that policy on October 30, 2023. Employee stated that he was also aware that intramuscular Narcan was solely an ALS modality of injection. Tr. Vol. II. pg. 103. Employee testified that the patient refused to go to the hospital. He explained that if a patient refuses to go to the hospital, they ask the patient a series of questions to ensure that the patient has the legal capacity to refuse, the medical capacity to refuse, and the situation capacity to refuse. Employee affirmed that he asked these questions and did the tests to ensure that the patient was eligible to refuse to go to the hospital. Employee cited that on the day of the incident, he thought that the BLS – Ambulance 16, was responsible for completing the refusal form since it was a BLS run. He explained that Narcan is a BLS drug, which was what was administered to the patient, but there was a disconnect because he used an ALS modality. Employee asserted that he had a disagreement with Firefighter Nguyen on who was responsible for completing the refusal paperwork and Cpt. Drucker, a supervisor, was called to the scene. Employee noted that he was not

subjected to any discipline for taking the position that the BLS unit was responsible for completing the refusal paperwork. He cited that Ambulance 16 completed the refusal paperwork. Employee asserted that in December 2023, he became aware that there was an issue with the treatment he provided to the patient on October 30, 2023. Tr. Vol. II. pgs. 20-26, 103-107.

Employee affirmed being interviewed by Cpt. Barnes from Internal Affairs. He stated that he did not receive any interview preparation material such as the BWC to review from Cpt. Barnes prior to the interview. Employee cited that the interview took place within two (2) hours from when he was notified that he would be interviewed. Employee noted that he was interviewed by Cpt. Barnes on January 23, 2024, approximately three (3) months after the October 30, 2023, incident. Tr. Vol. II. pgs. 27-28.

Employee stated that during the interview, he had a conversation with Cpt. Barnes about what happened on October 30, 2023. He explained that he played back what happened in his brain, and he told Cpt. Barnes everything he remembered from the call. Employee stated that Cpt. Barnes played video footage of the incident after he finished explaining his version of the event. He highlighted that he did not know that the video footage existed prior to that moment. Employee explained that Cpt. Barnes' demeanor changed after she showed him the video footage and she asked him a lot of questions and accused him of things that weren't true. Tr. Vol. II. pgs. 29-30.

Employee identified Employee's Exhibit 3 as his 3B-Notice of Proposed Action. Tr. Vol. II. pg. 30. Employee read the first sentence under the heading 'Findings' on page 7 of this Exhibit into the record and he noted that he did not agree with the sentence because everything he said was the truth. He also identified the paragraphs in this Exhibit that highlighted every point he was accused of being willfully misleading, contradictory, or untruthful. Tr. Vol. II. pgs. 32-33.

Referring to Exhibit 8 at timecode 2 minutes and 51 seconds and Exhibit 5 from timecode 14 minutes and 32 seconds, Employee cited that the officer standing behind the patient is holding the patient up and does not let go of the patient. Also, referring to time code starting at 15 minutes and 42 seconds of Exhibit 5, Employee cited that the patient's head slumped over after the officer lets it go. Employee confirms that when he said in the interview with Cpt. Barnes that the patient was slumped over in a wheelchair and there was an officer holding his head up, that was actually accurate. Tr. Vol. II. pgs. 33-35.

While referencing Exhibit 3, Employee cited that he had a conversation with his partner, FF/EMT Peterson "who advised that the ambulance was reporting a heart rate of 42 and that the patient was pinpoint alternating." Referring to Exhibit 8 at timecode 39 minutes and 42 seconds, Employee confirmed that this was an accurate description of how he remembers the events of October 30, 2023. He noted that Cpt. Barnes did not ask him what happened when he and his partner were off camera. Employee stated that he was next to the patient and the office at 15:42 timecode, identifying his blue gloves in the video footage. He affirmed that this was approximately one (1) minute before he administered the Narcan to the patient. He confirmed that while off camera, he was able to observe his partner, FF/EMT Peterson's interaction with the patient. Tr. Vol. II. pgs. 36-39.

Employee acknowledged that he was informed on the scene that the patient kept slumping over since they arrived at the scene and Employee stated that based on this information, he concluded that the patient was sick. Citing to timecode 16 minutes and 15 seconds, a firefighter is seen using a painful stimulus to assess the patient's mentation. Employee confirmed that the patient reacted which implied that the patient was responsive to painful stimulus. Tr. Vol. II. pgs. 39-40.

Employee did not agree with the findings that he intentionally deceived Cpt. Barnes when he stated that he took a quick look at the patient, who was altered and had pinpoint pupils. He affirmed that at the time he administered the Narcan, he was convinced that the patient was altered and had pinpoint pupils Tr. Vol. II. pgs. 40-41.

Referring to Exhibit 8 starting at timestamp 4 minutes and 13 seconds (4:13), Employee noted that he did not tell Cpt. Barnes that he gave the patient oxygen during the interview. Employee cited that he did not give the patient oxygen because the patient's oxygen saturation was within normal limits when he measured it, which was contraindicated. Employee noted that he did not agree with the charge stating that he was willfully misleading because he didn't give the patient oxygen. Tr. Vol. II. pgs. 41-43.

Employee affirmed that he told Cpt. Barnes during the interview that the patient's sleeve was rolled up before he saw the body-worn camera footage. He cited that it had been approximately three (3) months since the incident occurred and about 20 runs later. He noted that he was never asked to write a report of the incident. Employee highlighted that EMTs get blood pressure readings on the non-dominant arm usually exposed, but not always. Employee noted that he was not intentionally telling a lie when he stated to Cpt. Barnes that the patient's sleeve was rolled up. He testified that "When I played it in my head, I thought the sleeve was rolled up. But evidently, I was wrong. I wasn't trying to lie or anything. It's just when I played it back in my head, I thought the sleeve was up." Tr. Vol. II. pgs. 43- 45.

Referring to Exhibit 3 starting at page 7, Employee stated that he and Firefighter Nguyen had a dispute about who should complete the refusal; a supervisor, Cpt. Drucker was called to the scene to resolve the dispute. Employee asserted that he had a conversation with Cpt. Drucker, and it was concluded that Ambulance 16 would complete the refusal, and they did that. He noted that he was not being willfully misleading, contradictory, or untruthful when he stated during the interview that Cpt. Drucker sided with him. Tr. Vol. II. pgs. 46-47, 115-116.

Referring to Exhibit 3 and upon review of Exhibit 8 starting at timecode 19 minutes and 30 seconds (19:30), Employee noted that he did not firmly dispute that he may have administered the Narcan through the patient's clothes on October 30, 2023. He affirmed that he did not know that there was BWC footage of the incident. He testified that when he stated that he could not remember whether he went through the patient's clothes, he was telling the truth. Tr. Vol. II. pgs. 47-49. Employee confirmed that as of October 30, 2023, he believed administering Narcan through clothing was consistent with the department's protocols for administering Narcan. Tr. Vol. II. pg. 51. Employee identified an email dated February 24, 2024, as an EMS morning report sent by Captain Lammert to all the 4th Battalion members working on number four. Employee read the fourth bullet point in the document into the record: "Giving IM injections through clothing appears to be a trend on the rise. This is an unacceptable practice, use trauma shears to cut a hole in the injection location and follow appropriate IM injection procedures." When asked if he knew if any of the other paramedics that were part of this trend had been disciplined, Employee said 'No'. He cited that going forward, he would not administer Narcan through clothing because it's in Agency's policies and he plans on following Agency's rules policies and not violate them. Tr. Vol. II. pgs. 53 – 54, 64.

Referring to Exhibit 3, from the bottom of page 7 to page 8, Employee noted that he did not willfully mislead the Cpt. Barnes about whether he had ever administered Narcan through clothing prior to reviewing the video footage. He also noted that he did not change his story on that point after watching the video. Employee asserted that he did not remember if he administered Narcan through the patient's clothing. Tr. Vol. II. pgs. 54-55, 113-115.

Employee stated that Cpt. Barnes asked him about the side effects of administering Narcan through clothing and he responded that the worst thing that could happen was an infection. Employee did not agree with Cpt. Barnes' assertion that his response showed a cavalier attitude and contrasted with Agency's core values of compassion, service, and integrity. Employee noted that he did not tell Cpt. Barnes that he violated Agency's core values. Tr. Vol. II. pgs. 55-58.

Employee stated that he did not know Firefighter Nguyen personally, but they've had a couple of run-ins. Employee testified that Firefighter Nguyen filed a provider complaint against him on September 20, 2023. He cited that Firefighter Nguyen's complaint against him was false and Agency did not bring charges against him for that incident. Tr. Vol. II. pgs. 58-60.

Employee confirmed that he authored Exhibit 16 from page 37, which was his ePCR. He also stated that the time is automatically recorded by the CAD system but can be changed for accuracy. He explained that the CAD is not always updated immediately, so the time might be off by a few minutes or seconds. Employee testified that normally for the ePCR, the back in service time is not filled when he opens TripTix. Employee asserted that he was the author of Exhibit 17. Tr. Vol. II. pgs. 74-90.

7) Johnie Griffin ("Lt. Griffin") – Tr. Vol. II. pgs. 158 - 164

Lieutenant Johnie Griffin has been employed with Agency for 18 years. He testified that Employee worked with him when he was assigned to Engine 26. He noted that he was with Employee on September 30, 2023, and that Employee did not stab a patient multiple times as a painful stimulus as reported by the EMTs on Ambulance 16. Lt. Griffin did not remember Employee injecting the patient on September 30, 2023, through their clothing. Tr. Vol. II. pgs. 158-159.

8) Philip Lammert ("Cpt. Lammert") – Tr. Vol. II. pgs. 164 -193

Captain Philip Lammert is an EMS captain unit supervisor with the 4th Battalion. He explained that in this role, he assists the battalion chief in anything that's EMS related within the battalion. Cpt. Lammert confirmed that part of his role was to ensure that providers operate up to the medical director's standards. He cited that he has been a trained paramedic for approximately 20 years. Tr. Vol. II. pgs. 164-165.

Cpt. Lammert confirmed that it was okay for a medic to rely on information such as vital signs passed to them by an EMT that was already on the scene. He stated that they can take that information to start their assessment, but they're encouraged to get their own assessment done. Tr. Vol. II. pgs. 165-166.

Cpt. Lammert testified that a "heart rate of 42 is in most cases dangerously low. So, based off of other parts of the assessment, that would raise some red flags, and cause the paramedic to be concerned." When asked what Agency's protocol was for administering Narcan, Cpt. Lammert asserted that "… Narcan is indicated for suspected opioid overdose, as indicated by the altered level of consciousness, pinpoint pupils, or decreased respirations." He explained that per Protocol 9.1, the GCS of less than 13 is a required measure of altered consciousness relevant for issuing Narcan. Cpt. Lammert cited that the maximum GCS score is 15. He affirmed that it is permissible for a paramedic to assess whether a patient is altered by observing other people asking questions or interacting with the patient. Tr. Vol. II. pgs. 166-167.

Cpt. Lammert confirmed that based on the video footage, Employee had enough information to reasonably determine that this patient was altered. He explained that pinpoint pupils describe the constriction of the pupil. He stated that the pinpoint pupils are fully constricted when you look at them. Cpt.

Lammert confirmed that it was permissible for a medic to rely on a report from their partner that a patient had pinpoint pupils. He testified that Employee would have done an independent assessment, "but given the situation, and the vital signs that he was given, and the fact that the patient was altered, a lot of times when we view those situations … treating the patient quickly is more important than starting over, doing the full assessment over again." Tr. Vol. II. pgs. 168, 180, 184.

When asked if under Agency's protocol, it was ever best practice for a paramedic to administer Narcan through the patient's clothing, Cpt. Lammert said 'No.' He cited that in his 20 years of experience, apart from epi pen, he has never seen medicines administered through a patient's clothes. Cpt. Lammert explained that if he was on the scene on October 30, 2023, and saw Employee administer Narcan through the patient's clothing, he would have pulled him aside after the call was over and had a discussion with Employee about how he had administered the medication and reviewed the proper procedure for administering item of medication. Tr. Vol. II. pgs. 168-170, 185-186.

Cpt. Lammert testified that Continuous Quality Improvement ("CQI") was their group under the Office of the Medical Director that provides training, feedback, and guidance for providers when needed with regards to any issues that arise, such as chart reviews, patient care etc. He cited that CQI is not intended to be punitive. Cpt. Lammert did not think termination was an appropriate response to the October 30, 2023, incident. He asserted that he believed this is a training issue "because it was a medical error in the way that the medicine was administered. And in that case it would be referred to CQI for retraining, or remediation." Tr. Vol. II. pgs. 170 -171.

Cpt. Lammert identified Employee's Exhibit 4 as "this is my morning email that I send to members working in my battalion." He asserted that the current email was dated February 24, 2024, to "every member working that day in my battalion, overtime, trades, regularly assigned people, but every member from my battalion chief, the EMS battalion chief, to all the firefighters working." Cpt. Lammert testified that the fourth bullet point in the email stated that "Giving IM injections through clothing appears to be a trend on the rise. This is an unacceptable practice. Use trauma shears to cut a hole in the injection location, and follow appropriate IM injection procedures." He explained that this issue was brought to his attention by another EMS supervisor who stated that they had seen it and wondered if Cpt. Lammert had seen it too. Cpt. Lammert asserted that "And then following that actually, was on a call with a provider that was about to do it. So, that provider was attempting to do it, and I stopped that provider, and essentially said what I've said on this. We're not doing that, it takes two seconds to cut a hole in the clothing, to wipe the skin and give an injection the way we're supposed to. I prevented it from happening, but it was right in front of me." Cpt. Lammert noted that apart from the field remediation, he did not discipline the medic or recommend that Agency pursue disciplinary action against any of the medics who were part of this trend. Cpt. Lammert cited that his email was effective in putting a stop to that practice. Tr. Vol. II. pgs. 171-174, 176-179. Cpt. Lammert confirmed that in practice, it is common for an ALS provider to administer an IM drug and then ask the BLS unit to complete the refusal. Tr. Vol. II. pgs. 176.

9) Daniel Kloss ("Cpt. Kloss") – Tr. Vol. II. pgs. 194 - 202

Captain Daniel Kloss has been employed by Agency for 17 years and he is currently assigned to Rock Platoon Number Four. His previous assignment was a Lieutenant at Engine Company 26 Number One. He affirmed that he has worked with, and supervised paramedics during his tenure with Agency. Cpt. Kloss testified that Employee was a rookie assigned to his company and he was Employee's supervisor. Cpt. Kloss cited that Employee was excited, nervous, had lots of questions, he was willing to learn and he was hardworking. Cpt. Kloss noted that on "… [Employee's] first day he hit the ground running …

checked out everything, wanted to know everything, took a lot of notes, went through the fire truck. His bedside manner was great, never had issues carrying all the equipment." Cpt. Kloss testified that Employee helped everyone in the firehouse, he had a lot of passion for the job, and he really cared about what he was doing. He cited that he trusted Employee's work as a paramedic, and he did not know if Employee had any disciplinary issues. Cpt. Kloss highlighted that Employee was receptive to correction and instructions and willing to grow. Cpt. Kloss noted that he was still at Engine 26 when Employee was removed from active duty. He asserted that he did not think anyone liked the fact that Employee was removed from active duty. He explained that initially, they were not aware of what was going on and that Engine 26 missed Employee as he was an asset. Tr. Vol. II. pgs. 194-198.

Cpt. Kloss defined a Special Report as "a document of record in whoever's words that's asked to type up." He stated that a Special Report is part of an investigation or can be requested for awards or to answer questions. Cpt. Kloss noted that he frequently instructed people to submit special reports. He confirmed that he was aware that Employee was never asked to write a special report in the current case, which he noted was not normal as Employee never got to tell his side of the story. Cpt. Kloss noted that he did not review the BWC video footage in this case and that he did not have any understanding of the incident at issue in the current matter. Tr. Vol. II. pgs. 199-201.

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10) John Busch ("FF/P Busch")– Tr. Vol. III. pgs. 9-35

Firefighter/Paramedic Busch has been a Firefighter Paramedic for approximately five (5) years. He is currently assigned to Engine 26, Platoon Number 1. He stated that Employee was also assigned to Engine 26, Platoon Number 1. He affirmed that based on his observation, Employee was a good paramedic. FF/P Busch cited that Employee was a very thorough medic, careful with his assessments, he cared about his patients, and he did the right thing. Tr. Vol. III. pgs. 10-12.

FF/P Busch confirmed that he was aware that Employee was charged with "conduct unbecoming an employee" based on his decision to administer an intramuscular dose of Narcan through a patient's clothing in October 2023. He asserted that he had not seen the BWC footage Tr. Vol. III. pg. 12. FF/P Busch acknowledged that as of October 2023, he believed that there were some circumstances where it would be appropriate for an employee to administer Narcan through a patient's clothing. He testified that this was justified in "Patients with bradycardia, severely hypoxic, severe altered mental status." FF/P Busch asserted that a patient with a heart rate of 42 qualified as bradycardic. Tr. Vol. III. pg. 13.

FF/P Busch testified that he had observed other paramedics administer Narcan through a patient's clothing quite a few times and he did not think anything was wrong with that. FF/P Busch affirmed that he had personally administered Narcan through a patient's clothing when the patient had bradycardia, altered mental status, or severe hypoxia as he believed he was acting in the best interests of the patient. He noted that he did not think he was violating Agency's core values and no one said anything until recently. FF/P Busch cited that he could not recall the first time he administered Narcan through a patient's clothing, the number of times he had done so, or the number of FEMS personnel he had seen administer Narcan through a patient's clothing. FF/P Busch noted that if faced with the same circumstance today, he would not administer Narcan through a patient's clothing based on the recent information they received from Dr. Vitberg during 'grand rounds', which is mandatory training. Tr. Vol. III. pgs. 13-18, 26-28.

FF/P Busch affirmed that he was a trained paramedic, and he explained that the protocol for injecting Narcan was to expose the skin, clean the skin, and inject the medication. He stated that in a perfect world, exposing the patient's skin would be the preferred method to administer Narcan to a patient because they are able to clean the skin and use an aseptic technique. He explained that in a perfect world, Agency would have enough ALS hands on scene to handle every patient and do everything that's asked but in reality, you could be the only paramedic on scene, and BLS providers are not allowed to give medication. He stated that they would use the BLS partners to get vital signs, do assessments and they base their treatment on those numbers. FF/P Busch cited that physically visualizing the muscle is important if possible and if it's not a life-threatening condition. He noted that in making decisions, they must think about multiple things at once, as well as do everything that's in the best interest of the patient. FF/P Busch asserted that any life-threatening situation is time sensitive especially in an overdose situation where "… the hypoxia becomes so severe that the patient is so altered to the point where they're unconscious or they're bradycardic, or they're blue, or they're not breathing at all." He confirmed they would have to assess the patient to figure out what the criteria were. Tr. Vol. III. pgs. 18-126, 33-34.

FF/P Busch testified that "you can assess the patient walking up to them. You can see their respiratory rate. You can feel a radial pulse. There's a bunch of different things. We also have partners that we're assigned on the ambulance that can do part of that assessment for you." Tr. Vol. III. pg. 26. FF/P Busch testified that if he renders care to a conscious patient after a BLS provider has evaluated them, he will get the vital signs from the BLS care providers and base his treatment off that and what he can see. He cited that doing a reassessment will depend on the situation. He explained that a reassessment could be a visual reassessment such as counting respirations by watching or feeling a radial pulse. FF/P Busch restated that the basic assessment, vital signs would fall under BLS skills. He defined BLS as Basic Life Support and ALS as Advanced Life Support. Tr. Vol. III. pgs. 31-35.

11) Kenneth Long ("Sgt. Long") – Tr. Vol. III. pgs. 37-74

Seargeant Long has been a certified paramedic for 20 years and an ALS provider for 21 years. He's currently assigned to Truck 15, Platoon Number 1, Engine Company 26. Sgt. Long stated that he has been a sergeant paramedic since October 9, 2022. He asserted that Employee was assigned to the same Engine and that he observed Employee on several occasions. Sgt. Long testified that Employee was a good clinician, and he enjoyed Employee's treatment modality and how he treated patients. When asked if he had ever seen anything to indicate that Employee was casual or cavalier about his patient care, Sgt. Long responded "No, not to my knowledge." Tr. Vol. III. pgs. 37-39, 47.

Sgt. Long affirmed that he was aware that Employee had been charged with conduct unbecoming an employee based on a decision to administer an intramuscular dose of Narcan through a patient's clothing in October 2023. Sgt. Long testified that he has witnessed other paramedics administer Narcan through a patient's clothing in an emergent situation. He cited that he would administer Narcan through a patient's clothing in an emergent situation because there are other drugs that they can administer through clothing. He cited that he had witnessed and was aware of other instances in which paramedics in the district administered Narcan through a patient's clothing. Sgt. Long explained that he administered IM Narcan in 2014 to a patient before they started chest compression because the patent was respiratory depressed and in a situation of borderline cardiac arrest. He confirmed that a patient with a heart rate of 42 was an emergent situation. Sgt. Long explained that if a patient's heart rate is in the 40s, then the patient is not getting enough oxygen to the heart, and their respiratory rate should be depressed. Tr. Vol. III. pgs. 41-44. Sgt. Long testified that around September during the paramedic ground round, they were notified by Dr. Vitberg

that Narcan is usually not given through clothing. He stated that the issue of injecting an IM Narcan through a patient's clothing had never been talked about before. Vol. III. pgs. 44-45, 48, 58-63.

Sgt. Long explained that they were taught the proper technique for injections in controlled environments. He described a controlled environment like "… going to a doctor's office, in controlled environments… you're not really much instructed in emergency environments…" Sgt. Long noted that while he does not advocate breaking protocol without repercussion, every case is different. He testified that this current situation does not warrant a termination, but rather that it was a teachable moment. Vol. III. pgs. 48-54.

Sgt. Long testified that he did not report the incident of paramedics injecting IM Narcan through patients' clothing because there's no protocol stating that it's against the rule to inject Narcan through the patient's clothing. Tr. Vol. III. pgs. 72-73.

12) Brooks Woitas – ("FF/P Woitas") Tr. Vol. III. pgs. 76 - 100

Firefighter/Paramedic Woitas has been a paramedic for a total of eight (8) years and a firefighter paramedic with Agency for six (6) years. He is currently assigned to Engine Company 15 Platoon Number 1. He also serves as a field training officer ("FTO") with Agency and has served in this role since June or July 2023. FF/P explained that as an FTO, his role with Agency was to train new paramedics within the District of Columbia to the standards that the department requires. He stated that FTOs also retrain paramedics who have been found to be deficient in skills through the continuous quality improvement ("CQI") process. Tr. Vol. III. pgs. 77-78. FF/P Woitas described the process of becoming an FTO. He also stated that as an FTO, he observed paramedics in the field. Tr. Vol. III. pgs. 79, 85-87.

FF/P Woitas confirmed knowing Employee, citing that they have crossed paths frequently. He affirmed that he's had enough opportunities to observe Employee. He testified that Employee was a pretty good paramedic. FF/P Woitas stated that Employee was very confident, knowledgeable, comfortable with the patient care he provided. He cited that based on his experience working with Employee, Employee had a very good understanding of Agency's protocols. Tr. Vol. III. pgs. 79 -81.

FF/P Woitas affirmed that he was aware that Employee had been charged with conduct unbecoming an employee based on a decision to administer an intramuscular dose of Narcan through a patient's clothing in October 2023. He testified that he has observed paramedics administer IM Narcan through a patient's clothing numerous times. FF/P Woitas also affirmed that he has administered Narcan through a patient's clothing when it's in the best interest of the patient. FF/P Woitas described the circumstance he would do so to include "… a situation where it's an imminent situation where the patient is crashing and the patient could potentially go into respiratory arrest, which would lead to cardiac arrest if not treated properly. Additionally, like I said, I think it's in the best interest of the patient." He described a situation where he administered IM Narcan to a patient through their clothing and he cited that he did not think he was violating Agency's protocols when he administered the IM Narcan through the patient's clothing. FF/P Woitas testified that he had never been pulled aside or told that that was against the department standards and violated patient's bill of rights. FF/P Woitas stated that the first time he was told not to administer IM Narcan through a patient's clothing was during their last grand rounds by Dr. Vitberg. Tr. Vol. III. pgs. 81-84, 88-90.

FF/P Woitas noted that between June 2023 and October 2023, he did not discuss with anyone in the medical director's office about administering IM Narcan through a patient's clothing. He cited that he did

not recall notifying anyone at the medical director's office or recording in any documentation about administering IM Narcan through a patient's clothing. Tr. Vol. III. pgs. 87-89. FF/P Woitas testified that he started administering IM Narcan through patient clothing from seeing other FTOs do so and following instructions from the former medical director stating that they are to do "what's in the best interest of the patient and he will back us up." FF/P Woitas asserted that he was "fairly versed with the protocol, and I've never seen anything that … states that the clothing must be removed. There is a spot that says an aseptic technique must be used, but nothing that specifically states that clothing must be removed prior to injection of intramuscular Narcan…" He noted that the protocol specifically referenced aseptic technique. FF/P Woitas stated that he had no reason to believe that Agency's management knew that this was going on. Tr. Vol. III. pgs. 92-95.

FF/P Woitas testified that after reviewing the BWC video footage of Employee, it is their opinion that "… this is a retraining process. As … an FTO, I always tell my students, you're going to make mistakes. I have as a paramedic … I as a paramedic have made numerous mistakes on this job. And the biggest thing I take away is … can I learn from that mistake and not make the same mistake twice? And I do think this is a retraining process. I think -- in my opinion, this would be best-served as retraining and I would be willing to retrain [Employee] to department standards, if allowed to." Tr. Vol. III. pgs. 99-100.

13) Stephen Faulkner ("Cpt. Faulkner") – Tr. Vol. III. pgs. 102 – 118

Captain Faulkner had been employed with Agency for 17 and a half years. He testified that he has worked with Employee "… a couple of times when he was detailed to Medic 21, when I was still the captain of Engine 21. And I've also worked with him at a couple of special events when he was serving as an apparatus driver for the event." He confirmed that he has had significant opportunity to observe Employee at work and he would rate Employee "as a 9 or 10… And [Employee] always stood out to me as one of the ones who came in with a positive attitude and -- especially on the runs that we went on, he was proactive." Cpt. Faulkner noted that he served as Employee's direct supervisor during the shifts Employee worked at Engine 21 as medic 21. He cited that he worked with Employee a handful of times. When asked if he had seen anything in Employee that would indicate that he was cavalier or casual about his patient care, Cpt. Faulkner said "No." Tr. Vol. III. pgs. 102-104, 116.

Cpt. Faulkner confirmed that he was aware that Employee had been charged with conduct unbecoming an employee based on a decision to administer an intramuscular dose of Narcan through a patient's clothing in October 2023. He noted that he was not aware that Employee was also charged with misleading internal affairs about those events in an interview that happened three months later. Given these charges, Cpt. Faulkner cited that his impression about Employee has not changed. He noted he did not know Employee to be dishonest. He also stated that this matter is more appropriately addressed through training. Cpt. Faulkner testified that he was aware that there are times when a provider needs to make a judgment call in the moment and that could be affected by the patient's vital signs, the patient's status, the environment etc. Tr. Vol. III. pgs. 106-110, 115.

Cpt. Faulkner testified that "… I just think it's a dangerous precedent to ever second-guess what the provider saw in a moment or assessed with his assessment, especially if the treatment given is what should have been given by the protocols. The matter of how it was done, like I said, I think that puts us back in more of a training issue, more so than a failure to perform your job… even on that note with the protocols too … when we're looking at the protocols as a framework, they give us a general … list of rules to follow based off of what we generally see in the performance of our duty, with patients presenting with certain attributes, certain signs and symptoms, and certain medical histories… It might be written, but you have to

make judgment calls, and you have to be comfortable with what you decide to do. And then you have to stand behind that. And to me, if you could justify that and you did not cause harm, training issue. But to answer your question, yes, I think that was appropriate to administer that medication." Tr. Vol. III. pgs. 113- 115.

Panel Findings[6]

The Trial Board Panel made the following findings of fact based on their review of the evidence presented at the hearing:

Charge 1, Specification 1

1. Although FF/P [Employee] pled not guilty, all evidence presented led the Panel to conclude that — by on boarding medicine through his patient's clothing — the member is guilty of violating the Patient Bill of Rights as well as the Department's Mission Statement, Vision Statement and Core Values.

2. FF/P [Employee] attempted to justify his actions by stating his belief that the patient was in immediate need of medication; however, the record evidence clearly confirms that:

    a. FF/P [Employee] violated the Patient Bill of Rights by failing to perform an assessment, failing to obtain vitals, and failing to assess the patient's mental status.

    b. While standing beside the patient, FF/P [Employee] stuck the patient in the left arm through clothing, then he reassigned the patient to the EMT's without even doing a secondary patient assessment — which is, again, another violation of Department policy.

    c. Even as the EMT attempted to redirect FF/P [Employee], he became confrontational, took no ownership of his action, and walked away without rendering additional care after administering Narcan IM, which is an advance life support (ALS) intervention. d. FF/P Ahmed's actions showed a lack of compassion or concern for the patient, which clearly contradicts our Core Values.

3. The Panel was alarmed and concerned by FF/P [Employee's] testimonial admission that he administered medicine through clothing on multiple occasions. This practice contradicts both written policies / protocols and paramedic training that required FF/P [Employee] to use an aseptic method when giving IM medication to his patients. FF/P [Employee's] conduct in this case (as well as his general practice) was not only grossly negligent but also constitutes Conduct Unbecoming.

Charge 2, Specification 1

1. The statements FF/P [Employee] articulated during his Office of Internal Affairs administrative interview were riddled with contradictions:

    a. He claimed the patient was in a critical condition, but the video evidence painted a different picture.

[6] *Id*. at Tab 27.

b. FF/P [Employee] adamantly denied ever administering IM medication through a patient's clothing until the video evidence was presented.

c. The Panel was particularly concerned by the fact that FF/P [Employee] showed no accountability for his misconduct — i.e., he gave excuses that he only does this when it is an emergency or, alternatively, when he does not have the proper equipment.

2. The contradictions between his statements and the video evidence led the Panel to conclude that FF/P [Employee] purposely misled the investigators.

3. By making misleading and untruthful statements to investigators, FF/P [Employee] violated both Order Book Article VI and Rules & Regulations Article VI.

4. The preponderant evidence confirms that FF/P [Employee] neglected his duty of candor during OIA's investigation into a matter relating directly to his official duties as an ALS provider.

FINDINGS OF FACT, ANALYSIS AND CONCLUSIONS OF LAW[7]

Pursuant to the D.C. Court of Appeals holding in *Elton Pinkard v. D.C. Metropolitan Police Department*,[8] OEA has a limited role where a departmental hearing has been held. According to *Pinkard*, the D. C. Court of Appeals found that OEA generally has jurisdiction over employee appeals from final agency decisions involving adverse actions under the CMPA. The statute gives OEA broad discretion to decide its own procedures for handling such appeals and to conduct evidentiary hearings.[9] The Court of Appeals held that:

> "OEA may not substitute its judgment for that of an agency. Its review of the agency decision…is limited to a determination of whether it was supported by substantial evidence, whether there was harmful procedural error, or whether it was in accordance with law or applicable regulations. The OEA, as a reviewing authority, must generally defer to the agency's credibility determinations."

Additionally, the Court of Appeals found that OEA's broad power to establish its own appellate procedures is limited by Agency's Collective Bargaining Agreement. Thus, pursuant to *Pinkard*, an Administrative Judge of this Office may not conduct a *de novo* hearing in an appeal before him/her, but must rather base his/her decision solely on the record below, when all of the following conditions are met:

> 1. The appellant (Employee) is an employee of the Metropolitan Police Department or the D.C. Fire & Emergency Medical Services Department;
>
> 2. The employee has been subjected to an adverse action;

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[7] Although I may not discuss every aspect of the evidence in the analysis of this case, I have carefully considered the entire record. *See Antelope Coal Co./Rio Tino Energy America v. Goodin*, 743 F.3d 1331, 1350 (10th Cir. 2014) (citing *Clifton v. Chater*, 79 F.3d 1007, 1009-10 (10th Cir. 1996)) ("The record must demonstrate that the ALJ considered all of the evidence, but an ALJ is not required to discuss every piece of evidence").
[8] 801 A.2d 86 (D.C. 2002).
[9] *See* D.C. Code §§ 1-606.02(a)(2), 1-606.03(a)(c); 1-606.04 (2001).

> 3. The employee is a member of a bargaining unit covered by a collective bargaining agreement;
>
> 4. The collective bargaining agreement contains language essentially the same as that found in *Pinkard*, *i.e.*: "[An] employee may appeal his adverse action to the Office of Employee Appeals. In cases where a Departmental hearing [*i.e.*, Adverse Action Panel] has been held, any further appeal shall be based solely on the record established in the Departmental hearing"; *and*
>
> 5. *At the agency level, Employee appeared before an Adverse Action Panel that conducted an evidentiary hearing*, made findings of fact and conclusions of law, and recommended a course of action to the deciding official that resulted in an adverse action being taken against Employee (emphasis added).

There is no dispute that the current matter falls under the purview of *Pinkard*. Employee is a member of the D.C. Fire and Emergency Medical Services Department and was the subject of an adverse action (termination); Employee is a member of the International Fire Fighters Local 36, AFL-CIO MWC Union ("Union") which has a Collective Bargaining Agreement ("CBA") with Agency. The CBA contains language similar to that found in *Pinkard* and Employee appeared before an Adverse Action Panel on August 20, 2024, August 21, 2024, and October 24, 2024, for an evidentiary hearing. This Panel made findings of fact, conclusions of law and recommended that Employee be terminated for the current charges. Consequently, I find that *Pinkard* applies in this matter. Accordingly, pursuant to *Pinkard*, OEA may not substitute its judgement for that of the Agency, and the undersigned's review of Agency's decision in this matter is limited to the determination of (1) whether the Adverse Action Panel's decision was supported by substantial evidence; (2) whether there was harmful procedural error; and (3) whether Agency's action was done in accordance with applicable laws or regulations.

1) Whether the Adverse Action Panel's decision was supported by substantial evidence

Pursuant to *Pinkard*, I must determine whether the Adverse Action Panel's ("Panel") decision was supported by substantial evidence. Substantial evidence is defined as evidence that a reasonable mind could accept as adequate to support a conclusion.[10] If the Panel's findings are supported by substantial evidence, then the undersigned must accept them even if there is substantial evidence in the record to support findings to the contrary.[11]

After reviewing the record, as well as the arguments presented by the parties in their respective briefs to this Office, I find that the Panel met its burden of substantial evidence for Charge No. 1, Specification No. 1. Employee admitted during the Trial Board hearing that he administered Narcan through the patient's clothing and that this action was not consistent with Agency's protocol. He also submitted in his brief to this Office that "there is no dispute in the record that [Employee] violated Agency protocols by giving the Narcan injection through the patient's clothing."[12] The Trial Board Panel noted that all evidence presented led the Panel to conclude that Employee was guilty of violating the Patient Bill of Rights as well as the Department's Mission Statement, Vision Statement and Core Values when he administered medication through the patient's clothing. The Trial Board Panel was additionally concerned with Employee's testimony that he had administered medicine through clothing on multiple occasions. The

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[10] *Mills v. District of Columbia Department of Employment Services*, 838 A.2d 325 (D.C. 2003) and *Black v. District of Columbia Department of Employment Services*, 801 A.2d 983 (D.C. 2002).
[11] *Baumgartner v. Police and Firemen's Retirement and Relief Board,* 527 A.2d 313 (D.C. 1987).
[12] Employee's Brief at pg. 2 (February 13, 2026).

Trial Board Panel cited that this practice contradicts both written policies / protocols and paramedic training that required Employee to use an aseptic method when giving IM medication to his patients.[13]

While Dr. Vitberg, Agency's interim medical director testified that protocols are a guide for how treatment should be rendered and that there may be situations in which a paramedic or an EMT must do something outside of what can be described or dictated in an EMS protocol, when asked if Employee administered the injection consistent with the protocols, Dr. Vitberg, said "Absolutely not." He testified that injecting Narcan through the patient's clothing was "… not compatible with our protocols." Tr. Vol. I. pgs. 235-236, 252. He explained that according to protocol and common sense, it was important to remove clothing before administering injection because the injection site needs to be exposed, and the area wiped with alcohol to avoid pushing bacteria or other contaminants on the skin surface through the skin into the muscle. Tr. Vol. I. pgs. 220 -225.

Additionally, Cpt. Drucker testified that administering Narcan through a patient's clothing is "a nuanced decision, but I think there are instances where getting something through clothing would be appropriate…" He further explained that "So if you're asking the protocol answer would be no, under no circumstances." He also stated that "I mean … there's no exception for that in protocol if that's what you're asking." And when asked if he has heard of this practice being taught at Agency, Cpt. Drucker stated that "I'm not familiar with that being taught officially in any DC Fire/EMS capacity." Tr. Vol. I. pgs. 154-157, 161, 164-166. Moreover, when asked if under Agency's protocol, it was ever best practice for a paramedic to administer Narcan through the patient's clothing, Cpt. Lammert said 'No.' Tr. Vol. II. pgs. 168-170, 185-186. Accordingly, based on Employee's own admission, and evidence presented during the Trial Board Hearing, I find that the Trial Board Panel's decision to find Employee guilty of Charge No. 1., Specification No. 1., is supported by substantial evidence.[14]

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[13] Tr. Vol. II. pgs. 14 -17, 88-89, 92-93, 98-102, 130.

[14] Regarding Agency's assertion under Charge No. 1., Specification No. 1., that Employee did not assess the patient before administering the IM Narcan, I find that this is not supported by substantial evidence. Employee explained that his assessment of the patient started from when they were dispatched to the scene, canceled and dispatched again and this continued until he visualized the patient when they arrived at the scene. FF/P Busch testified that "you can assess the patient walking up to them. You can see their respiratory rate. You can feel a radial pulse. There's a bunch of different things." Also, Cpt. Drucker testified that he was informed by the ambulance crew that when Employee arrived, he did a "shortened assessment and gives the person Narcan." This confirms that Employee did some sort of assessment prior to injecting the patient with Narcan. Moreover, Dr. Vitberg also stated that "a lot of times you don't have to lay hands on the patient immediately." Tr. Vol. III. pg. 26. Additionally, Employee cited that his partner talked to the ambulance crew and assessed the patient while he was getting his gear. Employee explained that he and his partner then had a conversation about what was going on and his partner informed him that the patient had pinpoint eyes and his heart rate was 42 as recounted by the ambulance crew. Employee's partner, FF/EMT Peterson confirmed this when she testified that she hooked the patient to a monitor to get baseline items and that she assessed the patient when she first encountered the patient and she relayed that information to Employee before he administered Narcan to the patient. She affirmed that both she and Employee were paramedics and that in general, she would defer to Employee's medical assessment. Furthermore, Dr. Vitberg, stated that the requirement to perform an assessment on the scene is not so much an individual requirement as a requirement that the team perform together. He also stated that if he showed up as a paramedic to a scene, he would put a lot of faith in what he's told by his colleagues on the scene regarding what was going on and what needed to be done next. Cpt. Lammert confirmed that it was okay for a medic to rely on information such as vital signs passed to them by an EMT that was already on the scene. He stated that they can take that information to start their assessment, but they're always encouraged to get their own assessment done. Tr. Vol. II. pgs. 165-166. Cpt. Lammert also confirmed that it was permissible for a medic to rely on a report from their partner that a patient had pinpoint pupils. He testified that while Employee would have done an independent assessment, "… given the situation, and the vital signs that he was given, and the fact that the patient was altered, a lot of times when we view those situations … treating the patient quickly is more important than starting over, doing the full assessment over again." FF/P Busch also asserted that "we also have partners that we're assigned on the ambulance that can do part of that assessment for you." Therefore, I find that Employee did not have to conduct an independent assessment and that he could rely on his partner's assessment and the information provided by Ambulance 16. Employee also testified that after administering Narcan to the patient, they placed the patient on a monitor, and he continued his assessment to figure out what was wrong with the patient. Dr. Vitberg confirmed that sometimes there are emergencies where it's appropriate to interrupt the assessment to intervene and then continue the assessment after the intervention. He affirmed that this would be based on the paramedic's judgment. Dr. Vitberg also testified that if a patient is obviously intoxicated with opioid and has

For Charge No. 2, Specification No. 1, I find that the record does not support the Trial Board Panel's findings. The Trial Board Panel asserted that Employee's statements to the OIA during the Affairs administrative interview were riddled with contradictions and that Employee made contradictory statements to *purposely* misled the investigators. (Emphasis added). The Trial Board Panel further noted that Employee neglected his duty of candor during OIA's investigation into a matter relating directly to his official duties as an ALS provider. This cause of action provides that "[a]ny member who *willfully* and *knowingly* makes *untruthful statements* of any kind, or who refuses, or fails to make truthful statements in a verbal or written report pertaining to his official duties as a Fire & EMS Department employee is subject to disciplinary action, including dismissal." I find that the Trial Board has not established that Employee knowingly made contradictory statements or that the alleged contradictory statements were made with the intent of willfully misleading. Moreover, Employee reiterated during the interview with OIG that his statements were based on what he could remember of the incident which occurred over almost three (3) months and approximately 20 runs since the incident occurred.[15] Therefore, based on the foregoing, I conclude that the Trial Board Panel's finding for Charge No. 2, Specification No. 1, is not supported by substantial evidence.

2) Whether there was harmful procedural error.

Pursuant to *Pinkard* and OEA Rule 634.6, the undersigned is required to make a finding of whether Agency committed harmful error. OEA Rule 634.6 provides as follows: "notwithstanding any other provision of these rules, the Office shall not reverse an agency's action for error in the application of its rules, regulations, or policies if the agency can demonstrate that the error was harmless. Harmless error shall mean an error in the application of the agency's procedures, which did not cause substantial harm or prejudice to the employee's rights and did not significantly affect the agency's final decision to take the action."

Employee asserts that the Trial Board Panel committed harmful procedural error by ignoring relevant evidence about his character and intention. He also avers that Agency violated rules and regulations requiring the proper consideration and application of the *Douglas* factors[16] when it

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significant respiratory depression, it would be more appropriate to prioritize the administration of Narcan/naloxone before testing their blood glucose levels. Accordingly, I conclude that even if Employee did not perform an assessment of the patient before administering the Narcan, he was justified to rely on the assessment conducted by his partner or the information they received from the ambulance crew and that he did not violate Agency's policies when he completed his assessment after administering the Narcan.

[15] Employee also referenced portions of the BWC video footage supporting the statements he made to Cpt. Barnes during the OIG investigation. Further, when presented with evidence from the BWC video footage that was in support of the statements Employee made during the OIA investigation, Cpt. Barnes testified that while she reviewed the video footage during the investigation, she does not necessarily review them closely. She also confirmed that the BWC was pointed away from the patient at some point and that there were instances were Employee was not captured on the BWC although he was on the scene. Furthermore, Cpt. Barnes and the Trial Board Panel asserted that Employee *firmly/adamantly denied* ever administering IM medication through a patient's clothing until the video evidence was presented. (Emphasis added). The undersigned finds otherwise. Upon review of Agency's Exhibit 8, the undersigned finds that during the investigation interview, when Employee was asked if he administered Narcan through the patient's clothing, Employee stated that "to be honest with you ma'am, I do not remember. But if you have a document that says I did, maybe I did, I don't remember…" *See*. Agency's Exhibit 8 at timestamp 19:30.

[16] In *Douglas v. Veterans Administration*, the Merit Systems Protection Board ("MSPB"), this Office's federal counterpart, set forth "a number of factors that are relevant for consideration in determining the appropriateness of a penalty." Although not an exhaustive list, the factors are as follows: (1) the nature and seriousness of the offense, and its relation to the employee's duties, position, and responsibilities including whether the offense was intentional or technical or inadvertent, or was committed maliciously or for gain, or was frequently repeated; (2) the employee's job level and type of employment, including supervisory or fiduciary role, contacts with the public, and prominence of the position; (3) the employee's past disciplinary record; (4) the employee's past work record, including length of service, performance on the job, ability to get along with fellow workers, and dependability; (5) the effect of the offense upon the employee's ability to perform at a satisfactory level and its effect upon supervisors' confidence in employee's ability to perform assigned duties; (6) consistency of the penalty with those imposed upon other employees for the same or similar offenses; (7) consistency of the penalty with any applicable agency table of penalties; (8) the notoriety of the offense or its impact upon the reputation of the agency; (9) the clarity

recommended the penalty of termination. Employee cites that the Trial Board Panel misapplied the *Douglas* factors thereby abusing its discretion, and this warrants a reversal of the penalty. Employee asserts that OEA can reverse or reduce a penalty when an agency fails to properly consider or apply the *Douglas* factor. Employee maintains that the Trial Boad Panel plainly misapplied, failed to consider and/or outright ignored several *Douglas* factors to include *Douglas* factors numbers 1, 3, 4, 6, 9, 10.

Agency on the other hand asserts that Employee statements relate entirely to whether termination was the appropriate penalty and not in support of its assertion that Agency committed harmful procedural error. I must agree with Agency's assertion. Furthermore, apart from the above statements regarding Agency's application of the *Douglas* factors and its alleged failure to consider relevant evidence about Employee's character and intention, I find that Employee has not alleged any concrete procedural errors.[17] Therefore, I conclude that there was no harmful procedural error in this matter.

3) Whether Agency's action was in accordance with law or applicable regulation

The record contains substantial evidence that Employee neglected his duties when he violated Agency's protocol for administering Narcan. Specifically, Employee admitted to administering Narcan through the patient's clothing and that it was against his paramedic training and Agency's protocol. Additionally, Dr. Vitberg testified that administering Narcan through a patient's clothing is against protocol. Therefore, the undersigned finds that there is sufficient evidence in the record to support Charge No1. 1., Specification No. 1, as such, I conclude that Agency's action was in accordance with law or applicable regulations.

As previously noted, I also find that the record does not support Charge No 2., Specification No.1. as the record does not support a finding that Employee made contradictory statements. Even assuming Employee made contradictory statements during the OIA investigation, the record does not establish that these statements were made with the intent to willfully mislead rather than due to a lapse in memory given that almost three (3) months had passed since the incident occurred. Consequently, I conclude that Agency cannot rely on this charge to discipline Employee.

Whether the Penalty was Appropriate

In determining the appropriateness of an agency's penalty, OEA has consistently relied on *Stokes v. District of* Columbia, 502 A.2d 1006 (D.C. 1985).[18] According to the Court in *Stokes,* OEA must determine whether the penalty was within the range allowed by law, regulation, and any applicable Table of Penalties; whether the penalty is based on a consideration of the relevant factors; and whether there is a clear error of judgment by agency. In the instant matter, I find that Agency does not have substantial evidence to support

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with which the employee was on notice of any rules that were violated in committing the offense, or had been warned about the conduct in question; (10) potential for the employee's rehabilitation; (11) mitigating circumstances surrounding the offense such as unusual job tensions, personality problems, mental impairment, harassment, or bad faith, malice or provocation on the part of others involved in the matter; and (12) the adequacy and effectiveness of alternative sanctions to deter such conduct in the future by the employee or others.

[17] Employee contends that he was never asked to write a Special Report regarding this incident. Additionally, Cpt. Barnes testified that while she directed Captain Drucker to submit a Special Report in this matter, she did not request that Employee submit a Special Report. According to Cpt. Kloss, a Special Report is "a document of record in whoever's words that's asked to type up." He confirmed that he was aware that Employee was never asked to write a special report in the current case, which he noted was not normal as Employee never got to tell his side of the story. While the record supports Employee's assertion that he was not afforded the opportunity to write a Special Report of the incident, I find that this constitutes harmless error.

[18] *See also. Robert Atcheson v. D.C. Metropolitan Police Department,* OEA Matter No. 1601-0055-06, *Opinion and Order on Petition for Review* (October 25, 2010); and *Christopher Scurlock v. Alcoholic Beverage Regulation Administration*, OEA Matter No. 1601-0055-09, *Opinion and Order on Petition for Review* (October 3, 2011).

Charge No. 2, Specification No. 1., as such, Agency cannot rely on this cause of action to discipline Employee. However, because Agency has met its burden for the cause of action as provided in Charge No. 1., Specification No. 1., as described in D.C. Fire and Emergency Medical Services Department Order Book Article VII, § 2(f)(3), which states: "Any on-duty or employment-related act or omission that interferes with the efficiency or integrity of government operations, to include: Neglect of Duty,"[19] I conclude that Agency can rely on this charge to discipline Employee.

The misconduct contained in Charge No. 1, Specification No. 1, is defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII, § 2(f)(3), which states: "Any on-duty or employment-related act or omission that interferes with the efficiency or integrity of government operations, to include: Neglect of Duty." The record shows that this is the first time Employee violated this cause of action. Pursuant to the Table of Penalties and the Table of Illustrative Actions, the penalty for a first offense for this cause of action ranges from Counseling to Removal.

Penalty Based on Consideration of Relevant Factors

As provided in *Love v. Department of Corrections,*[20] selection of a penalty is a management prerogative, not subject to the exercise of discretionary disagreement by this Office.[21] When an Agency's charge is upheld, this Office has held that it will leave the agency's penalty undisturbed when the penalty is within the range allowed by law, regulation or guidelines, is based on consideration of the relevant factors and is clearly not an error of judgment. Here, Agency chose to terminate Employee despite several testimonies from several other paramedics, as well as Agency management, to include documentary evidence establishing that administering Narcan through a patient's clothing in an emergent situation was a growing trend at Agency which did not warrant a termination, but rather retraining and/or remediation.[22]

Although OEA has a "marginally greater latitude of review" than a court, it may not substitute its judgment for that of the agency in deciding whether a particular penalty is appropriate.[23] The "primary discretion" in selecting a penalty "has been entrusted to agency management, not to the OEA."[24] Selection of an appropriate penalty must involve a responsible balancing of the relevant factors in the individual case.[25] OEA's role in this process is not to insist that the balance be struck precisely where the OEA would choose to strike it if OEA were in Agency's shoes in the first instance; such an approach would fail to make proper deference to the Agency's primary discretion in managing its workforce. Rather, OEA's review of an agency-imposed penalty is essentially to ensure that Agency conscientiously considered the relevant factors and did strike a responsible balance within tolerable limits of reasonableness. Only if OEA finds that the agency failed to weigh the relevant factors, or that Agency's judgment clearly exceeded the limits

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[19] *See also* 16 DPM § 1603.3(f)(3) (rev. 08/27/2012); *see also* 16 DPM § 1605.4(e) (rev. 06/12/2019).
[20] OEA Matter No. 1601-0034-08R11 (August 10, 2011).
[21] *Love* also provided that "[OEA's] role in this process is not to insist that the balance be struck precisely where the [OEA] would choose to strike it if the [OEA] were in the agency's shoes in the first instance; such an approach would fail to accord proper deference to the agency's primary discretion in managing its workforce. Rather, the [OEA's] review of an agency-imposed penalty is essentially to assure that the agency did conscientiously consider the relevant factors and did strike a responsible balance within tolerable limits of reasonableness. Only if the [OEA] finds that the agency failed to weigh the relevant factors, or that the agency's judgment clearly exceeded the limits of reasonableness, is it appropriate for the [OEA] then to specify how the agency's decision should be corrected to bring the penalty within the parameters of reasonableness." Citing *Douglas v. Veterans Administration,* 5 M.S.P.R. 313 (1981).
[22] Referring to Employee's Exhibit 4, Cpt. Lammert testified that he sent out an email on February 24, 2024, stating that "Giving IM injections through clothing *appears to be a trend on the rise*. This is an unacceptable practice. Use trauma shears to cut a hole in the injection location, and follow appropriate IM injection procedures." (Emphasis added).
[23] *See*, *Douglas v. Veterans Administration*, 5 MSPB 313, 328, 5 M.S.P.R. 280, 301(1981) (Federal Merit Protection Board case).
[24] *Id*.
[25] *Id*.

of reasonableness, is it appropriate for OEA then to specify how the Agency's decision should be corrected to bring the penalty within the parameters of reasonableness.[26]

Here, Agency asserts that its consideration of the penalty met the standard in *Stokes v. District of* Columbia. It cites that the Trial Board Panel conducted a full examination of all the *Douglas* factors and that OEA should defer to its reasonable decision to terminate Employee. Agency avers that Employee does not raise any issues with its application of *Douglas* factors numbers 2, 7, 8, 11, 12, and as such, this Office should not disturb its unchallenged and reasonable consideration of these factors.

Citing to case law, Agency avers that *Douglas* factor No. 1 is the most important factor in assessing the reasonableness of a penalty.[27] Agency maintains that Employee's failure to provide care in a manner consistent with Agency protocol is serious and his untruthfulness violated his oath, all of which makes this factor 'aggravating.' Agency explains that regardless of Employee's subjective motivation, the Trial Board Panel found Employee's violation of protocol when he administered an unsterile injection without consent or assessment to be serious. Agency further affirms that the Trial Board Panel did not give *Douglas* factor No. 3 any weight. Regarding *Douglas* factor Nos. 4 and 5, Agency cites that although Employee asserts that the Trial Board Panel erred in its analysis, Employee has not provided any meaningful argument that the Trial Board Panel was required to consider Employee to be dependable and have confidence in his continued employment.

Citing to *Singh*, Agency contends that *Douglas* factor No. 6 should never be given too much weight or become the sole outcome determinative factor. Agency explains that it treated Employee similar to other employees in similar circumstances who were also terminated and Employee has made no showing to the contrary. Agency states that nothing in the record suggests that it knowingly treated Employee differently as there are no testimonies in the record indicating that a senior Agency decision maker was aware that other employees acted like Employee. Agency also cites that the other circumstances described at the Trial Board Hearing are distinguishable from Employee's circumstance in that, the employee who injected Narcan through the patient's clothing did so during a cardiac arrect and was unable to find trauma shears. Whereas, Employee's patient was sitting and breathing, and Employee did not even check the patient's heart rate before administering the Narcan.

Regarding *Douglas* factor No. 9, Agency avers that Employee was on notice of Agency's expectations from Agency's clear protocols concerning patient care, Employee's training on those protocols and his paramedic education and training on how to administer IM Narcan. Agency also asserts that Employee was on notice that making a false statement was a violation of rules and that he made no arguments to the contrary, only that he did not intentionally lie. Agency further notes that the Trial Board Panel's determination that Employee could not be rehabilitated was based on the seriousness of Employee's misconduct and his failure to take responsibility for his misconduct through testimony. Agency asserts that OEA should not second guess the Trial Board Panel's determination.

Employee on the other hand argues that Agency violated rules and regulations requiring the proper consideration and application of the *Douglas* factors. Employee cites that the Trial Board Panel misapplied the *Douglas* factors thereby abusing its discretion, and this warrants a reversal of the penalty. Employee further contends that the Trial Boad Panel plainly misapplied, failed to consider and/or outright ignored several *Douglas* factors to include *Douglas* factors numbers 1, 3, 4, 6, 9, 10. Employee asserts that OEA

[26] *Raphel* 740 A. 2d at 945.
[27] *Singh v. U.S. Postal Services*, 2022 M.S. P. B. 15, ¶ 18 (M.S.P.B. May 31, 2022).

can reverse or reduce a penalty when an agency fails to properly consider or apply the *Douglas* factors.[28] Employee explained that there is no dispute that the Narcan Employee administered helped the patient recover to the point where he was lucid enough to refuse further treatment. Employee further noted that while Agency tried to demonize his conduct, the record paints a different picture, one of Employee's good faith and patient centered actions, all of which undermines the Trial Board Panel's findings of fact regarding Employee's intention and potential for rehabilitation.

For *Douglas* factor No. 1, Employee argues that while the record shows that he violated protocol when he administered IM Narcan through the patient's clothing, he did so in good faith and with no malice or willful intent. Employee also asserts that he testified truthfully during his interview with Cpt. Barnes and, at most, innocently misremembered a small detail that had no bearing on the investigation. Employee contends that the Trial Board Panel's conclusion that his actions were intentional and that many of his statements were misleading and untruthful is a clear misapplication of *Douglas* factor No. 1. Employee further argues that the Trial Board Panel misapplied *Douglas* factor No. 3. Citing to case law, Employee explained that his lack of prior disciplinary action should have been a mitigating factor, instead, the Trial Board Panel found this to be neutral.[29]

Additionally, for *Douglas* factors No. 4 and 5, Employee asserts that the Trial Board summarily concluded despite unimpeached testimonies and without reasonable or meaningful explanation that Employee was not dependable. Employee stated that several witnesses, including Cpt Kloss testified on his behalf, attesting to his character and dependability, in contrast to the Trial Board Panel's findings.

Employee argues that despite the Trial Board Panel's assertion in *Douglas* factor No. 6 that the penalty of termination was consistent with the penalty imposed on others committing similar infraction, pursuant to the record, this is not true. Employee asserts that Agency's representative at the Trial Board Hearing stated that Employee's prosecution was the first of its kind. Regarding *Douglas* factor No. 9, Employee argues that the record clearly established that there was some confusion with the protocol for establishing IM Narcan, and Employee's action in this instance was not unique as other Agency members have engaged in similar conduct as evidenced by Cpt. Lammert's February 24, 2024, email to the entire Battalion, to include his chief. Employee also argues that Cpt. Drucker testified that though administering IM Narcan is not allowed per official protocol, it is a nuanced decision that there are instances where getting something through the patient's clothing would be appropriate and that the current situation would qualify as that.

Referring to *Douglas* factor No. 10, Employee contends that there are no testimonies in the record, not even from the medical director, asserting that Employee could not be rehabilitated. Employee cites that in reaching the conclusion that Employee could not be rehabilitated, the Trial Board Panel ignored the testimonies of three (3) EMS supervisors, proving that the Trial Board Panel patently misapplied *Douglas* factor No. 10. Employee also contends that this conclusion is also inconsistent with the Trial Board Panel's finding under *Douglas* factor No. 12 which the Trial Board Panel found to be neutral. Employee maintains that the Trial Board Panel's neutral finding for *Douglas* factor No. 12 provides an independent basis to believe that an alternative sanction could be appropriate. Employee explains that Cpt. Drucker testified that had he been there when Employee administered the Narcan through the patient's clothing, he would have referred Employee to peer review under Agency's CQI process. Employee also notes that Cpt. Lammert

[28] Citing to *Employee v. Office of the Chief Technology Officer*, OEA Matter No. 1601-0058-23, Opinion and Order on Petition for Review (December 18, 2025).
[29] *See. Aronson v. D.C. Fire and Emergency Medical Services Department*, OEA Matter 1601-0128-99, Opinion and Order on Petition for Review (January 26, 2007).

testified that he would have pulled Employee to the side and had a conversation with him. Employee also stated that according to Cpt. Lammert, this incident was a training issue and not a disciplinary issue.

In *Barry v. Department of Public Works*[30], the OEA Board held that an Agency's penalty will not be reversed unless it fails to consider relevant factors, or the imposed penalty constitutes an abuse of discretion. Therefore, even if an agency's selected penalty falls within the range allowed by law, it is not entitled to deference if the reviewing authority determines that the agency exceeded its discretionary authority. In *Employee v. D.C. Public Schools*[31], the OEA Board held that the record was void of any evidence that the agency considered relevant factors when terminating the employee, which constituted an abuse of discretion. Similarly, in *Bryant and Love v. D.C. Department of Corrections*[32], the OEA AJ found that the agency exceeded the exercise of its managerial discretion and failed to properly consider the relevant *Douglas* factors.

In the instant matter, the undersigned finds that while the penalty of termination was within the range allowed by law, it was not based on a balanced weighing of the relevant factors and thus exceeded the limits of what is reasonable. In assessing and weighing the *Douglas* factors, and in determining the severity of Employee's conduct, Agency's improper analysis had the effect of making the conduct at issue more severe than the record supports. Thus, the undersigned concludes that Agency's weighing of the *Douglas* factors was not a reasonable assessment based on the record.

The Trial Board Panel found *Douglas* factor No. 1 to be 'aggravating'. In support of this assertion, Agency stated that

> "These are very serious offenses that relate directly to FF/P [Employee's] duties as an advance life support (ALS) provider. FF/P [Employee's] actions were also intentional. As a First Responder with more than ten (10) years of experience, FF/P [Employee] knew or should have known that the way he administered medication to his patient was inconsistent with both Department policy and his training; further, by his own admission, FF/P [Employee] testified that his misconduct was frequently repeated. FF/P [Employee] took an oath to be truthful. Yet, when being interviewed by Internal Affairs personnel, many of his statements were misleading and untruthful."

While Employee acknowledged that he violated Agency's protocol on administering IM Narcan, he testified that he did so in good faith, under the belief that he was faced with an emergent situation based on the patient assessment he received from his partner and Ambulance 16. The record supports Employee's assertion that the Narcan he administered through the patient's clothing did not harm the patient but helped the patient recover to the point where he was lucid enough to refuse further treatment. While Agency asserts that the record does not support the fact that the patient's heart rate was 40, both Employee testified that they were informed by Ambulance 16 that the patient's heart rate was in the 40s. Moreover, Agency has the burden of proof in this matter and Agency did not secure the testimony of any of the members on ambulance 16 to discredit Employee's assertion that the patient's heart rate was in the 40s. Employee further testified that he was concerned about the patient's heart rate of 42 as he feared that the patient might be heading towards cardiac arrest, so he quickly grabbed Narcan and injected the patient with it. Employee

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[30] OEA Matter No. 1601-0083-14, Opinion and Order on Petition for Review (July 11, 2017) (citing *Holland v. Department of Corrections*, OEA Matter No. 1601-0062-08, Opinion and Order on Petition for Review (September 17, 2012).
[31] OEA Matter No. 1601-0015-20, Opinion and Order on Petition for Review (January 4, 2024).
[32] OEA Matter Nos. 1601-0034-08R14 and 1601-0038-08R14 (November 4, 2014).

also testified that the patient had pinpoint eyes and his GCS level was below 13. Agency did not provide any evidence to the contrary.

Additionally, the record suggests that administering Narcan through patient clothing was a trend at Agency. Sgt. Long testified that he had witnessed and was aware of other instances in which paramedics in the district administered Narcan through a patient's clothing in an emergent situation. Sgt. Long also confirmed that a patient with a heart rate of 42 was an emergent situation. Sgt. Long explained that if a patient's heart rate is in the 40s, then the patient is not getting enough oxygen to the heart, and their respiratory rate should be depressed. Also, Cpt. Faulkner testified that "… I just think it's a dangerous precedent to ever second-guess what the provider saw in a moment or assessed with his assessment, especially if the treatment given is what should have been given by the protocols. The matter of how it was done, like I said, I think that puts us back in more of a training issue, more so than a failure to perform your job… even on that note with the protocols too … when we're looking at the protocols as a framework, they give us a general … list of rules to follow based off of what we generally see in the performance of our duty, with patients presenting with certain attributes, certain signs and symptoms, and certain medical histories… It might be written, but you have to make judgment calls, and you have to be comfortable with what you decide to do. And then you have to stand behind that. And to me, if you could justify that and you did not cause harm, training issue. But to answer your question, yes, I think that was appropriate to administer that medication." Tr. Vol. III. pgs. 113- 115.

Further, Cpt. Lammert, Cpt. Faulkner, and Sgt. Long, all top-ranking members at Agency, and FTO Firefighter/P Woitas, testified that the current issue would be better resolved by training and not disciplinary action, thereby downgrading the severity of Employee's overall conduct in relation to the employee's duties, position, and responsibilities including *whether the offense was intentional or technical or inadvertent, or was committed maliciously or for gain*, or was frequently repeated. (Emphasis added). Moreover, Employee and multiple Agency paramedics testified during the Trial Board Hearing that they were only made aware that administering IM Narcan through a patient's clothing was a violation of Agency's protocols after the current incident and /or sometime in 2024, through Cpt. Lammert's email or during the 2024 grand rounds.

Additionally, as noted above, I find that Agency did not have cause to charge Employee with willfully misleading during his OIG investigation. In *Aguilar v. D.C. Office of Employee Appeals, et al*.[33], the Superior Court for the District of Columbia held that if a penalty was imposed based on numerous incidents of misconduct and some of those incidents of misconduct are not substantiated, the Court must "scrutinize carefully the appropriateness of the penalty imposed." Here, I find that because *Douglas* factor No. 1 was also based on the misconduct in Charge No. 2. Specification No. 1, which is not supported by the record, I find that the penalty of termination is excessive.

In assessing *Douglas* factor No. 3, the Trial Board Panel asserted that this factor was 'neutral'. It stated that Employee had no prior disciplinary history. Employee explained that his lack of prior disciplinary action should have been a mitigating factor, instead, the Trial Board Panel found this to be neutral. In *Aronson v. D.C. Fire and Emergency Medical Services Department,*[34] the OEA Board found that the employee's ten-year history, coupled with no previous adverse actions and his strong potential for rehabilitation, supported a different penalty.[35] Here, the record suggests that Employee had no adverse actions against him prior to the current action. Moreover, Employee testified that going forward, he would

[33] 2022 CA 003383 P(MPA) (D.C. Super. Ct. March 13, 2023).
[34] OEA Matter 1601-0128-99, Opinion and Order on Petition for Review (January 26, 2007).
[35] *See also* 2007 CA 001923 P(MPA) (D.C. Super Ct. April 22, 2008).

not administer Narcan through clothing because it's in Agency's policies and he plans on following Agency's rules policies and not violate them. Further, Cpt. Kloss testified that he trusted Employee's work as a paramedic, that Employee was receptive to correction instructions and that he was willing to grow.

In assessing *Douglas* factor No. 4, the Trial Board Panel asserted that:

> FF/P [Employee] has been a Department member since March 13, 2022 and, as stated above, this is his first disciplinary infraction within the past 3 years. However, given the severity of these offenses — stemming from FF/P [Employee's] blatant and serial violations of Department policy —the Panel concludes that FF/P [Employee] is not dependable.

The record supports the assertion that this was Employee's first disciplinary infraction. However, the record does not support the Trial Board Panel's assertion that Employee was not dependable. In fact, Agency's high-ranking members who supervised Employee during his tenure at Agency all testified that Employee was dependable. Cpt. Kloss testified that he trusted Employee's work as a paramedic, that Employee was receptive to correction instructions and that he was willing to grow. Cpt. Kloss asserted that he did not think anyone liked the fact that Employee was removed from active duty and that Engine 26 missed Employee as he was an asset. Tr. Vol. II. pgs. 194-198. Additionally, Cpt. Faulkner who had supervised Employee denied seeing anything in Employee that would indicate that he was cavalier or casual about his patient care. Cpt. Faulkner cited that given the charges against Employee, his impression about Employee had not changed.

In assessing *Douglas* factor No. 6, the Trial Board Panel found that:

> Based on our review of prior discipline charts provided during the hearing, the Panel concludes that the recommended penalty is consistent with those imposed on others committing similar infractions and is, likewise, consistent with the seriousness of FF/P [Employee'] infractions.

Because I have found that Charge No. 2, Specification No. 1, is not substantiated by the record, I will based my analysis on Charge No. 1, Specification No. 1. While Agency did provide records of others it claimed committed similar infractions, as Employee, I find that Agency further contradicts itself when it argued that nothing in the record suggests that it knowingly treated Employee differently as there are no testimonies in the record indicating that any senior Agency decision maker was aware that other employees acted like Employee. Agency cannot in one statement argue that it was not aware that Agency employees were administering Narcan through patient clothing prior to the current incident, and in another statement argue that the penalty levied against Employee was consistent with those imposed on other employees committing similar offenses. Additionally, explaining the seriousness of Employee's misconduct, Agency attempts to distinguish the circumstances surrounding the instant matter with that of another member who testified to administering Narcan through a patient's clothing. Agency argues that the employee who injected Narcan through the patient's clothing did so during a cardiac arrect and was unable to find trauma shears. Whereas, Employee's patient was sitting and breathing, and Employee did not even check the patient's heart rate before administering the Narcan. I find this argument to be flawed, as this would suggest that Agency's protocol does provide for an exception as to when a member can administer IM Narcan through a patient's clothing without facing consequences, even though the record suggests otherwise. Furthermore, Employee testified that he was faced with an emergency and that with a heart rate of 42, he feared the patient was heading to cardiac arrest. Sgt. Long testified that he had witnessed and was aware of other instances in which paramedics in the district administered Narcan through a patient's

clothing in an emergent situation. He did not state that cardiac arrest was required for a member to administer Narcan through a patient's clothing. Sgt. Long confirmed that a patient with a heart rate of 42 was an emergent situation. Sgt. Long explained that if a patient's heart rate is in the 40s, then the patient is not getting enough oxygen to the heart, and their respiratory rate should be depressed.

Relying on *Singh*, Agency argues that *Douglas* factor No. 6 should never be given too much weight or become the sole outcome determinative factor. The MSPB Board in *Singh* held that the proper inquiry for a disparate treatment analysis is whether an agency knowingly treated employees differently "in a way not justified by the facts, and intentionally for reasons other than the efficiency of the service." Here, although several members testified to administering IM Narcan through a patient's clothing, or being aware of other paramedics who have administered IM Narcan through a patient's clothing, the record is void of any disciplinary action against any member for such actions. Therefore, I further conclude that because this appears to be the first time Agency has commenced adverse action against a member for administering IM Narcan through a patient's clothing, and Agency has asserted that prior to the current matter no decision maker was aware of employees administering IM Narcan through a patient's clothing, *Singh* is not applicable here.

Regarding *Douglas* factor No. 9, the Trial Board Panel stated that:

> This factor is aggravating. FF/P [Employee] clearly knew that he was responsible for providing care and being truthful in a manner consistent with Department standards. FF/P [Employee] completed his probationary period and, during this time, he was responsible for reading, studying, and being tested on Department manuals and regulations. Further, FF/P [Employee] received on–going training on the Department's expectations of its Advance Life Support providers, and the Department's Core Values are referenced in training. In addition, FF/P [Employee] is a nationally registered Paramedic, who participated in paramedic preceptor evaluations and several grand rounds; thus, FF/P [Employee] had ample opportunities to pose questions / scenarios to his supervisors, the Medical Director, and other senior ALS providers concerning aseptic techniques when administering medications. Additionally, FF/P [Employee] took an oath to be truthful, and this duty clearly applied to his interview by OIA personnel. FF/P [Employee] should have known that his misconduct violated Department policy.

Here, Employee argues that the record clearly established that there was some confusion with the protocol for administering IM Narcan, and Employee's action in this instance was not unique as other Agency members have engaged in similar conduct as evidenced by Cpt. Lammert's February 24, 2024, email to the entire Battalion, to include his chief. Employee also argues that Cpt. Drucker testified that though administering IM Narcan through a patient's clothing is not allowed per official protocol, it is a nuanced decision that there are instances where getting something through the patient's clothing would be appropriate and that the current situation would qualify as that. I agree with Employee's assertion. Moreover, other paramedics testified that prior to the current incident, it was an Agency practice to inject IM Narcan through a patient's clothing in emergent situations. FF/P Busch testified that he had observed other paramedics administer Narcan through a patient's clothing quite a few times and he did not think anything was wrong with that. These paramedics, including Employee, testified that they were not aware that administering IM Narcan through a patient's clothing violated Agency's protocol. Therefore, according to the record, I find that when the incident occurred on October 30, 2023, it was not clear to Agency's members, not just Employee, that administering IM Narcan through a patient's clothing in an emergent

situation was a violation of protocol. Moreover, prior to this incident, Employee had not been warned about the conduct in question.

Under *Douglas* factor No. 10, the Trial Board Panel cited that:

> FF/P [Employee's] action of administering medication through the patient's clothing was negligent, showed a lack of compassion/empathy for his patient, and was in gross disregard of his training. The video footage showed that FF/P [Employee] willfully and knowingly failed to comply with Department policy and blatantly violated the Patient Bill of Rights — then, to make matters worse, he misled OIA personnel about his misconduct. As stated above, the Panel is particularly troubled by the fact that:
>
> > (a) video footage confirms that FF/P [Employee] administered medication through his patient's clothing without using an aseptic technique or doing an initial or secondary assessment;
> >
> > (b) FF/P [Employee] did not admit to violating Department policy, but claimed he did not know it was a violation;
> >
> > (c) FF/P [Employee] failed to do a reassessment before reassigning his patient to the Basic Life Support unit;
> >
> > (d) FF/P [Employee] unilaterally adopted this aseptic technique as his own practice and admittedly applied this practice to multiple patients; and
> >
> > (e) FF/P [Employee] not only showed no accountability for his actions but also provided untruthful / misleading information during his Internal Affairs interview.
> >
> > Rehabilitation is not possible in the circumstance.

Pursuant to the record, I find that Employee was not the only Agency member that administered IM Narcan through a patient's clothing. I also find that based on Dr. Vitberg's testimony, Employee was within his rights to rely on the assessment of his partner and that of Ambulance 16. I further find that pursuant to Dr. Vitberg's testimony, Employee was justified in administering IM Narcan to the patient before laying hands on the patient and continuing his assessment after. Furthermore, the record does not support the Trial Board's finding that Employee did not show accountability for his action. Employee testified that now that he knows that administering IM Narcan through a patient's clothing is a violation of Agency's protocol, he would not do so again. Moreover, Employee was not the only Agency member that stated that they were not aware that administering Narcan through a patient's clothing was a violation of Agency's policy and protocol. As previously noted, the Superior Court for the District of Columbia in *Aguilar v. D.C. Office of Employee Appeals, et al.*, held that if a penalty was imposed based on numerous incidents of misconduct and some of those incidents of misconduct are not substantiated, the Court must "scrutinize carefully the appropriateness of the penalty imposed." Here, I find that Agency did not meet its burden of proof for Charge No. 2, Specification No. 1, which is also part of this *Douglas* factor analysis.

In assessing *Douglas* factor No. 12, the Trial Board Panel asserted that this factor was neutral without providing any explanation of how it arrived at this conclusion. Employee maintains that the Trial

Board Panel's neutral finding for *Douglas* factor No. 12 provides an independent basis to believe that an alternative sanction could be appropriate. Employee explains that Cpt. Drucker testified that had he been there when Employee administered the Narcan through the patient's clothing, he would have referred Employee to peer review under Agency's CQI process. Employee also notes that Cpt. Lammert testified that he would have pulled Employee to the side and had a conversation with him. Employee also stated that according to Cpt. Lammert, this incident was a training issue and not a disciplinary issue. Pursuant to the record, I find that this factor should have been mitigating. Cpt. Lammert cited that his February 24, 2024, email was effective in putting a stop to the practice of administering IM Narcan through a patient's clothing. He testified that he thought training was an appropriate response to the October 30, 2023, incident. Additionally, upon review of the BWC video footage of October 30, 2023, Firefighter/P Woitas testified that in his opinion as an FTO, this would have been a retraining process. Cpt. Faulkner also asserted that this matter would have more appropriately been addressed through training. Therefore, based on the record, I find that training was an adequate, effective and alternative sanction to deter such conduct in the future by the employee or others.

In *Jones v. D.C. Public Schools Division of Transportation*[36], the AJ ruled that although the agency argued that it presented sufficient evidence to establish that its selection of the imposed penalty was not arbitrary or capricious, removal was too harsh and the record lacked a sufficient evidentiary basis for the penalty of termination. Similarly, I find that Agency did not engage in a responsible balancing of the factors it considered, and in doing so clearly exceeded the limits of reasonableness. I further find that Agency exceeded the exercise of its managerial discretion and failed to properly consider the relevant *Douglas* factors. Thus, I conclude that Agency's penalty of termination constitutes an abuse of discretion.

ORDER

Based on the foregoing it is hereby **ORDERED that:**

1. Agency's action of terminating Employee is **REVERSED** and Employee shall be **REINSTATED** to his previous position of record.

2. Agency shall reimburse Employee all back-pay and benefits lost as a result of the termination.

3. Agency shall file within thirty (30) days from the date this decision becomes final, documents evidencing compliance with the terms of this Order.

FOR THE OFFICE:

/s/ *Monica N. Dohnji*
MONICA DOHNJI, Esq.
Senior Administrative Judge

[36] OEA Matter No. 1601-0077-09 (January 7, 2010).