THE DISTRICT OF COLUMBIA

BEFORE

THE OFFICE OF EMPLOYEE APPEALS

In the Matter of:	)	
	)	
EMPLOYEE,[1]	)	
Employee	)	OEA Matter No. 1601-0027-23
	)	
v.	)	Date of Issuance: November 27, 2024
	)	
DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH,	)	
Agency	)	ERIC T. ROBINSON, ESQ.
	)	SENIOR ADMINISTRATIVE JUDGE
	)	

Employee, *Pro Se*
Connor Finch, Esq., Agency Representative

INTIAL DECISION

PROCEDURAL HISTORY

On February 6, 2023, Employee filed a Petition for Appeal with the Office of Employee Appeals ("OEA" or the "Office") contesting the Department of Behavioral Health's ("DBH" or the "Agency") action of suspending him for twenty (20) days due to two (2) separate incidents that occurred in July and August 2022. At the time of the incidents, Employee served as a Behavioral Health Technician ("BHT"). The Advance Notice of Proposed Discipline recommended that Employee be suspended for twenty (20) days. According to the Advance Notice, Employee was charged with two causes of action: (1) Failure/Refusal to Follow Instructions[2] and (2) Conduct Prejudicial to the District Government.[3] According to the Final Notice dated January 6, 2023, the charges were sustained, and through it, DBH imposed the proposed twenty (20) day suspension.

On February 7, 2023, the OEA, through its Executive Director, sent a letter to the Agency

[1] During the pendency of this matter, Employee legally changed his name. Since Employe first filed under the last name of **[REDACTED]**, the case caption will remain unchanged, but the Undersigned will note for the record that the Office of Employee Appeals is aware of the name change.
[2] 6-B DCMR § 1605.4(d).
[3] 6-B DCMR § 1605.4(a) and Hospital Policy No 513.00 Code of Ethical Conduct.

requiring it to provide an Answer to Employee's Petition for Appeal by March 9, 2023. On March 2, 2023, Agency, in lieu of an Answer, submitted a Motion to Dismiss asserting that Employee's submission was premature because he had yet to serve his suspension. This matter was assigned to the Undersigned Senior Administrative Judge on March 6, 2023. A Status Conference was held on April 13, 2023. During the conference, Employee noted that he had since served his suspension. As a result, another Status Conference was scheduled for May 23, 2023. An Evidentiary Hearing was held in this matter on December 14, 2023, and March 7, 2024. Thereafter, the parties were ordered to submit written closing arguments. Both parties timely submitted their briefs. Of note, Employee resigned from the Agency on May 3, 2024.[4] After reviewing the documents of record, I have determined that no further proceedings are warranted. 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 Agency's adverse action was taken for cause. And,
2. If so, whether the penalty was appropriate under the circumstances.

BURDEN OF PROOF

OEA Rule 631.1, 6-B DCMR Ch. 600 (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:
>
> That degree of relevant evidence which a reasonable mind, considering the record as a whole, would accept as sufficient to find a contested fact more probably true than untrue.

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.

[4] *See* Agency Closing Argument at footnote 1 (June 3, 2024).

SUMMARY OF MATERIAL TESTIMONY

Volume I: December 14, 2023

Agency's Case-in-Chief

Majed Sanori ("Sanori") Transcript Tr. pp.15-56.

Sanori worked as a Nursing Supervisor with the D.C. Department of Behavioral Health ("Agency") at the United Medical Center ("UMC"). His role as a supervisor was to ensure the smooth functioning of the UMC. Sanori testified that he was familiar with the term "sitter" and explained that a sitter was there to ensure a patient's safety. Tr. 15-18. He recalled an incident that occurred between ("Employee") and a staff member at UMC on the night of July 3, 2022. Sanori testified that he was contacted to intervene and assess the situation. He stated that upon entering the room, he was informed by staff that a patient was found in the bathroom with the door closed. According to Sanori, Employee was in the room, but did not inform anyone that the patient had gotten up and entered the bathroom unattended. Sanori testified that he spoke with Employee, who at the time, was very belligerent towards him. He could not recall Employee's name. Tr. 20.

On cross-examination, Sanori explained that the concern was that a patient had gone into the bathroom and closed the door, which was not supposed to happen, because patients were not to be left unattended. Tr. 30. He conceded that he could not recall all the events that occurred on July 3, 2022, but testified that the patient was assisted by the staff. Tr. 38. Sanori stated that he did not threaten to have Employee removed by security. Tr. 52. He further affirmed that when an unsafe environment arose, the charge nurse would contact him, and he could assess the situation. Tr. 33.

On redirect examination, Sanori confirmed that when he arrived in the patient's room, Employee was seated. He provided that at some point that the conversation escalated, and Employee's voice became elevated and loud. Sanori opined that Employee's actions were inappropriate and detrimental to the patient's care. Tr. 53-56.

Raphael Iwuji ("Iwuji") Transcript (Tr.) pp. 57-141.

Iwuji worked as a Psychiatric Nurse with Agency and served as an assistant to the unit manager at St. Elizabeth. While on duty, he oversaw Unit 1E. Tr. 57-61. Iwuji testified that Employee, was one of the Behavioral Health Technicians ("BHT") that worked in Unit 1E. He explained that he worked with Employee approximately two to three times a week and knew that Employee's schedule was from 11:00 p.m. to 7:15 a.m.

Iwuji reviewed Agency's Exhibit B, which provided a detailed description of what kind of work BHTs performed. He confirmed that BHTs worked with their psychiatric patients by providing counseling, conducting comfort plans, participating in and/or leading groups, and aiding in the dining area. However, Iwuji attested that their most important duty was to remain on the floor and provide hands-on assistance with the patient. Tr. 67-70.

Iwuji stated that he reported Employee for misconduct because Employee neglected a patient. Tr. 76. He identified Agency's Exhibit D, as an assignment sheet and explained that during Employee's shifts on August 29, 2022, and August 30, 2022, at approximately 6:00 a.m., Iwuji observed Employee at the front desk/ nurses' station completing his college schoolwork, instead of monitoring the station and helping patients in need of assistance. He explained that a patient asked Employee for laundry detergent and Employee directed the patient to sit down. After witnessing the exchange, Iwuji testified that he noticed that the computer monitor displayed Employee's schoolwork. Iwuji confronted Employee and told him that he should not be completing schoolwork because patients were in the vicinity at the time. Tr. 82-88.

Iwuji stated that approximately fifteen minutes later, he was shocked to see that Employee had not stopped his schoolwork. When Iwuji confronted Employee again, Employee asked if Iwuji had a problem with it, which Iwuji confirmed that he did. Iwuji attested that he told Employee that he would write him up and proceeded to write up an incident report. Tr. 89-93. According to Iwuji, Employee raised his voice and became loud when he was written up. Tr. 97. After completing the incident report, Iwuji stated that he emailed it to Martha Pontes, who was the unit manager. Additionally, he attested that he emailed the report to the Office of Risk Management. Tr. 94.

On cross examination, Iwuji testified that approximately every fifteen minutes, he would stand at the nurses' station to ensure that employees and patients were in place and the area was running smoothly. Tr. 99. Iwuji admitted to approaching Employee twice before writing him up. He stated that if Employee had complied on the first request to stop working on his school assignments, Iwuji would not have written Employee up. Tr. 102.

According to Iwuji, Agency's policy was to monitor the patients and remain in the group room. Iwuji testified that at times, Employee was not timely in returning from his breaks. He further provided that he would have to wake Employee up because he overslept while on break. Tr. 109.

While Iwuji had never seen Employee completing schoolwork, he did aver that he has witnessed Employee be tardy for work, noting that Employee was two hours late for work every day. Tr. 112. Iwuji recalled Employee's Exhibit G, which was a statement that Iwuji wrote wherein he observed Employee at 5:30 a.m. sitting at the front desk in Unit 1E, using the front desk computer, conducting work unrelated to patient monitoring. When Iwuji asked Employee why he was not monitoring patients, Employee responded that he was taking notes. According to Iwuji, Employee ignored his directives concerning patient monitoring and continued reading and taking notes on the computer. He testified that by 6:16 a.m., he observed that Employee remained utilizing the computer at the front desk instead of monitoring patients. Iwuji subsequently recalled that a patient requested bathing soap and wanted the laundry room open so that he could wash his clothes. He stated that Employee told the patient to sit down, and an argument erupted between him and the patient. Tr. 128. While Iwuji did not hear the exchange between the two, he confirmed that his primary focus was on Employee, and he should have attended to the patient. Tr. 139.

On redirect, Iwuji conceded that he did not recall checking the time Employee was using the computer. He also acknowledged that he did not check the time when he entered the incident

report. Iwuji recalled the incident taking place at 6:16 a.m. because the report was completed on the computer. Tr. 140.

Denis Ala Andem ("Andem") Transcript (Tr.) pp. 146-197.

Andem worked as a Registered Nurse ("RN") with Agency at St. Elizabeth's Hospital. He worked the night shift in Unit 1E and served as an assistant charge nurse, as well as a medication and treatment nurse. As a charge nurse, Andem testified that he was responsible for coordinating the activities of the entire unit, ranging from managing patients to the staff. Tr. 146-149.

Andem testified to working with Employee for three (3) months in Unit 1E. He recalled an altercation between Iwuji and Employee. Andem explained that Iwuji asked Employee to monitor the hallway; however, Employee continued to work on his school assignment. He stated that instead of showing remorse, Employee confronted Iwuji and asked if Iwuji had a problem with him working on the computer. Andem stated that he witnessed Iwuji ask Employee him to monitor the hallway a second time and noted that during the exchange, he was leaving the medication room to the direction of the nurses' station where Employee and Iwuji were. According to Andem, he could tell that Employee was doing homework because he also went to nursing school. Tr. 151-155. Andem provided that at the time of the incident, he was also working on completing COVID-19 assessments on patients that he had conducted. He testified that thereafter, a patient approached Employee requesting laundry detergent and Employee told the patient to wait. Andem said that he asked Employee how long he was going to have the patient wait before he served the patient. He attested that Employee's response to him was "Denis, don't talk to me. You have been asleep all night…" Tr. 160. However, Andem testified that he had not been asleep. Tr. 168.

Andem stated that he motioned Employee to the back of the nurse's station, so that he could talk to him before Iwuji returned, but Employee refused to talk in the back. He testified that in response, Employee "bashed him out." Tr. 159. Andem averred that he did not want a confrontation at the nurses' station because the patients were awake. He testified that subsequently, Iwuji appeared and noticed that Employee was still completing the homework assignment that he was asked to stop working on thirty minutes ago. Andem explained that Iwuji wrote Employee up for after confirming that he was refusing to adhere to Iwuji's directions. Tr. 156-158.

Andem reiterated that it was against Agency policy to complete schoolwork while on duty. Tr. 173. He asserted that only one employee is assigned to the front desk. Thus, if a patient approaches the front desk and requests an item, and the employee must leave the desk to retrieve the item, the employee should contact another staff member to retrieve the item. However, he specified that if the item was within the range of the desk the employee assigned to, the desk can provide said item to the patient. Andem stated that in Employee's case, he directed the patient to sit down, while completing personal schoolwork, which was not patient related. Tr. 180-183.

On redirect, Andem clarified that generally there is one staff member at the front desk. However, if the staff member did not want to wait for a break, they could remain at the front desk. He stated that if a patient approached the front desk, it was the job of the staff member to either

assist the patient or find someone who could assist them. As it is related to a patient's ability to do laundry, Andem claimed that the procedure was to contact the charge nurse to determine whether the patients could or could not. If the staff member at the front desk needed to contact the charge nurse, Andem stated the staff member could simply turn around and ask the front desk to be covered while they retrieve an item, like detergent, for a patient.Tr.194-196.

Mukala Siklya ("Siklya") Transcript (Tr.) pp. 200-211.

Siklya worked as an Incident Review Specialist with the Office of Risk Management. His role was to investigate cases of abuse, neglect, and exploitations for individuals in care. Siklya testified that once an investigation is assigned to him, he would read the Unusual Incident ("UI") report, take notes, and conduct any background medical checks through Agency's AVATAR system. Tr. 200-204. Siklya explained that AVATAR is a medical system where documentation is housed and allows the review of medical records and progress notes. After performing the background check, Siklya stated that he tabulated a list of people to interview and conduct the interview. Tr. 204-205. Siklya provided that Agency also used a system called E-Risk which tracked incidents that occurred at St. Elizabeth's Hospital that were categorized as either abuse/neglect, exploitation, or contraband. Tr. 205. Siklya reviewed an email from Sanori that detailed information related to the complaint filed against Employee. He attested that he interviewed Employee and discussed two separate cases with him, noting that the first incident occurred between July 3rd and 4th of 2022. Tr. 209-210.

Martha Pontes ("Pontes") Transcript (Tr.) pp. 212-248.

Pontes worked as a Chief Nurse Executive at St. Elizabeth's Hospital. She testified that she presided over the entire nursing department, which consisted of approximately four hundred registered nurses, nurse managers, nursing team leaders, and behavioral technicians. Additionally, she provided direct patient care. Tr. 212.

Pontes explained that the role of BHTs at St. Elizabeth's was to report to the charge nurse and noted that BHTs were considered front-line individuals that worked with all the patients. She indicated that employees in this position were also responsible for helping patients with their activities of daily living, monitoring patient activities, providing for their safety, deescalating a patient when they became anxious, and providing assistance with anything the nurses directed. Pontes further provided that BHTs could work outside of the hospital and work as a sitter or escort to patients. Pontes testified that a sitter was responsible for making sure that the staff understood the patient and the patient's triggers, and overall needs to ensure that their safety was paramount. Pontes explained that an escort was also considered a BHT, who went out into the community with patients. According to her, BHTs could accompany patients for medical appointments, housing appointments, or emergency room visits. Tr. 213-216. Pontes further explained that there were two classifications of patients that did not require a sitter; those who were voluntarily with the hospital, and those who were outpatient permitted. However, if a patient was admitted, was a forensic patient, or was an elopement risk/difficult to manage, then a sitter would be assigned and expected to remain with the patient. Pontes confirmed that all BHTs were trained to assist with managing difficult patients. Tr.217-218.

Pontes testified that Agency's Exhibit H, Reporting Suspected Abuse Neglect and Exploitation of Individuals in Care, was a hospital policy that applied to all employees. She explained that all employees, including BHTs, were trained on the Nursing Department Policy. She noted that the policy has since been updated, but insisted that it was valid at the time of Employee's incident. Tr. 218-219.

Pontes identified Agency's Exhibit J, as the policy for Escorting Individuals in Care to and From Clinical Appointments, Internal and External. She explained that the latter portion of the document pertained to sitters and what could occur in the emergency room. Pontes stated that BHTs were trained to escort individuals to the emergency room, so when a patient left a specific unit, the remaining BHTs that were in that unit would be selected according to the floating policy. Tr. 222-223.

As it related to Agency's Exhibit M, Pontes testified that on Sunday, July 3, 2022, Employee began work at 11:19 p.m. and left at 8:38 a.m. Tr. 231. Pontes recognized Agency's Exhibit O as an email that she wrote to one of her direct reports. The email documented the July 3, 2022, incident between Employee and Iwuji. Tr. 236. Pontes affirmed that she signed a document drafted by Human Resources ("HR") upholding the decision to suspend Employee for twenty days. She explained that she reviewed the document in its entirety before signing and viewed the infraction as serious misconduct. Pontes stated that it was a neglect of the individual in care. She further explained that Employe's conduct constituted an inappropriate representation of the hospital and his behavior. Tr. 241-244.

Volume II: March 7, 2024

Mildred Kromah ("Kromah") Transcript (Tr.) pp. 11-46.

Kromah performed her work as a Nursing Supervisor with Agency for thirteen (13) years. Her role involved supervising the night shift, providing customer service, ensuring the well-being of patients, and making sure that the hospital's rules and regulations were followed. Her tour of duty was from 11:15 p.m. to 9:00 a.m. Tr. 11-13.

Kromah stated that she knew Employee since he also worked the night shift. She testified that she was the supervisor on duty on July 3, 2022, and she received a call from Sanori, informing her that an employee from St. Elizabth's Hospital was loud, argumentative with a staff member, and disruptive to the unit. Kromah testified that Sanori informed her that he was going to call security to have Employee removed from the unit. She explained that the phone call was brief, and she did not know the name of supervisor who contacted her. Tr. 14- 15.

Kromah recalled contacting Employee to inquire about the incident. She spoke with him for approximately three (3) minutes during which she indicated that Employee was loud and was upset. Employee explained to Kromah that Sanori expected Employee to care for the patient. However, Employee argued that it was not his duty to care for the patient. Tr. 16-17. Kromah stated that she conducted a write-up about the incident and submitted the report to Pontes. Tr. 18.

On cross-examination, Kromah confirmed that she did not recall whether Employee contacted her before she spoke with Sanori. However, after reviewing Employee's exhibit, which contained cellular phone records, she acknowledged that she spoke with Employee on July 4, 2022, at 2:50 a.m. and 2:56 a.m. Kromah testified that the first call was made after she was contacted by Sanori. The second call was to make sure that Employee had calmed down after the argument with Sanori. Tr. 33-34.

Kromah reiterated that Sanori contacted her to report that Employee was disrupting the unit. In turn, Kromah contacted Employee at 2:50 a.m. to find out what occurred. According to Kromah, Employee told her that Sanori expected him to conduct bedside care for the patient and Employee argued with Sanori that it was not his responsibility to provide this type of care. Kromah asked Employee to stop arguing with Sanori and explain to him his duty and that he was there as security and not a nursing assistant. She called Employee back at 2: 56 a.m. to ensure that he had remained calm because Sanori wanted him to be removed from the premises and Employee responded that everything was fine. Kromah stated that she did not hear arguing during the second call. Tr. 35-37, 41.

On redirect, Kromah testified that the first call she received entailed a lot of arguing from Employee and Sanori; however, the second call was calm. Kromah explained that Sanori wanted Employee to be removed, but Employee had to take care of the patient as a security personnel member because she did not have another staff member to send to the unit. She further stated that she told Sanori that she would speak with Employee, which was why she contacted Employee again at 2:56 a.m. Tr. 43.

Employee's Case-in-Chief

Mark Rowe ("Rowe") Transcript (Tr.) pp. 51-73.

Rowe worked as a Registered Nurse at St. Elizabeth's Hospital in Unit 1E with Employee until the time of his resignation in August of 2022. Rowe testified that he pulled Employee aside to remind him to be on his best behavior because management was watching Employee. According to Rowe, management asked employees to report Employee's behavior through email. Tr. 51-53. Rowe testified that he had not seen Iwuji reprimand any employee for using the computer. Tr. 68. On cross-examination, Rowe testified that he had not worked at UMC on the night of July 3, 2022. He also did not witness the incident involving Iwuji and Employee. Tr. 71.

Tony Conway ("Conway") Transcript (Tr.) pp.76-91.

Conway worked at St. Elizabeth's Hospital, Unit 1E. Tr. 76. He testified that Iwuji reprimanded an employee for using the computer but could not recall which employee. He stated that it was common for Iwuji to reprimand employees for not performing their job. Tr. 84. Conway recalled speaking with Employee on July 4, 2022, at 3:00 a.m. and then again at 3:09 a.m., because Employee was upset with someone. He told Employee that if it was serious, he should contact the nurse. Tr. 87. On cross-examination, Conway confirmed that he was in Unit 1E on July 3, 2022. However, he could not recall any of the events that occurred that day. He conceded that his only knowledge was from Employee's perspective. Tr. 90-91.

DeLawrence Williams ("Williams") Transcript (Tr.) p. 96-116.

Williams testified that staff could use the computer located at the front desk at any time for time keeping or writing a note for a patient. He stated that any staff member could use the computer, and no one was reprimanded. Tr. 105-108. On cross-examination, Williams testified that he worked as a BHT for seven (7) years. He stated that the use of the computer is specifically for submitting work orders for supplies, writing patient notes, and time keeping. He claimed that use of the computer for other reasons was prohibited. However, Williams had not seen a supervisor instruct an employee to stop using a computer for personal reasons. He also claimed that the reason could be because a supervisor used the computer for a personal matter. Tr. 110-113.

FINDINGS OF FACT, ANALYSIS AND CONCLUSIONS OF LAW

Employee was on duty during the night shift on July 3–4, 2022. The night shift was scheduled for 11:15 p.m. until 7:15 a.m. During his shift between July 3–4, Employee was assigned to work as a "sitter" for a patient at the United Medical Center ("UMC"). The patient was a St. Elizabeth's Hospital ("SEH") patient but was being cared for by UMC on the night of July 3–4. As a sitter, Employee was responsible for observing and assisting a patient under psychiatric care. The patient did not have the physical and mental capability to use the bathroom safely without assistance. Further, the patient required nonstop direct observation. On the night of July 3–4, the patient Employee monitored the patient as he got out of bed to use the bathroom. Employee did not intervene. Employee allowed the patient to close the door to the bathroom such that he was not able to directly observe the patient he had been tasked with observing. Agency, in its Closing Argument, depicted Employee's actions as follows:

> During the early morning hours of July 4, Sanori, who was working in his office on a different floor, was called to respond to an incident in the room of Employee's patient. When Sanori arrived in the patient's room, UMC staff told him that when they arrived, the patient was found in the bathroom with the door closed, and that Employee had not informed anybody of the patient's activity. At the time of Sanori's arrival, Employee was sitting in a chair. When Sanori spoke to Employee to ascertain what happened, Employee "became very loud . . . got up and started saying . . . things about the staff." When Sanori asked Employee why he did not call anybody, Employee responded that "[the staff] don't listen to [him] anyhow, [he] is not going to be bothered with them." Employee raised his voice when speaking with Sanori. When Sanori asked Employee to sit down, Employee refused and became "more belligerent," and began "pointing his finger at [Sanori] and saying 'you can't tell me nothing.'"
>
> After Employee refused to comply with Sanori's repeated instructions to calm down and refused to engage in a professional conversation regarding

> patient care, Sanori called SEH and spoke to Kromah, an SEH nursing supervisor. Sanori informed Kromah that Employee was being "argumentative, unruly[,] and loud with an employee of UMC . . . concerning patient care" and requested that SEH send another employee to relieve Employee.[5]

Regarding the alleged misconduct on August 29 – 30, 2022, Agency asserted that Employee was tasked to man the front desk and in that role was responsible for monitoring the flow of foot traffic (general public, patients and staff) and providing information and guidance to persons in his vicinity.[6] However, during the period in question, Employee was found to be doing schoolwork (Employee was enrolled in a nursing school program) and was found to not be paying attention to persons in his vicinity by Iwuji (the unit manager on duty). It was also noted that Employee ignored a request by a patient for laundry detergent. Iwuji admonished Employee multiple times to stop doing his schoolwork on Agency's computer and to monitor the front desk and its foot traffic in a more attentive manner. Another co-worker attempted to counsel Employee which led to a heated verbal argument between the two. Iwuji noted that Employee disregarded his command and with everything involved proceeded to "formally report the misconduct."[7]

After reviewing the entirety of the record presented, the Undersigned finds that Agency's witnesses (Sanori, Pontes, Iwuji, Siklya and Kromeh) all testified in a credible, consistent and forthright manner regarding this matter. They collectively testified that regarding the July incident, Employee failed to follow DBH policy specifying the duties and responsibilities of a patient escort. Those failed responsibilities included not actively providing help to the UMC staff when the patient went to the restroom, letting the patient go into the restroom without his supervision, and Employee failing to keep a calm and professional demeanor in his interactions with the patient and UMC staff. Employee's words, actions and demeanor were not consistent with his duties as an BHT/escort. Pursuant to 6-B DCMR § 1605.4(d); Failure or refusal to follow instruction warrants corrective or adverse action when sustained. During the July incident, Employee was instructed to escort the patient and to monitor him while he was at UMC. I find that Employee failed to monitor the patient and worse over engaged in a verbal argument with several staff at UMC. Employee was lawfully tasked with escorting the patient. However, as soon as the patient went to the bathroom Employee seemingly asserts that it was not his job to monitor/assist/ask for help. This reasoning is incredulous and inconsistent with the collective testimonies of Agency's witnesses.

Regarding the August incident, I find that Employee, while assigned to the front desk, was using Agency's computer to conduct personal business. Moreover, Employee was not attentive to his assigned area leading to multiple requests for Employee to stop doing personal work using Agency resources while on duty. At this time, he provided a hospital patient lackluster care when that patient asked for assistance in doing his laundry. Iwuji provided Employee with more than one opportunity to cease his personal work and conduct Agency's business but Employee disregarded this order. Iwuji's testimony in this regard was forthright and consistent. I further find that Employee's explanation to be self-serving and unreliable. Accordingly, I find that Agency has

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[5] Agency Closing Argument pp. 3 – 4 (June 3, 2024).
[6] *Id*. pp. 5- 6.
[7] *Id*.

met its burden of proof relative to the charge of violating 6-B DCMR § 1605.4(d) for both the July and August incidents.

I hereby incorporate by reference my foregoing analysis and further find that Employee engaged in the "use of unprofessional language, gestures, or other conduct; quarreling; creating a disturbance or disruption," in violation of 6-B DCMR § 1605.4(a) and Hospital Policy No 513.00 Code of Ethical Conduct, in both the July and August Incidents. I note that Sanori witnessed and credibly testified about her firsthand experience of Employee's disruptive behavior during the July incident. Kromah corroborated Sanori's depiction of this event as she heard them over the telephone. For the August incident, Iwuji and Andem provided a consistent description of Employee's unprofessional behavior. Employee's only first-hand testimony to rebut these descriptions came from his own dubious viewpoint. None of the witnesses Employee provided had any first-hand knowledge of the incidents that led to his suspension.

Given the gravity of the conduct and the proper procedural safeguards of due process that Agency undertook, I find that Agency proved by a preponderance of the evidence that it had cause to suspend Employee. Although the 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.[8] The "primary discretion" in selecting a penalty "has been entrusted to agency management, not to the OEA."[9] Selection of an appropriate penalty must involve a responsible balancing of the relevant factors in the individual case. 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 DBH'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 DBH conscientiously considered 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 DBH's judgment clearly exceeded the limits of reasonableness, is it appropriate for the OEA then to specify how the DBH's decision should be corrected to bring the penalty within the parameters of reasonableness.[10] I find that the evidence did not establish that the penalty of a twenty (20) day suspension constituted an abuse of discretion.[11] I conclude that the Agency has met its burden of proof in this matter and that Employee's suspension should be sustained.

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[8] *See*, Douglas v. Veterans Administration, 5 MSPB 313, 328, 5 M.S.P.R. 280, 301(1981)(Federal Merit Protection Board case); Raphael 740 A. 2d 945).
[9] *Id*.
[10] *Raphel* 740 A. 2d at 945.
[11] 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").

ORDER

Based on the foregoing, it is ORDERED that the Agency's action of SUSPENDING Employee for twenty (20) days is hereby UPHELD.

FOR THE OFFICE:

/s/ *Eric T. Robinson*
ERIC T. ROBINSON, ESQ.
SENIOR ADMINISTRATIVE JUDGE