THE DISTRICT OF COLUMBIA

BEFORE

THE OFFICE OF EMPLOYEE APPEALS

In the Matter of:	)	
	)	
EMPLOYEE,[1]	)	
Employee	)	OEA Matter No. 1601-0012-24
	)	
v.	)	Date of Issuance: February 18, 2025
	)	
D.C. FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT,	)	NATIYA CURTIS, Esq.
Agency	)	Administrative Judge
	)	

Kristen Farr, Esq., Employee Representative
Daniel Thaler, Esq., Agency Representative

INITIAL DECISION

INTRODUCTION AND PROCEDURAL HISTORY

On November 27, 2023, Employee filed a Petition for Appeal with the Office of Employee Appeals ("OEA" or "Office") contesting the District of Columbia Fire and Emergency Medical Services Department's ("Agency" or "FEMS") decision to terminate him from his position as a Firefighter/Emergency Medical Technician ("FF/EMT") effective October 28, 2023. OEA issued a Request for Agency's Answer to Petition for Appeal on November 27, 2023. Agency submitted its Answer to Employee's Petition for Appeal on December 15, 2023. This matter was assigned to the undersigned on December 19, 2023.

On December 29, 2023, the undersigned issued an Order Scheduling a Prehearing Conference in this matter for February 1, 2024. On January 22, 2024, Agency filed a Joint Motion to Continue the Prehearing Conference and Extend the Prehearing Statement Deadline. On January 29, 2024, the undersigned issued an Order Granting the Joint Motion to Continue the Prehearing Conference. Accordingly, the Prehearing Conference was rescheduled to February 15, 2024. Prehearing statements were now due on or before February 8, 2024. During the Prehearing Conference convened on February 15, 2024, the undersigned informed the parties that because a Fire Trial Board Hearing was convened in this matter on September 7, 2023, OEA's review of this appeal is subject to the standard of review outlined in *Elton Pinkard v. D.C. Metropolitan Police Department,* 801 A.2d 86 (D.C. 2002). Thereafter, I issued a Post Prehearing Conference Order on

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

February 15, 2024, requiring the parties to submit briefs addressing the issues raised during the Prehearing Conference. Agency's brief was due on or before April 10, 2024. Employee's brief was due on or before May 17, 2024. Agency had the option to submit a Sur-Reply brief on or before May 31, 2024. On March 26, 2024, I issued a subsequent Order requiring the parties address which District Personnel Manual ("DPM") version is controlling in this matter, as Agency cited to both the 2012 and 2019 DPM in its Answer to Employee's Petition for Appeal. The undersigned amended the dates briefs were due to afford the parties additional time to respond. Agency's brief was now due by April 24, 2024. Employee's brief was due by May 31, 2024. Agency had the option to submit a Sur Reply brief by June 14, 2024. On April 8, 2024, Agency filed a Consent Motion to Extend the Briefing Schedule, citing a scheduling conflict. The undersigned granted the motion in an Order on April 9, 2024. Agency's brief was now due by May 8, 2024. Employee's brief was due by June 14, 2024. Agency had the option to submit a Sur-Reply brief by June 24, 2024. The parties have submitted their respective briefs as prescribed. 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.

STATEMENT OF THE CHARGES

According to the Fire Trial Board's Findings of Facts and Recommendation of Termination, which was accepted by the Agency in a Final Notice of Adverse Action, and received by Employee

[2] OEA Rule § 699.1.

on October 18, 2023, Agency terminated Employee effective October 28, 2023, based on the following charges and specifications, which are reprinted in pertinent part below:[3]

Case No. U-23-410

Charge 1: Violation of D.C. Fire and 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 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 Order Book Article XXIV, § 8, **Emergency Responses**, which states: Upon receipt of an emergency response, EMS Providers shall immediately report to the apparatus, status the DEK Button # 1 within one (1) minute and respond to the incident.
>
> Further violation of D.C. Fire and Emergency Medical Services Department Bulletin No. 3, **Patient Bill of Rights**, § 11, which states:
>
> As our patient, you have the right to expect competent and compassionate service from us. You may expect:
>
> 11. That all of our personnel will be polite, compassionate, considerate, empathetic, respectful, and well mannered.
>
> This misconduct is defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII, Section 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 DPM § 1603.3(f)(3)(08/27/2012); see also DPM § 1605.4(e) (06/12/2019).

Specification 1:

> In his Special Report (dated 03/24/2023), FF/EMT [Employee] describes his misconduct as follows: While heading to pick up food up which was already ordered from a local restaurant (Chick-Fil A) we were dispatched to a run incident number F2300048765. **While in route to the call we stopped to pick up our food.**

[3]Agency Answer, tab 24 (December 15, 2023).

Further, in His 2nd Endorsement (dated 03/29/2023), Battalion Fire Chief Jason C. Auth describes FF/EMT [Employee]'s misconduct as follows:

> On Friday March 24, 2023, I was working an overtime assignment as the 6th Battalion Fire Chief when I was notified of an extended response involving A-03. Based on information provided by the Fire Liaison Officer (Sgt. Jason Collins), A-03 was alleged to have delayed their response for approximately 4 minutes in the vicinity of 1401 Maryland Avenue, NE (Chick-Fil-A). […] The special report obtained from FF/EMT [Employee] indicates that the crew did in fact stop to pick up food from the restaurant while assigned to incident # F2300048765.

Further, in his 3rd Endorsement (dated 04/13/2023), Deputy Fire Chief Jon C. Grover, II describes FF/EMT [Employee]'s misconduct as follows:

> After reviewing the I/NetViewer, Ambulance 3 went available from incident number F230048704. They did not return to their corridors. Instead, they traveled from George Washington Hospital past their corridors to go to a fast-food restaurant located at 14th Street and Maryland Ave., NE.
>
> Upon being dispatched on incident No. F230048765, both Order Book Article XXIV and the Patient Bill of Rights required FF/EMT [Employee] to at least attempt to render competent, compassionate and empathetic emergency medical services by immediately responding to the incident. Yet, FF/EMT [Employee] showed virtually no concern for this patient. Rather than initiate an immediate response, FF/EMT [Employee] affirmatively chose to stop at Chick-fil-A. FF/EMT [Employee] admitted discourteous treatment of the public, violation of Department customer-service standards, failure to offer assistance when requested, failure to carry out assigned tasks and careless 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 XVII, **Driving Safety**, which states:

2.0-POLICY

2.2: All members and occupants in the vehicle, other than those covered in 2.7, shall be seated and belted in approved riding positions while the vehicle is a motion (NFPA 1451, 8.3.4).

***

2.21: Drivers encountering any of the following situations shall bring the vehicle to a complete stop and shall not proceed until it is confirmed that it is safe to do so (NFPA 1451, 7.1.3):

2.21.1: Any "stop" signal;

***

4.0-RESPONSIBILITY

***

4.7: All Members and Occupants: All members are responsible for maintaining general awareness and promoting safety while riding in a Department vehicle.

4.8: All members and occupants riding in or on a vehicle shall be seated in approved riding positions and shall be secured to the vehicle by seatbelts whenever the vehicle is in motion (NFPA 1451, 8.3.1).

Further violation of D.C. Fire and Emergency Medical Services Department Order Book Article XXI, **Uniforms**, which states:

2.6: The regulation dark blue NFPA compliant uniform shirt with the official Department patch attached to the left sleeve with the thread, centered one inch below the shoulder seam, shall be worn as the work uniform shirt by all uniform employees assigned or detailed to the Operations Bureau, except for the Chief Officers or those acting in their stead.

This misconduct is defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII, Section 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 DPM § 1603.3(f)(3)(08/27/2012); see also DPM § 1605.4(e) (06/12/2019).

Specification 1:

In his 3rd endorsement (dated 4/13/2023), Deputy Fire Chief Jon C. Grover, II describes FF/EMT[Employee]'s misconduct as follows:

After a review of the Rosco camera footage concerning this case, I further cite FF/EMT [Employee] with the violations listed below.

Viewing the passenger compartment footage FF/EMT [Employee] was not using his seat belt during the entire response. Viewing the forward view of the footage FF/EMT [Employee] did not bring the ambulance to a complete stop at 5 stop signs while traveling westbound on G Street NE to the incident. In addition, the member was eating while driving in the emergency response mode. Viewing the passenger compartment footage FF/EMT [Employee] was not wearing his regulation dark blue NFPA Compliant uniform shirt. Notwithstanding the clear directives outlined in both Order Book Article XVII (**Driving Safety**) and Order Book Article XXI (**Uniforms**), FF/EMT [Employee] failed to don the proper uniform shirt, and otherwise, failed to follow numerous driving safety standards.

SUMMARY OF THE TESTIMONY[4]

On September 7, 2023, Agency held a Fire Trial Board ("Trial Board") Hearing in this matter. During the hearing, testimonial and documentary 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.

Agency's Case-in-Chief

Sergeant Jason Collins ("Sgt. Collins") – Tr. pp. 23-78

Sgt. Collins is the Sergeant Liaison Officer at the Office of Unified Communications. He affirms that he was on Duty the day of March 24, 2023, and received notification that Employee's Ambulance 3 had a delayed response for an incident. Sgt. Collins testified that he investigated that delay and determined that Ambulance 3 made a stop during a response time. Tr. pp. 24-25. Sgt. Collins further explained his observation about this stop. He testified that in his Computer Aided-Dispatch System ("CAD"), there is a route alarm that goes off at the ten (10)-minute mark, once a unit is in route and changes the color of the unit on the dispatch screen. Tr. p. 25. Sgt. Collins stated that he noticed this alarm activated, which prompted the initial investigation. Tr. Pp. 25-26.

Sgt. Collins clarified that once an ambulance unit is in route to an incident, an alarm goes off if more than ten minutes have elapsed before the ambulance arrives at the scene of the incident. He testified that when this alarm goes off, he will investigate the different reasons as to why it could have been activated. He testified that in the instant matter, this alarm was activated, so he investigated the reasons why there was not a response at the ten-minute mark, thus prompting the initial investigation. Tr. pp. 25-26. Sgt. Collins identified Agency's Exhibit 5, page 14 as a screenshot from the I/Net Tracker Software, which he testified is used to determine the location of units. He testified that this screenshot showed that Ambulance 3 was headed eastbound on H Street, when they were dispatched and they continued eastbound on H Street to 14th Street, made a stop on 14th Street and Maryland Avenue, before heading back westbound toward the emergency. Tr. pp. 26-27. Sgt. Collins further indicated that a screen shot of the I/Net tracking software showed that Ambulance 3 stopped moving between 4:13 and 26 seconds and 4:14 and 0 seconds. Sgt Collins asserted that Ambulance 3 started moving again between 4:17 and 5 seconds and 4:17 and 24 seconds. He clarified that there is usually a ten (10) to fifteen (15) second lapse time in the I/Net tracking software. of Tr. p. 29.

Sgt. Collins identified Agency's Exhibit 5, page 18, as the information collected in the CAD for each event that is created and dispatched. Tr. p. 30. Sgt. Collins further testified that Ambulance 3 was dispatched to Kaiser Permanente Capitol Hill, located at 700 Second Street, NE for chest pains. Tr. p. 30. Sgt. Collins described that a dispatch feature estimated that it would take Ambulance 3 two (2) minutes to respond to the incident, based on its location at the time of dispatch. Tr. pp 30-31. Sgt. Collins testified that Ambulance 3 did not arrive in two (2) minutes. Tr. p. 31. Sgt. Collins identified Agency's Exhibit 2, page 5, as a unit history for a specific time period. He testified that the event number on this document is the same as the event numbers on prior documents reviewed

[4] *Id*. at tab 22.

during testimony thus far. He testified that the dispatch time reflected on this document was 16:11 and 13 seconds and the in-route time was 16:11 and 34 seconds. Sgt. Collins further testified that the arrival time was 16:21 and 34 seconds. Tr. pp 32-33. Sgt Collins testified that because the CAD estimated that this dispatch should have taken two minutes, further investigation was warranted. Tr. p. 33.

Sgt. Collins viewed Agency's Exhibit 9-B, which was video footage of Ambulance 3 with no audio. It started at the one 1:05 mark and stopped at the 1:13 mark. He identified the date stamp in the video as March 24, 2023, and noted it as the same date reflected on the previous exhibits reviewed. He also testified that the time stamp on the video lines up with the dispatch time reviewed on the I/NetViewer. Tr. p. 34. Sgt Collins further viewed this video starting at 1:18 and stopping at the 1:33 mark. He testified that during this portion of the video it appears as though the passenger is updating their status and activating the audible and visual alarms system. Tr. p. 35-36.

Sgt. Collins then viewed Agency's exhibit 9-A, which is the front-facing video footage of Ambulance 3. Sgt. Collins identified the date on this video as March 24, 2023. Tr. p. 36. Sgt. Collins testified that Ambulance 3 was crossing over 10th Street and headed east on H Street at the 1:13 mark. Tr. p. 37. He further testified that Ambulance 3 should have been going to the location of the emergency at 2nd and G Streets, NE. Tr. p. 38-39. Sgt. Collins further reviewed the video at several other time frames. He testified that the video showed that the person in the video activated the ambulance lights but was not headed toward the location of the emergency. Tr. p. 41. Sgt. Collins confirmed that while Ambulance 3 was required to go in the direction of the emergency, they headed to 14th Street, Northeast. Tr. pp. 43-44. Sgt. Collins further reported that the route he observed on Exhibit 9-A was consistent with Agency's Exhibit 5, page 14, a screenshot from the I/Net tracker software used to determine the locations of units. He testified that this exhibit shows that Ambulance 3 rode on H Street, NE, and 10th Street, NE, and eventually turned on 14th Street, NE. Tr. p. 44.

Sgt. Collins further testified that at the 3:33 mark in Agency's Exhibit 9-A video, it appeared that the emergency lights were discontinued, and the unit stopped. He further noted that from what he observed in the video, there would be no basis for the ambulance to turn off its lights. Tr. p 45. Sgt. Collins noted that at the time Ambulance 3 stopped, two (2) minutes and twenty (20) seconds had elapsed since dispatch. He indicated that during these two (2) minutes and twenty (20) seconds, Ambulance 3 was required to be going toward the emergency but did not. Tr. 46.

Sgt. Collins was directed back to Agency Exhibit 9-B video footage of Ambulance 3. Sgt. Collins reviewed the video starting at the 3:16 mark. Sgt. Collins confirmed that the passenger of Ambulance 3 exited the ambulance at the 3:16 mark. Tr. p. 46. At the 4:59 mark, Sgt. Collins testified that he observed that the passenger remained out of the ambulance and the driver of the ambulance was eating. Tr. p. 47. Sgt. Collins testified that the driver made a stop at 6th and H Streets prior to the dispatch in question and purchased food. Tr. p. 48.

Sgt. Collins reviewed Agency's exhibit 9-D and testified that at the two-minute mark, the passenger re-entered the video and appeared to put something on the floorboard. Tr. p. 49. Sgt. Collins observed Agency's Exhibit 9-C at the two-minute, five second mark, and testified that Ambulance 3 reactivated their emergency lights and began moving. He further noted that Ambulance 3 was parked at Chick-Fil-A a little under four (4) minutes. Tr. pp. 50-51. Sgt. Collins confirmed that almost six (6) minutes passed before Ambulance 3 went in the direction of the emergency. Tr. pp. 53-54. Sgt. Collins testified that at roughly the ten (10)-minute mark, the CAD would receive

notification that the unit had been in route for more than ten (10) minutes, which prompted the initial investigation. Tr. pp. 54-55. Sgt. Collins testified that based on Agency's exhibit 9-B, Ambulance 3 took over ten (10) minutes to arrive at the scene of the emergency and arrived behind Medic 3 which was already on the scene. Tr. p. 55. Sgt. Collins stated that he then checked to make sure the information was correct, which included checking the router on the unit to make sure it was functioning and checking I/Net tracker to make sure it reflects information received in the CAD. Once he deemed these systems were working, and the information was accurate, he created an email with the particulars of the incident and sent them to the on-duty Lieutenant fire chief, deputy fire chief of operations, and the fire operations. Tr. p. 56.

On cross-examination, Sgt. Collins described his position as Fire Liaison Officer. He stated that his responsibilities include overseeing resource and asset management utilization of the department, as these relate to the Office of Unified Communications. He further stated his responsibilities include approving received responses, ensuring units arrive safely, are at their designated locations, and rendering services effectively. Tr. p. 57. Sgt. Collins is questioned about Agency's Exhibit 6, which is an NBC news article about the event in question. The article states that sources familiar with the investigation say that Ambulance 3 was assigned to this dispatch because it was closer than Medic 3. Tr. p. 57-58. Sgt. Collins testified that he did not know where Medic 3 was located at the time of dispatch. Sgt. Collins is then shown firefighter's exhibit 2, which Sgt. Collins identifies as a unit history report. Tr. p. 59. When asked if this document shows that Medic 3 was in quarters, Sgt. Collins clarifies that he cannot determine where Medic 3 was because the status update was done by the Medic 3 crew and can be done from any location. He further stated, without a map, it would be speculation to say they were in quarters at the time of dispatch. Tr. p. 61. Sgt. Collins is then shown video footage of Medic 3 (the exhibit number was not specified) and confirms that the date on the video is March 24, 2023. Tr. p. 62. Sgt. Collins testified that he can see the footage is in quarters, but he cannot verify which quarters. Tr. p. 63.

Sgt. Collins answered in the affirmative when asked if Medic 3 is .7 miles from Kaiser Permanente, the location of the emergency. He further answered affirmatively when asked if Employee's Ambulance 3 was at H Streets and 10th Streets when it received the dispatch. Sgt. Collins also answered in the affirmative when asked if H and 10th Streets is .7 miles from Kaiser Permanente. Tr. p. 63. Sgt. Collins agreed that the dispatch call came into Medic 3 at 16:11:13, and Medic 3 changed its status to in route at 16:12:43. Sgt. Collins reviewed video footage of Medic 3 at the time stamp 16:15:04 and answered in the affirmative when asked if Medic 3 was in quarters at 16:15 and not in route. Tr. p. 64. Sgt. Collins further testified that he observed the driver of Medic 3 getting into the unit and preparing to drive at the 16:15 and 37 seconds timestamp. Tr. p. 65.

Upon review of the video footage of Medic 3, Sgt. Collins stated that the unit began to move and confirmed the video was at time stamp 16:16 and four (4) seconds. Tr. p. 70-71. When questioned about Medic 3's delay, Sgt. Collins confirmed that Medic 3 had a 6.6-minute delay in responding to the emergency. Sgt. Collins further testified that Medic 3's estimated response time was 2.4 minutes. Tr. p. 72. When asked if he provided the Fire Chief documentation of Medic 3's delay, Sgt. Collins testified in the affirmative. He further noted that the ten (10)-minute mark is when a physical alarm is received and overseen by the Fire Liaison Office. He testified that Medic 3 never broke the threshold of the ten (10)-minute mark which would alert that there was a significant delay in their response and initiate an investigation. Tr. pp. 72-73. Sgt Collins additionally testified that information about Medic 3's response time was provided to the fire chief because he requested it, even though Medic 3's response time did not initiate an alarm. Tr. p. 74. When Sgt. Collins was

questioned whether he observed Medic 3 stop at a food establishment, he testified that he did not. Tr. p. 74

The Trial Board questioned Sgt. Collins about the process of confirming the accuracy of both the router and the I/tracker. Sgt Collins testified that the AMS website goes directly to the router to make sure that the router is online and determines how many satellites it is getting signals from. He further explained that once that is determined, he goes to the CAD to show him where the unit is on a map. He stated that this process confirms that the router and CAD are communicating, and thus the I/tracker is accurate. He confirmed that he could get inaccurate information if the router was showing that it was not pinging in a normal way. Sgt. Collins reported that during the incident in question, his initial notification indicated that the AMS was tracking properly for the duration of the incident. Tr. pp 75-77. When the Trial Board questioned Sgt. Collins how many times a day he receives alerts for the ten-minute arrival alarm, Sgt. Collins testified that it varies because the alarm can go off for multiple reasons. He testified that all reasons are not potentially nefarious and malicious. Tr. p. 77. He indicated that a specific number of times the alarm goes off would be difficult to ascertain, but it does happen. Tr. p. 78.

Chief Jason Auth. ("Chief Auth") Tr. pp 79-99

Chief Auth testified that he has been employed by FEMS for over three years, and his current position is Battalion Fire Chief. Tr. p. 79. Chief Auth identified Agency's exhibit 5, page 11 as his endorsement to the report from Employee. Tr. p. 80. Chief Auth testified that on the day in question, he received documents regarding Ambulance 3's delayed response. He testified that the documents clearly showed that Ambulance 3 went the opposite direction for a period, stopped at another location, and then after some time proceeded the rest of the way to the incident. Tr. p. 81-82. He further testified that based on his investigation and knowledge, Ambulance 3 stopped in the vicinity of Chick-Fil-A restaurant. Tr. p. 82. Chief Auth testifies that in reference to Employee's special report, Employee's statement that this particular day was busy and thus they were not able to eat is not a valid excuse to delay a response. Tr. p. 83. Chief Auth was further questioned regarding Agency's Exhibit 3, which contains Employee's special report, in which Employee states that "this call was a medic unit call in which Medic 3 was dispatched on the call with us. We knew we would just be assisting them. So, we stopped for literally a few minutes, tops." Chief Auth testified that Employee's statement is not a valid excuse to delay a response. Tr. pp. 83- 84. When questioned about Employee's statement that there was no delay in patient care or response, Chief Auth testified that anytime you delay your response to an emergency, then you are delaying initiating care to a patient. Chief Auth agreed that minutes can be of significance to the care of a patient. Tr. p. 84.

Chief Auth testified regarding Agency's Exhibit 9E, which is video footage of Ambulance 3 during the incident in question. Chief Auth confirmed that the date stamp on the video was March 24, 2023, and is the same date that was reflected on his endorsement. Tr. p. 85. Chief Auth reviewed the video at the 1:32 mark and confirmed that he saw another ambulance unit at the location where Ambulance 3 arrived. Tr. p. 85. He testified that Employee's statement that Ambulance 3 arrived at Kaiser Permanente at the same time as Medic 3 was incorrect. Tr. p. 86. Chief Auth reviewed Agency's Exhibit 5 page 11, which is Chief Auth's endorsement. Chief Auth testified that he agreed with the endorsement provided by Lieutenant J. Brown. Tr. p. 86. When asked to review Agency's Exhibit 5 page 10, which is Lieutenant Brown's endorsement, Chief Auth agreed with the endorsement that Employee violated the Order Book, Article 6, General Rule of Conduct, Section 6, conduct unbecoming or any conduct that violates public trust or law of the United States, a law,

municipal ordinance, or regulation of the District of Columbia, committed while on duty or off duty. He testified that it is a clear neglect of duty to delay your response to an emergency. Tr. p. 87. Chief Auth also concurred with the statement "I cite [Employee] under Section 1603 of the District Personnel Manual, because no. 2, Subsection F, any on-duty or employment related to acts or omission that interferes with the efficiency or integrity of the Government operations to include neglect of duty." Tr. pp. 87-88. Chief Auth further reviewed Agency's Exhibit 6, pages 23-34, which he described as news articles that depicted the incident in question. Tr. pp. 88-89. He testified that these news articles reflected negatively upon the department. Tr. p. 89.

On cross-examination, Chief Auth reviewed Firefighter's Exhibit 1. He confirmed that this document is titled 'Medical Dispatches to Healthcare Facilities' and noted the effective date on this exhibit as June 30, 2023, and confirmed this date is after the incident in question. Tr. p. 90. Chief Auth further agreed that this document says, "The Office of Unified Communications in collaboration with the Office of the Medical Director, OMD, will implement new protocols for handling 911 calls from healthcare facilities beginning July 3, 2023" Tr. Pp. 90-91. Chief Auth further responded affirmatively when asked if the dispatch in question came from a healthcare facility. He further agreed that the document stated "a sole ALS transport unit will be dispatched for chest pains/heart problems, and difficulty breathing…. If an ALS transport unit is not available within that time frame, a paramedic engine company and the BLS transport unit will be sent." Tr, p. 92. Chief Auth testified that Ambulance 3 is a BLS unit, which stands for Basic Life Support unit. He further testified that the other unit dispatched to this call was Medic 3, which is an Advance Life-support unit. Tr. pp. 92-93. When Chief Auth was questioned whether Medic 3 was within thirty (30) minutes of Kaiser Permanente at the time the call went out, he answered 'yes'.

When questioned if he was aware of how long it took Medic 3 to respond to the dispatch in question, Chief Auth answered that he was aware of Medic 3's response time but did not have that information in front of him. Tr. P. 93. Chief Auth testified that he became aware of Medic 3's response time because they also had a delay in responding. Tr. p. 94-95. When asked if the personnel on Medic 3 were issued disciplinary charges, Chief Auth stated that he believed they were and that he drafted their endorsements. Tr. pp. 95-96. However, he also noted that he could not recall with one-hundred percent accuracy if he drafted their endorsements, but he is pretty confident that he did. Chief Auth testified that he did not know if there were subsequent endorsements, and he was never asked to testify in a Trial Board Hearing involving Medic 3. Tr. pp. 97-98.

When asked by the Trial Board what normal standard procedures are followed in operations when there is a notification from the fire liaison that a member wasn't within their time to respond, Chief Auth testified that an investigation is initiated, and the members are cited if charges are warranted. Tr. P. 99.

Chief Jon Grover ("Chief Grover") Tr. pp. 100-119

Chief Grover testified that he is the Deputy Fire Chief of Operation, Platoon Number 3. He reviewed Agency's Exhibit 5, page 20, and identified it as his endorsement of Employee's discussion report. He testified that he remembered watching Rosco video footage of Employee on March 24, 2023, consistent with his endorsement. Tr. pp. 102-103. He further reviewed video footage identified as Exhibit 9B and testified that the date stamp on the video was March 24, 2023, which was the same date of his endorsement. Tr. p. 103. After further reviewing the video footage, he testified that he saw several violations. Chief Grover testified that the members were not wearing seatbelts, Employee was

eating while driving, and the member riding was on her telephone. Tr. pp. 104-105. He further testified that at one point in the video, not only was Employee eating, he also did not have either hand on the steering wheel. Chief Grover further noted that the ambulance was moving twenty-five miles per hour, which was noted in the bottom screen of the video. Tr. p. 104-105. Chief Grover also observed that Employee was not in proper uniform and that during that time of year he was required to wear his NFPA compliant navy-blue uniform shirt, displaying his name and rank. Tr. p. 105-106.

When asked about the observations he made regarding Employee in his endorsement as noted at Agency's Exhibit 5, Chief Grover stated that he concluded that Employee was not wearing a seatbelt, which was not in compliance with Order Book, Article 17. Tr. p. 106. He further stated that in his endorsement he addressed the observation made regarding Employee's eating while driving and concluded that eating while driving was clearly a distraction, in violation of Order Book, Article 17, subsection 4.7, which notes that all members are responsible for maintaining general awareness and promoting safety while riding in a department vehicle. Tr. p. 107. Chief Grover indicated that in his endorsement he concluded that Employee and his partner were not wearing uniforms, in compliance with Article 21. Chief Grover was then asked to review a video noted as Agency's exhibit 9-E. Chief Grover confirmed that the date stamp on the video showed the date in question, March 24, 2023. He noted that he observed that the ambulance was not brought to a complete stop at stop signs prior to proceeding to the intersection five times in the video. Tr. p. 109-112. Chief Grover testified that in his endorsement, he concluded that Employee did not stop as required by department policy. Tr. p. 112. Chief Grover confirmed that he reviewed the I/NetViewer information for Ambulance 3 in making his endorsement. Tr. p. 112-113.

Chief Grover reviewed Agency's Exhibit 2, page 5 and identified this document as a tracking of the I/NetViewer. He was questioned regarding the "run reference" in his endorsement, "path 230058704." Chief Grover affirmed that Ambulance 3 cleared this event number at timestamp 15:54. Chief Grover also agreed at that point, Ambulance 3 was required to travel in the most direct route possible and return to quarters. Tr. p. 113. Chief Grover affirmed that the next dispatch for Ambulance 3 was at timestamp 16:11:13, which is about seventeen minutes from the previous entry. Tr. p. 113. He agreed that EMS Operations Bulletin Number 19, states in part "without delay, the unit shall return to quarters, utilizing the fastest and most direct route of travel." He affirmed that if Ambulance 3 was using the fastest and most direct route of travel, it should have been able to make it back to quarters within those seventeen minutes. Chief Grover noted that to his knowledge, Ambulance 3, which was driven by Employee did not return to quarters during those seventeen minutes. Tr. pp. 113-114.

Chief Grover affirmed that he reviewed the Rosco camera footage to come up with the citations that are recorded in his endorsement. Chief Grover confirmed that Employee was wearing a quarter zip sweatshirt, with his department logo, name and rank on it. Tr. p. 115. Chief Grover stated that he is not aware of any firefighters and EMTs getting fired for wearing the wrong shirt, but further testified "that doesn't mean it hasn't happened. I'm just not aware of." He testified that it is against department policy for firefighters and EMTs not to wear seatbelts. He noted that every time he is in a fire Department vehicle he puts on his seat belt. He reported that it has been the rule for years and it should be adhered to by everyone. Chief Grover further testified that he was not aware of anyone getting fired for eating in their vehicle. Tr. pp. 116-117. When asked if he checked every unit's footage to see if they were wearing the right shirt, or to see if they ate in their ambulance, or to see if they stopped at every signal, he indicated that he had not. Tr. p. 117.

Chief Grover responded affirmatively when questioned whether his endorsement stated that Ambulance 3 traveled from George Washington Hospital past their quarters to a fast-food restaurant, and whether that aspect of this case played a part in this matter coming to his attention. Chief Grover further testified that he does not recall any other units stopping at a fast-food restaurant that day. Tr. pp 118-119.

Employee's Case-in-Chief

Employee - Tr. pp. 120-195

Employee testified that he is from Northeast Washington, D.C. and attended Phelps Career High School. He testified he wanted to become a firefighter because it is an admirable career. Employee noted that firefighters put their lives on the line every day for the safety of others, and he felt like that was something that his community would be proud of. He indicated that he grew up down the street from Engine 10 and always looked up to them. Employee reported that he told himself if he did not become a ball player that he would pursue being a firefighter. He testified that he joined the Department in April 2019. Employee noted that his favorite part of the job was its fast-paced environment. He indicated that he learned something new every tour and how to better do his job and serve the community. He further stated that there is camaraderie and brotherhood, and the heroics of the job are rewarding. Tr. pp 121-122.

Employee further testified that he received the Outstanding EMT award in 2021 and 2022, as well as CPR pins for CPR saves and rescues. He testified that on the day in question he was on an overtime shift-working day off. Tr. p. 123. He testified that he works overtime all the time and is available any day that is not his shift, day and night. Employee reported that his overtime varies but provided a range of 48 to 100 hours, depending on the availability of the overtime. Tr. p. 123-124. Employee indicated that on the day in question, he had been working thirty-three (33) hours when the call at issue came in. Employee testified that he was located at 10th and H Streets NE, when he received the call. Employee reported that the call location was 700 2nd Street, which is Kaiser, a medical facility. He testified that it would take about four (4) or five (5) minutes to get from the corner of 10th Street NE to Kaiser. Tr. P. 124. He further testified that the distance between the two locations is .7 miles. Employee testified that he was traveling east on H Street when he received the call, and Kaiser was west of his location. Employee indicated that he did not immediately turn around when he received the call. He testified that he traveled about three to four blocks down H Street, made a right on 14th Street, pulled over, and stopped at Chick-fil-A on 14th Street and Maryland Avenue. When asked why he did this he testified that it was for his partner. Employee stated that she "complained about how she was feeling tired, fatigued, headaches, stomachaches and all that stuff from the lack of eating." Tr. Pp. 125. Employee testified that he did not want his partner to become a patient. Accordingly, he stopped, allowing her to pick up food that she had ordered through an app on her phone. Tr. pp. 125-126.

Employee testified that his partner had ordered the food approximately ten (10) to fifteen (15) minutes prior to arriving at Chick Fil-A, and prior to the call coming in. Employee noted that he did not get any food on that stop. He testified that the call came in around 16:11 and his shift started at 7:00a.m. Employee indicated that his partner had not eaten during that shift. Tr. p. 126. Employee indicated that in his experience, the side effects of not eating included becoming "hangry," and less empathetic and compassionate with the patients. He stated that you may miss things and take shortcuts. Employee testified that he felt horrible about his decision to stop at Chick-fil-A. Tr. p. 127.

When asked if he could explain why his partner was so fatigued, Employee responded that his partner later learned that she was pregnant. Tr. p. 128. Employee further testified that they were already in route to the restaurant when they received the call and were approximately four blocks away from the restaurant. Tr. pp. 128-129. Employee confirmed that his partner was the ambulance crewmember in charge. Employee reported that this was his first time working with his partner on the day in question. He further stated that he believes his partner had been employed with the Department for six years. Employee stated that in addition to his unit being sent to the call, Medic 3 was also dispatched to the same call. When asked why Medic 3 was also dispatched, he testified that this was an ALS call, which stands for Advance Life Support. Tr. p. 129. Employee reported that Medic 3 is a medic unit that provides advanced life support. Employee testified that an ALS unit knows how to administer medication that corrects heart rhythm. He testified that his unit is a Basic Life Support Unit. Tr. pp. 129-130.

Employee indicated that when he arrived at Kaiser Permanente, the ALS unit was parked in front of 700 2nd Street and arrived seconds before his unit. He testified that when his unit pulled up, Medic 3 was putting the cot on the curb, and walking towards the building. Tr. pp 130-131. Upon review of Agency's Exhibit 9-E, Employee identified the building in the footage as Kaiser, 200 2nd Street. He also identified another paramedic in the footage. When asked if this paramedic saw Employee pull up, Employee responded in the affirmative and noted that the firefighter looked back and looked at him and his partner when they were at the corner of 2nd and G Streets. Tr. p. 131-132. Employee testified that they receive many calls to Kaiser Permanente, and almost every call was for an ALS unit. He testified that the doctors feel more comfortable with passing care of a patient to an ALS Unit versus a BLS unit. He further testified that an ALS unit has one paramedic and one firefighter emergency medical technician, and BLS unit has two firefighter emergency medical technicians. Tr. p. 132. Employee testified that a paramedic can administer medication to correct cardiac issues. Employee confirmed that a firefighter EMT cannot start an IV, transport a patient with an IV, or put heart monitors on a patient. Employee testified that the call in question to Kaiser Permanente was for cardiac-related hypertension, irregular EKG, and chest pain. Tr. p. 133.

Employee was questioned about the process when both an ALS and BLS unit are assigned to a call, and the BLS arrives first. Employee testified that a BLS unit would go introduce themselves to the patient, doctor, and nurse, and let them know that they are waiting for a medic to arrive. Tr. p. 134. Employee further testified that the medical staff expects an ALS unit to arrive. When asked if his BLS unit had arrived first on the scene that day, what would have happened, Employee testified they generally stand by in case additional manpower is required or the call is downgraded to a BLS unit. He testified that standby meant they generally sit outside and wait for the instruction. Tr. pp. 134-135. When asked what he could have done if he went inside Kaiser on the day in question, Employee testified that there was not much he could do other than introduce himself. Employee affirmed that, due to a change in policy, if this call came in today, only the ALS unit would have been called. Tr. p. 135.

Employee is shown Firefighter's Exhibit 1 and asked to read the first paragraph, and states "The Office of Unified Communication in collaboration with the office of the Medical Director, OMB, will implement new protocols for handling 911 calls from health-care facilities beginning July 3, 2023." Tr. p. 135-136. Employee answered 'yes' when asked if this policy went into effect a few months after the incident in question. Tr. p. 136. Employee was asked what the phrase unnecessary strain on the system means to which he explained that it was using unnecessary resources or having too many units on one call that should not be there. He testified that the consequences of assigning

too many units to one call had the effect of taking units away that could be helping other people. Tr. pp. 136-137. Employee was directed back to Exhibit 1 and asked to look at the first bullet point. He confirmed that it stated a sole ALS transporting unit available to arrive within thirty (30) minutes will be dispatched for chest pain or heart problems. He also confirmed that this document also lists cardiac monitoring. Employee further affirmed that the call at issue was coded as a cardiac issue, irregular EKG, and chest pains Tr. p. 137-138. Employee testified that Medic 3 was in quarters when the call came in. He noted that Medic 3's quarters are four (4) or five (5) minutes from Kaiser Permanente and approximately .7 miles. Tr. p. 138. Employee was directed to turn to page 3 of Exhibit 1 and he confirmed that Kaiser Permanente was one of the approved medical facilities in the document. Employee implied that if the call at issue happened today, a BLS unit would not be placed on this call. It would solely be an ALS unit. Tr. pp. 138-139.

Employee reviewed Agency's Exhibit 3 and identified it as his own special report, dated March 24, 2023. He testified that this was not the first special report he wrote about the incident in question. Employee testified that his first special report was a one-liner saying he made a mistake and was apologetic about it. Employee testified that this initial special report was "scrapped" by Lieutenant Jay Brown. Employee testified that Lieutenant Brown pointed him in a different direction, telling him to elaborate on what happened on the call, and that Employee did not want to seem like he did not care, or give the Department a reason to look at it like that. Employee testified that Lieutenant Brown prompted him to write his most recent special report. Tr. p. 139. Employee reported that he had never been in trouble on his job before, he had never written a special report and had no disciplinary history with Agency. Tr. pp. 139-141.

Employee testified that if he could go back in time to when he was on Ambulance 3 and received that call, he would have just gone to the call, went upstairs to make contact with the patient and the nurses. He testified that this has been a teachable moment, and while he made a mistake, it is not who he is and is a contradiction to who he is. He testified that he learned from it and if given the opportunity, he would never be in this situation again. Employee testified that he worked hard to get here, and to be in that situation is disappointing. Tr. pp. 141-142. When asked if there is anything else he would like to tell the Trial Board, Employee responded that he apologized for his actions. He learned from them, and if given the opportunity to retain his career, he would never be in this type of situation again. He also apologized for the negativity that he caused on the Department. He testified that moving forward, if given the opportunity, he would be more positive and encourage the newer members not to make the same mistakes. Tr. p. 142.

Upon review of page 5 of Agency's Exhibit 2, Employee confirmed that this document was the I/NetViewer information for Ambulance 3 on March 24, 2023. Employee further confirmed that he was the driver of Ambulance 3 at this time. Tr. p. 143. Employee additionally confirmed that according to this document, Ambulance 3 went back into service at timestamp 15:54:15, from the prior run which was at George Washington University Hospital. Tr. p. 143. When asked what action was taken to signal that a unit was back in service, Employee testified that one of the people in the unit would hit "in service" from the cab, and it is sent to "communications." Employee testified that he did not recall if it was him or his partner who signaled that Ambulance 3 was back in service. Tr. p. 145. Employee was questioned whether he was paged by Sgt. Collins to go back in service at that time or if he did on his own volition. Employee responded that he did on his own. He testified that after going back in service, he made a stop at 6th and H Streets, the location of Cava to get something to eat. He testified that this was between the prior service call and the dispatch in question. Tr. p. 146. He confirmed that his partner had the opportunity to also get food from Cava, and if she

had, the stop at Chick-fil-A would never have happened. When asked whether the notion that Employee's partner simply never had time to get food is incorrect, Employee responded that his partner does not eat Cava. When asked if he and his partner lacked the time to get food of their own preference, Employee affirmed that was a fair assessment. Tr. p. 147.

Employee identified Agency's Exhibit 3 page 8, as Employee's special report. Employee was asked to review the portion of this document that stated 'there is no delay in patient care or response.' When asked if this statement was inaccurate, Employee testified that he was prompted to say that and put emphasis on that. Employee testified that he was not forced to write it but was encouraged to write it. Tr. P. 148. He further testified that since he had never been in trouble before, he was not privy to how special reports work for disciplinary action. Employee noted that when he was prompted to write it, he agreed with it because a higher-ranking officer brought something to his attention that he agreed with. Tr. p. 149.

Employee confirmed that at the time of the dispatch he was on 10th and H Streets, NE, which is four or five minutes from Kaiser Permanente. Tr. p. 149. When asked whether the document he had in front of him is Google Maps documenting the spot where he received the dispatch location to the emergency, he replied, "not totally. This is saying now 5th and H Street. I was on 10th and H Street." Employee confirmed that the estimated time to the emergency was three minutes, which is less than four or five minutes, as he estimated in his earlier testimony. Tr. pp. 150-151. He confirmed that it took him over ten minutes to respond to the emergency, and that the delay included driving several blocks in the wrong direction and sitting at Chick-Fil-A for approximately four minutes. Tr. p. 151. Employee further affirmed that chest pain can be indicative of a serious emergency, and in such an emergency every second counts. Tr. p. 151.

Employee reviewed Agency's video Exhibit 9-D, which was video footage of Ambulance 3 and identified himself in the footage. When asked if he agreed that he looked nonchalant in that portion of the video, Employee disagreed. He testified that he is always concerned about his patients. Tr. 152. Employee was questioned about his statement in Agency's Exhibit 3, page 8, in which Employee stated, "still ended up arriving on scene at the same time as Medic 3." He was asked if that statement was accurate, to which Employee testified that they did not arrive at the exact same time as Medic 3, but seconds after them. Tr. p. 153. Employee was asked to review Agency's Exhibit 2, page 5, and Employee affirmed that the arrival time for this dispatch was 16:21:44. Tr. pp 153-154. Referencing Firefighter's Exhibit 2, Employee was is asked if Medic 3's arrival time was 16:19:31. Employee confirms that this was about a two-minute difference in arrival times between Medic 3 and Ambulance 3. Tr. p. 155. Employee further confirmed that if he had reported directly to the emergency, he would have arrived a few minutes before Medic 3. Employee was questioned about his statement in Firefighters Exhibit 1, in which he mentioned that the unnecessary strain on the system referred to the fact that it was taking units away from helping patients at other places. Tr. p. 155-156. Employee was then asked whether that unnecessary strain refers to taking time from units spending time at Chick-fil-A., to which he replied "no, I don't." Tr. p. 156.

While referencing Firefighter's Exhibit 1, which gives a few scenarios where a BLS unit would be called to an emergency, Employee was asked whether he would not go to a dispatch because he did not think it necessary as a BLS unit. Employee responded that he would always go. He agreed that it was important for units to respond and report when dispatched. Employee further confirmed that he thought this was a serious case, perception is reality, and how it was perceived was not his intention. He further testifies that it was not his intention to cast a negative light on the

Department. Tr. pp. 156-157. Employee stated that he made a mistake for which he was truly sorry. Tr. pp. 157-158.

On redirect, Employee testified that a higher-ranking officer influenced what he wrote in his special report. Employee testified that the officer noted to address the length of the report, provide more detail, add that there was not a delay in care due to another ALS unit arriving at the emergency, and that the ALS unit was the same distance from quarters. Tr. p. 158. Employee reviewed video footage identified as Firefighter's Exhibit 2, which is video footage of Ambulance 3 on the day in question, at timestamp 16:19:30. Employee confirmed that at this timestamp Medic 3 was still moving and accordingly arrived after 16:19:30. Tr. p. 159.

When questioned by the Trial Board, Employee affirmed that he was assigned Engine 3, Number 2 Platoon. He testified that he graduated from the academy in June 2020. Tr. p. 160-161. Employee affirmed that at the time of the incident in question, he had been in operation for almost three years. Employee confirmed that he has never been assigned anywhere other than Engine 3, Number 2. Employee testified that he generally worked a lot of overtime and ninety-five percent of the time it is on Ambulance 3 or Medic 3. Tr. pp. 161-162. He affirmed that most of his overtime had been in the firehouse on one of these two transport units. Employee testified that he was not trained to stop for any reason during a dispatch. Tr. p. 162. Employee noted that there have been times in the firehouse when a call comes in, you may run to the bathroom, which is common. Employee indicated that he has never been on a dispatch and stopped somewhere other than the dispatch location. Tr. p. 163. Employed confirmed that neither formally or informally was he ever given directions to make a stop on the way to an emergency. He further confirmed that no one has given him the impression that he, as an emergency responder had a role in determining either the dispatch priority or what types of runs to which he is required to respond. Tr. p. 164. Employee agreed that once a unit is dispatched, the unit is to go to the emergency and figure it out. It can be elevated to a larger response or escalated to a smaller response, but that cannot happen until the unit arrives on the scene. Tr. p. 165.

A member of the Trial board asked Employee for clarification of his testimony in which he stated that an EMT cannot offer assistance for a patient complaining of chest pain, and whether he stands by this testimony. Tr. p. 165. Employee testified that at that particular setting, there is nothing they can do because the transfer of care has not been granted to them. He testified that once they arrive at Kaiser, generally the doctor and nurse are there, and they are not willing to transfer care because they requested an ALS unit. The Trial Board asked Employee what the Department's expectation was when he arrived on the scene of an emergency. Tr. p. 166. Employee responded that he is meant to render care. He testified that when they walk in and see the patient, they are supposed to get a general impression. Employee stated his next step would be to talk to the patient, and ask them what is going on, and how are they feeling. Tr. p 166-167.

The Trial Board asked Employee whether he was able to downgrade the emergency to a BLS unit after making his initial assessment. Employee noted that in this particular case he could not have downgraded it because it was already deemed that the patient had an irregular EKG, and chest pain. Tr. p. 169. When asked by the Trial Board whether a BLS unit was able to make an assessment and determine whether the emergency was ALS or BLS, Employee responded in the affirmative. Tr. p. 170. The Trial Board asked Employee what time he assumed duty that day, to which Employee replied he was already there. Tr. p. 170. Member Carmody asked Employee what time his partner assumed duty and Employee testified that he was not sure. Employee confirmed that both he and his partner stated in their special reports that it was a busy day. Tr. p. 172. Employee indicated that a

busy day can consist of eight (8) or more runs in a twelve (12)-hour shift. Employee testified that he was not sure of how many runs he had on the day of the incident in question but stated that they had approximately seven (7) or eight (8) runs. Employee noted that it was not just the runs, but the time spent at a dispatch location, which may be twenty minutes or two to three hours. Tr. p. 173-174.

When questioned by the Trial Board why his partner did not eat during the break they had between 7:41 and 8:42. Employee testified that he was not sure why his partner did not eat. Employee further stated that he had been there for twenty-four (24) hours and preferred to use that time to attend to personal care. Tr. pp. 174-175. When asked by the Trial Board why his fifth run of the day was for the exact same transport number and location as a previous run, Employee responded that it could have been a glitch with the system, and they do not have control over the dispatches they receive. Tr. pp 176-178.

Employee confirmed that after clearing a dispatch at 12:30p.m. his partner left the ambulance and went to the restroom for an extensive time and noted that she said she was feeling bad all day. Employee stated that his partner entered a high-rise building while they were on a call and went inside to use the facility. Tr. pp. 180-182. The Trial Board sought clarification on Employee's statement that it was a very busy day, and they had no time to eat. When the Trial Board indicated that Employee and his partner had a break right in the middle of what most would consider lunchtime and neither of them took the opportunity to eat, Employee stated that he could only speak for himself, but he prefers to fast and does not eat prior to certain times. Employee stated that he tried to eat after 12:00p.m. Tr. pp. 183. Employee stated that he stopped at Cava prior to the incident in question. When the Trial Board asked Employee in his opinion whether there was any acceptable reason, aside from coming across another emergency, for stopping an emergency response vehicle in route to a medical emergency or other emergency, Employee testified there was not, not even for personal reasons. Tr p. 184.

When asked by the Trial Board how much time was spent on Medic 3 versus Engine 3 when he was at work on a regular shift, Employee testified that there were three of them and they rotated out. Employee confirmed that at least half of his time was spent on some sort of transport. Tr. pp. 185-186. Employee testified that he has done many runs to Kaiser Permanente, and those runs were routine. Employee confirmed that he told his partner that he was heading to Cava to order lunch and his partner told him she did not like Cava, which was why she ordered from a different location. Employee affirmed that his partner did not decline Cava because she was not feeling well or was not hungry, but because she did not like Cava. Tr. pp. 186-187. He further stated that his partner orders from Chick-Fil-A at the same time Employee ordered from Cava. Employee testified that when they received the dispatch in question, he suggested to his partner that they quickly go get her food, then head to the location of the emergency Tr. p. 187-188. Employee indicated this his partner said she felt as if she would pass out and was feeling nauseated. Employee testified that he remembered in the academy they were taught to prioritize their own safety, their partner's safety, then the safety of the patient. He further testified that he did not want his partner to become a patient because she would be no good to him if she could not help. Tr. p. 188-89.

Employee further testified that he turned off the sirens when they arrived at Chick-fil-A to be inconspicuous. Employee confirmed that if the emergency had been for a patient choking versus a patient at Kaiser Permanente, then he would not have stopped. Tr. p. 189. When asked by the Trial Board whether he requested a union representative when asked by a higher ranking official to change his special report, Employee testified that he did not know that was an option because he had never

been in trouble before. He stated that he complied with the suggestion because it came from a higher ranking official, and did not question it. Tr. p. 190. When the Trial Board asked Employee what he would have written in his special report, Employee testified that he would have written that he made a mistake, and he was truly apologizing for it, and that he was trying to protect the interests of his partner. He further stated that he would have noted that his partner was about to pass out or something along those lines. Employee stated that the higher-ranking official advised him that he was coming across like he did not care, and that he did not want to give the impression to the Department that he did not care and advised Employee to go into more detail. Tr. p. 191.

The Trial Board questioned Employee about his statements about his partner's fatigue on the day in question. The Trial Board noted in the ambulance footage that Employee's partner was singing loudly and talking on her phone. When asked by the Trial Board about his partner's behavior on the ambulance video footage, Employee responded that his partner had been saying she was not feeling well that day. Employee testified that his partner received a phone call when they were at Cava, and whomever it was must have been a bright spot for her, because it was obvious she liked the conversation. Tr. p. 192.

On re-cross examination, When Employee was asked why he did not go get his partner's food if she was feeling fatigued, Employee testified that since he was driving and in control of the unit, it was better for her to get out. He confirmed that when they stopped at Cava, he was the one who went into Cava, not his partner. Tr. p. 193.

Employee stated that he apologized for his behavior and took full accountability for his role. He further stated that he was an asset to the Department, he loved his job and was proud of it. He asked for the ability to retain his career as this was a teachable moment for him from which he had learned. Employee stated that it would never happen again. Tr. pp 194-195.

Lieutenant Stanley Jaworski ("Lieutenant Jaworksi"). Tr. Pp. 196-203

Lieutenant Jaworski he was a lieutenant assigned to Engine Company Number 3. Tr. p. 196. Lieutenant Jaworski testified that Employee had been assigned to his company for approximately three years. Lieutenant Jaworski testified that when Employee completed the academy, Employee was appointed to his shift. He testified that he has had the opportunity to observe Employee's abilities as an EMT. Tr. pp. 196-197. Lieutenant Jaworski described Employee as very competent at the EMT part of his job and noted that Employee has great bedside manners, and there had never been an issue with job performance. Lieutenant Jaworski further described Employee as hard-working with a work ethic equal to the other good employees because he is a good employee. Tr. pp. 197-198. Lieutenant Jaworski further noted that Employee had a great willingness to learn, loved driving the rig, and had a great interest in learning the District so he could be a better driver. He further testified that when he heard about the incident at issue, and that Employee would no longer be working with him, he was surprised because Employee had always done a good job. He acknowledged that he was surprised at the bad decision made. Lieutenant Jaworski stated that Employee was a valuable member of the team. Tr. p. 198.

Lieutenant Jaworski stated he had hoped Employee had learned his lesson, and from the few times he spoke with him, in general, it seems like he realized that he had made a bad mistake and was hoping to receive a second chance. Lieutenant Jaworski stated that if given the opportunity he would like to have him back as an Employee, because he did good work, he was very capable of doing the

job and had never had any problems prior to this one. Tr. p. 199. Lieutenant Jaworski further testified that today's new hires were mixed bag unlike years ago. He stated that Employee was one of the people who was clearly capable of doing the job, was hard-working, and did very good work. Lieutenant Jaworski further testified that Employee worked a lot of overtime that the Department needed. He further stated that Employee was always signing up to help out. He further stated that Employee kept himself fit. Lieutenant Jaworski testified that whenever firefighting was necessary, Employee had defeated each door when forcible entry was required. Tr. p. 200-201.

Lieutenant Jaworski further confirmed that bedside manners were really important for the EMT side of the job. He testified that Employee knew the protocols and provides good care. Lieutenant Jaworski indicated that Employee had a great personality and was able to relate to people. He stated that Employee could sometimes bridge in difficult situations where the patient was going through a bad episode. He testified that Employee was able to speak to them and make them comfortable. Tr. p. 202. Lieutenant Jaworski testified that the incident in question was a very out of character event that got him in trouble.

When asked if he thought Employee could be valuable during a medical emergency, even if he needed to wait for someone else to get there to provide transport or other measures, Lieutenant Jaworski answered in the affirmative. Lieutenant Jaworski testified that Employee had bedside manners, knew his protocols, provided good care, and was very dependable. Tr. p. 203. Lieutenant Jaworski further noted that Employee would provide the proper care and would not need someone there to oversee his work. Tr. p. 203.

Firefighter Delonte Nelson ("Nelson") Tr. pp. 205-220

Nelson testified that he was an 'am' Firefighter EMT beside Engine 5 and Ambulance 2. He noted that he was at Engine 3 before that and had been with the department since 2012. Tr. p. 205. He stated that he was appointed to Engine 3 in 2013. Tr. p. 206. He testified that he typically rode on a BLS and ALS unit. Nelson reported that he has been called to Kaiser Permanente numerous times. Nelson noted that Kaiser requested an ALS unit ninety to ninety-five percent of the time. Tr. P. 206. Nelson testified that generally, when on a Kaiser call, if a BLS unit was called, an ALS unit would be present as well. He indicated that when a BLS unit arrived first, they usually go into Kaiser and make contact with the doctor or nurse Tr. p. 207. Nelson noted that nine out of ten times, they want an ALS unit. Tr. p. 208.

Nelson indicated that on an ALS call to a house, they go in, make an assessment, evaluate the patient, and then make the determination as to whether to upgrade, downgrade, or transport the patient themselves. He testified that the difference at Kaiser is that this evaluation and assessment has already been done. Nelson indicated that at Kaiser, when the BLS unit arrives first, they will get on the radio and officially request an ALS. In the meantime, the BLS unit is on standby. The BLS unit EMT's may gather the patient's belongings, get the 'face sheet' and demographics and input them into the "ePCR" to get the ball rolling for the ALS, but they do not perform patient care. The patient remains under Kaiser's care until the ALS unit arrives. Tr. p. 208. Nelson testified that an ALS unit is requested because a higher level of care is required than EMTs can provide. So if Kaiser cannot provide care, they want the call transferred to the highest level of care. Tr. p. 209.

Nelson testified that when he has been on a BLS call for an ALS call to Kaiser, there have been times when he arrived after the ALS unit. They are generally instructed to fall back and

standby. Tr. p. 209. The ALS unit then makes their evaluation and either transports the patient or downgrades the call to the BLS unit. Nelson testified that it usually takes approximately five minutes to get from Engine 3 to Kaiser.

Nelson reported that he met Employee when he was a recruit at the training school. He had the opportunity to ride third on Engine 3, so Nelson and Employee became close through that experience. Nelson further testified that Employee was assigned to Engine 3 straight out of the academy. Tr. p. 210. Nelson reported that he and Employee have worked together and done years of worth of calls together. He stated they got a lot of calls. Nelson testified that Employee was an exceptional firefighter with excellent physical ability, and a positive attitude. Nelson testified that he never had to second guess Employee's abilities. Tr. p. 211. Nelson further testified that Employee had great work ethic, always shows up on time, asked questions, took initiative, and was a team player Tr. p. 212. Nelson testified that his work ethic was above that of his peers. He noted that some of the younger firefighters were lazy and you could not tell them anything, but Employee was the opposite and a starter. Tr. p. 213.

Nelson reported that Employee worked a lot of overtime and made himself available almost every day outside of his normal shift and would come in at the last minute if needed. Tr. p. 214. Nelson noted that he had never witnessed Employee make a mistake with patient care or protocol. Tr. p. 215. Nelson stated that if given the opportunity to work with Employee again he would with "no question, one hundred percent." Tr. p. 216. He testified that he believed Employee has learned his lesson. Tr. p. 217.

On cross-examination, Nelson was questioned whether he knew when Kaiser would accept a BLS unit and he testified that there were very few times when Kaiser accepted a BLS unit. He testified that for a 911 call, Kaiser wanted an ALS unit and that in very rare instances, a BLS unit would be required. Tr. pp. 218-219.

A member of the Trial Board asked Nelson if a BLS unit arrived prior to an ALS and it was of high priority, what the protocol says regarding the transport of the patient. Nelson responded that a BLS unit would likely transport the patient. Tr. pp. 219-220.

Panel Findings[5]

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

Findings of Fact

1) All evidence presented led the Panel to conclude that FF/EMT [Employee] of the offenses described in **Charge 1:**

    a. Although he pled not guilty at the hearing, FF/EMT [Employee] admitted that he violated Department Policy by stopping at Chick-fil-A while on an emergency run. FF/EMT [Employee's] testimony confirms that he violated Department policy by receiving an emergency medical services dispatch and

[5] *Id*. at tabs 25 & 27.

driving in the opposite direction to get lunch for his partner at the Chick-Fil-A Restaurant. Both the ambulance video footage and the I-Tracker data confirmed this misconduct.

b. FF/EMT [Employee] testified that his misconduct did not impact patient care; however, the Panel concludes that it hampered the Department's efficiency and diminished the public trust in the Department's ability to achieve its mission to preserve life and promote health and safety through excellent pre-hospital treatment and transportation. FF/EMT [Employee's] blatant disregard of Department policies and standards requiring providers to properly respond to dispatched emergencies was grossly negligent.

c. FF/EMT [Employee] testified that he stopped because his partner was fatigued; however, video footage showed a joyful partner who exhibited no signs of fatigue throughout the response.

d. The Panel is particularly troubled by the fact that FF/EMT [Employee] had a two-hour break before this response, which was ample time for him to get lunch.

2) All evidence presented led the Panel to also conclude that FF/EMT [Employee] is guilty of the offenses described in Charge 2; specifically, the ambulance footage established by preponderant evidence that FF/EMT [Employee] neglected his duties by showing the following careless actions and attitudes after he was dispatched:

a. He willingly responded to Chick-fil-A with lights and sirens and stopped at the location for several minutes, knowing he was on an emergency response.

b. FF/EMT [Employee] ate lunch while on a dispatched response while waiting for his partner to return from Chick-fil-A.

c. In addition, once his partner was in the ambulance, FF/EMT [Employee] began responding and he violated Department policy by eating while driving, not wearing a seatbelt, and disregarding stop signs on several occasions.

d. Finally, FF/EMT [Employee] failed to don the proper uniform shirt required by Order Book Article XXI (Uniforms).

Upon consideration and evaluation of all the testimony, The Trial Board found that there was a preponderance of evidence to sustain the charges against Employee. In addition to making the findings of fact, the Panel also weighed the offenses against the relevant *Douglas* factors[6] and concluded that termination was the appropriate penalty for these offenses.[7]

[6] *Douglas v. Veterans Administration,* 5 M.S.P.R. 313 (1981). The *Douglas* factors provide that an agency should consider the following when determining the penalty of adverse action matters:

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;

ANALYSIS AND CONCLUSIONS OF LAW[8]

Pursuant to the D.C. Court of Appeals holding in *Elton Pinkard v. D.C. Metropolitan Police Department*,[9] 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 Comprehensive Merit Personnel Act ("CMPA"). The statute gives OEA broad discretion to decide its own procedures for handling such appeals and to conduct evidentiary hearings.[10] The Court of Appeals held that:

> "OEA may not substitute its judgment for that of an agency. Its review of the agency's 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;
>
> 3. The employee is a member of a bargaining unit covered by a collective bargaining agreement;

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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 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

the adequacy and effectiveness of alternative sanctions to deter such conduct in the future by the employee or others.

[7] Agency Answer, tabs 25 & 27 (December 15, 2023).

[8] 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").

[9] 801 A.2d 86 (D.C. 2002).

[10] *See* D.C. Code §§ 1-606.02(a)(2), 1-606.03(a)(c); 1-606.04 (2001).

> 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 September 7, 2023, 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 Trial Board 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.

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

Pursuant to *Pinkard*, the undersigned must determine whether the Trial Board 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.[11] 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.[12]

Agency's Position

Agency maintains that the evidence supports the charges and specifications. Agency argues that Employee intentionally delayed his response to a medical dispatch to make a food stop, and further disregarded Agency safety protocols by failing to completely stop at five (5) signs, driving without a seatbelt, driving with no hands on the wheel at one point, and eating while driving.[13] Agency maintains that Employee's misconduct was documented by tracking data, video footage, and Employee's own admission.[14]

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[11] *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).
[12] *Baumgartner v. Police and Firemen's Retirement and Relief Board,* 527 A.2d 313 (D.C. 1987).
[13] Agency's Answer to Petition for Appeal, tab 27 (December 15, 2023). *See also.* Agency's Brief, p. 3 (May 8, 2024).
[14] Agency's Brief, pp. 6, 7 (May 8, 2024).

Agency notes that video footage presented at the Trial Board Hearing shows that Employee received the dispatch at 4:11p.m. on the day in question. Agency avers that the video shows Ambulance 3 continuing in the opposite direction of the dispatch location and arriving at Chick-Fil-A. Agency maintains that Employee then sat idle in the Ambulance for four minutes, while his partner went inside Chick-Fil-A, then returned with her meal. Agency maintains that Ambulance 3 did not head in the direction of the dispatch location until approximately six minutes had passed from the time Employee received the initial dispatch Agency further avers that Employee did not show concern for the patient, violated Agency public service standards, failed to offer assistance when requested, failed to carry out assigned tasks, and demonstrated careless work habits, amounting to neglect of duty.[15]

Agency maintains that Employee was properly terminated, and Employee's rationale does not excuse his misconduct.[16] Agency argues that Employee had a two-hour break prior to the dispatch during which he and his partner could have taken a lunch break. Agency further notes that while Employee stated that his partner claimed fatigue and malaise, the video footage shows her laughing on her phone in route to Chick-Fil-A.[17] Agency also notes that the video footage shows Employee's partner get out of the ambulance on her own and back into the ambulance after retrieving her food without any problem. According to Agency, Employee did not offer to retrieve his partner's food from Chick-Fil-A. Agency argues that Employee's actions are not consistent with his rationale that he stopped because his partner was feeling fatigued and ill.[18]

In support of the second charge of neglect of duty, Agency notes that the Trial Board found that Employee violated department policy by eating while driving, not wearing a seatbelt, and disregarding stop signs on several occasions.[19] Agency also notes that Employee failed to wear the proper uniform shirt required by Order Book Article XXI.[20] Agency maintains that there is substantial evidence in the record to support its findings, including testimony by Chief Grover, in which he identified these violations in his review of the ambulance video footage. Agency notes that during his testimony, Chief Grover identified the points in the ambulance video footage where Employee committed each driving infraction. Agency maintains that the I- Tracker data, Ambulance 3 video footage, and Employee's own admissions are substantial, and show that Employee delayed its response to an emergency dispatch which supports the neglect of duty charges.[21]

Employee's Position

Employee maintains that his actions do not amount to neglect of duty. Employee argues that he stopped for food at Chick-fil-A while dispatched on an emergency because his partner complained of feeling fatigued from not eating. Employee stated that he feared his partner would become a patient; thus, he stopped to let her pick up the food she had previously ordered from the Chick-fil-A mobile application several minutes prior to receiving the dispatch.[22] Employee further averred that the dispatch was an Advanced Life Support Unit call. Employee explained that an Advanced Life Support Unit ("ALS") can offer services, including starting an IV, transporting a patient with an IV,

[15] *Id*. at 6.
[16] *Id*. at 7.
[17] *Id*.
[18] Agency's Reply Brief, p. 3 (June 28, 2024)
[19] Agency's Brief, *supra* note 13 at 7.
[20] *Id*.
[21] *Id*. at 7-8
[22] Employee's Brief pp. 2, 3 (June 14, 2024).

perform EKGs, and place heart monitors on patients. Employee noted that Kaiser Permanente, the call location was one of his frequent runs. Employee argues that because his unit, Ambulance 3 was a Basic Life Support unit, he and his partner would have likely been on standby until an ALS unit arrived.[23]

Employee further avers that on the day in question, there was no more he could have done for the patient other than introduce himself because an ALS unit was requested. Employee further notes that Agency changed its policy shortly after the incident in question. Per this new policy, only an ALS unit is dispatched to healthcare facilities for patients with chest and/or heart problems.[24] Employee maintains that despite stopping to get food for his partner, there was no delay in patient care and therefore his conduct does not rise to the level of neglect of duty.[25] Employee further argues that despite arriving at the same time as the ALS Unit-Medic 3, this unit was not disciplined for a late response.[26]

Employee maintains that he advised his partner that stopping to get food was not a good idea; but Employee decided to stop because his partner said she felt as if she would pass out.[27] Employee avers he did not gain anything from stopping at Chick-Fil-A and did so to put his partner's safety first.[28] Employee argues that he recognized his mistake and apologized profusely for it.[29]

Additionally, Employee argues that Agency relied on inaccurate call records in determining that Employee had a two-hour break when he and his partner could have eaten.[30] Employee maintains that the call record Agency relied upon contains duplicate calls, which Employee stated in his testimony may have been a glitch in the system. Employee notes that Agency did not explain the discrepancy. Employee maintains the day in question was a busy day. He testified that he had seven (7) or eight (8) dispatch runs that day.[31] Employee maintains that because the day was busy, he did not have time to eat prior to the dispatch in question. Employee further maintains that his lack of time to eat is inconsistent with Agency's assessment that he and his partner had a two-hour break in which to eat.[32] Employee argues that Agency's decision to terminate Employee is not supported by substantial evidence because Employee stopped due to his partner feeling fatigued, there was no lapse in patient care, and Agency relied on erroneous call records.[33]

ANALYSIS

Substantial Evidence

After reviewing the record, as well as the arguments presented by the parties in their respective briefs to this Office, the undersigned finds that the Trial Board Panel met its burden of substantial evidence for this matter. Agency charged Employee with two charges of neglect of duty,

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[23] *Id*. at 3.
[24] *Id*. at 4 (citing Agency's Special Order SO-2023-166).
[25] *Id*. at 7.
[26] Employee's Prehearing Statement, p. 3 (February 8, 2024).
[27] Employee's Brief, *supra* note 21, at 14.
[28] *Id*.
[29] *Id*. at 11.
[30] *Id*. at 8.
[31] *Id*. at 9.
[32] *Id*. at 10.
[33] *Id*. at 7-12.

citing violations of several D.C. Fire and Emergency Medical Services Department Order Book Articles and other internal policy. Agency provided video footage, tracking data, and testimony that support the charges of misconduct.

In Charge 1, Agency charged Employee with: Violation of D.C. Fire and Emergency Medical Services Department Order Book Article VI, § 6 Conduct Unbecoming an Employee and Article XXIV, § 8, Emergency Responses: "Conduct unbecoming an employee includes conduct detrimental to good discipline, conduct that would adversely affect the employee 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, The Order Book section governing Emergency Responses states that "[u]pon receipt of an emergency response, EMS Providers shall immediately report to the apparatus, status the DEK Button # 1 within one (1) minute and respond to the incident."[34]

The undersigned reviewed the video footage and finds it to be consistent with Agency's findings and testimony in this matter. Consistent with the testimony of Chief Grover, the video footage shows that Employee initiated Ambulance 3s emergency sirens and traveled in the opposite direction of Kaiser Permanente to Chick Fil-A. Employee waited at Chick-Fil-A for several minutes while his partner went inside in to retrieve her food. Employee sat in Ambulance 3 while parked outside of Chick-Fil-A and began eating his food although he was on an active dispatch. Ambulance 3 then traveled to the location of the dispatch, Kaiser Permanente, several minutes after receiving the dispatch. Further, Seargeant Collins testified that Ambulance 3s delay activated an alarm that goes off if more than ten-minutes have elapsed before the ambulance arrives to the dispatch location.[35] Seargeant Collins confirmed that the I/Net Tracking software showed that Ambulance 3 was heading in the opposite direction of the dispatch location.[36] Further, Employee admitted in his testimony that he did not immediately turn around when he received the dispatch to Kaiser Permanente. He testified that he stopped at Chick-fil-A on 14th Street and Maryland Avenue, NE during an active dispatch. Agency has submitted substantial evidence to support Charge 1-Neglect of duty. Employee's decision to delay an emergency response adversely affects the Agency's ability to perform effectively, violates District regulations, and is in direct violation of the emergency response requirements noted above.

Agency further noted that Employee violated 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:

> 11. That all of our personnel will be polite, compassionate, considerate, empathetic, respectful, and well mannered.

According to Battalion Fire Chief Jason C. Auth, "[b]oth Order Book Article XXIV and the Patient Bill of Rights required FF/EMT [Employee] to attempt to render competent, compassionate and empathetic emergency medical services by immediately responding to the incident."[37] Instead, Employee intentionally traveled away from the location of his dispatch to retrieve food, creating an extended delay in Ambulance 3s arrival at Kaiser Permanente. Employee's failure to render an

[34] Agency's Answer to Petition for Appeal, tab 23 (December 15, 2023).
[35] Tr. pp. 25-26
[36] Tr. pp. 26-29; *See also* Agency's Answer to Petition for Appeal, exhibits at tab 20 (December 15, 2023).
[37] Agency Answer, tab 24 (December 15, 2023).

immediate response supports violation of the Patient Bill of Rights. While Employee testified that he stopped because his partner "complained about how she was feeling tired, fatigued, headaches, stomachaches and all that stuff from the lack of eating" the undersigned found Employee's rationale for delaying his response to be inconsistent with the evidence.[38] Employee stated that his partner was feeling fatigue and malaise, yet Employee's partner can be seen talking on her cell phone and laughing, which is not consistent with Employee's report that she was feeling fatigued. Further, Employee's argument that his actions did not delay patient care does not overrule his conduct. While Employee may have correctly reasoned that he would only be aiding an ALS unit once he arrived at Kaiser, Employee was not the authority on whether a dispatch required an immediate response. Further it is a violation of Agency policy to delay a response to the scene of an emergency.

Agency notes that Employee's "misconduct is defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII, Section 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 DPM § 1603.3(f)(3)(08/27/2012); see also DPM § 1605.4(e) (06/12/2019)." The undersigned finds the Trial Board's reliance on the video footage, I/Net tracking Data, and Employee's admissions that he delayed his response to pick up food provide substantial evidence to support Employee's charges of misconduct for Charge 1.

Agency further charged Employee with Charge 2: Violation of D.C. Fire and Emergency Medical Services Department Order Book Article XVII, **Driving Safety**, which requires occupants to wear seat belts:

> The driver of the vehicle is required to stop at any stop signal, and required to promote safety while riding in a Department vehicle (2.2: All members and occupants in the vehicle, other than those covered in 2.7, shall be seated and belted in approve riding positions while the vehicle is in motion (NFPA 1451, 8.3.4). 2.21: Drivers encountering any of the following situations shall bring the vehicle to a complete stop and shall not proceed until it is confirmed that it is safe to do so (NFPA 1451, 7.1.3)):

Agency further noted that Employee failed to wear the correct uniform short, in violation of Order Book Article XXI, **Uniforms**, which states:

> 2.6: The regulation dark blue NFPA compliant uniform shirt with the official Department patch attached to the left sleeve with the thread, centered one inch below the shoulder seam, shall be worn as the work uniform shirt by all uniform employees assigned or detailed to the Operations Bureau, except for the Chief Officers or those acting in their stead.

I also find that Agency has presented substantial evidence to support the charges of misconduct for Charge 2. The undersigned's review of the video footage on the day in question is consistent with Chief Grover's testimony and the charges of misconduct levied against Employee. In his testimony, Chief Grover confirmed that the video footage shows Employee was eating while

[38] Tr pp. 125-126

driving, not wearing a seatbelt, and failed to come to a complete stop at five (5) stop signs. Chief Grover further offered that Employee's conduct was not in compliance with Order Book, Article 17.[39] He testified that eating while driving is a distraction, in violation of Order Book, Article 17, subsection 4.7, which notes that all members are responsible for maintaining general awareness and promoting safety while riding in a Department vehicle.[40] The undersigned find chief Grover's testimony to be credible. Further upon review of the video footage, I find that it shows Ambulance 3 not fully stopping at stop signs. The video also shows that Employee is also eating while driving, visibly not wearing a seatbelt, and wearing an Agency-issued sweatshirt. This evidence demonstrates that Employee committed safety infractions, in violation of Agency's Order Book. While not wearing the proper Agency-issued shirt may not be reason to terminate Employee, this offense in totality with the other violations cited by Agency support termination. Accordingly, Agency has substantial evidence to support the charges against Employee.

After reviewing the record, as well as the arguments presented by the parties in their respective briefs to this Office, the undersigned finds that the Panel met its burden of substantial evidence for this matter. Agency charged Employee with two charges of neglect of duty, citing violations of several D.C. Fire and Emergency Medical Services Department Order Book Articles and other internal policy. Agency provided video footage, tracking data, and testimony that support the charges of misconduct.

Whether There was Harmful Procedural Error

Agency maintains that there was no harmful procedural error in this administration of the adverse action in this matter. In terminating Employee, Agency relied on the 2012 version of the DPM, which is not the current version. Agency also cited both the 2012 and 2019 versions of the DPM in its submissions to the Office in this matter. Agency maintains that the Order Book is the controlling authority and accordingly it establishes cause independent of the DPM. [41]Agency avers that while the charges are pursuant to the Order Book, Agency often includes a citation to the 2012 DPM because the Order Book is modeled after the 2012 DPM. Agency notes that Article VII incorporates the charges and table of penalties found in the 2012 DPM.[42] Agency avers that the use of the 2012 DPM is correct because this is the version that was the subject of a collective bargaining agreement with the International Association of Firefighters, Local 36. Agency maintains that Agency cannot utilize a post 2012-DPM until a new collective bargaining agreement is reached.[43] Agency argues that it added the citation to the 2019 DPM as a "see also" signal in a good faith effort to comply with OEA precedent at that time.[44] Agency further maintains that there is no substantive difference regarding neglect of duty that could have impacted Employee's notice of his charges.

Whether Agency bargained for the use of the 2012 DPM, has to date been addressed by this Office and the Superior Court of the District of Columbia.[45] In the instant matter, whether use of the

[39] Tr. p. 106.
[40] Tr. p. 107
[41] Agency's Brief, p. 9 (May 8, 2024).
[42] *Id*. at 10
[43] *Id*.
[44] *Id*.
[45] *Employee v. DC Fire and Emergency Medical Services Department*, OEA Matter 1601-0046-21, *Opinion and Order on Petition for Review* (January 19, 2025); *D.C. Fire and Emergency Medical Services Department v D.C. Office of Appeals, et al.* No. 2023-CAB-1076 (D.C. Super. CT. Feb, 2011*)(reversing* OEA Matter 1601-0046-21 and holding that OEA's reliance on the 2017 version of the DPM was not supported by substantial evidence in the record).

2012 DPM amounts to harmful error is not an issue that requires substantive analysis because the charge of neglect of duty is found in both the 2012 and 2019 DPM versions, with the same penalty for the first offense, which is counseling to removal and removal as the maximum penalty for both.[46] This Office has held that an employee must be aware of the charges for which they are penalized in order to appropriately address and appeal those charges.[47] Here, Employee was charged two counts of neglect of duty for violating several Articles of the Medical Services Department Order Book. Accordingly, to Agency:

> This misconduct is defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII, Section 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: "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 DPM § 1603.3(f)(3)(08/27/2012); see also DPM § 1605.4(e) (06/12/2019).

Accordingly, I find that Employee was aware of the charges before him and how to address those charges because the penalty was the same, despite Agency's use of the 2012 DPM version. According to OEA Rule 634.6 "[n]otwithstanding 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 a harmless error." Thus, the undersigned finds Agency's use of both the 2012 and 2019 DPM versions to be harmless error in this matter. Employee thus had adequate notice of the charges against him and that these charges could result in his removal.

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

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). 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 Illustrative Actions ("TIA"); whether the penalty is based on a consideration of the relevant factors; and whether there is a clear error of judgment by Agency. An Agency's decision will not be reversed unless it failed to consider relevant factors, or the imposed penalty constitutes an abuse of discretion.[48]

Employee avers that the penalty was unreasonable. He asserts that there was no delay in patient care and that Employee has no past disciplinary record.[49] Employee further argues that

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[46] *See Employee v District of Columbia Fire and Emergency Medical Services Department*, OEA Matter 1601-0027-24 (July 10, 2024)(noting that Agency's use of the 2012 DPM amounted to harmless error because the charge of neglect of duty is found in both the 2012 and 2019 versions*)*.

[47] *Rachel George v. D.C. Office of the Attorney General,* OEA Matter No. 1601-0050-16, Opinion and Order (July 16, 2019); *See also Office of the District of Columbia Controller v. Frost*, 638 A.2d 657, 662 (D.C. 1994); *Johnston v. Government Printing Office*, 5 M.S.P.R. 354, 357 (1981); and *Sefton v. D.C. Fire and Emergency Svcs*., OEA Matter No. 1601-0109-13 (August 18, 2014).

[48] *Butler v. Department of Motor Vehicles,* OEA Matter No. 1601-0199-09 (February 10, 2011) citing *Employee v. Agency*, OEA Matter No. 1601-0012-82, *Opinion and Order on Petition for Review*, 30 D.C. Reg. 352 (1985).

[49] Employee's Prehearing Statement, pp. 5-6 (February 8, 2024); *See also.* Employee's Brief, pp. 10, 14 (June 14, 2024).

Medic 3 also had a delayed response and did not receive similar discipline.[50] Employee also maintains that seven of the twelve *Douglas* factors were not considered or were misapplied. Specifically factors, one, three, four, five, six, seven, eleven, twelve.[51]

Agency maintains that the evidence supports the charges levied against Employee.[52] Agency further iterates that based on the factual findings and testimony, the Trial Board found several of the *Douglas* Factors to be aggravating. Agency additionally avers that the Trial Board's decision to terminate Employee was appropriate considering that Employee acted against Agency policy and jeopardized Agency's operations and public trust.[53]

The undersigned finds that the penalty was appropriate in this matter. Agency presented substantial evidence to discipline Employee, including video footage, testimony and the Employee's own admission in his special report and during his testimony.[54] Thus, I find that the specifications listed in the Trial Board's Findings of Fact and Recommendation support the charges levied against Employee.[55] Further, the undersigned finds that the penalty was within the range allowed by law, and regulation. As previously noted, Agency applied the 2012 DPM in assessing the charge of neglect of duty. Agency also cited to the 2019 DPM sections concerning Neglect of Duty.[56] As indicated above, the use of the 2012 DPM amounts to harmless error here because the penalty range for neglect of duty in both the 2012 and 2019 versions of the DPM is reprimand to removal.[57] Thus, the penalty levied against Employee by Agency is within the range contemplated by the DPM, as required by *Stokes*.[58]

While Employee argues that the *Douglas* Factors were misapplied, the evidence does not suggest that Agency abused its discretion or failed to consider relevant evidence in assessing the Douglas factors. As noted in *Douglas*, the question is whether "managerial judgment has been properly exercised within the tolerable limits of reasonableness."[59] It must be clear that agency "conscientiously consider[ed] the relevant factors and did strike a responsible balance within tolerable limits of reasonableness."[60]

In this matter, Agency presented evidence that it considered the relevant *Douglas* Factors as outlined in *Douglas v. Veterans Administration,* including the nature and seriousness of the offense, Employee's job level and type of employment and contact with the public, Employee's dependability, the consistency of the penalty with those imposed upon others for similar offenses, the notoriety of the offense and its impact on Agency, the clarity with which Employee was on notice of any rules that were violated, and Employee's potential for rehabilitation. While Employee may not agree with the analysis and conclusions reached by Agency, this alone is not sufficient to overturn Agency's decision. The undersigned finds that Agency provided a detailed analysis of these factors,

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[50] Employee Prehearing Statement, p. 3 (February 8, 2024).
[51] *Id*. at p. 5; *See also. Supra* note 5
[52] Agency's Brief, pp. 5-6; 12-13 (May 8, 2024).
[53] Agency's Brief, *supra* note 51 at 13.
[54] Tr. pp. 187-188; *See also* Agency's Answer to Petition for Appeal, tab 3 (December 15, 2023).
[55] Agency's Answer to Petition for Appeal, tab 3 (December 15, 2023).
[56] *Id*. at tab 23.
[57] *See* 16 DPM § 1603.3(f)(3)(2012) and 1619.1(6)(c)(2012); 16 DPM § 1605.4(e)(2019) and 1607.2(e)(2019)).
[58] *Stokes v. District of Columbia*, 502 A.2d 1006 (D.C. 1985).
[59] *Douglas v. Veterans Administration,* 5 M.S.P.R. at 329.
[60] *See*. *Alphonso Bryant v. Office of Employee Appeals*, Memorandum Opinion and Order, Civil Action No.: 2009 CA 006180, citing *Stokes v. District of Columbia*, 502 A.2d 1006, 1010 (D.C. 1985) (quoting *Douglas v. Veterans Administration*, 5 M.S.P.R. at 332-33).

and found some to be aggravating.[61] Employee has not shown that the analysis was not "within the "tolerable limits of reasonableness." Accordingly, the undersigned will leave the penalty undisturbed.

Employee further asserts that Medic 3 also had a delayed response, but did not receive the same penalty.[62] Agency asserts that there were no comparator employees.[63] OEA has held that, to establish disparate treatment, an employee *must* show that he worked in the same organizational unit as the comparison employees (emphasis added). They *must* also show that both the petitioner and the comparison employees were disciplined by the same supervisor for the same offense within the same general time period (emphasis added).[64] Further, In *Jordan v. Metropolitan Police Department*, OEA's board set forth the considerations regarding a claim of disparate treatment.[65] The Board held that:

> [An Agency must] apply practical realism to each [disciplinary] situation to ensure that employees receive fair and equitable treatment where genuinely similar cases are presented. It is not sufficient for an employee to simply show that other employees engaged in misconduct and that the agency was aware of it, the employee must also show that the circumstances surrounding the misconduct are substantially similar to [their] own. Normally, in order to show disparate treatment, the employee must demonstrate that he or she worked in the same organizational unit as the comparison employees and that they were subject to [disparate] discipline by the same supervisor [for the same offense] within the same general time period.

If a showing is made, then the burden shifts to the agency to produce evidence that establishes a legitimate reason for imposing a different penalty on the employee raising the issue.[66] The undersigned finds that Employee has not provided sufficient evidence to support a finding disparate treatment in the instant matter. Sgt. Collins testified that Medic 3 never broke the threshold of the ten (10)-minute mark, which would alert that there was a significant delay in their response and initiate an investigation.[67] Accordingly, the prongs discussed above have not been satisfied in this matter.

Based on the aforementioned, the undersigned finds that Agency acted in accordance with all applicable laws, rules and regulations, that its charges were based on substantial evidence and that there was no harmful procedural error. Further, the undersigned notes that removal is within the range of penalties for the charges assessed against Employee. Accordingly, I find that termination was an appropriate penalty. Consequently, the undersigned concludes that the Agency's action should be upheld.

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[61] Agency's Answer to Petition for Appeal, tab 27, (December 15, 2023).
[62] Employee's Prehearing Statement p. 3 (February 8, 2024).
[63] Agency's Answer to Petition for Appeal, *supra* note 60 at tab 13.
[64] *Mills v. D.C. Department of Public Works*, OEA Matter No. 1601-0001-09, Opinion and Order on Petition for Review (December 12, 2011), citing *Manning v. Department of Corrections*, OEA Matter No. 1601-0049-04 (January 7, 2005); *Ira Bell v. Department of Human Services*, OEA Matter No. 1601-0020-03, Opinion and Order on Petition for Review (May 6, 2009); *Frost v. Office of D.C. Controller*, OEA Matter No. 1601-0098-86R94 (May 18, 1995); and *Hutchinson v. District of Columbia Office of Employee Appeals*, 710 A.2d 227, 236 (D.C. 1998).
[65] *Jordan v. Metropolitan Police Department*, OEA. Matter No. 1601-0285-95, *Opinion and Order on Petition for Review* (September 29, 1995).
[66] *Id*.
[67] Agency's Answer to Petition for Appeal, tab 22 (December 15, 2023). *See also.* Tr. p. 74.

ORDER

Based on the foregoing, it is **ORDERED** that Agency's action of terminating Employee from service is hereby **UPHELD**.

FOR THE OFFICE:

/s/ Natiya Curtis
NATIYA CURTIS, Esq.
Administrative Judge