THE DISTRICT OF COLUMBIA

BEFORE

THE OFFICE OF EMPLOYEE APPEALS

In the Matter of:	)	
	)	
EMPLOYEE,[1]	)	
Employee	)	OEA Matter No. 1601-0038-23
	)	
v.	)	Date of Issuance: November 17, 2025
	)	
D.C. FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT,	)	NATIYA CURTIS, Esq.
Agency	)	Administrative Judge
	)	

Michael Goldstein, Esq., Employee Representative
Donna Rucker Williams, Esq., Employee Representative
Daniel Thaler, Esq., Agency Representative

INITIAL DECISION

INTRODUCTION AND PROCEDURAL HISTORY

On April 6, 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 her from her position as a Firefighter/Emergency Medical Technician ("FF/EMT") effective March 11, 2023. OEA issued a Request for Agency's Answer to Petition for Appeal on April 6, 2023. Agency submitted its Answer to Employee's Petition for Appeal on May 4, 2023. This matter was initially assigned to Administrative Judge Hochauser and was later reassigned to the undersigned administrative judge ("AJ") on October 28, 2024.

On November 12, 2024, the undersigned issued an Order Scheduling a Status Conference in this matter for December 3, 2024. During the Status Conference, the undersigned established dates for a Prehearing Conference. However, after further review of the record, the undersigned determined that the parties had sufficiently briefed the issues in this matter. Thus, on December 9, 2024, the undersigned issued an Order canceling the Prehearing Conference and scheduled a Status Conference for January 16, 2025. On January 15, 2025, Employee emailed the undersigned and requested to continue the Status Conference citing that they were unavailable due to medical reasons. On January 21, 2025, Employee filed a Consent Motion for Continuance of the January 16, 2025, Status Conference. The undersigned granted the Consent Motion in an Order dated January 21, 2025, and

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

rescheduled the Status Conference for January 23, 2025. The Status Conference was held as scheduled and both parties appeared as required. On January 27, 2025, the undersigned issued a Post Status Conference Order, which required the parties to submit briefs to address outstanding issues.[2] Agency's brief was due by February 27, 2025, Employee's brief was due by March 27, 2025, and Agency's optional sur reply was due by April 10, 2025. The parties submitted their brief by the prescribed deadlines. Following a review of the record and the parties submissions, the undersigned determined that supplemental information was required. As a result, I issued three Orders to Supplement the Record on August 22, 2025, September 2, 2025, and October 28, 2025, respectively. The parties provided the information as required. 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.[3]

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 Trial Board's Findings of Facts and Recommendation of Termination, which was accepted by the Agency in a Final Notice of Adverse Action dated March 7, 2023, and received

[2] The parties were required to submit briefs addressing the following issues: information regarding the roles and responsibilities of an Ambulance Crewmember In Charge ("ACIC") and the Ambulance Crewmember Aide ("ACA") while assigned to an EMS unit, according to Agency's Order Book, Rules, and Protocols.
[3] OEA Rule § 699.1.

by Employee on March 10, 2023, Agency terminated Employee effective March 11, 2023, based on the following charges and specifications, which are reprinted in pertinent part below:[4]

Case No. U-22-459

Charge 1: Violation of DC Fire and Emergency Medical Services Department Bulletin No. 3, which states:

As our patient, you have the right to expect competent and compassionate service from us… You may expect:

1. To receive timely and appropriate medical services without regard to age, race, religion, gender, sexual orientation or national origin.

2. To receive a timely medical assessment and determination of an appropriate level of medical care.

8. That you can refuse drugs, treatment, procedures or transportation offered to the extent permitted by law, and to be informed of the potential consequences of the refusal of any drugs, treatment, procedures, or transportation.

11. That all of our personnel will be polite, compassionate, considerate, empathetic, respectful, and well mannered. Any employee will furnish their unit number and Fire/EMS Department ID number upon request.

Further violation of D.C. Fire and Emergency Medical Services Department Emergency Medical Services Manual and Pre-Hospital Treatment Protocols (2017), Standard Operating Guidelines, **CONSENT/REFUSAL OF CARE POLICY,** Part II, § 2, which states:

2. Patient Assessment

A. providers should attempt to obtain a history and perform a physical assessment in as much detail as is permitted by the patient.

B. Conduct Three Assessments: Providers should attempt to assess the following 3 major areas prior to permitting patient to refuse care and/or transportation:

Mental Capacity to Refuse Care

Ensure that patient is oriented to person, place, time and purpose.

[4]Agency's Answer to Employee's Petition for Appeal, tab 12 (May 4, 2023).

Establish that patient is not a danger to himself or others.

Ensure that patient is capable of understanding the risks of refusing care or transportation **and any proposed alternatives.**

Medical or situational capacity

Ensure that patient is suffering from no acute medical conditions that might impair his or her ability to make an informed decision to refuse care or transportation.

Check to be sure that patient is exhibiting no other signs or symptoms of potential mental incapacity, including drug or alcohol intoxication, unsteady gait, slurred speech, post ictal period after seizure, cognitive deficits after hypoglycemia or drug intoxication. Etc.

If possible rule out conditions such as, hypovolemia, hypoxia, head trauma, metabolic emergencies (e.g., diabetic shock); hypothermia, hyperthermia, etc.

Attempt to determine if patient lost consciousness for any period of time.

III.. **Who May Refuse Care**

1. The Patient:

A. If patient has legal, mental, medical and situational capacity to understand the risks and alternatives to treatment and transportation, the patient has a right to refuse care. ***Obtain refusal signature*****.**
B. Implied consent-if patient is unconscious lacks capacity and/or is seriously injured or in need of further medical attention, ***treat and transport patient*** *despite patient's inability to consent or the unavailability of another party to provide consent.*

IV. Managing Incompetent Patients and Patients who lack Medical or Situational capacity:

1. Take all reasonable steps to secure treatment or transportation for patient who is legally or mentally incompetent to refuse care, but do not put yourself or your crew in jeopardy.
2. ***The Metropolitan Police Department should be summoned to the scene to assist with patients that you believe may be mentally incompetent and refusing services.*** A Battalion EMS Supervisor will also be requested to the scene to facilitate the FD 12 process with the responding law enforcement officer.
3. ***If a patient lacks medical or situational capacity and no other authorized individual is available to provide a refusal signature, the patient may be treated and transported*** as long as you act in good faith and without

knowledge that the patient or authorized individual would refuse care. Patients may be transported against their objections if they lack medical or situational capacity to refuse care.

Further violation of D.C. Fire and Emergency Medical Services Department Order Book Article XXIV, § 9, which states:

7) EMS Providers, specifically the members designated as the ACIC, assigned to EMS Units should not hesitate to contact the EMS Battalion Supervisor, on-duty platoon commander or EMS Chief supervisor of any requests or issues arising during the tour of duty that requires clarification or immediate resolution. Do Not Hesitate to Seek Any Assistance Necessary-Ask for Help!!!

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: Unreasonable failure to give assistance to the public." See also DPM § 1603.3(f)(9)(August 27, 2012);

Specification 1:

Lieutenant Andrew Arnold describes your misconduct in his Special Report (dated 5/152022) as follows:

It is confirmed that Firefighter [Employee] was one of the crew members on Ambulance 30 for Incident Number F220033690 at 400 Galloway Street NE. The notes from OUC at the time of dispatch (11:14) indicate that patient is "21 'Y/O MALE ILL AFTER DRINKING ALCOHOL." "CALLER ADV MALE HAS BEEN VOMITING". Ambulance 30 arrived on scene at 11:21 hours. OUC notes indicate "A30 ADVISED NO EMS REQ" at 11:35 hours. In searching Safety Pad, there was no ePCR documentation completed for this run.

Furthermore, the caller advises that patient was ill and vomiting, which would have required a full patient assessment along with following the proper procedures for obtaining a signed release. The journal for Ambulance 30 did not have entries showing there was a failure with the ePCR software or hardware, and showed no documentation in the journal of having to have the tablet repaired.

Charge 2: Violation of D.C. Fire and Emergency Medical Services Manual and Pre-Hospital Treatment Protocols (2017), **Standard Operating Guidelines, CONSENT/REFUSAL OF CARE POLICY,** Part V, § 2, which states:

V. Refusal Procedures:

2. ***If patient refuses care,*** or insists on being transported to a facility that is on closure or a facility other than the destination recommended by EMS personnel, ***have the patient or designee complete the refusal of treatment or transport section of the patient care report (PCR).***

A. Conduct a thorough patient assessment to include vital signs and blood" level.

B. ***Inform the patient*** that units responded to the same for the purpose of providing emergency medical care and with the expectation of terminal outcome that the patient would accept transport to the hospital for further evaluation and treatment.

C. Review form with patient or designee. If required the body of the text shall be read aloud to the patient.

D. ***Provide a detailed explanation of possible risks and dangers signs to patient*** *or other designee.*

E. ***Inform the patient to call 911, call their doctor or go to an emergency department*** if symptoms persist or get worse or any of the dangers signs you inform them of appear.

F. ***Obtain the signature of the patient*** *or designee* ***. If the patient refuses to sign, document this fact on the patient care report (PCR).***

G***.*** ***Have the patient*** *or designee* ***date the patient care report (PCR).***

H. ***Obtain signature of a witness*****; preferably the witness should be someone who witnessed your explanation of risks and benefits to the patient, and who watched the patient sign the form. Witnesses may include law enforcement personnel. All witnesses should be 18 years or older if possible.**

I. ***Contact the EMS Liaison Officer or Battalion EMS Supervisor*** *to provide an update via radio consultation confirming that all evaluation and inclusion criteria have been met.* If a Battalion EMS supervisor is on the same, providers may dispense with the radio consult.

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)(August 27, 2012).

> This Misconduct is further defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII, §2(f)(9), which states: "Any on-duty or employment-related act or omission that interferes with the efficiency or integrity of government operations, to include: Unreasonable failure to give assistance to the public." *See also* DPM § 1603.3(f)(9) (August 27, 2012).

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SUMMARY OF THE TESTIMONY[5]

On November 17, 2022, and December 7, 2022, 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.[6]

Agency's Case-in-Chief

November 17, 2022

D.D. – Tr. pp. 24-57

[5] *Id*. at tab 22.
[6] The Trial Board Hearing occurred on two dates, November 17, 2022, and December 7, 2022.

D.D. was the patient's girlfriend at the time of the incident in question, and the individual who made the 911 call. D.D. testified that the patient, D.O. was visiting her from March 3, 2022 to March 5, 2022. Tr. 26. She testified that on the morning of March 4th, she heard a thud in the bathroom and found the patient on the floor. Tr. 26. D.D. identified the audio recording of the first call she made to 911 on March 4, 2022, and noted that she called "[f]irst thing in the morning… After he was on the ground of the bathroom." Tr. 27-28. D.D. affirmed that in the call she stated that the patient could not get up, was moving weird, was moaning and not saying full words. She thought at first that the patient was hung over and needed to "throw up a little bit." She testified that she got the patient to bed, and he was able to walk a little bit with her. D.D. then noted that by the time she called 911 the patient's words were becoming worse, which is why she noted in the call to please hurry up because she knew something was wrong." Tr. 28.

D.D. testified that two EMT's arrived, a man and a woman, and she said to them "Well, just please take him. He's not good." She testified that the patient was moaning and saying, "I'm good.", but not saying full, coherent words. Tr. 29. She further testified that the patient could not stand up and would not be able to follow a command to "lift an arm" if so directed. D.D. testified that the male EMT stated to her regarding the patient, "He probably just had a few too many drinks." Tr. 30. D.D. noted that the patient "obviously was enjoying himself the night before, but not to an excess of anything he's ever done, and definitely not to where he [wouldn't] be able to get up the next day." She stated that the EMTs told her that the patient "...has to want to go" and told her that if the patient "…continues like this, just call us again." D.D. indicated that the EMT's did not go in the room and yelled at the patient from outside the room. She questioned how the EMT's would even know the patient was ok based on that interaction. Tr. 30.

D.D. testified that she spent the rest of the day with the patient, and he did not improve. Tr. 31. D.D. affirmed that she was not asked to sign anything by the two EMT's that were present on March 4, 2022. Tr. 32. D.D. affirmed that the second audio played was her second call to 911 on the morning of March 5, 2022. She noted that by this time the patient's state had worsened. Tr. 33. D.D. described the patient's symptoms, which she noted as arm movements, "weird" body movements, and incontinence. Tr. 34. D.D. testified that when the second set of EMT's arrived on March 5, 2022, they asked him to stand up, lift an alarm, but he could not do that. She noted that the most the EMTs could get him to do was sit up on the side of the bed, and that was a struggle. Tr. 35. D.D. indicated that the patient was transported to the hospital at that time and later confirmed to have had a massive stroke. Tr. 35.

D.D. described the patient's physical state after the stroke and testified that he cannot read, write, walks with a cane, cannot see out of his right eye, and spends the majority of the day in bed. She noted that before the stroke he was on a track scholarship. Tr. 38-39.

On cross-examination, D.D. iterated that that the night before the incident in question, she and the patient had gone out with friends to eat and get drinks. Tr. 43. She affirmed that the patient "smoked weed, he took edibles, he drank tequila, and he did probably half of a baby line of coke." Tr. 44. D.D. affirmed that the patient's state became concerning on the morning of March 4, 2022, and that he had been in this state for approximately two (2) hours when she called 911. Tr. 44-45. D.D. testified that she thought he might be hungover because the night before, the patient vomited. Tr. 45. She affirmed that when the EMTs arrived, she told them that the patient had consumed edibles and alcohol but testified that she could not remember if she also told them the patient had consumed cocaine. She testified that she did not remember if she went into the bedroom while the EMTs were there but

probably did. Tr. 47. D.D. stated that the EMTs told her to "just keep an eye on him. Call back if it doesn't get better." She said their response was casual and they did not provide a specific time frame or specific information of what to look for. She affirmed that it did not take long to realize that the patient was not improving. Tr. 48. When asked if she testified that the patient was getting worse throughout the course of the day, she answered that his condition was not progressive, "like you could chart it out as an exponential down chart…. He was, like, relatively the same after the EMTs left. They told me he was good …. They told me he wasn't having anything critical happening." Tr. 48-49.

D.D. testified that she called 911 again because when she and the patient went to sleep, he wet the bed, and she found that to be a huge red flag that something was obviously wrong. She also noticed his arm movement, which is why she called 911 so aggressively the second time. Tr. 49-50. She affirmed that to her the arm spasms and incontinence were indicative that his condition had worsened. Tr. 50. D.D. affirmed that when the second set of EMTs arrived the patient was able to sit up, but not on his own. She noted that the second set of EMTs were "really trying to figure out what was going on. Like, they came in and they, you know, tried to move him around. And they were able to sit him up, but it wasn't like he was stable by any means." Tr. 50. D.D. indicated that the EMTs picked him up and put him on a stretcher. Tr. 51. D.D. stated she did not know if either half of his face looked like it was sagging during the day of March 4, 2022. Tr. 52.

When asked by the Panel whether the first EMTs did anything more than stand there and talk to her, D.D. testified that the first EMTs did not perform "any type of wellness check with" the patient. She stated that they shouted in the room and asked if the patient was okay and stated that the patient was probably just getting over the night. Tr. 53. D.D. affirmed that on March 4, 2022, the patient could not walk to the bathroom or use the bathroom on his own, and was in bed the entire day, even after the ambulance came. Tr. 53-54. D.D. testified that the first EMTs said to the patient, "You good?" and the patient replied "Mm-hmm. Mm-hmm" but did not make a coherent statement. She said the second EMTs asked questions like "What is your name?" What day is it? And the patient could not answer those questions. Tr. 54-55. D.D. affirmed that she told the first EMT crew that the patient had fallen. Tr. 56.

Lieutenant Andrew Arnold ("Lt. Arnold") Tr. pp 57-82

Lt. Arnold testified that he has been employed by FEMS for over twenty years, and his current position is Lieutenant Paramedic, and he had that position in March 2022. Tr. p. 58. Lt. Arnold testified that in his position, he conducts investigations to see if any policies, procedures or protocols have been broken. He noted that the underlying process for doing such depends on the situation, but generally he would be requested to do an investigation based on a complaint that either comes from above or a complaint that comes from a citizen or firefighter. Tr. 59-60. He affirmed that he is slightly familiar with Employee because he was the EMS supervisor on her platoon of the Battalion management team when she was at Engine 30. Tr. 60. Lt. Arnold testified that he did not know about the event until he was required to do an investigation. Tr. 61. He testified that his investigation revealed that there was no ePCR for this dispatch. Tr. 62. Lt. Arnold testified that it appeared that the ePCR software was working and that that run before and after the incident in question seem to be inputted with no problem. Tr. 63. Lt. Arnold testified that an ePCR has to be done on every dispatch regardless of the outcome of the dispatch, even for someone who may refuse transport. Tr. 63-64. Lt. Arnold testified that his endorsement concerned firefighter [Employee]. He affirmed that she was required to complete an ePCR for the dispatch in question. Tr. 64.

Lt. Arnold noted that the protocol for a patient that had been ill after drinking alcohol and vomiting is to "determine who the patient is, what the complaints are, and then you would start your assessment or your primary assessment." Tr. 64-65. Lt. Arnold noted that assessment consists of "an initial impression, whether they're sick or not sick, and we use those terms as "sick" being critical or "not sick" having complaints but not being…critical." Tr. 65-66. He noted that the firefighter employee would get a general impression, interview the patient, bystanders, obtain a set of vital signs, conduct a head-to-toe assessment, and assess mental acuity. He further noted that the employee would check skin color, temperature, and condition, determine the rate of breathing, rhythm and quality, look for injuries, do a sample history where you get the patient's allergies, medications, histories, what happened to lead up to this incident, determine the chief complaint, and other subsequent complaints. Tr. 66. Lt. Arnold affirmed that this process is required even if the patient is intoxicated. He further noted that for any intoxicated patient a determination of whether they are alert and oriented and able to make decisions for themselves is required. He indicated that this involves assessing a patient's mental acuity, and mental status to see if they are in fact intoxicated and not able to make decisions for themselves. Lt. Arnold testified that he did not see any indication from what he reviewed of whether Employee conducted a full patient assessment. He further noted that there is also "a patient refusal procedure that in cases like these, if somebody has a complaint-- for example, if they were ill after drinking alcohol or taking-- you know, I think she--- maybe in her initial report she cited that it was an infused candy or something like that. You would… do your assessment and determine whether they can make their decisions for themselves, and then you would do a refusal protocol. And then there is a whole procedure behind that refusal protocol." Tr. 67-68.

Lt. Arnold testified that there was no indication that Employee followed the refusal protocol. He explained that the process of getting a refusal is twofold. He testified that the refusal has to be documented on the ePCR and that the employee would also document that the patient was provided the information for them to fully understand their risk of refusing. He noted that an employee would get the patient's signature and a witness's signature. Tr. 68. He stated that if the patient refused to sign you would also get a witness's signature. Lt. Arnold noted that… "Most of the time if MPD is on the scene, they would be our witness signature…." Tr. 68-69. Lt. Arnold testified that after getting the signatures, "you then call the ELO, EMS liaison at office of communications, and you verbalize all of which took place to the ELO so that they… can acknowledge that all of the proper procedures were performed." Tr. 69. Lt. Arnold explained that "if there is a vital sign that is out of whack or if there is something that they don't feel comfortable, they may say, "I need more information" or "Make sure you tell the patient this." Or most often they would send a supervisor to actually put eyes on the situation. So there was no indication that that was done" Tr. 69.

On cross-examination, Lt. Arnold affirmed that he never spoke with Employee while investigating and also affirmed that an ePCR is required to be done for every medical run and noted that there were at least thirteen (13) missing ePCRS for runs from 10:40am to 11:26 am on March 4, 2022. He also clarified that he was not familiar with the program that tracks this information Tr. 71-72. Lt. Arnold affirmed that he did not review documents related to the second call to this address in making his determination and noted that he did not know there was a second run. He indicated that he was provided a "pretty generic order for me to investigate the run and make sure the policies and procedures were followed." Tr. 74. He affirmed that he was not aware that the second set of EMTs who responded and downgraded the patient to "AMR." He affirmed that policy dictates that when a patient is suspected to be having a stroke the EMTs should not wait for AMR. Tr. 74-75.

On redirect examination, Lt. Arnold affirmed that he reviewed submissions from Employee such as a special report. Tr. 76. He affirmed that the missing ePCRs to which he testified on direct could have been non-medical runs, which did not require an ePCR, but clarified that he did not have knowledge of the events underlying those other runs. Tr. 77.

Lt. Arnold affirmed to the Panel that the there was an ePCR immediately before and immediately after the dispatch in question, completed by either Employee or her partner. Tr. 78-79. Lt. Arnold affirmed that there was no failure in the ePCR on the SafetyPad that he could see. Tr. 79. When asked by the Panel what the typical time frame is to perform a trauma assessment and a medical assessment, Lt. Arnold testified that a full assessment should be done within three (3) to five (5) minutes upon arrival to start assessing the situation for both medical and trauma. Tr. 81.

Ryan Gerecht, MD ("Dr. Gerecht") 83-154

Dr. Gerecht provided testimony as an expert witness. He testified that he is employed with the District of Columbia Fire and EMS Department as the Assistant Medical Director within the Office of the Medical Director. He further stated that he is employed as an attending emergency physician and an assistant professor of emergency medicine at Medstar Washington Hospital Center and Georgetown University School of Medicine. Dr. Gerecht noted that he has been employed with the DC Fire and EMS since January 6, 2020, and has held that position the entire time. He testified that he has been employed by Washington Hospital Center since March 1, 2020. Tr. 83-84. Dr. Gerecht affirmed that he was working on March 5, 2022, and noted that he was an attending physician at Washington Hospital Center on that day. He stated he was approached by the attending physician on the other side of the emergency department who stated that "he was taking care of a young male who had a devastating stroke." Dr. Gerecht further noted that the attending physician "… was concerned because the patient's significant other had told him that the EMTs had… evaluated the patient the day before and the patient had not been transported. And so the patient was transported the next day, March 5, 2022." Dr. Gerecht indicated that the attending physician was concerned about the delay in care that the patient potentially received and reported it to Dr. Gerecht because of his role and rank within DC Fire and EMS. Tr. 87-88.

Dr. Gerecht testified that he took down the patient's information and then "verified with my own eyes the current state that the patient was in." He affirmed that the treating physician at that time was Dr. Amit Shah. Tr. 89. Dr. Gerecht stated that based on the patient's "History of Present illness" section in his medical records, the patient was a 21-year-old brought to the hospital by ambulance on March 5, 2022, for altered mental status, and right-sided weakness. Tr. 93-94. Dr. Gerecht explained that the patient was non-verbal thus the physician obtained the patient's history from the EMS. Tr. 94. Dr. Gerecht noted that the physician's note in his medical records indicated that the patient had "right-sided neglect and right-sided weakness in the upper and lower extremities." He explained that 'neglect' is when a patient is not aware of the right side of their body; thus, they focus on the left side of their body. He noted that the right side of the body is essentially absent due to a brain injury. Tr. 94. Dr. Gerecht testified that the patient was noted to have engaged in alcohol and edible marijuana consumption, had right-sided neglect and weakness ongoing for two (2) days, and while able to say some words they were mostly non-coherent words and sounds. Tr. 94-95. He further noted that based on the medical records, the patient was not oriented to person, place, or time upon arrival to the hospital. Tr. 95.

Dr. Gerecht explained that "[g]iven that the symptoms have been ongoing for over 2 days, a code 1 stroke was not called… because to qualify for a code 1 activation at Washington Hospital Center you have to present with symptoms within 24 hours. And so based off the history of present illness that was provided…, the attending physician noted that the patient was disqualified from receiving a code 1 activation at that time." Tr. 96.

Dr. Gerecht testified that upon being admitted to the neurologic ICU, the patient's condition declined as he was no longer able to follow commands. Dr. Gerecht noted that additional CT scans showed increased brain swelling, edema, and intracranial pressure which resulted in worsening neurologic decline. Tr. 100-101. Dr. Gerecht indicated that on March 6, 2022, the patient underwent a decompressive hemicraniectomy, which involved the surgeon removing a portion of the skull surrounding the brain to allow the pressure to be relieved and to allow the brain to swell outside of the skull". Dr. Gerecht explained that if this procedure was not performed, the pressure would continue to increase in the patient would herniate meaning "his brain would be smashed down into his spinal cord, and that would be fatal." Tr. 101.

Dr. Gerecht noted that a hemicraniectomy is not the first option for a stroke patient. Tr. 102. He testified that the patient had an ischemic stroke and the first line of treatment is medication that has to be given within four and a half hours (4.5 hours) of onset of symptoms. Tr. 103. He noted that the first line of treatment, in addition to medication, may be a small catheter into the brain to suck out the clot. Tr. 104. He noted that this procedure had to be done within twenty-four hours of onset. Tr. 105. Dr. Gerecht confirmed that the patient's medical records noted that the patient was not a candidate for the first-line treatments for stroke given the timing of the onset of symptoms. Tr. 106.

Dr. Gerecht opined that considering the totality of the medical records reviewed, that the patient experienced a "devastating catastrophic left middle cerebral artery stroke. It involved a large part of his brain,.. and there was delay to treatment. He was not afforded the standard of care treatment due to the to the delay in presentation, which resulted in worsening brain function and disability as a result." Tr. 110. Dr. Gerecht explained that the stroke the patient experienced is always severe, so there is always the risk for death or disability. He noted that however when treated early with first line treatment, and "they're afforded the care of a comprehensive stroke center like Washington Hospital Center… The patient can have marked improvement in their symptoms. They can walk again…they can resume function." Tr. 111.

Dr. Gerecht testified that from his understanding of the events, "the earlier opportunity to recognize and afford [the patient] earlier recognition of the stroke and potentially avail him of the treatments we have discussed would have been his encounter with DC Fire and EMS on March 4." Tr. 112. Dr. Gerecht noted that when he learned of this event he spoke with Dr. Shah and obtained the number for D.D. and called her regarding the March 4th dispatch. Dr. Gerecht surmised that based on the conversation with D.D. as well as reviewing the CT imaging, that there was an opportunity for earlier recognition of the patient's stroke symptoms. Tr. 113. He explained that an EMS encountering a patient who is having trouble moving, is not speaking in complete sentences is to give the patient a full history and physical exam. Tr. 113-114.

Dr. Gerecht further explained that if a patient did not want to go to the hospital there are protocols and policies surrounding how to handle this. Tr. 116. Dr. Gerecht testified that Agency's refusal protocol "includes things like evaluating the mental capacity to make a decision. So, in other words, patients may say, 'I don't want to go to the hospital,' that is the EMTs duty to assess whether

or not the patient has the ability, the cognitive awareness to understand the risks of that decision, to understand alternative treatments and make what we call an informed decision." Dr. Gerecht further explained that the protocol also outlines what to do if a patient does not have capacity, which includes calling an EMS supervisor, and an EMS liaison at the Office of Unified Communications for approval of all refusals. Tr. 117.

When asked what one would look for in a patient's speech to make the conclusion that they have the cognitive ability to refuse care, Dr. Gerecht responded that it depends on the on the patient's ability to engage in meaningful conversation. Tr. 118. He explained that he would need to hear the patient say back to the EMT that they understand the risk of not going to the hospital, such as "if you don't go to the hospital, you could get worse… You could even get to the point where you die" and would expect to hear the patient say that they accept those risks. Tr. 118-119. He noted that it is more than a patient being alert and awake. He explained that someone having a very big stroke like what the patient experienced is like a dementia patient-they might be awake and looking at you but they may not be able to understand certain things about their care." Tr. 119. He further noted that patients who have been consuming alcohol or illicit drugs may have the same presentation "and are at high-risk for not having the capacity to understand what they are doing and the risks and the consequences of… That decision." Tr. 120.

On cross-examination Dr. Gerecht affirmed that the patient's condition worsened over time. Dr. Gerecht testified that a Glascow coma scale is used to test eye opening, and verbal and motor responses and noted that is the entirety of what the Glascow coma score tests. Tr. 125. Dr. Gerecht affirmed that the patient received the highest Glascow coma score at 9:43a.m. on March 5, 2022. Tr. 127. When asked if the Glascow coma score meant that the patient was responding to questions, Dr. Gerecht testified it depends on the questions he was being asked. He noted that the questions vary by provider. Tr. 127-128. Dr. Gerecht affirmed that the patient's medical records note that the patient's condition deteriorated on March 5th as the day progressed based on test results. He testified that it is important to note that the tests are taken by different nurses in different parts of the hospital with varying levels of specific training in neurologic ICU conditions. Tr. 129. Dr. Gerecht further affirmed that the patient was deteriorating over March 5th, and March 6th based on a midline shift in his brain from 2 millimeters to 7millimeters. Tr. 132.

Dr. Gerecht testified that he was not present on the scene on March 4, 2022, and thus did not personally assess the patient. Tr. 134. Dr. Gerecht affirmed that he was aware that Ambulance 14, which responded to a dispatch regarding the patient on March 5, 2022, downgraded the patient to AMR and affirmed that this crew did not document any stroke symptoms. Tr. 135. Dr. Gerecht testified that coaching and feedback was provided to that ambulance crew. Tr. 136.

On redirect, Dr. Gerecht affirmed that the patient saying, "I'm good. I'm good" is not sufficient to conclude that the patient had a cognitive ability to refuse care. He testified that "being able to speak or be awake enough to speak, to have a GCS of 15 simply means that the patient can open their eyes, say words that are comprehensible, and follow commands to get a GCS of 15… It doesn't assess for the patient's ability to understand the risk of their decision, to understand alternative and care, that there is a risk to saying, 'I don't want to go to the hospital.' And they have to be able to articulate that, and that is not assessed in the GCS." Tr. 139. Dr. Gerecht further testified that once an EMT determines that a refusal is made he has to call the EMS liaison officer at OUC and have that refusal approved. Tr. 141. He noted that this protocol is for the safety of the patient and for the protection of the EMT, so they have a record that they followed protocol. Tr. 142. Dr. Gerecht indicated that 'no EMS required'

means that Ambulance 30 felt that they did not have a patient, "that they didn't have someone that they were assessing or caring for. So if they didn't think [the patient] needed care and treatment, they wouldn't have called the ELO for refusal." He further testified that "No EMS Required" means that the EMTs arrived on the scene and determined there was no one to treat, thus no decision to be made about medical care. Tr. 144. Dr. Gerecht affirmed that based on what he knows about the circumstances of March 4, 2022, there was a patient to be cared for. Tr. 145.

Dr. Gerecht affirmed that the EMTs that arrived on March 5, 2022, noted in their ePCR that their primary impression was a stroke. Tr. 145. Dr. Gerecht further testified that on the morning of March 5, the patient's CT scan noted that he had "so much brain edema and he already clearly had elevated intracranial pressure causing that 2 millimeters of shift." He testified that the symptoms do not happen immediately, they develop over hours and days. He noted that on March 5th the patient was already so progressed, which was consistent with D.D.'s reports about when the patient's symptoms started. Tr. 146-147. Dr. Gerecht affirmed that he believed with a reasonable degree of medical certainty that the patient's stroke started on March 4th. Tr. 148.

When questioned by the Panel whether what occurred on March 4th could be a training issue, Dr. Gerecht answered in the negative. He elaborated that on March 4th, the team did not recognize a stroke because they did not follow basic policies and procedures such as performing an assessment, taking vital signs and documenting those findings. He noted that D.D. indicated that Employee and her partner did not ask the patient to raise his arms, which is standard for a stroke assessment, did not contact the ELO regarding the refusal, and did not document the encounter correctly, all of which are standard operating procedures. Tr. 153-154. When asked if he was aware of how often EMTs are given training on strokes, he noted that stroke is part of the reoccurring neurological emergency continuing education the EMTs complete.

Trial Board Hearing Day 2, December 7, 2022

Employee's Case-in-Chief

Employee - Tr. pp. 52-78

Employee testified that she is a firefighter EMT in the District of Columbia, Fire and EMS Department, and has been with the Department for eight (8) years. She testified that her most recent assignment was Engine 30, Platoon 2 (two). Tr. 15. Employee indicated that she worked on ambulance 30 as the Ambulance Crew Aide ("ACA") on March 4, 2022, and her partner was the Ambulance Crewmember in Charge ("ACIC"). Employee testified that she and her partner ride together the majority of time during ambulance duty. Tr. 17. When asked what the normal separations of duties were, Employee testified that her partner handled the majority of duties. Employee affirmed that she and her partner responded to a dispatch at [address of dispatch location] for a report of a twenty-one-year-old male overdose. She testified that an MPD unit also responded. Employee stated that when they arrived at the dispatch location, D.D. let them in and told them what was going on with the patient. Tr. 17-18. Employee testified that D.D. told them that the patient had been drinking the night before and also consumed four(4) marijuana edibles. She stated that her partner went all the way into the bedroom and she stayed at the doorway to observe the patient and spoke with D.D. Employee stated that D.D. was trying to make sure the patient was okay because he had been "moving funny" in his sleep.

When asked if D.D. mentioned anything about cocaine, Employee stated that she did not. Employee also cited that D.D. did not mention that the patient had fallen. Tr. 18-19. Employee affirmed that she was able to see what was happening in the bedroom and testified that her partner stood in front of the patient. She indicated that the patient was initially lying down but then sat up to the left side of the bed was able to put his feet on the floor. Employee stated that her partner was giving the patient an assessment but was not sure what questions he was asking. She stated that she overheard the patient saying, "no I'm okay. I'm good." in a loud and clear voice. Tr. 19. Employee affirmed that the patient was not slurring his words and he was not exhibiting facial drooping or sagging. Employee testified that the conclusion of her partner's assessment was that the patient did not want to go to the hospital. Employee testified that they explained to D.D. that the patient did not want to be transported to the hospital and he was able to make his own medical decision. Employee noted that they told D.D. if anything changed, "like his mental status, or him not being able to get up or anything, don't hesitate to call back." Tr. 20.

Employee also maintained that patients are allowed to refuse medical care. She noted that to refuse care, the patient has to be "fully alert and oriented, competent to understand and be aware of what's going on." Employee noted that the patient was fully alert and oriented "[b]ecause he kept saying, I'm good. He don't want no medical treatment." Employee testified that when they left the apartment and were back in their unit, they notified communications that there was no EMS required, "and my partner completed the ePCR." Tr. 21. Employee affirmed that they did not call the ELO or supervisor or obtain signatures. When asked if they should have gotten signatures, Employee responded, "Yes. We could have." When asked if she would have done anything differently on a call like this in the future, Employee testified that she would call the supervisor "to basically drill into the patient that it is necessary to be fully and further assessed under medical care to be fully evaluated and treated even though you don't want to." Tr. 22-23.

On cross-examination, Employee affirmed that she did not follow the refusal of care procedures and stated that at the moment they did not feel that a refusal was necessary. Tr. 27. Employee told D.D. that they would not be taking the patient to the hospital because he did not want to go and was adamant about not going. Employee affirmed that this situation was a refusal. Employee asserted that she and her partner ensured that the patient had the capacity to make the decision not to go to the hospital. Tr. 28. Employee testified that in that moment, the patient was not acting like he was under the influence or incapable and was fully aware of what was going on. Employee testified that D.D. noted that the patient had been drinking and taking edibles the night before and was not under the influence of alcohol or edibles in that moment. Tr. 29. When asked why she believed that they were called to the scene if the patient was completely normal, Employee stated that, "Even though we came out for an overdose, she stated that she actually called because he was moving funny in his sleep." When asked if she agreed that involuntary movements can be a sign of a stroke, Employee testified they can be, "but people jerk in their sleep all the time." Tr. 30. Employee testified that technically they did not get a refusal because the patient was adamant about "not having anything done to him. So he had the right to do so, so we felt as though it was no EMS required." Tr. 30-31.

Employee testified that she witnessed her partner complete an ePCR for the dispatch in question. Tr. 31. She stated that there was a problem with the system. Employee affirmed that she was disciplined previously for a similar incident. Employee testified that in the prior case the ePCR was improperly completed. In that case, the patient refused to go to the hospital and suffered a heart attack. Tr. 33-34. Employee further testified that they cannot force someone to go to the hospital. Tr. 35. Employee affirmed that the refusal of care procedure is important. Tr. 35-36.

Employee listened to audio recording of D.D.'s 911 call. When asked if she agreed that D.D. said that the patient could not get up, Employee stated that is not what she and her partner were told. Tr. 38. Employee affirmed that in the 911 call D.D. stated that the patient "is moving weird" and was speaking in moans instead of words and vomited.[7] Employee affirmed that these are all signs of a stroke and stated at the time they were with the patient, he was not exhibiting any of those signs. Tr. 42. Employee testified that when her partner was assessing the patient, he was not moaning and was loud and clear. Employee affirmed that they did not get any signatures on the scene, which is required for a refusal. Tr. 43. Employee stated that the patient could have signed considering his condition, and D.D. or the MPD officers present could have signed if the patient was incapable. Tr. 44. Employee testified that the MPD officers were outside the bedroom and testified that they could have overheard the conversation but were not in the bedroom to actually see anything. Tr. 45.

Regarding the dispatch, Employee testified that she remembered that both the patient and D.D. had been drinking the night before and the patient consumed four (4) edibles. She testified that D.D. wanted to see if the patient was okay so they could go out later. Tr. 46. She testified that it was not a "dramatic scene to really know much. It was a small unit… The patient was able to sit up on his own. He was speaking loud and clear and she didn't tell us much, so we went off what we was told and what the patient was able to do." Tr. 47. Employee testified that her partner explained to D.D. the risks of the patient not going to the hospital. She stated she was not sure if anyone explained those risks to the patient because she stepped out of the room to speak to D.D. Tr. 49-50. Employee affirmed that she has knowledge of the procedures and policies, including the ePCR requirements, refusal of care procedures, and patient assessment procedures. Tr. 55-56.

Employee acknowledged that she did not follow the procedures and policies on March 4, 2022. Tr. 56. When asked if she failed to recognize that the patient was having a stroke, she testified that she did not fail to recognize that. She stated that at the moment, her partner did not see that the patient was having a stroke. Tr. 56. She testified she would not say it was her partner's fault, but he was actually standing in front of the patient and asking him questions, but the patient did not want anything to do with them. Tr. 57. Employee testified that it is not hard to notice a stroke and the patient did not have any signs or symptoms of a stroke. Tr. 57. She testified that when she overheard the patient speaking, he was loud and clear, and she could see that he was able to sit up. Tr. 58.

On redirect examination, Employee affirmed that she was not on the dispatch call made by D.D. and she was not played that call. She also affirmed that what was mentioned on the dispatch call was different from what she was told when they arrived at the apartment. Tr. 65. Employee cited that a stroke assessment is not performed with every patient and is only done if there is suspicion of a stroke. Employee affirmed that there was nothing in this case that made her suspect that the patient was having a stroke. Tr. 66.

When asked by the panel whether an ePCR was done prior to this dispatch and after this dispatch, Employee responded affirmatively. Employee testified that the ePCR completed for the dispatch in question cannot be found in the system. Tr. 72. Employee affirmed that at no time did she or her partner take the patient's vitals and indicated that the patient refused. Tr. 73-74. Employee testified that they decided no EMS was required because the patient "didn't want anything to do with EMS." She testified that at the moment she felt there was no need to call a supervisor or the ELO to get assistance. Tr. 74. When asked why her partner "did the heavy lifting on this call" Employee

[7] Employee's representative objected because Employee did not hear the 911 call before being dispatched.

responded that her partner was the lead provider and she assisted him. Tr. 75. When asked if the patient was exhibiting any of the signs or symptoms that he had ingested edibles, Employee replied in the negative. Employee also indicated that D.D. was alert and reasonably comfortable. Tr. 76.

Khalid Bullock ("Bullock") Tr. 79-111

Bullock identified himself as a firefighter EMT assigned to Engine 30, Platoon two (2) for ten (10) years. Tr. 81. He affirmed that this was his assignment on March 4, 2022. He testified that the dispatch was for intoxication. Tr. 82. He testified that upon arrival, D.D. explained that she wanted the patient evaluated because he had consumed alcohol and edibles. Bullock testified that he went into the room to assess the patient while Employee continued to talk to D.D. Tr. 83. Bullock indicated that D.D. did not mention a fall or the patient's cocaine use. Tr. 83. Bullock testified that when he went into the bedroom, the patient was lying down, and he asked the patient several questions to see if he was oriented and alert. Tr. 84. Bullock testified that his assessment was that the patient was alert and under the influence. He indicated that he did not take the patient's vitals because the patient refused and continued to state that "he was good." Tr. 85. Bullock further testified that a patient must meet the legal, mental, physical, situational and medical capacity to refuse care. Tr. 85-86. Bullock stated that the patient was alert and responsive to Bullock's questions, spoke clearly, and did not have issues with his face. Tr. 86.

Bullock testified that he told the MPD Officer and D.D. that the patient was refusing to be evaluated, and if anything changed with his mental or medical status that D.D. should call 911 again. Tr. 87. When asked if Bullock got any signatures or called a supervisor, he answered in the negative. He testified that he submitted the ePCR and documented that no EMS services were required. Bullock identified Ambulance 30's journal, dated March 4, 2022. Tr. 88 He identified an entry in the journal dated March 4, 2022, which noted that the dispatch in question was "no transport" and "no ems." Tr. 89.

On cross-examination, Bullock affirmed that he and Employee had gone on many dispatches together. Tr. 90. When asked if he and Employee would discuss the call to which they are dispatched, he stated that it depended on the call. He testified that during the drive to the dispatch in question, he asked Employee what the dispatch was for and noted that Employee stated the call was for an intoxicated male. Tr. 91. Bullock testified that when he arrived at the residence and entered the bedroom where the patient was, he greeted the patient. He stated that the patient sat up in bed and said, "I'm good." Tr. 92. Bullock noted that he asked the patient specific questions, including what is your name, where he was at the moment, and did he recognize Bullock. Tr. 93. Bullock further testified that the patient noted that he was at home and recognized Bullock as a paramedic. Tr. 93. When Bullock was asked if he was aware the patient resided in Louisiana and was in Washington, DC on vacation, Bullock responded that the patient did not communicate that to him. Tr. 95. Bullock noted that he did not ask the patient for his address, only where he was at that moment and he was not aware that the patient did not reside in the apartment. Tr 95.

Bullock testified that he asked the patient if he could continue to examine him, but the patient continued to say that he was good. Bullock stated that he then explained to the patient that he would not continue to bother him and also explained to the MPD officer and D.D. that the patient was refusing an assessment, and they could not force him to go to the hospital. Bullock testified that after the patient demonstrated that he was alert and oriented and did not want EMS care, Bullock determined that the

patient was refusing care. Tr. 96. When asked whether he followed the steps for a refusal of care, Bullock replied that he determined that no EMS was required.

Bullock testified that while he was examining the patient, Employee was in and out of the room and also talking to D.D. Tr. 97. Bullock testified that D.D. wanted the patient examined because she had to get ready for work. Bullock stated that D.D. told him that the patient had been drinking and consuming edibles. Tr. 98. When Bullock was questioned whether he asked questions specifically about the patient's symptoms, such as whether he had fallen or vomited, Bullock answered that the patient was alert and oriented and had no slurred speech. Tr. 99-100. Bullock testified that the dispatch was for intoxication and D.D. informed them that the patient had consumed alcohol and edibles, but the patient was not intoxicated when they arrived. Bullock testified that based on the assessment of the patient that he was able to perform, the patient seemed alert and oriented and did not seem hung over. Tr. 101. Bullock testified that he documented the dispatch by submitting an ePCR and as well as documenting the dispatch in the journal. Tr. 104. Bullock affirmed that he did not know why the ePCR showed as unsubmitted and affirmed that the ePCRs for the dispatches before and after the dispatch in question were on record as submitted. Tr. 107.

Bullock testified that he did not bring the ePCR "tough book" into the apartment. He stated that he would write down the patient's information and transfer it later because some of the ePCRs have charging problems. Tr. 109-110

Jason Freiwirth ("Ofc. Freiwirth (112-132)

Ofc. Freiwirth testified that he has been a Metropolitan Police Department ("MPD") Officer for eight (8) years. Tr. 112-113. Ofc. Freiwirth testified that he was on patrol on March 4, 2022, and responded to the dispatch in question with another officer. Tr. 113-114. Ofc. Freiwirth stated that when he entered the residence, they observed a gentleman in his bed under the influence and D.D. in the kitchen/living area. Ofc. Freiwirth testified that he believed D.D. called for dispatch because the patient was under the influence. Tr. 114. He noted that he did not remember the exact wording that D.D. used, but he remembers that the patient did not want medical or police services. Tr. 114. Ofc. Freiwirth noted that the patient was in bed, conscious and breathing but appeared under the influence. He noted that he heard the patient speak, and nothing about his speech seemed concerning. Tr. 114-115. When asked how he knew the patient did not want them there, Ofc. Freiwirth stated that "…I don't know exactly how he said it, it was just him not wanting ---like us to leave." Tr. 115. Ofc. Freiwirth testified that they left with the EMTs and that was it. Tr. 116.

On cross-examination, Ofc. Freiwirth testified that he believed the patient was under the influence because D.D. stated that the patient had taken gummies or smoked within the day and they were going to a concert later that night and she wanted to make sure that the patient would be okay to attend. Tr. 117. Ofc. Freiwirth testified that he did not recall if either of the EMTs asked D.D. for the patient's symptoms. Tr. 117-118. When asked if he observed behavior that made him believe the patient was under the influence, Ofc. Freiwirth testified that based on his past experiences and what D.D. reported to them, the patient could have been intoxicated or under the influence. Ofc. Freiwirth affirmed that he saw the patient and noted that the apartment was small, so he was able to enter the room while the paramedics were in there and then step out of the way so they could take over. Tr. 118. Ofc. Freiwirth cited that he entered the room because it is protocol for MPD to observe and assess the situation to ensure that no crime was committed. He clarified that he did not assess the patient because he is not a doctor, but he observed from where he stood. Tr. 119.

Ofc. Freiwirth testified that the patient "obviously did not want any kind of medical attention. Like he was under the influence, but he was fully capable of- - and we've dealt with people like this all the time that don't want police services-he was fully of not wanting any kind of attention." Tr. 121. Ofc. Freiwirth affirmed that he was not entirely familiar with the outcome of the patient. Tr. 123. He testified that he did not recall the patient having a stroke on the scene and he believed if the patient was having a stroke then the EMTs on the scene would have taken steps to take him to the hospital. Tr. 127.

When asked by the panel whether he saw the EMTs take any medical equipment inside or take the patient's vitals, he noted that he did not recall. Tr. 128-129. Ofc. Freiwirth testified that the EMTs present acted professionally. He noted that he is trained to "step in" if there is unprofessional conduct. Tr. 130. Ofc. Freiwirth noted that he was not worried about the status of the patient when he left the apartment because he did not want medical treatment and did not appear to have life-threatening symptoms. Tr. 130.

Panel Findings[8]

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) Testimony delivered by all witnesses support the charge. All witnesses stated that FF [Employee] did not perform a proper patient assessment and did not document a refusal of care.
2) No evidence was provided that there was a problem in the system that prevented the ePCR from being completed and showing complete. Thus, the panel concluded that the report was not completed.
3) The assistant medical director testified that in his opinion this was not a simple mistake but gross negligence by the ambulance crew.

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

[8] Agency's Answer, tab 11 (May 4, 2023).

findings of fact, the Panel also weighed the offenses against the relevant *Douglas* factors[9] and concluded that termination was the appropriate penalty for these offenses.[10]

ANALYSIS AND CONCLUSIONS OF LAW[11]

Pursuant to the D.C. Court of Appeals holding in *Elton Pinkard v. D.C. Metropolitan Police Department*,[12] 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 of 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.[13] 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:

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[9] *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;
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.

[10] Agency's Answer to Employee's Petition for Appeal, tab 12 (May 4, 2023).

[11] Although I may not discuss every aspect of the evidence in the analysis of this case, I have carefully considered the entire record. *See Antelope Coal Co./Rio Tino Energy America v. Goodin*, 743 F.3d 1331, 1350 (10th Cir. 2014) (citing *Clifton v. Chater*, 79 F.3d 1007, 1009-10 (10th Cir. 1996)) ("The record must demonstrate that the ALJ considered all of the evidence, but an ALJ is not required to discuss every piece of evidence").

[12] 801 A.2d 86 (D.C. 2002).

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

> 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;
>
> 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 November 17, 2022, and December 7, 2022, for an evidentiary hearing. This Panel made findings of fact, conclusions of law and recommended that Employee be terminated for the current charges.[14] 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.[15] 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.[16]

[14] Agency's Answer to Employee's Petition for Appeal, tab 15 (May 4, 2023).
[15] *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).
[16] *Baumgartner v. Police and Firemen's Retirement and Relief Board,* 527 A.2d 313 (D.C. 1987).

Agency's Position

Agency asserts that Employee failed to conduct "a proper assessment of a 21-year-old patient who was suffering from severe stroke."[17] Agency maintains that Employee only took a cursory look at the patient and was never fully in the room the with the patient. Agency asserts that Employee spent the duration of the dispatch speaking to the patient's significant other, did not check the patient's vital signs and wrote the patient's symptoms off as the result of intoxication. Agency asserts that Employee and her partner left without performing any medical assessment, incorrectly noted that there was no EMS required, and did not follow the proper protocol for a patient refusal of care. Agency asserts that Employee also failed to follow additional Agency protocol when she failed to complete an electronic patient care report ("ePCR") in the safety pad application.[18] Agency notes that it requires its EMTs to complete an ePCR for every dispatch so that the dispatch events are documented. Agency notes that Employee's ePCR was missing when the analytics page was printed.[19] Agency maintains that as a result of Employee's actions, Employee missed classic signs that the patient was experiencing a stroke. Agency asserts that the patient's condition worsened overnight, and because he was left untreated, the stroke caused unnecessary brain damage.[20]

Agency asserts that its decision to terminate Employee was supported by substantial evidence. Agency avers that witnesses stated that Employee did not perform a proper patient assessment. Agency notes that the patient's girlfriend testified that Employee and her partner did not provide the patient any medical attention despite her pleas for them to take him to the hospital.[21] Agency maintains that there was no evidence provided that a system error prevented the ePCR from being completed and showing as complete. Agency further avers that the assistant medical director Gerecht noted that this was not a simple mistake but gross negligence by the ambulance crew.[22] Agency asserts that Employee failed to conduct a proper patient assessment and thus failed to provide the patient with proper care. Agency maintains that Employee's failure to conduct a proper patient assessment violated Agency's policy and amounted to neglect of duty and failure to provide assistance to the public.[23]

Agency argues that there were no procedural errors. Agency asserts that Employee was provided notice over a month and a half in advance of the Trial Board Hearing that Captain Szugye would be one of the Trial Board members. Agency asserts that Employee's argument that he was suddenly substituted for another captain on the Trial Board and thus was not prepared to serve as a Panel member is false.[24] Further, Agency argues that its use of the 2012 DPM was not error and consistent with established OEA precedent and its negotiations with Local 36.[25] Agency further notes that Employee's disagreement with the balancing of the Douglas factors "is not a valid basis for reversible error."[26]

[17] Agency's Brief, p. 1 (February 28, 2024).
[18] Agency's Answer to Employee's Petition for Appeal, pp. 1, 2 (May 4, 2023).
[19] Agency's Brief, p. 9 (February 28, 2024).
[20] *Id*. at page 10
[21] *Id*. at p. 8
[22] Agency's Answer to Employee's Petition for Appeal, p. 12 (May 4, 2023)).
[23] Agency's Brief, p. 8 (February 28, 2024).
[24] *Id*. at pp 10-11
[25] Agency's Reply Regarding 2012 DPM Citations, pp.3-4 (August 20, 2024).
[26] Agency's Brief, p. 11 (February 28, 2024).

Employee's Position

Employee avers that she was wrongfully terminated. Employee maintains that she was not the ambulance crew member in charge ("ACIC") and thus was not in charge of the unit on the day in question.[27] Employee argues that Agency is blaming her for her partner's missteps and ignored the fact that she was not in charge of her unit on the day in question.[28] Employee avers that she was the Ambulance Crew Member Aide ("ACA") there to assist her partner, the ACIC.[29] Employee asserts that as the ACIC, her partner was "responsible for "handl[ing] the majority of duties" and so for the day they visited [the patient], he was handling the patient assessment, as he described in detail during his testimony." Employee further asserts that as the ACIC her partner was responsible for documenting the refusal of care, and there was no testimony presented that she as the ACA was responsible for documenting a refusal of care when the ACIC failed to do so. Employee maintains that her partner completed an e-PCR. Employee contends that "while the Board's second finding indicates that it found no report was completed, it ignores the fact that there were some e-PCR entries missing for the day in question." Employee avers that she is being blamed and charged for actions that were her partner's responsibility.[30]

Employee further argues that while Dr. Gerecht testified that Employee's actions on the day in question caused the patient significant medical distress, the Board ignored relevant evidence of what occurred on March 5, 2022, the day after the dispatch in question. Employee contends that on this day Ambulance 14 came to check on the patient, yet the firefighters with Ambulance 14 also did not "catch and/or record that Mr. [patient] was having a stroke, and, as Dr. Gerecht testified, if they thought he was having a stroke, they should immediately [drive] to the hospital to get the patient in the emergency room as it "is a time-sensitive condition.""[31] Employee contends that instead Ambulance 14 "downgraded and marked him as "AMR," which indicated he was not having an emergency, and for which Lt. Arnold testified would not be appropriate for a patient who was exhibiting signs of a stroke because "time is of the essence kind of thing."[32]

Employee contends that Ambulance 14 was given coaching and feedback, but it was not apparent what, if any discipline they may have received. Employee argues that Agency placed the onus of the entirety of what transpired on Employee, ignoring the fact that Ambulance 14 also did not recognize that patient was having a stroke, "which could mean that even on March 5, [patient] was not exhibiting clear signs of a stroke, and/or if he was, his symptoms should have been caught by Ambulance 14 on March 5…"[33]

Employee further avers that the Trial Board relied on the patient's girlfriend's testimony of what occurred over that of Employee, Employee's partner, and a police officer on the scene, even though the patient's girlfriend presented inconsistent testimony. Employee contends that the patient's girlfriend testified that Employee and Employee's partner did not go into the room where the patient was and were yelling at him from outside the room. Employee asserts that this testimony was

[27] Employee's Brief, p. 2 (December 19, 2023).
[28] *Id*. at p. 9; *See also* Employee's Brief, p. 4 (February 28, 2024)
[29] Employee's Brief, p. 4 (February 28, 2024).
[30] *Id*. at pp. 3-6.
[31] *Id*. at 6-7 (quoting Dr. Gerecht's testimony at Tr. 135).
[32] *Id.* at p. 7 (quoting Lt. Arnold's testimony at Day 1, Tr. 74-75)
[33] Employee's Brief, p. 7 (February 28, 2024).

contradicted by Employee, her partner, and MPD officer, Ofc. Freiwirth, who testified that Employee's partner assessed the patient inside the bedroom where he was located.[34]

Employee further asserts that Agency incorrectly asserted that all witnesses gave testimony that supported Employee's charge that she did not perform a proper patient assessment and did not document a refusal of care."[35] Employee contends that her partner was handling the patient assessment on the day in question and testified that the patient refused a full assessment. Employee further asserts that another witness on the scene, Ofc. Freiwirth also testified that patient seemed to be refusing care, possibly due to intoxication.[36] Employee further notes that the patient's girlfriend testified that the patient had "smoked weed,…took edibles,…drank tequila,…and…did probably half of a baby line of coke" but Employee contends that this information was "almost entirely left out of her 911 call that led to Employee and her partner's arrival on the scene, where she simply indicated he had ingested some alcohol…drank the night before and took some marijuana edibles."[37]

Employee asserts that Agency "produced 2,700 pages of medical documents regarding the patient at issue, which she avers was not provided to her and her counsel within enough time for the Trial Board hearing to properly evaluate them leading to the fact that the agency was able to submit only a subset of documents that help support her removal and to prevent her and her counsel from rebutting those." Employee contends that she did not have enough time to review all the documents in preparation for the hearing. Employee further asserts that one of the Trial Board members Captain Szguye had never been trained to serve on a Trial Board, which she argues is a procedural error because it likely impacted the member's ability to analyze her case. Employee additionally asserts that Agency misapplied the Douglas Factors, including not indicating which factors are mitigating, neutral, or aggravating.[38] Employee further asserts that she was incorrectly charged under a prior District Personnel Manual ("DPM") which constituted harmful procedural error. Employee noted that Agency used the 2012 version of the DPM in levying charges against her, which amounted to procedural error.[39]

ANALYSIS

Whether the Trial Board Panel's decision was supported by 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 in this matter. 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.[40] 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.[41] In this matter, the undersigned

[34] *Id*. at pp. 7-8, 10 (February 28, 2024).
[35] Employee's Brief, p. 3 (February 28, 2024).
[36] *Id*. at pp. 3, 4.
[37] *Id*. at p. 4, (citing D.D.'s testimony at Tr. 44-45).
[38] Employee's Brief, pp 5-6 (December 19, 2023)
[39] Employee's Brief, pp. 1-2 (February 28, 2024).
[40] *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).
[41] *Baumgartner v. Police and Firemen's Retirement and Relief Board,* 527 A.2d 313 (D.C. 1987).

finds that Employee's failure to obtain a refusal of care and follow the refusal of care protocol is sufficient to support both charges 1 and 2 in this matter.

In assessing Charge 1, Agency asserted that Employee violated Agency's policy, including the Department Emergency Medical Services Manual and Pre-Hospital Treatment Protocols (2017), Standard Operating Guidelines, which concerns Agency's Consent/Refusal of Care Policy. Part II, § 2 states in pertinent part that the providers of care should attempt to assess the patient's mental capacity to refuse and assess the patient's medical or situational capacity by ensuring "that the patient is suffering from no acute medical conditions that might impair his or her ability to make an informed decision to refuse care or transportation." This Protocol further states that the providers are also required to "[c]heck to be sure that patient is exhibiting no other signs or symptoms of potential mental incapacity, including drug or alcohol intoxication, unsteady gait, slurred speech, post ictal period after seizure, cognitive deficits after hypoglycemia or drug intoxication. Etc."[42]

The undersigned finds that Agency has presented substantial evidence that Employee did not adhere to Agency's policies in assessing the patient's mental and medical capacity to refuse transportation to a hospital. The record supports that Employee did not sufficiently ensure that the patient was not exhibiting signs or symptoms of potential mental incapacity, including drug or alcohol intoxication, unsteady gait, slurred speech, post ictal period after seizure, cognitive deficits after hypoglycemia or drug intoxication that would determine his capacity to refuse treatment, as Agency's policy requires.[43] While Employee noted that the patient did not appear to be intoxicated or under the influence of substances, Employee had knowledge that the patient had consumed four (4) edibles and had been drinking the night before.[44] The patient's girlfriend D.D. testified that the EMTs present told her that the patient "was probably just getting over the night," and "[h]e probably just had a few too many drinks," suggesting that he appeared to be intoxicated or at a minimum, recovering from intoxication. Tr. 30, 53. Ofc. Freiwirth testified that when he entered the room where the patient was, he observed a gentleman in his bed *under the influence,* again suggesting that the patient could have been impaired, which would affect his capacity to refuse treatment. (Emphasis added). Tr. 114-118.

Further, in determining that the patient had the capacity to refuse treatment, Employee noted that the patient said, "I'm good." However, D.D. testified that the patient's statements were not fully coherent, and the patient replied "mmm-hmmm" to the EMTs asking if he was good. She stated at no time was the patient making fully coherent statements. Tr. 29. Dr. Gerecht noted that solely vocalizing "I'm good" is not sufficient to determine mental capacity. He noted that to demonstrate the cognitive ability to refuse care, the patient must show the ability to engage in meaningful conversation and vocalize that he understands and accepts the risks of refusing transport to a hospital. Tr. 118-119.

Employee further failed to ensure that the patient was not suffering from any "acute medical conditions that might impair his or her ability to make an informed decision to refuse care or transportation" even though she had sufficient information to determine that the patient could be experiencing a medical event. Employee had knowledge that the patient had consumed substances and noted that the girlfriend's main concern was that the patient had been moving funny in his sleep. Tr. 30. Employee further testified that the patient did not let them collect vital signs, suggesting that she and her partner potentially lacked crucial information regarding the patient's basic functioning.

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[42] Agency's Praecipe to Supplement the Record Exhibit 4, pp 57-61 (September 2, 2025)(page numbers included for ease of reference).
[43] *Id*.
[44] Tr. 29.

Employee testified that they could not fully assess the patient or take vital signs because the patient did not want treatment. Thus, based on the evidence, Employee and her partner assessed the patients' capacity to refuse transportation to a hospital solely based on the patient's observed behavior, and his statements that he "was good." Thus, the undersigned finds that Employee and her partner lacked sufficient information to determine whether the patient could make an informed decision about his care.

Further, the evidence supports that the Employee and her partner did not obtain a proper refusal of care from the patient. Ageny protocol directs that "If patient has legal, mental, medical and situational capacity to understand the risks and alternatives to treatment and transportation, the patient has a right to refuse care; however the provider of care should *obtain a refusal signature*. (Emphasis added). Notably, Agency's Consent/Refusal of Care Policy details very specific procedures to follow in documenting a patient's refusal, including:[45]

- having the patient or designee complete the refusal of treatment or transport section of the patient care report (PCR).
- Review form with patient or designee. If required the body of the text shall be read aloud to the patient.
- Provide a detailed explanation of possible risks and dangers signs to patient or other designee.
- Obtain the signature of *the patient or designee*. *If the patient refuses to sign, document this fact on the patient care report (PCR).* (Emphasis added).
- Have the patient or designee date the patient care report (PCR).
- Obtain the signature of a witness
- Contact the EMS Liaison Officer or Battalion EMS Supervisor to provide an update via radio consultation confirming that all evaluation and inclusion criteria have been met.

Thus, while Employee testified that the patient refused treatment, and "did not want anything to do with EMS" and was not exhibiting signs of intoxication or stroke, the undersigned finds that Employee still had a duty to follow protocol by obtaining a proper refusal.[46] As Dr. Gerecht testified, the refusal protocol is to protect both the patient and the EMT.[47] Further, Dr. Gerecht indicated that 'no EMS required' means that Ambulance 30 felt that they did not have a patient, "that they didn't have someone that they were assessing or caring for.", He further testified that "No EMS Required means that the EMTs arrived on the scene and determined there was no one to treat, thus no decision to be made about medical care."[48] However, as Dr. Gerecht affirmed, there was a patient to treat and who had a right to refuse care. Accordingly, because Employee and her partner did not follow Agency protocol in assessing his mental and medical capacity to refuse care and did not follow the steps to obtain a proper refusal, the undersigned finds that the record supports the charges of misconduct assessed.[49]

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[45] Agency's Praecipe to Supplement the Record Exhibit 4, pp 57-61 (September 2, 2025)(page numbers included for ease of reference).
[46] Tr. 29; 74-76
[47] Tr. 144
[48] *Id.*
[49] Tr. 145

Employee argues that because she was not the Ambulance Crew Member in Charge (ACIC), she should not be blamed her for her partner's missteps, as her partner was in charge of the unit that day.[50] The D.C. Fire and Emergency Medical Services Department Order Book Article XXIV, § 7, reinforces that the "EMS Providers, specifically the members designated as the ACIC, assigned to EMS Units should not hesitate to contact an EMS Battalion Supervisor, on-duty platoon commander or EMS Chief supervisor of any requests or issues arising during the tour of duty that requires clarification or immediate resolution. Do Not Hesitate to Seek Any Assistance Necessary-Ask for Help!!!"[51] While Employee's partner was the lead EMS as the ACIC, Employee has not presented evidence that she was absolved of her duty follow proper protocol. In fact, Employee acknowledged during her testimony that if she could have done things differently, she would have documented a proper refusal and called a supervisor. Tr. 22. Employee, through her representative, also documented Agency's policy which states, [P]roviders are reminded that regardless of position assigned, all providers remain responsible for patient care." [52]

Employee further acknowledged that Employee "… would have been responsible for conducting the assessment of the Patient according to written policy…."[53] Thus the undersigned finds that Employee maintained a responsibility to follow Agency's protocol in the administration of care for a patient. While Agency presented additional arguments, including failure to document the dispatch with an ePCR and failure to identify the signs of a stroke, the undersigned does not find it necessary to delve into the nuance of those allegations because the Employee's failure to follow proper protocol and obtain a refusal is sufficient to support both Charges 1 and 2.

Whether There was Harmful Procedural Error

In terminating Employee, Agency relied on the 2012 version of the DPM. Employee maintains that Agency's use of the 2012 version of the DPM in levying charges against Employee amounts to harmful procedural error because it was not the version in force at the time of the misconduct.[54] Agency notes that current case law dictates that FEMS and Local 36 bargained for use of the 2012 DPM and is prohibited from relying on a post-2012 DPM version.[55]

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. In *D.C. Fire and Emergency Medical Servs. Department v. D.C. Office of Employee Appeals*, the Court agreed with Agency and found that Local 36 bargained to implement a disciplinary system consistent with the 2012 version of the DPM. It held that the action was brought in accordance with the charges and penalties outlined in the bargained-for version of the DPM, and "not the revisions which brought about "substantial changes…with regard to charges and penalties." [56] Additionally, the OEA Board noted in *Employee v. D.C. Fire and Emergency Medical Servs. Department v. D.C. Office of Employee Appeals*,[57] that "… current case law dictates

[50] Employee's Brief, p 9 (December 19, 2023)
[51] Agency's Brief, Exhibit 1 (February 26, 2025).
[52] Employee's Brief, p. 3 (March 31, 2025).
[53] *Id*.
[54] Employee's Response to Second Section of OEA's Order, p. 1 (February 28, 2024).
[55] Agency's Reply Regarding DPM 2012 Citations, (August 20, 2024) (citing D.C. Fire and Emergency Servs. Department v. D.C. Office of Employee Appeals, No. 2023-CAB-3610)(May 8, 2024).
[56] 2023-CAB1076 (D.C. Super Ct. December 29, 2023). See also. *D.C. Fire and Emergency Medical Servs. Department v. D.C. Office of Employee Appeals*, 2023-CAB 003933 (D.C. Super Ct. January 15, 2025).
[57] OEA Matter No. 1601-0050-23 (January 16, 2025).

that Agency's use of the 2012 DPM in this matter was proper."[58] Accordingly, the undersigned must hold consistent with the OEA Board's ruling and the current case law that dictates that Agency's use of the 2012 DPM in this matter was proper.[59]

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.[60]

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).[61] Therefore when assessing the appropriateness of a penalty, this Office is not to substitute its judgment for that of the Agency but is simply to ensure that "managerial discretion has been legitimately invoked and properly exercise." Specifically, OEA held in *Love v. Department of Corrections*, OEA Matter No. 1601-0034-08R11 (August 10, 2011), that selection of a penalty is a management prerogative that is not subject to the exercise of discretionary disagreement by this Office. As further noted in *Love*, "..[T]he [OEA's] review of an agency-imposed penalty is essentially to assure that the agency did conscientiously consider the relevant factors and did strike a responsible balance within tolerable limits of reasonableness. Only if the [OEA] finds that the agency failed to weigh the relevant factors, or that the agency's judgment clearly exceeded the limits of reasonableness, it is appropriate for the [OEA] then to specify how the agency's decision should be corrected to bring the penalty within the parameters of reasonableness."[62] Accordingly, when an Agency charge is upheld, this Office will "leave Agency's penalty undisturbed when the penalty is within the range allowed by law regulation or guidelines, is based on consideration of the relevant factors and is clearly not an error of judgement."[63]

Here, Employee asserts that the Trial Board misapplied the *Douglas* Factors, included erroneous analysis, and failed to indicate which factors were mitigating, neutral, or aggravating. Employee further asserts that Agency did not consider *Douglas* Factor 4.[64] The undersigned finds that the penalty was within the range allowed by law, which is reprimand to removal.[65] Thus, the penalty

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[58] Employee v. DC FEMS, 1601-0040-21R 24 (*citing* to OEA Board decision in *Employee v. DCFEMS, Opinion and Order on Petition for Review*, OEA Matter No. 1601-0050-23 (January 15, 2025)).
[59] Employee's remaining arguments concerning procedural error were considered, but the undersigned finds that the record does not contain sufficient evidence to support harmful procedural error resulting from Employee's access to the patient's full medical records and Captain Szugye's role as a panel member.
[60] *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).
[61] *See also. Anthony Payne v. D.C. Metropolitan Police Department,* OEA Matter No. 1601-0054-01, *Opinion and Order on Petition for Review* (May 23, 2008); *Dana Washington v. D.C. Department of Corrections,* OEA Matter No. 1601-0006-06, *Opinion and Order on Petition for Review* (April 3, 2009)
[62] *Love* (Citing *Douglas v. Veterans Administration,* 5 M.S.P.R. 313, 5 M.S.P.R. 280 (1981)).
[63] *Id. See also Sarah Guarin v Metropolitan Police Department*, 1601-0299-13 (May 24, 2013) citing *Stokes supra*.
[64] Employee's Brief, pp 6-8 (December 19 2023).
[65] *See* 16 DPM § 1603.3(f)(3)(2012) and 1603.3(f)(9)(2012).

levied against Employee by Agency is within the range contemplated by the DPM, as required by *Stokes*.[66] Further, Agency provided analysis for each of its *Douglas* Factor findings, and there is no evidence that Agency abused its discretion. Further, even if Agency found *Douglas* Factor 4 to be mitigating, this would not sway the evidence in favor of Employee. 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. Consequently, the undersigned concludes that the Agency's action should be upheld.

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

[66] *Stokes v. District of Columbia*, 502 A.2d 1006 (D.C. 1985).