Notice: This decision may be formally revised before it is published in the *District of Columbia Register* and the Office of Employee Appeals' website. Parties should promptly notify the Office Manager of any formal errors so that this Office can correct them before publishing the decision. This notice is not intended to provide an opportunity for a substantive challenge to the decision.

THE DISTRICT OF COLUMBIA

BEFORE

THE OFFICE OF EMPLOYEE APPEALS

In the Matter of:	)	
	)	
REGINA OGWUEGBU,	)	
Employee	)	OEA Matter No. 1601-0113-14
	)	
v.	)	Date of Issuance: August 10, 2016
	)	
DEPARTMENT OF BEHAVIORAL HEALTH,	)	Monica Dohnji, Esq.
Agency	)	Senior Administrative Judge
	)	

Rani Rolston, Esq., Employee's Representative
Frank McDougald, Esq., Agency's Representative

INITIAL DECISION

INTRODUCTION AND PROCEDURAL BACKGROUND

On August 18, 2014, Regina Ogwuegbu ("Employee") filed a Petition for Appeal with the D.C. Office of Employee Appeals ("OEA" or "Office") contesting the Department of Behavioral Health's ("DBH" or "Agency") decision to terminate her from her position as a Psychiatric Nurse/Team Lead, effective July 28, 2014. Employee was terminated based on the following charge: any on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operations; Neglect of Duty, specifically, (1) failure to observe precautions regarding safety; and (2) Patient Abuse. On September 22, 2014, Agency filed its Answer in response to Employee's Petition for Appeal.

This matter was assigned to the undersigned Administrative Judge ("AJ") on March 3, 2015. After several conferences and brief submissions, an Evidentiary Hearing was held on March 1, and 2, 2016. Both parties were present for the Evidentiary Hearing. Thereafter, I issued an Order dated April 5, 2016, notifying the parties that the transcript from the Evidentiary Hearing was available at OEA. The Order also provided the parties with a schedule for submitting their written closing arguments. The written closing arguments were due on or before May 20, 2016. Both parties have submitted their written closing argument as requested. 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 Agency's adverse action against Employee was done for cause; and
2) If so, whether the penalty of termination is within the range allowed by law, rules, or regulations.

SUMMARY OF MATERIAL TESTIMONY

Agency's Case in Chief

1. Estes Rogers III (Transcript pages 22-105)

Mr. Rogers is currently the Incident Review Specialist for the Department of Behavioral Health at Saint Elizabeths Hospital. He has held this position for three (3) years. The responsibilities of an Incident Review Specialist are to review unusual incidents that occur within the hospital on a daily basis. All the incidents that occur Monday through Friday are reviewed the following business day. The Incident Review Specialist and Risk Manager determine whether or not an action requires follow up or a full investigation. *Tr. pg. 23.* An unusual incident is defined as anything out of the norm, or an allegation of abuse, neglect, or exploitation. Also, aggressive behaviors from individuals in care are considered unusual incidents. The individuals in care have a wide range of diagnoses from schizophrenia to bipolar disorder. *Tr. pgs. 24-25.*

Mr. Rogers testified that an unusual incident transpired on March 9, 2014. Per the report, the individual in care ("Patient X") displayed aggressive behavior and was non-compliant. The staff was unable to redirect her, and as a result, she was denied the option to practice religious services. There was a physical altercation between Employee and the individual in care. Surveillance footage captured the altercation. *Tr. pgs. 27-30.*

The video depicts surveillance footage from Unit 1D. The nursing station is closest to the unit. The video began at 9:01:56 a.m. where there was a group exiting the unit to be escorted to church services. Four to five individuals were escorted by a staff member to exercise their religious beliefs. *Tr. pg. 32.* Mr. Rogers testified that the individual in care was 5½ months pregnant. *Tr. pg. 35.* He identified three staff members—Ms. Elaine Zellers, because of her hair; Employee, who is wearing white pants; and another staff member he could not identify but knew from speaking to said staff member during his investigation. *Tr. pgs. 37-38.* The video continued with the staff trying to redirect the individual in care into the group room. The individual in care was conversing with Employee who was headed towards the nursing station to call a Code 13. Code 13 is used to call the Service Center. Mr. Rogers explained that an announcement was made over the PA system that additional assistance was needed from staff members throughout the hospital to assist the individual in care who was exhibiting aggressive behaviors. *Tr. pgs. 43-*

44. According to Mr. Rogers, the video showed Employee leaving the nurses' station appearing to verbalize and point her finger in the direction of the group at the end of the hall. *Tr. pg. 47.*

Mr. Rogers testified that the staff members were behind the individual in care while walking in the direction of the nursing station. *Tr. pg. 48*. He described that Employee took a safety stance. The safety stance is taught by training staff to all employees during their orientation as part of the safety care manual. If the staff is attacked by a patient, they are trained to retreat into a safety stance. Mr. Rogers critiqued the placement of Employee hands, as they did not display how the stance was taught in training. *Tr. pg. 50.* He opined that Employee should not have come forward to engage in a physical altercation. The staff members redirected the individual in care away from Employee, but Employee began to approach from behind. According to Mr. Rogers, Employee came from behind and her hands entered Patient X's neck area. Mr. Reginald Ross was one of the housekeepers who attempted to assist in the de-escalation process. *Tr. pgs. 51-52*. Mr. Rogers provided that Mr. Ross placed his hands on Employee's wrist. He testified that the video then shows Employee's hand in Patient X's hair. *Tr. pg. 53.* At this point the Patient X has lowered herself onto the ground. Mr. Rogers' assessment is that Employee is trying to keep her in an upright position, but in doing so, she is pushing Patient X forward. Patient X then moved herself around and got to her knees. At this point, one of the Code 13 staff member responders came to the unit. *Tr. pgs. 54-55.*

The video continued and Mr. Rogers explained that Employee left the immediate area; and went into the hallway where there was a restroom with supplies for the individuals in care. During that time, the staff members continued to try and deescalate the situation. Employee returned to the immediate area where the individual in care and group of staff were. Employee approached from behind and pointed in the direction of the day room, which got the attention of the individual in care who attempted to speak to a staff member to describe what was going on. *Tr. pg. 58*. Mr. Rogers affirmed that the individual in care and Employee both sustained injuries. He stated per the report, that Employee had a scratch on her face, as evidenced in the pictures. The individual in care had a scratch on her face and scratches to the back of her neck. T*r. pg. 59.*

Mr. Rogers testified that he interviewed Patient X, Employee, and four staff members, including Mr. Ross. During the interview, the individual in care indicated that Employee scratched her face, her neck, and pulled her hair during a physical altercation. She also claimed that Employee did not let her attend church services. Employee stated during her interview that the individual in care was disruptive to the unit all day long. *Tr. pg. 62.*

Mr. Rogers testified that the staff is given an extensive training for safety care during two (2) weeks of orientation. *Tr. pg. 64.* Mr. Rogers stated that Employee received training based on Hospital's Policy Number 301-01 for reporting suspected abuse, neglect, and exploitations to the individuals in care. *Tr. pg. 68.* Mr. Rogers determined that Employee engaged in patient abuse against the individual in care. He found that the physical injuries sustained by the individual in care and the psychological nature in terms of which Employee engaged her were abusive. *Tr. pg. 72.*

Mr. Rogers asserted that he found at least two instances where the incident could have been avoided if Employee took different measurers while interacting with the individual in care.

He stated that when the individual in care charged towards Employee, Employee had an opportunity to create a barrier between them by stepping back inside the door to avoid any physical confrontation. *Tr. pgs. 76-78.* In his report dated March 9, 2014, Mr. Rogers specified that the individual in care suffers from bipolar disorder, with the most recent episode being manic severe with psychotic features. *Tr. pg. 81.*

Mr. Rogers also identified power struggle language which he stated is referenced in the safety care manual. He determined that a power struggle existed based on the interviews conducted and information conveyed to him by staff. The power struggle he alluded to was the individual in care wanting to attend church services. Employee violated the safety care training in terms of power struggle because it clearly stated that she should not have engaged in it. *Tr. pgs. 82-83.*

Mr. Rogers further testified that Employee should have called a Code 13 and stayed in the nursing station. Even if she informed other staff members of the Code 13, Employee had an opportunity to create a barrier between the two so that a physical altercation would not have occurred. *Tr. pg. 86.* When Rogers is questioned about the amount of finger pointing in the video, he provides that in accordance with the safety policy, this action could be deemed humiliating or an attempt to scorn an individual in care. Thus the finger pointing could be deemed as abusive behavior. There is language in the policy that indicates employees should not have those types of interactions. *Tr. pg. 92.* He stated that finger-pointing was prohibited after Employee made the initial Code 13 call and came back to the nurses' station. Per Mr. Rogers' report, the individual in care did not indicate that she was upset by Employee's gesture. *Tr. pg. 93.* Mr. Rogers stated his department does not make final determinations regarding the removal of an employee. He explained he only reported the incident and provided it to the department head that made the determination. *Tr. pg. 99-101.*

2. <u>Lori Yerrell Carter (Transcript pages 107-159)</u>

Ms. Carter has works for the Department of Behavioral Health, as a Deputy Chief Nurse, R.N., and she has been employed there for three (3) years. She has twenty-five (25) years of psychiatric nursing experience. *Tr. pgs. 107, 111-112.* Ms. Carter identified the types of patients with mental disorders who are hospitalized in the facility. *Tr. pgs. 113-115.*

Ms. Carter testified that she served Employee with a proposed removal notice. *Tr. pg. 117.* She stated that the individual in care (in the transcript Ms. Carter refers to her as "Patient X") was admitted on the 27th of February. Ms. Carter explained that per the reports she read, the individual in care was agitated that day. The individual in care targeted Employee by calling her derogatory names because she was supposed to attend church services but was unable to because the group left without her. *Tr. pg. 123.* At this point, the individual in care demanded that she be allowed to go to church, and she made loud remarks. There were four (4) staff members trying to calm the individual in care. *Tr. pg. 124.*

Ms. Carter described that in the video you could see the individual in care go into the group room, which was usually where treatment planning meetings were held. Employee stood at the door directing with her finger and her head, while she moved and pointed towards the

door. Carter pointed out that none of the other staff members were pointing and that they all remained calm. *Tr. pg. 127.* Employee went towards the nurse's station and appeared to go by the computer or the phone. Ms. Carter was asked why Employee may have gone towards the nurse's station, and her response was to probably call a Code 13 for more staffing assistance. Ms. Carter explained that according to Employee's UI[1], she was asking for help. The video showed Employee coming out of the hallway and shaking her finger. The individual in care ran down the hallway towards Employee. *Tr. pgs. 128-129.* Employee did not retreat back into the nurses' station, but she instead came into the hallway. She compared Employee coming into the hallway in front of the individual in care to jumping out in front of a car. *Tr. pg. 130.*

Ms. Carter further testified that Employee put her hands up, which is what you are expected to do to protect yourself and then shuffled backwards. Employee went out of the camera's view and reappeared on the other side facing the individual in care. It appeared that the staff members grabbed Patient X because she turned her attention towards the three people behind her. The individual in care turned to face them, and Employee was behind her. Ms. Carter stated that she had a problem with Employee being behind the individual in care, as Employee no longer remained in the patient's focus. Ms. Carter stated that Employee had time to leave but instead moved towards the individual in care. Ms. Carter explained that Employee had a badge and could have left but chose to be involved in the situation. She described Patient X to be six (6) months pregnant and morbidly obese. Ms. Carter further testified that Patient X fell on the floor, and Employee grabbed Patient X's hair. Ms. Carter stated that Mr. Roy held Employee.[2] Because of the lack of audio, Ms. Carter stated that she doesn't know if Mr. Roy was trying to say "take your hands down." Mr. Roy placed one hand on the individual in care while attempting to calm her. *Tr. pgs. 131-134.*

Ms. Carter argued that Employee never retreated, continued to move her finger, and shake her head while the individual in care remained upset throughout the process. *Tr. pgs. 135-136.* She posited that the removal of Employee was the most appropriate action taken. She explained that Employee is a registered nurse (R.N.) with many years of experience. She stated that "…it seemed that there were a lot of things that she didn't remember to do, didn't call into play. From all her years of history as a nurse or as a psychiatric nurse, some of these things are really basic, and as a team leader, an R.N., you're the one in charge, you really have to keep your wits about you. You have to be able to stay calm when people are calling you names, when people are even acting like they want to hit you, and sometimes you even get hit or bit or scratched or spat upon. It happens. It happens." *Tr. pgs. 138-139.* She also added that because of that incident, the individual in care had to be medicated and that is something they did not want to do nor should have had to do because of her pregnancy. *Tr. pg. 140.* Ms. Carter believed that Employee did not attempt to deescalate the matter based on the way her finger and head were nodding, as well as Employee's hand placement and body posture.

Ms. Carter stated that a safety method approach could have been achieved if Employee placed her hands on the lower and upper part of the back if there was a need for a patient to be lowered to the floor. *Tr. pg. 150.* Ms. Carter continued by providing that nurses take precautions to avoid accidents. She explained that the staff was critiqued during the training classes to best

[1] UI was never explained in the transcript**.**
[2] She is unsure of his name but knows he is wearing blue gloves.

determine how to handle a situation. *Tr. pgs. 151-154*. Ms. Carter did not recall any penalty considered other than removal. She did state that Employee's manager was involved in the decision to have her removed. *Tr. pg. 157-159.*

3. Clotilde Vidoni-Clark (Transcript pages 160-193)

Dr. Clotilde Vidoni-Clark has worked at the Department of Mental Health, as the Chief Nurse Executive for forty-two (42) years. Dr. Clark is responsible for the clinical nursing care that is provided on the units as well as other departments. She is responsible for a staff of four hundred (400), including psychiatric nursing care. *Tr. pgs. 160-164*.

Dr. Clark decided that removal of Employee was appropriate based on the video, the risk management report, the advance notice, and Employee's role. Employee was a Grade 11, Senior Psychiatric Nurse, the most advanced position held at the hospital. *Tr. pg. 165*.

Dr. Clark was questioned regarding an incident that transpired with another individual in care three (3) years ago and was asked why he determined that a hearing officer employee─Grace Graham─was able to retain her position. *Tr. pgs. 176-184*. Dr. Clarke read the report of Ms. Graham and determined that she did not support the removal of Ms. Graham. She felt that the incident with Ms. Graham was not similar to Employee. She stated that in Employee's case, she reviewed the risk management report, the video, Employee's position description and responsibilities, as well as the advanced notice, *Douglas* Factors, and the Hospital's zero tolerance for abuse and neglect. *Tr. pgs. 181-188*. As it related to Grace Graham, Dr. Clark testified that she was not a psychiatric nurse. She believed that she worked as an attorney for the Office of the Attorney General. *Tr. pgs. 191-193*.

Employee's Case in Chief **(Volume II:** Wednesday, March 2, 2016)

1. Regina Ogwuebu (Transcript pages 11-93)

Mrs. Regina Ogwuegbu ("Employee") stated that her formal educational background was in Nigeria, where she earned her Bachelor of Science in Nursing in 1979. She also received her Master's in Nutrition and a Master's in Nursing Management and Nutrition. She stated that she had over twenty-eight (28) years of nursing experience. *Tr. pgs. 11-12*

Employee testified that in her twenty-two (22) plus years working for Saint Elizabeths she received excellent reviews. Employee further testified that she had been beaten more than three times, but it did not stop her from providing patient care. She believed that patients did not really know what they were doing during that particular time. *Tr. pgs. 12-20.* Employee stated that the individual in care's pregnancy impacted the way they normally dealt with patients because the doctors did not want to heavily medicate her due to her prenatal condition. She explained that the psychotropic medications would go through the placenta and could have damaged the fetus. She asserted that the individual in care was psychotic, bipolar, and struggled with substance abuse (with an emphasis on the use of PCP). Employee claimed that the methods she used to deescalate the individual in care were timeout, quiet time, and talking to her. *Tr. pgs. 21-23*.

As related to the events of March 9, 2014, Employee stated that the individual in care was disruptive; threw herself in front of and fought other patients; jumped in the nursing office and beat up the staff; yelled and threatened; and was constantly disruptive. The individual in care was assigned to Ms. Patricia Mukum, one of the junior staff members. *Tr. pgs. 24-25*. Employee offered that none of the staff had a rapport with the individual in care and that everyone was a trigger to her when she was under the influence. *Tr. pg. 26.* Employee believed that this was because of her PCP use, not her bipolar disorder. *Tr. pg. 25*.

Employee explained that she directed the staff to send the other patients to their rooms because the protocol was to move the patients when a situation like this would occur. Employee testified that there was a list of patients who wanted to attend church. The individual in care spoke with another patient and did not realize that the staff took the other patients to church. When the individual in care realized that they were gone, she yelled, threatened, and banged on the nurses station. *Tr. pg. 26.* Employee testified that the video did not capture the beginning of the incident, and there was no audio. Employee stated that the individual in care pushed past two nurses to go into the hallway which led to the exit door outside of the unit. Employee claimed that was where the video began. *Tr. pgs. 27-28*. Employee further testified that two nurses ran after the individual in care who swung, banged, and threw herself all over the place, causing the nurses to call to Employee for help. Employee went to the individual in care and informed her that she would personally take her to the 9:00 or 10:00 a.m. church service if she would remain calm. *Tr. pg. 28*.

Employee alleged that she called a Code 13, as she did not want the situation to escalate to the point of people being hurt. Employee stated that she told the individual in care to leave the staff alone and to go into the quiet room or the day room. Employee claimed that when she turned around, the individual in care jumped on her and began to beat her. Employee screamed for help because the patient was heavier, younger, and stronger than she was. *Tr. pg. 29*. She explained that the staff had to help her get up and the reason that she ran towards the hallway and not the nursing station was because it was safer for her. When questioned why she did not go into the door at the nursing station and close the door, Employee responded that there was only one door she could use that was not an exit. Otherwise, she would have been trapped. Employee stated that traditionally nurses who ran out of the nursing station were safe and those who stayed were hurt. She explained that this happened to the team leader she replaced. *Tr. pgs. 30-31*. Employee testified that what flashed into her mind was, "… [n]o, I'm not dying today...." *Tr. pg. 31*. So for her and the patient's safety, she ran out of the nurse's station. *Tr. pg. 31*. Employee explained that she went back into the station because the staff called her for assistance. Her goal was to get additional help, so she went back and called for another Code.

Employee explained that the hospital was understaffed and as the team leader, she had to provide the staff with instruction and decide what needed to happen. Employee testified that the individual in care did not fall. She stated that the patient got up, swung, and slammed her body on the floor. *Tr. pg. 32.* Employee explained that she was the only experienced nurse and could not have handled the patient in care if she went into labor. She stated that they are a psychiatric hospital and they were not equipped for obstetric care. Therefore, the individual in care and staff would have been in grave danger if she would have continued to let her fall, which is why she reduced the force and stepped back into a safety stance. *Tr. pg. 33*. Employee further testified

that three other staff members served as a supportive guide and continued to do so until security came. Employee said that the video did not capture everything. For example, the video depicted her leaving and coming back but not when the patient got up, swung, and slammed herself onto floor. *Tr. pg. 34.*

When questioned about the finger pointing, Employee expressed that it could be cultural. She explained that she talked a lot with her hands and that she was not finger pointing, but she was asking the patient to go back to the nursing day room. *Tr. pg. 39.* She stated that she used the same hand gesture to instruct her staff to stay away and to leave the individual in care alone. *Tr. pg. 39.* Employee claimed that she did not point her finger in a derogatory way, as this was someone under her care. She explained that gestures should be used when telling the patient what to do because talking may escalate the situation. *Tr. pg. 40.* Employee stated that everyone was a trigger for the patient in care, as this was a woman who was hallucinating, delusional, and on PCP. Employee said that she never pulled the patient's hair but went to the patient's back to lessen the impact of her falls. She claimed that she did not remember pulling the patient's hair, scratching, or pushing her, and she had never done that in twenty-two (22) years. *Tr. pg. 43.*

After the incident, security came in and put the patient into seclusion. Employee called the weekend nurse supervisor and then wrote the incident report. The weekend supervisor called Ms. Johnson (Employee's supervisor was terminated, so Ms. Johnson was called instead). Ms. Johnson asked her to fill out a Workman's Compensation claim because she was injured during the incident. *Tr. pgs. 45-46.* Employee stated that security also told her to file a police report and she did.

Although Employee's manager told her to return to work on the following day, she did not want to because she was emotionally disturbed. *Tr. pg. 47.* Therefore, her manager told her to fill out a Workman's Compensation form so that she could take some days off. In addition, she had two days of administrative leave which started on March 10, 2014. *Tr. pgs. 47-48.*

Employee returned to work on March 25th. She explained that she previously requested leave to visit her sick mother in Africa. On March 27th, Employee's leave was approved, and Ms. Lori Carter told her to use that leave to recuperate. *Tr. pgs. 48-50.* Employee provided that her grade entitled her to one month of leave.

Employee returned to work on May 7th. *Tr. pgs. 50-51.* On that day, Employee was informed that she would be placed on administrative leave. Employee asked to see the notice and requested to speak with Ms. Carter. She was informed that Ms. Carter was unavailable. When Employee returned home, she called Ms. Carter to inquire about being placed on leave. Ms. Carter responded that she did not know why she was placed on administrative leave and advised Employee to get a lawyer. *Tr. pg. 52.*

On May 14th, Employee received a letter of proposed removal. The letter was signed by Ms. Lori Carter. Employee provided that she was interviewed by Mr. Rogers on the 26th or 27th. *Tr. pg. 55.* Employee stated she never returned to work after May 7th. *Tr. pg. 56.* When questioned about her relationships with her supervisors, Employee stated that every supervisor

she had at the Hospital was excellent. If her manager left the unit, they trusted that she would handle the unit appropriately. All of the managers provided her with good performance ratings.

When questioned about her colleagues, Employee testified that her unit fell apart because she was not there to hold everyone together. She explained there were fights and most of the staff had to go to the Education Department or were reassigned. *Tr. pgs. 57-58*.

On cross examination, Employee explained that the Code 13 was used because the patient was at the exit door. She reiterated that the video did not capture everything. *Tr. pgs. 74-75*. Employee claimed that she provided a directive with her index finger for the patient to go into the day room and to have the staff stay away from her. *Tr. pg. 77*. Employee testified that the patient charged her which is depicted in the video and that she took the safety stance. *Tr. pg. 81*.

Employee stated that she was encouraged by management to file a police report so that it would be in the record. She also filed an incident report. *Tr. pgs. 84-85.* Employee provided that the patient attacked her when she rushed through the exit. However, the video did not capture the patient swinging. She also pointed out that the audio is not available. *Tr. pgs. 87-88.* Employee testified that the video may or may not have been edited. *Tr. pg. 92.*

2. <u>Patricia Mukum (Transcript pages. 94 – 109)</u>

Patricia Mukum is a Registered Nurse (R.N.) who is currently employed with Saint Elizabeths. She worked with Employee, who was the charge nurse on her unit. She has worked with Employee since November 2012. *Tr. pg. 94*. As it relates to the incident that occurred on March 9, 2014, Ms. Mukum stated that the individual in care was disruptive on the unit in the morning. She did not recall if the patient went to church service or the gym, but she knew that she was disruptive so she could not go out of the unit. Ms. Mukum testified that the patient pushed past two staff members and came into the hallway towards the exit door. Ms. Mukum came out of the nursing station and spoke with the patient to inform her that she could not force herself out of the unit. *Tr. pg. 96.* During that time, Employee tried to talk to the patient to encourage her to come back to the unit, but the patient would not come back. Ms. Mukum explained that while Employee was returning to the nurse's station, the patient attacked her. *Tr. pg. 97.* Ms. Mukum further testified that since the area near the hallway/ nursing station was small, the staff tried to remove the patient because she lunged after Employee. After the incident, Ms. Mukum saw scratches on Employee and the patient. She recalled a code being called, but there was a delay in response to the code. *Tr. pg. 98.*

Ms. Mukum could not recall Employee violating any policies. *Tr. pg. 104*. Ms. Mukum testified that she has never struck a patient but she has been struck by one. She explained that a patient who is bipolar has a psychological problem. *Tr. pgs. 106-107.* Ms. Mukum concluded by stating that she did not see Employee strike the patient. *Tr. pg. 108*.

3. <u>Jinette Aku (Transcript pages 109-119)</u>

Ms. Jinette Aku was employed at Saint Elizabeths for nine (9) years as a Licensed Practical Nurse. Employee was Ms. Aku's charge nurse. *Tr. pg. 110.* Ms. Aku attested that she

saw the patient charge, beat and scratched Employee. During cross examination, Ms. Aku testified she did not recall anything from the March 9th incident other than the patient that charged Employee. *Tr. pg. 118.*

4. Elaine Zeller (Transcript pages 119 -128)

Ms. Elaine Zellers is a Behavior Health Technician who was currently employed at Saint Elizabeths for twenty-two to twenty-three (22-23) years. Ms. Zellers testified that Employee was her first line supervisor. *Tr. pg. 120.* Ms. Zellers did not recall the patient's name but did recall that the patient was angry and anxious. As the patient went through the doors, Ms. Zellers attempted to get her to come back, but she would not listen. Ms. Zellers testified that as Employee came through the door, the patient started charging toward her. *Tr. pg. 122.* At that point, Ms. Zellers called a Code 13. *Tr. pg. 124.*

5. Laverne Plattel (Transcript pages 128 – 136)

Ms. Laverne Plattel has been employed by the hospital for thirty-eight (38) years. She worked with Employee for fifteen (15) years. She is a Nurse Consultant. Her responsibilities included educating, training, and assessing, the nurse's competency on the unit. She confirmed that Employee was a team leader and was competent. She described Employee as a leader who was able to direct staff members appropriately and as someone others looked up to. *Tr. pg. 133.* Ms. Plattel stated that as a consultant, she never gave Employee a character and performance evaluation. *Tr. pg. 135.*

6. Jacquiline Farmer (Transcript pages 136-144)

In 2012, Ms. Jacquiline Farmer worked in Unit 1D at Saint Elizabeths. She was the nurse manager for two and one-half (2 ½) years. *Tr. pg.141.* Ms. Farmer did not recall the events of the March 9th incident, but she did recall hearing that Employee was removed because she abused a patient. *Tr. pg. 143.*

FINDINGS OF FACTS, ANALYSIS AND CONCLUSION

As part of the appeal process within this Office, I held an Evidentiary Hearing on the issues of whether Agency's action of terminating Employee for failure to observe precaution and patient abuse was in accordance with applicable law, rules, or regulations. During the Evidentiary Hearing, I had the opportunity to observe the poise, demeanor and credibility of the witnesses, as well as Employee. The following findings of facts, analysis and conclusions of law are based on the testimonial and documentary evidence as presented by the parties during the course of Employee's appeal process with this Office.

Employee was employed with Agency as a Psychiatric Nurse at Saint Elizabeth's Hospital. On March 9, 2014, Employee was the Lead Psychiatric Nurse/Team Leader in her unit (Unit 1D). Unit 1D is devoted to the care, treatment and supervision of female forensic patients in pretrial phase. As a Team Leader, Employee's responsibilities included, but were not limited to, the coordination of nursing care management of patients assigned to her unit, directing nurses

on an ongoing basis, developing and communicating team goals and balancing the workload among employee.

On the date of the incident, Unit 1D had a patient ("Patient X") who was approximately six (6) months pregnant. Patient X had been acting out since the beginning of the day shift which started at 7:00 a.m. She was loud, disruptive, verbally abusive, unruly and threatening. March 9, 2014 was a Sunday and a group of individuals in care were about to be escorted to church service. Patient X also wanted to go to church service. However, because of her behavior, Employee, the Team Lead for the shift, decided that Patient X would not attend church. When Patient X found out that the rest of the individuals in care had left for church without her, she became enraged and walked towards the nursing station, walked pass the staff, into the hallway, next to the exit door. Employee and three (3) other staff members made several attempts to redirect Patient X to the day room, to no avail. Employee then returned to the nursing station to call a Code 13, an emergency request for assistance that is broadcast over the hospital's intercom system. The other staff members stayed with Patient X in the hall way, continued talking to her, using hand gestures. When Employee was done placing the Code 13, she opened the door to the nursing station, standing in the hallway next to the nursing station, she gestured something towards the direction of the other staff and Patient X. Patient X charged down the hallway towards Employee. Employee opened the door to the nursing station and raised her hands. There was a struggle between Employee and Patient X. Employee got away from Patient X, started retreating towards the hallway entrance. She was pursued by Patient X, while the other employees attempted to restrain Patient X. A male staff member wearing blue gloves also came into the hallway to assist. As Patient X turned her attention towards the other employees, as they were attempting to direct her towards the day room. Employee placed her hand on the back of Patient X's neck/back, and the male staff member wearing blue gloves then puts his hands on Employee's hands, which were on Patient X's neck/back. The male staff member then places his hands on Patient X's shoulder, while Employee's hands were still on Patient X's neck/back, as they tried to direct Patient X toward an exit door next to the nursing station.

Patient X sat on the floor. She attempted to lean backward, but Employee pushed her forward. She touched the back of her neck and seemed agitated by Employee's touch. Patient X turned around, attempted to swing at Employee, and then attempted to fall backwards, with her back resting on the nursing station door. Employee made a few hand gestures pointing towards the door ahead. While Patient X was still on the floor, with her back resting against the wall, security officers and other hospital staff responded to the unit. Employee left the hallway, and returned a little while later. As more staff members entered the hallway, Employee exited through the nursing station direction. Patient X was helped off the floor by the security staff and she exited the hallway with them.

The incident was investigated by an Incident Review Specialist. The Incident Review Specialist also interviewed the other employees present during the March 9, 2014, incident. They also provided written statements of the incident. On May 14, 2014, Agency issued to Employee, a Proposed Discipline- Removal from her position as Psychiatric Nurse for the following cause of action:[3]

[3] Agency issued a Corrected Notice on May 16, 2014.

Cause: Any on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operation: Neglect of duty

1. Failure to observe precautions regarding safety

You received training on the Abuse Policy on January 23, 2013, and January 30, 2014, yet on March 9, 2014, you failed to adhere to it. The Abuse Policy requires staff not to handle individuals in care with more force than is reasonably necessary to ensure the safety of the individual in care. Specifically, the Abuse Policy states the following:

> It is the policy of Saint Elizabeths Hospital that any knowing, reckless, or intentional abuse, neglect, or exploitation of individual in care will not be tolerated and is considered to be extremely serious misconduct.

On March 9, 2014, you failed to adhere to the Hospital's Abuse Policy to ensure Patient X returned to the dayroom. As you know or should reasonably know, you are required not to use more force than is reasonably necessary to ensure an individual in care's safety. As a Psychiatric Nurse, you were required to calm Patient X through therapeutic communication skills or other intervention techniques to ensure Patient X returned to the dayroom. Instead, you responded to Patient X's poor behavior by finger-pointing at Patient X causing her to become even more aggravated. Your finger-pointing towards Patient X was demeaning and humiliating. Your actions escalated the situation, were not therapeutic, and exposed the patient to risk of injury.

You also used more force than necessary when you confronted Patient X as she charged at you in the hallway. You pushed the door open in the direction of Patient X positioning yourself for physical contact. However, you had ample time to retreat back in the nursing station to avoid physical confrontation with Patient X. Again, you did not employ therapeutic intervention techniques consistent with Safety-Care training, such as removing yourself from the situation. Your actions were reckless and could have caused serious harm to Patient X.

2. Patient Abuse

On March 9, 2014, you used more force than was reasonable in handling Patient X. The Abuse Policy defines physical abuse as physical contact with, or handling of, an individual in care with more force than reasonably necessary to ensure the safety of the individual in care or others. Specifically, you pulled Patient X's hair from the back while she was being placed in a hold by your colleague. The Hospital's housekeeper intervened to remove your hands from Patient X's hair. Your action of pulling Patient X's hair was excessive force.

You used excessive force by touching Patient X's back when she did not pose an imminent threat to you or other staff. You pushed Patient X from behind in her

> back cognizant that she was five (5) months pregnant, while she was seated on the floor and being restrained by other staff. Your actions only agitated Patient X to the extend she attempted to swing at you.
>
> During the struggle, Patient X sustained scratches on the back of her neck and face. You were the only person who came in direct contact with Patient X's neck and face, and Patient X reacted to your touching of her on the neck. Your actions of pulling of Patient X's hair, scratching her neck and face, and then pushing her in the back was excessive force.
>
> The SEH will not tolerate abuse of individuals in care. It is your responsibility to ensure that the individuals are protected, safe and treated with respect. You neglected your duties to protect and treat Patient X with respect. In fact, you placed Patient X in harm's way by finger-pointing at Patient X and then later pulling her hair and touching her back.[4]

Employee responded to the May 16, 2014, notice on May 29, 2014. Following an administrative review, the Hearing Officer in her recommendation report stated that Agency did not meet its burden of proving the above cause of action and as such, she does not recommend that Employee be removed. On July 24, 2014, Agency issued a Final Decision Notice removing Employee from her position as Psychiatric Nurse effective July 28, 2014.

Analysis

Pursuant to OEA Rule 628.2, 59 DCR 2129 (March 16, 2012), Agency has the burden of proving by a preponderance of the evidence that the proposed disciplinary action was taken for cause. Further, DPM § 1603.2 provides that disciplinary action against an employee may only be taken for cause.

1) Whether Employee's action constituted cause for termination

Under DPM §1603.3(f)(3),[5] the definition of "cause" includes any on duty or employment-related act or omission that interferes with the efficiency and integrity of government operations: neglect of duty – Failure to observe precautions regarding safety and Patient abuse. According to the record, Agency's decision to terminate Employee was based on this cause of action.

> **Any on-duty act or employment-related act or omission that interfered with the efficiency and integrity of government operations: Neglect of Duty**

Neglect of duty is defined, in part, as a failure to follow instructions or observe precautions regarding safety.

[4] Proposed Discipline – Removal Corrected Notice (May 16, 2014).
[5] *See also* D.C. Mun. Reg. tit. 16 § 1603(f)(3).

A) Failure to observe precautions regarding safety

In this matter Agency alleges that, On March 9, 2014, Employee failed to adhere to the Hospital's Abuse Policy to ensure Patient X returned to the dayroom.[6] Agency notes that Employee used more force than was reasonably necessary to ensure an individual in care's safety. Agency explains that Employee's finger-pointing at Patient X caused her to become even more aggravated. The finger pointing was demeaning and humiliating. Employee's actions escalated the situation, and exposed Patient X to risk of injury. According to Agency, Employee used more force than necessary when she confronted Patient X who charged at her in the hallway by pushing the door open in the direction of Patient X, positioning herself for physical contact. Employee had ample time to retreat back in the nursing station to avoid physical confrontation with Patient X. She did not employ therapeutic intervention techniques consistent with Safety-Care training such as removing herself from the situation. Her actions were reckless and could cause serious harm to Patient X.

However, I find that Agency has not provided this Office with sufficient evidence to support this assertion. A review of the video tape[7] of the incident that was introduced as evidence during the Evidentiary Hearing as well as witness testimony does not support Agency's assertion. Mr. Rogers testified that the video showed Employee leaving the nurses' station appearing to verbalize and point her finger in the direction of the group at the end of the hall. *Tr. pg. 47.* There is no evidence that Employee's finger-pointing gesture was specifically at Patient X. Without audio, this fact is difficult to prove... Moreover, given the fact that Patient X was disruptive the entire morning, her charging towards Employee could have been in reaction to Employee's message to her colleagues that she had called a Code 13, because Patient X knew help was on the way. There is no statement in the record from Patient X stating that she felt humiliated or demeaned when Employee came out of the nursing station and made several finger pointing gestures towards her direction. On the contrary, Per Mr. Rogers' testimony, the individual in care did not indicate that she was upset by Employee's gesture. *Tr. pg. 93.*

Furthermore, Employee explained that she talked a lot with her hands and that she was not finger pointing, but she was asking the patient to go back to the nursing day room. *Tr. pg. 39.* She stated that she used the same hand gesture to instruct her staff to stay away and to leave the individual in care alone. Tr. pgs. 39 & 77. I find this testimony credible because, prior to going into the nursing station to place a Code 13, Employee is seen in the video using hand/finger gestures as she talks to the other staff members and to Patient X, in an attempt to deescalate the situation and get Patient X back to the day room.

While critiquing the positioning of Employee's hands when Patient X charged after her, Mr. Rogers described that Employee took a safety stance. He explained that the safety stance is taught by training staff to all employees during their orientation as part of the safety care manual. If the staff is attacked by a patient, they are trained to retreat into a safety stance. Furthermore, Ms. Carter testified that Employee put her hands up, which is what you are expected to do to

[6]Agency's Abuse policy states as follows, it is the policy of Saint Elizabeths Hospital that any knowing, reckless, or intentional abuse, neglect, or exploitation of individual in care will not be tolerated and is considered to be extremely serious misconduct.
[7] The video does not have any audio.

protect yourself and then shuffled backwards. This is exactly what Employee did on the date of the incident, while her safety stance posture may not have been perfect per Mr. Rogers' testimony, given the fact that this was an actual incident and not a training exercise, I find that Employee was not positioning herself for physical contact, but was rather taking a safety stance.

Additionally, Agency highlights that Employee had ample time to retreat into the nursing station. I find this assertion implausible. Employee had less than five (5) seconds to decide her next move. No reasonable person will consider a few seconds "ample" time when dealing with a chaotic situation. Furthermore, Employee testified that she ran towards the hallway and not the nursing station because it was safer for her. When questioned why she did not go into the door at the nursing station and close the door, Employee responded that there was only one door she could use that was not an exit. Otherwise, she would have been trapped. Employee stated that traditionally nurses who ran out of the nursing station were safe and those who stayed were hurt. She explained that this happened to the team leader she replaced. *Tr. pgs. 30-31*., Volume II. So for her and the patient's safety, she ran out of the nurse's station. *Tr. pg. 31*. Agency did not provide evidence to the contrary. I conclude that Employee was faced with a split second decision given the chaos that was unfolding, and based on past experience in the unit, and out of concern for the safety of Patient X and herself, she decided against retreating into the nursing station. I also find her split second decision to be reasonable, given the totality of the circumstance. Patient X is seen charging after Employee. There is no way of knowing whether or not Employee would have successfully made it into the nursing station and close the door in time to keep Patient X away. If both Employee and Patient X found themselves in the nursing station, which was crowded with furniture, as well as other small and large equipment, Employee, Patient X, and the other staff members could have sustained far serious injury. Employee's action of not retreating into the nursing station did not increase the likelihood of physical confrontation with Patient X. Therefore, I further conclude that her actions were not reckless, and if anything, she had the safety of Patient X in mind.

Agency contends that Employee did not employ therapeutic intervention techniques consistent with Safety-Care training such as removing herself from the situation. Ms. Carter stated that she had a problem with Employee being behind Patient X, as Employee no longer remained in the patient's focus. There is no evidence that removing herself from the situation would have deescalated the situation. Further, Agency failed to pinpoint the exact point it thinks Employee would have successfully removed herself from the situation, and which would have calmed Patient X. In the video, when Employee went into the nursing station to call a Code 13, Patient X remained visibly upset and agitated while the other three (3) staff members were attempting to talk to her. Further, after Patient X's initial charge at Employee, the other staff members succeeded in separating them. Employee is seen walking away from Patient X and only reengages when Patient X turns her attention to the other staff members as they attempt to restrain her. Moreover, Employee was a Team Leader on the day of the incident. Her responsibilities included, but not limited to, the coordination of nursing care management of patients assigned to her unit, directing nurses on an ongoing basis, developing and communicating team goals and balancing the workload among employee. I find that, leaving the unit in the midst of a crisis would have been a neglect of Employee's duties.

Consequently, I conclude that, Agency has not met its burden of proof with regards to its charge of Neglect of duty, failure to observe precautions regarding safety as defined under DPM §1603.(f)(3).

B) Patient Abuse

Here, Agency contends that, Employee used more force than was reasonable in handling Patient X. It explained that, its Abuse Policy defines physical abuse as physical contact with, or handling of, an individual in care with more force than reasonably necessary to ensure the safety of the individual in care or others. Specifically, Agency highlights that Employee pulled Patient X's hair from the back while she was being placed in a hold by her colleague, and the hospital's housekeeper had to intervene to remove Employee's hands from Patient X's hair. Further, Agency alleges that Employee used excessive force by touching Patient X's back when she did not pose an imminent threat to her or other staff. Agency notes that Employee pushed Patient X from behind in her back cognizant that she was five (5) months pregnant, while she was seated on the floor and being restrained by other staff. It maintains that Patient X sustained scratches on the back of her neck and face during the struggle, and Employee was the only person who came in direct contact with Patient X's neck and face. Agency concluded that Employee's actions of pulling of Patient X's hair, scratching her neck and face, and then pushing her in the back was excessive force.

While Agency alleged that Patient X's hair was pulled, there is no clear evidence in the video showing Employee pulling Patient X's hair. A review of the video show that Employee places her hands on the back of Patient X's hair/neck. Thereafter, a male staff wearing gloves is seen placing his hands on top of Employee's hands, which are still on the back of Patient X's hair. However, there is no evidence of hair pulling, or pulling of any sort. Additionally, given the chaos that was unfolding, there is no evidence to support an assertion that Employee deliberately pulled Patient X's hair in an abusive manner. Moreover, during the internal investigation into this matter, the male staff member, Mr. Reginald Ross, whom Agency alleged had to intervene to remove Employee's hands from Patient X's hair, stated to Mr. Rodgers that he did not observe any of the staff members pull Patient X's hair or scratch her face or neck. He also stated that he did not have to physically intervene to separate any of the staff members from Patient X. Moreover, none of the other staff members present during the incident testified or stated that Employee abused Patient X by pulling her hair. Consequently, I find that Agency has not provided this Office with sufficient evidence to conclude that Employee indeed pulled Patient X's hair during the struggle.

There are pictures in the record of scratches sustained by both Employee and Patient X. Employee and Patient X were not the only two (2) individuals involved in the struggle. At one point, there were about four (4) female nursing staff members struggling to calm Patient X and get her into the day room. The scratch on Patient X's neck could have been inflicted by any of these individuals during the struggle. According to the video, Patient X had her back to all four (4) of these individuals at some point, as they were all attempting to calm her down. Moreover, the video does not indicate when Patient X was scratched, nor has Agency submitted evidence that shows that it was Employee who scratched Patient X, and not the other three (3) nurses. Additionally, the video does not constitute a complete narrative of what happened on the day in

question. Some parts of the March 9, 2014 struggle are not captured by the video provided by Agency, which was its sole evidence for its charges against Employee. Therefore, Agency has not met its burden of proof in this instance as it has not provided this Office with evidence to support its allegation that Employee abused Patient X by scratching her neck.

Furthermore, Agency's contention that Employee abused Patient X by pushing her in the back while she was seated on the floor is not convincing. Based on the video footage, Employee is seen "pushing Patient X forward, then disengages; and then Patient X swings at Employee, Employee again pushes Patient X forward, then disengages; Patient X falls backwards, but is supported by the door to the nursing station, and Employee again pushes her forward." Although there is evidence of Employee placing her hand on Patient X's back while she is on the floor, I conclude that this was done to stabilize Patient X, as well as prevent her from falling backwards.

Moreover, Ms. Carter testified that nurses take precautions to avoid accidents. She explained that, a safety method approach could have been achieved if Employee placed her hands on the lower and upper part of the back if there was a need for a patient to be lowered to the floor. *Tr. pg. 150.* She explained that the staff was critiqued during the training classes to best determine how to handle a situation. *Tr. pgs. 151-154.* Mr. Rodgers also testified that, Patient X had lowered herself on the ground, and Employee was trying to keep Patient X in an upright position, but in doing so, Employee is pushing Patient X forward. Additionally, Employee testified that Patient X got up, swung, and slammed her body on the floor. *Tr. pg. 32.* Therefore, Patient X would have been in grave danger if she would have continued to let her fall, which is why she reduced the force and stepped back into a safety stance. *Tr. pg. 33*. Moreover, Agency has not provided any evidence to show that Employee's action of pushing Patient X forward was not to stabilize/prevent her from falling backwards, but rather to abuse her. Thus, I find that Agency has not proven that by pushing Patient X in the back, Employee used excessive force.

2) Whether the penalty of termination is within the range allowed by law, rules, or regulations

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).[8] According to the Court in *Stokes,* OEA must determine whether the penalty was within the range allowed by law, regulation, and any applicable Table of Penalties ("TAP"); whether the penalty is based on a consideration of the relevant factors; and whether there is a clear error of judgment by Agency. In the instant case, I find that Agency has not met its burden of proof for the above-referenced charges, and as such, Agency cannot rely on these charges in disciplining Employee.

[8] *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); *Ernest Taylor v. D.C. Emergency Medical Services,* OEA Matter No. 1601-0101-02, *Opinion and Order on Petition for Review* (July 21, 2007); *Larry Corbett v. D.C. Department of Corrections,* OEA Matter No. 1601-0211-98, *Opinion and Order on Petition for Review* (September 5, 2007); *Monica Fenton v. D.C. Public Schools,* OEA Matter No. 1601-0013-05, *Opinion and Order on Petition for Review* (April 3, 2009); *Robert Atcheson v. D.C. Metropolitan Police Department,* OEA Matter No. 1601-0055-06, *Opinion and Order on Petition for Review* (October 25, 2010); and *Christopher Scurlock v. Alcoholic Beverage Regulation Administration,* OEA Matter No. 1601-0055-09, *Opinion and Order on Petition for Review* (October 3, 2011).

ORDER

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

1. Agency's action of terminating Employee from service is **REVERSED**; and
2. Agency shall reinstate Employee and reimburse her all back-pay, and benefits lost as a result of her removal; and
3. Agency shall file with this Office, within thirty (30) days from the date on which this decision becomes final, documents evidencing compliance with the terms of this Order.

FOR THE OFFICE:

_____
MONICA DOHNJI, Esq.
Senior Administrative Judge