**THE DISTRICT OF COLUMBIA**

**BEFORE**

**THE OFFICE OF EMPLOYEE APPEALS**

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| In the Matter of: | ) | |
| | ) | |
| EMPLOYEE[1], | ) | OEA Matter No. 1601-0046-21 |
| | ) | |
| v. | ) | Date of Issuance: August 24, 2022 |
| | ) | |
| D.C. FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT, Agency | ) | MONICA DOHNJI, Esq. Senior Administrative Judge |
| | ) | |

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

**INITIAL DECISION**

INTRODUCTION AND PROCEDURAL HISTORY

On September 15, 2021, Employee filed a Petition for Appeal with the Office of Employee Appeals ("OEA" or "Office") contesting the Fire and Emergency Medical Services Department's ("Agency" or "FEMS") decision to suspend him for seven hundred and forty-four (744) duty hours effective August 23, 2021, to January 5, 2022. On October 19, 2021, OEA issued a Request for Agency Answer to Petition for Appeal. On November 17, 2021, Agency submitted its Answer to Employee's Petition for Appeal. This matter was initially assigned to Administrative Judge ("AJ") Cannon. Thereafter, this matter was reassigned to the undersigned on April 5, 2022.

A Status/Prehearing Conference was convened in this matter on May 19, 2022. During the Status Conference, the undersigned was informed that there was an Adverse Action Panel Hearing in this matter. As such, OEA's review of this appeal was subject to the standard of review outlined in *Elton Pinkard v. D.C. Metropolitan Police Department,* 801 A.2d 86 (D.C. 2002). Thereafter, I issued a Post Status Conference Order requiring the parties to submit briefs addressing the issues raised during the Status/Prehearing Conference. Both parties have complied. The record is now closed.

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

## 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 628.1, 59 DCR 2129 (March 16, 2012) states:

> The burden of proof with regard to material issues of fact shall be by a preponderance of the evidence. "Preponderance of the evidence" shall mean:
>
> > That degree of relevant evidence which a reasonable mind, considering the record as a whole, would accept as sufficient to find a contested fact more probably true than untrue.

OEA Rule 628.2 *id.* states:

> 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 CHARGE(S)

According to Agency's Answer to Employee's Petition for Appeal at Tabs 13 and 21, Employee's adverse action was predicated on the following charges and specifications, which are reprinted in pertinent part below:

**Charge 1:** Violation of D.C. Fire and Emergency Medical Department Order Book Article XXIV, § 10 Position Responsibilities, which states:

**C.** Position Responsibilities Continued – Medical Duties: …

**Driver (Position No.** 1): …

**2.** Duties at the Incident Scene:

- Status DEK Button # 2 when arriving on scene.

- Applies Oxygen and AED, when applicable.
- Obtains Vital Signs.
- Establishes IV line, when applicable.
- Checks the scene for equipment prior to leaving the scene.
- Checks the scene for equipment and any discarded material that would be classified as medical waste prior to leaving the scene.
- Status DEK Button #6 when transporting to hospital.

Further violation of D.C. Fire and Emergency Medical Services Department Bulletin No. 13, § 11, 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.

3. …

4. That we will never use any method to discourage you from receiving medical treatment.

5. To have your vital signs checked and documented whether or not you are transported to the hospital.

6. To have your past medical history, medication and your current complaint of illness or injury, along with the assessment, interventions and treatment performed by our emergency personnel, thoroughly and truthfully documented on your patient care report.

7. …

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.

9. …

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

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

This misconduct is defined further as cause in D.C. Fire and Emergency Medical 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* 16 DPM § 1603.3(f)(9).

**Specification 1:** By email dated May 22, 2020, Battalion Fire Chief Michael Walko informed Deputy Fire Chief Kenneth Moore about a citizen complaint that describes FE/EMT [Employee]'s misconduct as follows:

FYI, A citizen called EMS 3 Sharon Moulton to complain about an ambulance crew that was dispatched to her residence located at 2323 Good Hope Ct, S.E. (F20087160) at 11:06:09. She advised her 6 year old son was not feeling well and requested an ambulance. According to her, the ambulance crew called her residence inquiring about the child. The ambulance crew advised the mother to give Tylenol and the child should be ok. The ambulance had arrived and was parked outside and then left. The crew never went inside or made contact other than a phone call to the mother.

Further in his Special Report (dated 05/22/2020), FF/EMT [Employee] describes his misconduct as follows:

On May 22, 2020, A32 was dispatched to 2323 Good Hope CT SE run F200087160 at 1105 AM for a yo male with a fever. On arrival, A32 called the mother of the pt because the notes did not highlight if the call was PPE advised. A32 called to see if the pt was a possible COVID and if the pt could be brought outside. Upon talking to the mother of the pt she stated that she did not know why her sons primary care physician told her to call 911. The mother stated that she hadn't given her son anything for the fever and that she did not want her son to be transported to the emergency room if it wasn't necessary because of COVID. She stated that she wanted to try giving her son Tylenol to see if the fever would break. The pts mother was made aware that if she needed EMS, she could always

call 911. The mother said that if the Tylenol did not work that she would take her son to the hospital by personal vehicle.

Further, in his 1st Endorsement (dated 05/22/2020), Captain Brian McAllister describes FF/EMT [Employee]'s misconduct as follows:

Firefighter/EMT [Employee] was interviewed by me after being notified by EMS 3 Captain Moulton of a citizen complaint in reference to Run Number F200087160.

Firefighter/EMT [Employee] admits in his Special Report that he nor his partner made contact with the juvenile patient. FF/EMT [Employee] stood by while his partner spoke to the patient's mother via personal cell phone advising her to administer over the counter medication to break a reported fever.

Firefighter/EMT [Employee] failed to properly administer patient care and never did a face to face with the child in order to get a first impression or monitor vitals before choosing to place Ambulance 32 in service from the run, therefore grossly neglecting his duties and placing the juvenile patient in danger.

Upon arriving at the pediatric patient's home, both Order Book, Article XXIV and the Patient Bill of Rights required FF/EMT [Employee] to at least attempt to render competent, compassionate, and empathetic emergency medical service to the child. Yet FF/EMT [Employee] showed virtually no concern for this patient. Rather than initiate (or make an attempt to initiate) patient care FF/EMT [Employee] did nothing more than watch his partner talk to the mother on her cell phone. FF/EMT [Employee] admitted discourteous treatment of the public, violation of department's customer service standards, failure to offer assistance when requested, failure to carry out assigned tasks, and careless work habits constitute both neglect of duty and unreasonable failure to give assistance to the public. Accordingly, this termination action is proposed.

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

**V**. **Refusal Procedures**:

…

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 glucose level.

B. Inform the patient that units responded to the scene 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 detailed explanation of possible risks and danger signs to patients or other designees.

E. …

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

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

H. Obtain signature of a witness; preferably 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 of age 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 scene, providers may dispense with the radio consult.

Further violation of the D.C. Fire and Emergency Medical Services Department Special Order No. 54, series 2012, Patient Care Reporting (ePCR) Directive (effective 10/25/2012) which states:

> **Documentation Policy**:
>
> **Regardless of the outcome of an event, all units are required to provide a written account of their actions and findings on EMS related event.** An ePCR must be completed and include clear, concise and accurate documentation. The ACIC on the transport

unit and the company OIC shall ensure the ePCR is completed on each dispatch, patient contact and/or transport.

Narratives are required for each patient contact. The narrative section shall include any information that is pertinent to the assessment, treatment(s), decisions, response/outcome and disposition that is not covered in the drop-down menu. The narrative should include, but not limited to: rationale for the use/non-use of controlled medication; law enforcement badge number; condition of surroundings; especially when abuse is suspected; whether medical control was conducted; name of physician; when resuscitation is terminated in the field; patient refusal of treatment; transport to the closet or appropriate facility; and any other special considerations

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* 16 DPM § 1603.3(f)(3) (August 27, 2012).

**Specification 1** Notwithstanding the clear directives outlined in both the Pre-hospital Treatment Protocols and the (**CONSENT / REFUSAL OF CARE POLICY**) and the Special Order No. 54, series 2012 (**Patient Care Reporting (ePCR) Directives**), FF/EMT [Employee] failed to perform any assessment of his pediatric patient, failed to follow the Department's Refusal of Care policy, and failed to properly complete the ePCR corresponding with his response on Incident No. F20087160. Accordingly, this termination action is proposed.

SUMMARY OF THE TESTIMONY

On June 21, 2021, Agency held a Trial Board Hearing. During the hearing, testimony and evidence were presented for consideration and adjudication relative to the instant matter. The following represents what the undersigned has determined to be the most relevant facts adduced from the findings of fact, as well as the transcript (hereinafter denoted as "Tr."), generated and reproduced as part of the Trial Board Hearing.

Danaryae Lewis - Tr. pgs. 22 – 84

Danaryae Lewis ("Lewis") has been a firefighter with Agency for eight (8) years. She was assigned to Ambulance 32 on May 22, 2020. Her tour of duty was 07:00 am to 07:00 am the next day. Tr. pg. 22. Lewis identified Employee's Exhibit 1 as the Journal for Ambulance 32. She explained that the journal was used to enter all dispatches and incidents related to Ambulance 32 during their tour of duty. Tr. pg. 25. Lewis stated that she worked with Employee

on Ambulance 32 on May 22, 2020. She noted that she had worked with Employee as a partner for over a year prior to May 22, 2020. Tr. pg. 26.

Lewis explained that she and Employee had a partnership system wherein, Lewis assumed the role of Ambulance Crew Member in Charge ("ACIC") because of her years of experience and Employee assumed the role of Ambulance Crew Member Aide ("ACA"). She explained that Employee would drive during the first 12 hours of their shift while Lewis did patient care. Lewis drove during the PM shift and Employee did patient care. Tr. pgs. 26-27, 49.

Referencing the 11:05 a.m. journal entry on May 22, 2020, Lewis testified that they are required to appropriately log all dispatches in the journal. She explained that the address, the type of calls created by the communication system and the outcome of what they found are also documented in the journal. Tr. pgs. 29-30. Lewis stated that she logged in the journal information for the May 22, 2020, incident. She further stated that she did patient care and journal entries from 7:00 am to 7:00 pm. Tr. pgs. 30-31.

Lewis identified Employee's Exhibit 2 as an Event Chronology. She acknowledged that the Exhibit specifically referenced the events that occurred at 2323 Good Hope Court. She also acknowledged that the call came in at 11:05 a.m. She explained that while the call was created at 11:05 a.m., it was dispatched at 11:06 a.m. Tr. pgs. 31-33. Lewis affirmed that they arrived at the address at 11:15 a.m. She testified that once they arrived, she and Employee began looking for the unit cell phone, but they could not locate it. Lewis stated that during the early part of the pandemic, they had developed a practice of trying to eliminate and limit indoor COVID-19 exposure for everyone involved in the assessment. Lewis explained that the dispatch notes stated that there was a six (6) year-old-boy experiencing high fever. She used her personal cell phone to call the mother of the patient to request if she could bring her son outside to be evaluated. Lewis testified that the mother informed her that she had spoken to the son's doctor who instructed her to give her son Tylenol and call 911. The mother informed Lewis that she was unsure as to why the doctor asked her to call 911 because she had not yet given her son the Tylenol. Tr. pgs. 36 - 37.

Lewis testified that she had the conversation with the mother on speakerphone. She explained that after introducing herself, and she asked if the mother could bring her son outside to be evaluated. Tr, pg. 38. Lewis stated that after the mother expressed concern about calling 911, she again asked the mother what was going on with her son, to which the mother responded that the son had a high fever, and he told his mother he was not feeling good. Lewis said he told the mother that they should get the son to the ambulance for an evaluation and get him to the hospital. The mother responded that she did not want to take her son to the hospital because of COVID-19. Tr. pg. 38. Lewis testified that she told the mother that they cannot give her son Tylenol, but they can take him to the hospital. Lewis affirmed that she made it clear to the mother that they could transport her son to the hospital. Tr. pg. 39. Lewis highlighted that the mother did not agree to bring her son out for evaluation. Tr. pg. 41. She testified that she advised the mother to follow the doctor's recommendation to give the son Tylenol to reduce the fever and to call 911 again if anything changed. The mother informed Lewis that she did not drive but her friend who was at the house would give them a ride to the hospital. Tr. pg. 42.

Lewis noted that the Journal entry for Ambulance 32, at11:20 am stated that "[t]here was no EMS Services required." Tr. pg. 43. Lewis testified that after she hung up the phone with the mother, she made a radio transmission to 2L communications on channel 11 to notify the dispatcher that they did not render any EMS services as none was required for the particular incident. She affirmed that she was placed back in service after the call. Tr. pg. 44.

Lewis denied that her refusal to enter the building was due to COVID-19. She testified that in March of 2020, her entire shift, except for her direct Lieutenant caught COVID from Employee, so they had all been introduced to COVID and they had been on numerous COVID calls. Tr. pg. 44. Lewis testified that their decision to not go into the building was their way of trying to protect everyone in the building, including the mother and the son. Tr. pg. 45. When asked if their refusal to enter the building was based on a desire to not provide assistance to the patient, Lewis said "no". Tr. pg. 45.

Lewis affirmed that she had COVID calls on the same shift with Employee. She explained that on the call following the 11:00 am call on May 22, 2020, they were dispatched to a scene where the patient was diagnosed with COVID. Tr. pgs. 45 - 46.

Lewis identified Employee's Exhibit 3 as the dispatch printout for the 2323 Good Hope Court address involving the six (6) year-old-boy. Tr. pg. 47. She stated that the dispatch event type said it was for a sick unknown person, with no additional information from the caller. Lewis explained that this meant no other information was provided to the dispatcher such as symptoms or any relevant information. With regard to the need for Personal Protective Equipment ("PPE"), Lewis testified that the dispatcher would communicate that over the radio channel and/or list it in the notes. Tr. pg. 48. Lewis noted that nothing about PPEs was mentioned in the 2323 Good Hope Court dispatch notes, and that was part of the reason for her call. Tr. pg. 49.

Lewis acknowledged completing a PCR report in conjunction with the call for service at 2323 Good Hope. She affirmed that there were two (2) reports prepared concerning this incident. She explained that the first report was completed in conjunction with not having any patient contact, demographic and details to submit into the ePCR report. The second report was an addendum to the first ePCR which included a narrative of her conversation with the patient's mother. Tr. pg. 50.

Lewis identified Employee's Exhibit 5, as the Special Report of the incident and she affirmed that the report was consistent with her testimony at the Trial Board Hearing. Tr. pg. 51. Lewis testified that the first report was completed on their way back to the fire station immediately after they left the scene. The second report was done after they learned that they were going out of service to type special report on the incident. Lewis further explained that she the addendum in the narrative to ensure the times matched the specific dispatch. She reiterated that she did this after they had written their special reports. She acknowledged that the PCR report stated that there was "no contact with patient" and "cancel on scene" because of the conversation with the mother. Tr. pgs. 52-53.

On cross examination, Lewis highlighted that she started calling patients when dispatched on an ambulance run specifically for COVID-19. Tr. pg. 54. When asked if this was part of

Agency's policy, Lewis testified that it was something that everyone was doing, so it was more of a learned behavior from offices all around the city. She reiterated that everyone was calling, even their own officers. Tr. pgs. 55 & 135-136.

Lewis acknowledged being in contact with the mother of the patient and learning that he had a fever, she did not know how high the patient's fever was because she did not ask the mother. Tr. pg. 55. Lewis stated that it did not cross her mind to ask the mother how high the son's fever was. She did not know how long the patient had been running a temperature. She averred that no other symptoms were stated in the notes or from the mother. Tr. pg. 56.

Lewis acknowledged that there are a number of steps that they normally do when evaluating a patient. She agreed that she did not learn from her conversation with the mother what she could have learned if she followed the normal steps. Tr. pg. 57. Lewis highlighted that she was not sure of how long she tried to convince the mother to bring the sick son outside, but she asserted that it was a few minutes. Tr. pgs. 57-58. Lewis testified that she asked the mother to bring down the sick son so they could evaluate him. She maintained that if she brought her son down to be evaluated, they would have taken the necessary steps to determine if the mother wanted the son to be transported by ambulance. Tr. pg. 58.

Lewis noted that she did not evaluate the patient. She testified that she did not know for certain if the patient needed to go to the hospital. Lewis stated that she simply respected the mother's wishes and allowed her to make the decision of whether to administer Tylenol and to have her friend take her son to the hospital. Tr. pg. 60. Lewis agreed that she was more versed with the protocol for transporting a COVID-19 patient to the hospital than the mother's friend. She acknowledged that it would have been more responsible for her to transport the patient to the hospital than for the friend to do so. Tr. pg. 60-61.

Lewis highlighted that she did not recommend that the mother give her son Tylenol. She simply concurred with the doctor's recommendation to give the child Tylenol when the mother asked her what to do. Tr. pg. 61. She reiterated that she did not recommend that the mother giver her son Tylenol. Instead, she encouraged the mother to follow the doctor's recommendation to give the son Tylenol by telling the mother that she, Lewis, did the same. Tr. pg. 62.

Lewis highlighted that May 22, 2020, was the only instance wherein, she called a patient and left without evaluating the patient. She noted that she did not radio any supervisor on May 22, 2020, to inform them that they were about to leave without first evaluating the patient because they did not have any patient contact and she did not feel that it was necessary to contact their emergency liaison officer on the appropriate channel (Channel 14) to notify them that they had not evaluated the patient and they would not be transporting to the hospital. She testified that she felt it was more appropriate to call Channel 11 to let them know that no EMS services had taken place. Tr. pgs. 62-63.

Lewis averred that, in hindsight, she should have gotten vitals, made a thorough assessment and obtained a signed release for either care and/or transport. She stated that she should have done the necessary steps just to limit liability altogether. Tr. pg. 63.

Lewis affirmed that everything in Agency's Exhibit 3 was truthful and accurate. Tr. pg. 65-66. Lewis asserted that she made the ultimate decision that no EMS services were requested. Lewis noted that Employee did not have any concerns about this decision. Employee also did not have any involvement in the ePCR report. She highlighted that Employee did not look at the report. Tr. pg. 66. Lewis affirmed that she radioed on channel 11 that no EMS services were requested. Tr. pg. 67. She noted that neither of them left the ambulance during that run. Lewis also stated that Employee did not speak directly to the mother, but she stated something in the background relating to the mother not wanting to have her son transported to the hospital. Tr. pg. 67.

Lewis acknowledged that they had adequate PPE on May 22, 2020. Tr. pg. 68. When asked if the department changed it policies regarding the need to evaluate or refusal procedure, Lewis said yes. She explained that there were different orders coming out weekly changing how they should approach COVID patients and how they were supposed to enter a residence; requesting for citizens to come outside; and what they were supposed to wear. Tr. pg. 68. When asked if anyone from the department ever advised them to call a patient and not evaluate them after the call, Lewis said "no". Tr. pg. 68.

When questioned by Member Edwards, Lewis affirmed that the reason she called the mother was to confirm whether PPE was advised. Tr. pg. 69. She stated that she did not see the portion of the Computer Aided Dispatch system ("CAD") note at 11:06, 45 seconds which stated that PPE was needed. She noted that they checked the notes en route and at the scene, and all it said was high fever, the mother's name and number. Lewis stated that it was a one page and they could not scroll. Tr. pg. 70. When asked why she did not call the Communications to call the mother to bring the son outside, Lewis stated that she did not think of having communications make the call. She explained that she had called by herself on numerous occasions. Tr. pg. 71. Lewis affirmed that calling to talk to the patient was a common procedure they adopted outside of the department policies. Tr. pg. 72.

Lewis asserted that the COVID procedure in place at the time was for one (1) member to go inside dressed in full PPE to do an evaluation, while their partner waited outside and not be within six (6) feet of a possible infected person. Tr. pgs. 72-73. Lewis testified that her rationale for requesting that the patient be brought outside was that the child had a high fever and she wanted him to be in a cooler environment because they had no knowledge of how warm it was inside and also because children with high fever could go into a febrile seizure, they wanted to get him in a cool environment and be able to assess him in an appropriate spot. Tr. pg. 73.

Lewis testified that she believed going inside to evaluate the child after the doctor had requested that the mother call 911 was the approach they should have taken. However, the doctor had also specified that the mother administer her son Tylenol. She explained that because the mother was confused as to why the doctor told her to call 911, Lewis told the mother she agreed with the doctor's recommendation to give her son Tylenol. Tr. pgs. 74 -75.

Lewis stated that she did not have experience with patients who were given medical advice by their doctors and did not know what to do. She explained that she has had patients who

were not sure or did not know what to do, and she followed proper procedure and protocol to provide them with the necessary care they needed. Tr. pgs. 75-76.

Lewis testified that Employee never questioned her ability to perform. She noted that she trained Employee and two (2) other members, and they had been over the proper ways of handling specific types of calls. But with COVID, things changed. She stated that their mistake was not intentional or deliberate, but rather, an honest mistake. Lewis asserted that looking back, they understand that they absolutely have to follow protocol for each and every run they go on. Tr. pgs. 76-77.

When asked by Captain Long ("Member Long") if they made any other phone calls on May 22, 2020, Lewis stated that they made a phone call for the very next call at 11:46 am, that was a positive COVID patient. Tr. pgs. 77-78. Lewis acknowledged making phone calls for the shifts prior to the May 22, 2020, shift. Lewis affirmed witnessing Employee making phone calls to patients during their shifts together. Tr. pg. 78.

When questioned by Chairperson Dawns how she would expect a kid's body respond to fever, Lewis stated that she would expect it to be hot, in and out, not necessarily in and out of consciousness, drowsy-like, and when they get to a point where their bodies can no long cope with being too heated, they go into a febrile seizure which is not good. Tr. pgs. 79 - 80. Lewis acknowledged that she would have been in a better position than the mother to evaluate the patient's vital signs such as their heart rate, respiratory rate, skin color, and the feel of their skin. She affirmed that she informed the mother of the things she wanted to take a look at. Tr. pg. 80.

Employee - Tr. pgs. 84 – 144

Employee has been employed with Agency for about three (3) years. The May 22, 2020, incident occurred approximately six (6) – seven (7) months after the end of Employee's probationary period. Tr. pg. 85. Employee affirmed that he was working with Lewis on Ambulance 32, on May 22, 2020, as the ACA. He was the driver during the AM shift when the 2323 Good Hope service call came in. Tr. pgs. 85 & 90. Employee affirmed that Lewis was on patient care when the 2323 Good Hope service call came in. Tr. pgs. 90-91.

Employee testified that on May 22, 2020, his shift started at 0700 a.m. At the start of the shift, they completed the checklist, check the equipment and cleaned the unit. He explained that they did not find the department cell phone at the beginning of the shift. Tr. pg. 86. Employee stated that when the call for 2323 Good Hope came in, there was no mention of PPE. When he checked the CAD system, he only saw "six (6) year-old male, with high fever", there was no mention of PPE or apartment unit number. They had the apartment address but no unit number. Tr. pgs. 87-88. Employee stated that because the CAD notes listed a COVID symptom, he told Lewis to call the mother when they got to the apartment and ask if she could bring her son downstairs to be evaluated in a cool environment. Tr. pgs. 88 -89.

Employee noted that during this COVID period, they were advised by the department via special order to encourage patients to come outside to be evaluated. One (1) member had to be dressed in full PPE and take vitals, while the other member stayed at least six (6) feet away from

the patient. All remaining crew members were to stay in the hallway. Upon completion of the evaluation, the other crew members assisted the member in PPE get out of the contaminated PPE and all the equipment sprayed. Tr. pg. 89.

Employee averred that when they got to 2323 Good Hope, Lewis called the mother on speaker phone and asked her several times during the call to bring her son downstairs to be evaluated and possibly get him to the hospital. The mother stated that she did not know why the doctor told her to call EMS. Employee explained that the mother had not given the son the Tylenol at the time the doctor told her to do so. The mother informed Lewis that she did not want her son transported to the hospital because she did not want him exposed to COVID and that she would much rather give him Tylenol and monitor the fever. Employee testified that Lewis told the mother that if she was comfortable with that, then she should go ahead and if she could not get the fever to break, she should call 911 and they would have an ambulance back at her place. Employee also stated that the mother said if she could not get the fever to break, she would have her friend drive her to the hospital since the mother did drive. Employee noted that the call was concluded at this point, and they made a radio transmission on channel 11 that no EMS was required, and Ambulance 32 was back in service. Tr. pgs. 90-93, & 99.

When asked if he observed the six (6) year-old-boy while on the scene, Employee said he did not. He stated that Lewis offered several times during the phone conversation to take the boy to the hospital. He also stated that Lewis informed the mother that they were not able to give her son medication to break his fever and the only thing they could do was transport her son to the hospital. Tr. pg. 93.

Employee testified that they were taught at EMT school that whenever a person has a body temperature issue such as high fever, the first thing to do is change the patient's environment, that why he asked Lewis to call the mother and ask if she could bring the son downstairs so he could be evaluated in a cool environment and off to the hospital. Tr. pgs. 94 - 95. Employee also noted that Lewis still had to dress in PPE and get the equipment, which was time wasted, as they could have provided the child with care at the back of the ambulance while rushing her to the hospital for a doctor to provide him with the best care. Employee affirmed that had the child been brought downstairs for evaluation, they would have followed the procedures and protocol necessary to transport the child to the hospital. Tr. pgs. 96 & 112-113.

Employee stated that upon review of the situation now, he would have made every effort to try to see the patient either by himself, calling the EMS supervisor or the paramedic engine company so the officer could attempt to do so. If the mother still refused, he would have at least got a proper signed release for this patient. Tr. pg. 97. Employee reiterated that the mother was adamant about not taking her son to the hospital because she did not want his exposed to COVID. Because they were not police officers, they could not force her. But he noted that in hindsight, there were other steps that they could have taken. Tr. pg. 98.

Employee affirmed that their next run after the 2323 Good Hope service call on May 22, 2020, was a positive COVID patient. Tr. pg. 99. Employee stated that when they arrived at this scene, they called the number listed for the patient in the CAD system. He noted that it was an elderly woman who was at home with her grandchildren. They got dressed into their PPE and as

they were walking to the house, the patient's daughter met them outside and told them her mother was COVID positive and she was not going inside. Employee noted that they went in, did and assessment of the patient and all her vitals were stable, so they sent the patient through the nurse triage line. Employee noted that they did not have any reservations going in to do the assessment though they were aware that it was a COVID positive patient. He asserted that they responded to many COVID related calls. Tr. pgs. 100 - 101. He stated that COVID would not stop him from going above and beyond to provide service for the public. Tr. pg. 102.

Employee testified that overall, he has never had an issue with Lewis. Tr. pg. 102. He stated that when they were put out of service and asked to type a special report because of the 2323 Good Hope services call, they agreed that they should have gotten a signed release from the patient's mother. Tr. pg. 103. Employee noted that he takes his job seriously as he is dealing with the lives of the public and his decisions can impact others working at Agency. Tr. pgs. 105-106.

Employee identified Employee Exhibit 4 as his Special Report. Tr. pg. 106. He affirmed that his testimony at the Trial Board Hearing was consistent with what he wrote in the Special Report in May 2020. Tr. pgs. 106-107.

On cross examination, Employee affirmed that everything in the Special Report was accurate. Tr. pg. 107. He noted that there had never been a time when he called a relative of a patient and left without seeing the patient. He however explained that there have been plenty of times where they, along with other member have called patients or their relatives to come outside to be evaluated per general orders which encouraged them to try to get patients outside to be evaluated. Tr. pgs. 107-108.

Employee stated that when dealing with patients with body temperature issues, especially minor, he does not like wasting time. He explained that since they cannot give the patient medication to regulate the temperature, the best course of action is to get the patient into the back of the ambulance, attempt to control the temperature and transport them to the hospital. Tr. pgs. 108 -109.

Employee stated that he heard the entire conversation between Lewis and the mother because she was on speakerphone. Tr. pg. 110. He noted that they did not ask the mother what the temperature in the house was. They were focused on getting the child the help he needed by getting him into a controlled environment - the ambulance where they could control the temperature, and if necessary, get the child to the hospital for the best possible care needed. Tr. pgs. 110 – 111. Employee explained that they did not just leave, they made efforts to get the child to the ambulance to provide him with the best help need, but he was unsure as to why the mother would not bring the son downstairs. Tr. pg. 111. Employee stated that they were in the ambulance during the phone conversation. He asserted that because he was the driver and Lewis was on patient care, Lewis would have been the one to go in. He noted that Lewis did not have on the PPE. Tr. pg. 112.

Employee stated that the reason Lewis called the mother was because he suggested to Lewis that the mother bring the child outside to be evaluated. Tr. pg. 113. Employee testified that he did not know how high the child's fever was or how long he had had the fever for. Tr. pg.

114. Employee asserted that the mother called 911 because of the doctor. He explained that the doctor told the mother to give the son Tylenol and if it did not work, then she should call 911. The mother never gave the son the Tylenol, instead she called 911. So they wanted to get the child to the hospital where the Tylenol could be administered along with any other help that the might have needed. But the mother adamantly stated that she did not want her son in the hospital because she did not want him exposed to COVID. She said she would rather give him the Tylenol and monitor the fever. Tr. pgs. 114 -115, & 121.

Employee testified that during the outbreak of the pandemic, people were encouraged by the television news channels everywhere not to come to the hospital even if they had COVID symptoms, unless they had trouble breathing. Therefore, Employee assumed the doctor recommended that they mother gave her son Tylenol, monitor the fever if it broke, if it did not, then call 911. He noted that regardless of the doctor's instructions, the mother could call 911 at any time and he, Employee wanted to get the child to the hospital as soon as possible. Tr. pgs. 115 -116, & 131.

Employee acknowledged seeing Agency's Exhibit 4 - the Department's Policy regarding pre-hospital treatment protocols at the recruitment school. Tr. pgs. 116 -117. Employee stated that he was trained on the proper procedure to evaluate patients and transporting them to the hospital. Tr. pg. 117. Employee agreed that his treatment of the patient at 2323 Good Hope was not in line with the proper procedure. He however, noted that the proper procedure/protocol did not account for a pandemic because the pandemic was something no one had ever dealt with before. He averred that expecting that the proper procedure be followed exactly as written was unrealistic, especially in a pandemic, which was why the Department constantly sent out special orders on the safest ways to handle medical calls on the scene during the pandemic. Tr. pgs. 117 -118. Employee noted that no Department document stated that they you call patients or not do an evaluation. He explained that the calling of patients was a learned behavior, and everyone was doing it since this was at the height COVID. He reiterated that the general orders encouraged them to get the patients outside to be evaluated. Tr. pgs. 118 – 119, & 135-136.

Employee stated that when Lewis made the call, the ambulance was parked 2323 Good Hope Court. They were parked in front of the building for about 10 -12 minutes. Tr. pg. 120. He affirmed that when a child has a fever, complications can arise very quickly. Tr. pgs. 120-121. Employee stated that he had no knowledge of whether the mother had any medical background. All he knew was what the mother told them he wanted to do. They offered to take her son to the hospital, and she did not want that because she did not want him exposed to COVID. Tr. 122.

Employee acknowledged that he was familiar with the Patient Bill of Rights and he noted that his conduct on May 22, 2020 did not conform with the Patient Bill of Rights. He explained that there was no negligence; malicious intent to deviate from the Patient Bill of Rights; nor any intention not to provide proper care to the child; or coerce the mother into not having her son transported to the hospital by the ambulance. The mother was asked to bring her son downstairs because it was beneficial for the son, the mother and Employee. Tr. pgs. 122 -123.

On redirect, Employee noted that he had never been disciplined during his tenure at Agency. He asserted that he has been recommended for an award on a fire ground by Chief Westfield. Tr. pg. 124.

When questioned by Member Edwards, Employee affirmed that he was the one who asked Lewis to call the mother on the phone. Tr. pg. 125. He affirmed that Lewis used her personal phone to make the call because they could not find the ambulance cell phone. Employee noted that he was not aware of any rules that prohibited them from using their personal phones to conduct official business. Tr. pg. 126. Employee stated that when they checked the CAD system, the only information available to them was "6-year-old male, high fever". They immediately left for the address and since he was driving, he could not scroll down to see any updates. From the time they left the station to the time they arrived at the scene, there was no mention of PPE. Tr. pgs. 126 -127. Employee explained that they did not call Communications because they had a more direct line of communication as they were able to speak directly with the mother on the cell phone. Tr. pg. 128.

Employee testified that the mother never said she was not bringing her son downstairs because she did not know what to do. She stated that she did not want her son transported to the hospital, so she would give him Tylenol and monitor his fever. If it did not break, she would take her son to the hospital by personal vehicle because she did not want her son transported in the ambulance since she did not want him exposed to COVID. Tr. pgs. 130 -131.

Employee stated that they did the same thing at their next run with the COVID positive patient. They called to see if the patient was able to come outside and were told the patient was an elderly woman and who was not able to come outside. Once they were informed that the patient was not able to come outside, they got dressed into their PPEs and proceeded to do their job. Tr. pgs. 132-133.

When questioned by Member Bozarth, Employee affirmed that he was familiar with the Patient Bill of Rights and the EMS protocol. Employee explained that as far as signing the release goes, they did not follow through with the protocol. Tr. pg. 134. He explained that treatment protocol for assessing patients during the pandemic was different from those listed in the Protocol Handbook and were constantly changing. Tr. pgs. 134-135. Employee noted that the patient care directives issued during the pandemic did not suggest that they do not conduct assessments. However, he explained that they did ask the mother to bring the son downstairs to be evaluated as they were encouraged by orders issued by the Department to do. Tr. pg. 135. When asked if he was satisfied with the performance of Ambulance 32 on May 22, 2020, he said "absolutely not". He noted that in hindsight, there were things that they could have done better. Tr. pg. 136.

Employee noted that he did not think that the mother of the child was satisfied with the performance of Ambulance 32. He testified that he did not neglect his duties on May 22, 2020, but believed there was a disconnect. Employee explained that neglect of duty would be accompanied by some malicious intent, and he did not do anything to intentionally cause harm to the child. Tr. pg. 137.

When questioned by Chairperson Downs, Employee testified that to him, neglect of duty meant they did something intentionally, knowing they should have done something else and that was not the case with their call, reason why he did not feel that he neglected his duty. He stated that what happened was an honest mistake and he wished it never happened. Tr. pgs. 138 -139.

Angelo Westfield - Tr. pgs. 145 – 157

Angelo Westfield ("Chief Westfield") is the Battalion Chief at D.C. Fire and FEMS and was assigned as the Battalion Chief in the 5th Battalion, for 2 and number 3. He has been at Agency for thirty-one (31) years. Chief Westfield knew Employee prior to Employee joining the Department. Tr. pg. 146. He stated that he advised Employee to join the Department. Tr. pg. 147. He got to know Employee based on his interaction with Employee and Employee's fiancé who was Chief Westfield's neighbor. He noted that Employee was a good father, Employee always asked questions about the fire department and Chief Westfield believed Employee would be a great fit for the department. Tr. pgs. 147-148.

Chief Westfield stated that he was not Employee's direct supervisor when he joined the department, but he mentored Employee as he went through the process. Chief Westfield stated that Employee would call him and ask questions about the job, which he, Chief Westfield appreciated. He stated that you could not find anyone who had something bad to say about Employee. Tr. pgs. 148 -149. Chief Westfield stated that he had nothing but positive feedback from Employee's co-worker. Tr. pg. 150. He testified that Employee is a very positive, hard-working young man and has never been in trouble. Tr. pg. 151.

When questioned about the Employee's conduct on May 22, 2020, Chief Westfield stated that based on his personal belief, he does not think Employee should be terminated. However, he thought Employee should be held accountable. He explained that based of his knowledge of the incident, the proper protocol was not followed, and Employee should be penalized for his decision making. Nonetheless, Chief Westfield stated that he did not think termination was applicable in this case. Tr. pg. 152.

On cross examination, Chief Westfield testified that he had worked overtime on Employee's shift with Employee, and he had no problem with Employee's performance. Tr. pg. 153. Chief Westfield stated that he had basic knowledge of the charges against Employee which he learned by talking to Employee and from the Department. Tr. pg. 154.

When questioned by Member Edwards if his testimony that termination was not appropriate for this matter was based on his relationship with Employee as a mentor or based on his opinion as a battalion fire chief, Chief Westfield testified that it was based on both roles. He explained that if he was a part of the Trial Panel in this matter, he would consider the history of the case, evidence, as well as the fact that the employee has never been in trouble, they had great work ethics on the job. He also noted that he would consider the fact that everyone makes mistakes and weigh all of that. Tr. pg. 155. Chief Westfield said he had made mistakes but not due to peer-pressure. Tr. pgs. 156-157.

Durrel Herman - Tr. pgs. 159 – 179

Durrel Herman ("Lieutenant Herman") has worked for Agency for about 14 years. Tr. pg. 159. He is currently a Lieutenant. He was an instructor at the training school while Employee was there, and Employee was currently under his direct supervision during the day. Tr. pg. 160. He stated that at the training school, Employee was studious, a quick learner, eager to help, and a good student for the most part. Tr. pg. 161. Lieutenant Herman explained that both he and Employee were detailed to the Property Division – logistics, and Employee was under his direct supervision. Their job duties include handling and distribution of COVID PPE supplies for the entire department. He noted that Employee helped out tremendously and kept the department supplied and well stocked throughout the pandemic crisis. Tr. pgs. 161-162. Lieutenant Herman testified that he would rate Employee's work performance a ten (10) during the period that he was under his supervision, with ten (10) being the highest rating and zero (0) the lowest rating. He stated that if he needed something done last minute, Employee would stay late and come in early to assist. Tr. pg. 162.

When asked if Employee had ever evaded his responsibility, Lieutenant Herman stated that he had never seen such behavior in Employee. Tr. pg. 163. He stated that although Employee had been going through the adverse action process, it did not affect his job performance. Tr. pg. 163.

Lieutenant Herman noted that he had a general idea of the charges levied against Employee. Tr. pg. 164. He stated that at the beginning of the pandemic around March 2020, there were special orders coming out everywhere. He cited one specific order which stated that if you had to interact with a patient, try to minimize the time inside the building such as residential buildings because there were huge concerns of COVID spreading easily indoor. He also noted that there was another special order which encouraged interaction with patients in outdoor settings. Tr. pg. 165.

On cross examination, Lieutenant Herman stated that he conducted a performance evaluation of Employee, and he scored the highest possible rating. Tr. pgs. 165-166.

When questioned by Member Edwards if he had deviated from official procedure and protocol, Lieutenant Herman answered in the affirmative. He explained that he had followed what was termed "unwritten rule". Tr. pg. 166. He noted that there are areas of the rules or policies that allowed them to be freethinkers and are sometimes allowed to make decisions on their own, including when working independently on the truck. Tr. pgs. 169 -170.

Lieutenant Herman affirmed that he knew the difference between a guideline and protocol. He explained that a protocol is stricter in nature, whereas a guideline gives you a basis to get an objective completed. He affirmed that they had EMS protocols and not guidelines. Tr. pg. 170.

When questioned by Chairperson Downs, Lieutenant Herman affirmed that he taught Protocols to Employee. Tr. pg. 171. He explained that the Protocols were still the same Protocols during the pandemic. However, the COVID pandemic was something that no one had

experienced before, and there were lots of rules changes. Different directives came out quickly and things changed very quickly. And working in the best interest of a patients during the pandemic, meant remaining flexible with the protocols. Tr. pg. 172. He stated that there was lots of information coming at them during the start of the pandemic from news outlets and the department and nobody knew what was going on. Lieutenant Herman further explained that working in the best interest of the patient would be to gather the knowledge you were given from the news, department, and the society around you; put it together, and make decisions that were best for the patients. Tr. pgs. 173 -175. He noted that outside of a hazmat situation, not seeing a patient is not in the best interest of the patient. Tr. pgs. 175-176.

Lieutenant Herman testified that as the protocol instructor, he had never taught anyone to go with the flow or what everyone else is doing and disregard protocol. He reiterated that protocols are just black and white documents of written rules and procedures and how you go about them. However, he explained that because protocols do not fit every patient scenario, there would be times when the protocols would not apply to achieve the best interest of a patient. He added that the protocol is a living document because every patient does not size it up. He testified that you cannot have a scenario for every patient in the world inside that two-three-hundred-page book. Tr. pg. 177.

Mark Colbert - Tr. pgs. 179 – 191

Mark Colbert ("Colbert") works for Agency as the Technician, Truck 16. He had been employed by Agency for 17.5 years. Tr. pg. 179. He affirmed that he knew Employee. He stated that Employee was assigned to Truck 16, Platoon Number 3, the shift that come after his shift. Colbert affirmed that they were assigned to the same firehouse. He testified that Employee came in the door very excited, passionate and wanting to learn. He stated that Employee was always in the kitchen helping out. Tr. pg. 180. Colbert asserted that Employee always came to him to ask questions and he took Employee under his wings and shared knowledge with Employee. He agreed that Employee was motivated to improve and better himself in the department. Tr. pg. 181.

When asked if he thought Employee was not taking his job seriously or unwilling to perform his job duties, Colbert said "No". He stated that Employee was very motivated and showed a lot of ambition on and off the job. Tr. pg. 182. Colbert affirmed that he would work again with Employee in the future if the opportunity presented itself. Tr. pg. 183.

On cross examination, Colbert stated that he had known Employee for approximately three (3) years, which was when he got assigned to Engine Company 32, in the same firehouse as Truck 16. He affirmed that he had heard about the allegations against Employee. Tr. pg. 184. He explained what his understanding of the matter was, citing that Employee and his partner responded to a call. They called the patient's mother to make contact, but the mother did not want their child to go to the hospital, so they left. Colbert stated that he thought Employee knew what he did and learned his lesson from it. Tr. pgs. 184-185.

When questioned by Member Edwards, Colbert stated that he had shared his job experiences with Employee and gave him guidance on how to carry himself in a professional

manner. Tr. pgs. 186-187. In responding to Member Edwards' hypothetical about no contact with a patient, Colbert testified that the situation with Employee happened at the height of the COVID pandemic where everyone was on pins and needles with regard to contact and he would consider the fact that people were trying to limit contact as much as possible. He noted that he would not have a problem with a phone call. However, the lack of contact and no transportation would raise an eyebrow. He also noted that the extend of care needed by the child or patient would be considered. Tr. pgs. 188 – 189.

Colbert testified that at the start of COVID, they called to see if the patient could meet them at the door to limit exposure. If the patient was not able to meet them at the door, the crew put on their full PPE and went inside. Tr. pg. 190.

Panel Findings

The Trial Board Panel made the following findings of fact based on their review of the evidence presented at the hearing:[2]

1) The crew of Ambulance 32 – comprised of FF/EMT Danaryae Lewis and FF/EMT [Employee] – was dispatched to a call on Good Hope Ct, and violated the Patient Bill of Rights when they:

    a. Did not make face to face contact with the patient;

    b. Failed to do a proper assessment of the patient; and

    c. Told the patient's caregiver (mother) that it was okay to give the patient Tylenol and call 911 again if needed.

2) The Ambulance 32 crew violated the Department's Patient Care Protocols when they return to service without obtaining a proper refusal.

3) In clear violation of the Department's documentation policy, Ambulance 32 crew admitted that they only drafted a proper ePCR narrative after learning that they were being ordered to type a Special Report regarding this incident.

4) FF/EMT[Employee] has been a Department member since August 21, 2017; whereas, his partner FF/EMT Lewis has been a Department since January 14, 2013. Pursuant to Order Book XXIV, § 2(4), FF/EMT was the Ambulance Crewmember in Charge (ACIC). While the mistakes made on this incident were severe, the fact of the matter is that FF/EMT[Employee] was the Ambulance Crewmember Aide (ACA) on this crew and was following – to his detriment – the advice and actions of the ACIC.

Upon consideration and evaluation of all the testimony and factors, The Trial Board Panel found that there was a preponderance of evidence to sustain the charges against Employee. The Panel found Employee guilty of Charge No.1, Specification No.1 and Charge No. 2,

[2] Agency Answer at Tab 21 (November 16, 2022).

Specification No. 2. In addition to making the findings of fact, the Panel also weighed the offenses against the relevant *Douglas* factors[3] and concluded that a 720-duty hours suspension for Charge No. 1, and 24-duty hours suspension for Charge No. 2, for a total of 744-duty hours, was an appropriate penalty for these offenses.[4]

## FINDINGS OF FACT, ANALYSIS AND CONCLUSIONS OF LAW[5]

Pursuant to the D.C. Court of Appeals holding in *Elton Pinkard v. D.C. Metropolitan Police Department*,[6] OEA has a limited role where a departmental hearing has been held. According to *Pinkard*, the D. C. Court of Appeals found that OEA generally has jurisdiction over employee appeals from final agency decisions involving adverse actions under the CMPA. The statute gives OEA broad discretion to decide its own procedures for handling such appeals and to conduct evidentiary hearings.[7] The Court of Appeals held that:

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

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[3] *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.

[4] Agency Answer, *supra*, at Tab 21.

[5] 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").

[6] 801 A.2d 86 (D.C. 2002).

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

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

> 1. The appellant (Employee) is an employee of the Metropolitan Police Department or the D.C. Fire & Emergency Medical Services Department;
>
> 2. The employee has been subjected to an adverse action;
>
> 3. The employee is a member of a bargaining unit covered by a collective bargaining agreement;
>
> 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 (744 duty hours suspension); 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 June 1, 2021, for an evidentiary hearing. This Panel made findings of fact, conclusions of law and recommended that Employee be suspended for 744-duty hours for the current charge. Consequently, I find that *Pinkard* applies in this matter. Accordingly, pursuant to *Pinkard*, OEA may not substitute its judgement for that of the Agency, and the undersigned's review of Agency's decision in this matter is limited to the determination of (1) whether the Adverse Action Panel's decision was supported by substantial evidence; (2) whether there was harmful procedural error; and (3) whether Agency's action was done in accordance with applicable laws or regulations.

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

Pursuant to *Pinkard*, I must determine whether the Adverse Action Panel's ("Panel") decision was supported by substantial evidence. Substantial evidence is defined as evidence that

a reasonable mind could accept as adequate to support a conclusion.[8] 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.[9]

Employee argued during the Trial Board Hearing that he did not neglect his duties on May 22, 2020, but believed there was a disconnect. Employee explained that neglect of duty would be accompanied by some malicious intent, and he did not do anything to intentionally cause harm to the child. He stated that what happened was an honest mistake and he wished it never happened. Tr. pg. 137 - 139.

After reviewing the record, as well as the arguments presented by the parties in their respective briefs to this Office, I find that the Panel met its burden of substantial evidence for Charge No. 1, Specification No. 1. Employee does not dispute that he and his partner did not follow the proper patient care protocol in their interaction with the 6-year-old patient and his mother, in violation of the Patient Bill of Rights. Specifically, Employee admitted to not having any contact with the patient prior to leaving the scene. During the Trial Board Hearing, Employee stated that looking back at the situation now, he would have made every effort to try to see the patient either by himself, calling the EMS supervisor or the paramedic engine company so the officer could attempt to do so. Tr. pg. 97. Employee acknowledged that he was familiar with the Patient Bill of Rights, and he noted that his conduct on May 22, 2020 did not conform with the Patient Bill of Rights. Tr. pgs. 122- 123.

Additionally, Employee explained that treatment protocol for assessing patients during the pandemic was different from those listed in the Protocol Handbook and were constantly changing. Tr. pgs. 134-135. However, Employee noted that the patient care directives issued during the pandemic did not suggest that they do not conduct assessments. Tr. pg. 135. Moreover, when asked if he was satisfied with the performance of Ambulance 32 on May 22, 2020, he said "absolutely not". He noted that in hindsight, there were thing that they could have done better. Tr. pg. 136. Employee noted that he did not think that the mother of the child was satisfied with the performance of Ambulance 32. Based on the aforementioned, I find that there was substantial evidence in the record to support the Panel's findings with regard to Charge No. 1., Specification No. 1.

For Charge No. 2., Specification No. 1., I also find that Agency had substantial evidence in the record to support its findings of Neglect of Duty. Agency asserted that despite clear directives outlined in both the Pre-hospital Treatment Protocols and the Consent/Refusal of Care Policy, as well as the Special Order No. 54, series 2012 (Patient Care Reporting (ePCR) Directives), Employee and her partner failed to perform any assessment of their pediatric patient, failed to follow the Department's Refusal of Care policy, and failed to properly complete the ePCR corresponding with his response on Incident No. F20087160. Employee pleaded guilty to this charge and specification during the Trial Board Hearing. Accordingly, I find that there's substantial evidence in the record to support the Panel's findings with regards to Charge No. 2., Specification No. 2.

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[8] *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).
[9] *Baumgartner v. Police and Firemen's Retirement and Relief Board,* 527 A.2d 313 (D.C. 1987).

The Panel found that the crew of Ambulance 32 (Employee and his partner Lewis) violated the Patient Bill of Rights when they: (1) did not make face to face contact with the patients; (2) failed to do a proper assessment of the patient; and (3) told the patient's mother that it was okay to give her son Tylenol. In addition, the Panel also found that the crew of Ambulance 32 violated the Department's documentation policy as they admitted that they only drafted a proper ePCR narrative after learning that they were being ordered to type a Special Report regarding this incident. Employee also testified that they did not get a signed refusal of service form from the patient's mother is required. Therefore, I find that there was substantial evidence in the record to support Agency's findings in both Charge No. 1, Specification No. 1; and Charge No. 2, Specification No. 1.

***2) Whether there was harmful procedural error***

None of the parties raised an issue with the version of the DPM Agency used in the current matter. However, the undersigned notes that, Agency used the wrong version of the DPM in this matter. The District of Columbia Municipal Regulations ("DCMR") and the corresponding District Personnel Manual ("DPM') regulate the manner in which agencies in the District of Columbia administer adverse and corrective actions. The current and applicable DCMR and DPM versions (DCMR 6-B Chapter 16 and DPM Chapter 16) regulating the manner in which agencies administer adverse action went into effect in the District on May 12, 2017. Consequently, all adverse actions commenced after this date were subject to the new regulation. In the instant matter, Employee was suspended effective August 23, 2021, to January 5, 2022, and the current version of the DPM was already in effect. Moreover, the incident occurred on May 22, 2020, after the current DPM was already in effect. However, Agency levied an adverse action against Employee utilizing an older version of the DPM (2012 version of the DPM). Specifically, Agency charged Employee with violating 16 DPM §1603.3(f)(3) (March 4, 2012). Under the old DPM version, this section correlated with "[a]ny on-duty or employment related act or omission that interferes with the efficiency and integrity of government operations, specifically neglect of duty". However, the current version of the DPM, moved all the adverse action charges to DPM § 1605. Thus, the charge of neglect of duty can now be found in DPM § 1605.4(e), with its corresponding penalty found in DPM § 1607.2(e).

Under the older version of the DPM, the specification for Neglect of Duty includes, but is not limited to: Failure to follow instructions or observe precautions regarding safety; failure by a supervisor to investigate a complaint; failure to carry out assigned tasks; careless or negligent work habits. The penalty for the first offense for neglect of duty ranges from reprimand to removal. Under the new version of the DPM, the specification for Neglect of Duty includes, but not limited to: "Failing to carry out official duties or responsibilities as would be expected of a reasonable individual in the same position; failure to perform assigned tasks or duties; failure to assist the public; undue delay in completing assigned tasks or duties; careless work habits; conducting personal business while on duty; abandoning an assigned post; sleeping or dozing on-duty, or loafing while on duty." The penalty for the first offense is counseling to removal. Here, Employee was charged with Neglect of Duty, for failing to carry out the essential functions of his position on May 22, 2020. This specification is captured in both the older and the new version of the DPM. Consequently, I find that in the current matter, the applicable DPM for the charge of neglect of duty is not substantively different from the older version utilized by Agency

as both the charge and penalty range are similar. Both provide that the maximum range for penalty may be removal. Thus, I conclude that Agency's action constitutes harmless error.[10]

Agency also charged Employee with "unreasonable failure to give assistance to the public. *See also* 16 DPM § 1603.3(f)(9)." This cause of action which was also levied against Employee in this matter under Charge No. 1, Specification No. 1, does not have a corresponding provision in the June 12, 2019, versions of the DPM. Further, there are substantive changes in the 2012 DPM with regard to the charges and penalties such that the undersigned would be unable to ascertain which charges should have been levied against Employee had Agency utilized the appropriate version.[11] OEA has held that it is required to adjudicate an appeal on the "grounds invoked by agency and may not substitute what it considers to be a more appropriate charge."[12] Additionally, this Office has held that an employees must be aware for the charges for which they are penalized in order to appropriately address/appeal those charges.[13] Therefore, I find that Agency's failure to follow the appropriate laws, rules and regulation is harmful procedural error in this instance. Agency did not provide a breakdown of the penalty with respect to each cause of action. Accordingly, it would be improper for the undersigned to essentially 'guess' or 'estimate' what the appropriate charge and/or penalty would have been had Agency used the appropriate DPM version. Based on the aforementioned, this charge will be dismissed.

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

**Charge No. 1**: Violation of D.C. Fire and Emergency Medical Department Order Book Article XXIV, § 10 Position Responsibilities, which states:

> …
>
> This misconduct is defined as cause in D.C. Fire and Emergency Medical Department Order Book Article VII, § 2(f)(3), which states: "Any on-duty or employment-related act or omission that interferes with the efficiency or integrity of government operations to include: Neglect of Duty." *See also* 16 DPM § 1603.3(f)(3) (August 27, 2012).
>
> This misconduct is defined further as cause in D.C. Fire and Emergency Medical Department Order Book Article VII, § 2(f)(9) which states: "Any on-duty or

[10] OEA Rule 631.3 provides that: "[n]otwithstanding any other provisions of these rules, the Office shall not reverse an agency's action for error in the application of its rules, regulations or policies if the agency can demonstrate that the error was harmless. Harmless error shall mean an error in the application of the agency's procedures, which did not cause substantial harm or prejudice to the employee's rights and did not significantly affect the agency's final decision to take action."

[11] *Madeleine Francois v. Office of the State Superintendent of Education*, OEA Matter No. 1601-0007-18, Opinion and Order (July 16, 2019); *See also Stephanie Linnen v. Office of the State Superintendent of Education*, OEA Matter No. (February 13, 2019).

[12] *Kenya Fulford-Cutberson v. Department of Corrections*, OEA Matter No. 1601-0010-13 (December 19, 2014). Citing to *Gottlieb v. Veteran Administration*, 39 M.S.P.R. 606, 609 (1989) and *Johnston v. Government Printing Office*, 5 M.S.P.R. 354, 357 (1981).

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

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* 16 DPM § 1603.3(f)(9).

Neglect of Duty is defined as "Failing to carry out official duties or responsibilities as would be expected of a reasonable individual in the same position; failure to perform assigned tasks or duties; failure to assist the public; undue delay in completing assigned tasks or duties; careless work habits; conducting personal business while on duty; abandoning an assigned post; sleeping or dozing on-duty or loafing while on duty."[14]

Contrary to Employee's assertion that he did not do anything to intentionally cause harm to the child, it should be noted that Neglect of Duty does not have an intent component. It is simply a failure to *"carry out official duties or responsibilities as would be expected of a reasonable individual in the same position."* (Emphasis added). Employee has admitted that his conduct on May 22, 2020, did not conform with the Patient Bill of Rights and proper patient care protocol. He also admitted that Ambulance 32 did not have a face-to-face contact with the patient and they did not do an assessment of the patient as required. Based on the record, I find that Agency's decision to levy the current charge of Neglect of Duty against Employee was done in accordance with applicable laws and regulations.

For the charge of unreasonable failure to give assistance to the public, I find that Employee's failure to have face-to-face contact or evaluate the six-year-old boy was not unreasonable giving the entire world was facing a novel pandemic. Employee and his partner encouraged the mother to bring her son outside for evaluation. Moreover, both Employee and his partner, Lewis testified that the patient's mother refused to bring the patient out for evaluation, she refused to have the patient transported to the hospital, and she stated that she would give the patient Tylenol, which was prescribed by the patient's physician. Furthermore, Employee and his partner advised the patient's mother that she could call 911 again if the fever did not break after giving the patient Tylenol.

Colbert testified that the situation with Employee happened at the height of the COVID pandemic where everyone was on pins and needles with regard to contact and people were trying to limit contact as much as possible. He noted that although the lack of contact and no transportation would raise an eyebrow, he explained that the extend of care needed by the child or patient would be considered. Tr. pgs. 188 – 189. Colbert testified that at the start of COVID, crewmembers called to see if the patient could meet them at the door to limit exposure. If the patient was not able to meet them at the door, the crew put on their full PPE and went inside. Tr. pg. 190. Employee and his partner testified that the mother did not state that she could not bring the son outside, rather, she was more concerned about potential COVID exposure, and she decided to transport her son to the hospital by herself. In addition, the mother of the patient was not present at the Trial Board Hearing to provide testimony regarding the incident.

Lieutenant Herman testified that as the protocol instructor, he had never taught anyone to go with the flow or what everyone else is doing and disregard protocol. He explained that protocols are just black and white documents of written rules and procedures and how you go

[14] District Personnel Manual ("EDPM") section 1607.2(e).

about them. However, he further explained that because protocols do not fit every patient scenario, there would be times when the protocols would not apply to achieve the best interest of a patient. He added that the protocol is a living document because every patient does not size it up. He testified that you cannot have a scenario for every patient in the world inside that two-three-hundred-page book. Tr. pg. 177.

Giving the totality of the circumstances, I find that Employee's failure to make face to face contact and to evaluate the patient was not unreasonable, because of the COVID-19 pandemic; the lack of proper guidance due to the novelty of the disease; the mother's concern for potential COVID exposure; and her refusal to have her son transported to the hospital with the ambulance. Consequently, I further find that Agency does not have cause to charge Employee with unreasonable failure to give assistance to the public.

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

> **V**. **Refusal Procedures**:
>
> …
>
> 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* 16 DPM § 1603.3(f)(3) (August 27, 2012).

Employee pleaded guilty to this cause of action. Therefore, I find that Agency has cause to charge Employee with Neglect of Duty in this instance.

**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).[15] 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

[15] *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).

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.[16]

In this case, I find that Agency's action was taken for cause with regard to Charge No. 2, Specification No. 1. When an Agency's charge is upheld, this Office has held that it will leave the Agency's penalty undisturbed when the penalty is within the range allowed by law, regulation or guidelines, is based on consideration of the relevant factors and is clearly not an error of judgment.[17]

Here, I find that Agency has met its burden of proof for the charge of "[a]ny on-duty or employment-related act or omission that interferes with the efficiency or integrity of government operations to include: Neglect of Duty" as it applies to Charge No. 2, Specification No. 1. According to the Table of Illustrative Action ("TIA"), the penalty for a first offense for Neglect of Duty is Counseling through Removal. The record shows that this is the first time Employee is being charged with this cause of action. Additionally, Agency did a thorough *Douglas* factors analysis in this matter. Therefore, I conclude that Agency had sufficient cause to suspend Employee for 24 duty hours for Charge No. 2., Specification No. 1.

As provided in *Love v. Department of Corrections*, OEA Matter No. 1601-0034-08R11 (August 10, 2011), selection of a penalty is a management prerogative, not subject to the exercise of discretionary disagreement by this Office.[18] When an Agency's charge is upheld, this Office has held that it will leave the agency's penalty undisturbed when the penalty is within the range allowed by law, regulation or guidelines, is based on consideration of the relevant factors, and is clearly not an error of judgment. I find that Agency has properly exercised its managerial discretion and its chosen penalty of suspension is reasonable and is clearly not an error of judgment. Accordingly, I conclude that Agency was within its authority to suspend Employee for 24 duty hours for Charge No. 2, Specification No. 1.

For Charge No. 1, Specification No. 1, because Agency failed to utilize the appropriate version of the District Personnel Manual in its administration of this action, as well as the fact that Agency failed to provide a breakdown of the penalty with respect to each cause of action as listed in Charge No. 1, Specification No. 1, I find that Agency engaged in harmful procedural error against Employee. Consequently, I further find that the 720 duty hours suspension levied against Employee for Charge No. 1, Specification No.1 was inappropriate under the circumstances.

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[16] *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).

[17] *Id.*; *See also Hutchinson*, *supra*; *Link v. Department of Corrections*, OEA Matter No. 1601-0079-92R95 (Feb.1, 1996); *Powell v. Office of the Secretary, Council of the District of Columbia*, OEA Matter No. 1601-0343-94 (Sept. 21, 1995).

[18] *Love* also provided that "[OEA's] role in this process is not to insist that the balance be struck precisely where the [OEA] would choose to strike it if the [OEA] were in the agency's shoes in the first instance; such an approach would fail to accord proper deference to the agency's primary discretion in managing its workforce. Rather, the [OEA's] review of an agency-imposed penalty is essentially to assure that the agency did conscientiously consider the relevant factors and did strike a responsible balance within tolerable limits of reasonableness. Only if the [OEA] finds that the agency failed to weigh the relevant factors, or that the agency's judgment clearly exceeded the limits of reasonableness, is it appropriate for the [OEA] then to specify how the agency's decision should be corrected to bring the penalty within the parameters of reasonableness." *Citing Douglas v. Veterans Administration.*

***Disparate Treatment***

Employee alleged that the penalty of 744 duty hours suspension for Charge No. 1, Specification No. 1, was too excessive and not in line with the *Douglas* factors. Employee asserted that a comparable employee (Case # U-19-237)[19] received a penalty of 120 duty hours suspension, whereas Employee was levied a penalty of 744 duty hours suspension. Since the undersigned has concluded that Agency engaged in harmful procedural error, the issue of disparate treatment will not be addressed.

ORDER

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

1. Agency's action of suspending Employee for 24 duty hours for Charge No. 2, Specification No. 1 is hereby **UPHELD**.

2. Agency's action of suspending Employee for 720 duty hours for Charge No. 1, Specification No. 1 is hereby **REVERSED.**

3. Agency shall reimburse Employee all pay and benefits lost as a result of the 720 duty hours suspension.

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

FOR THE OFFICE:

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

[19] It should be noted that but for the case number, Employee did not provide any additional information about the comparable employee in this case.