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:	)	
	)	
EMPLOYEE[1],	)	OEA Matter No. 1601-0011-23
	)	
v.	)	Date of Issuance: June 24, 2025
	)	
D.C. DEPARTMENT OF BEHAVIORAL HEALTH,	)	MONICA DOHNJI, ESQ.
Agency	)	Senior Administrative Judge
	)	

Charles T. Tucker, Jr., Esq., Employee's Representative
Michele McGee, Esq., Agency's Representative

INITIAL DECISION

INTRODUCTION AND PROCEDURAL HISTORY

On October 28, 2022, Employee filed a Petition for Appeal with the D.C. Office of Employee Appeals ("OEA" or "Office") contesting the District of Columbia Department of Behavioral Health's ("DBH" or "Agency") decision to terminate him from his position as a Registered Nurse, effective September 30, 2022. Employee was terminated pursuant to District Personnel Manual ("DPM") §§ 1605.4(a)(3) and 1607.2(a)(4)[2]; 1605.4(i) and 1607.2(i)(4)[3]; 1601.4(b)(3) and 1607.2(b)(3)[4]; and 1605.4(d) and 1607.2(e).[5] On October 28, 2022, OEA issued a Request for Agency Answer to Employee's Petition for Appeal. Thereafter, on November 23, 2022, Agency submitted its Response to Employee's Petition for Appeal.

This matter was assigned to the undersigned Senior Administrative Judge ("SAJ") on December 2, 2022. Thereafter, the undersigned issued an Order on December 15, 2022, convening a Status/Prehearing Conference for January 19, 2022. On December 22, 2022, Employee filed a Request to Reschedule Status/Prehearing Conference. On January 20, 2023, Agency filed a Consent Motion to Extend Deadline for Discovery. The undersigned issued an

[1] Employee's name was removed from this decision for the purposes of publication on the Office of Employee Appeals' website.
[2] DPM §§ 1605.4(a)(3) and 1607.2(a)(4) - Conduct prejudicial to the District of Columbia government, including … (3) Conduct that an employee should reasonably know is a violation of law or regulation.
[3] DPM §§ 1605.4(i) and 1607.2(1)(4) - Safety and health violations.
[4] DPM §§ 1605.4(b)(3) and 1607.2(b)(3) - Knowingly and willfully making an incorrect entry on an official record or approving an incorrect official record.
[5] DPM §§ 1605.4(d) and 1607.2(e) - Neglect of duty.

Order Granting Employee's Request to Reschedule Status/Prehearing Conference and Agency's Consent Motion to Extend Deadline for Discovery on January 23, 2023. A Status/Prehearing Conference was convened on February 15, 2023. Thereafter, on February 16, 2023, the undersigned issued an Order scheduling a Prehearing Conference for April 4, 2023. On March 23, 2023, Employee filed a Consent Request to Extend Discovery Period and Prehearing Date. This request was granted in an Order dated March 24, 2023. Employee's counsel filed a Notice of Withdrawal of Counsel.[6] On May 22, 2023, Employee filed another Consent Request to Extend Discovery Period and Prehearing Date, noting that Employee recently retained new counsel.[7] This request was granted in an Order dated May 23, 2023. On June 7, 2023, Employee's counsel filed a Notice of Withdrawal of Counsel.

On June 21, 2023, Attorney Charles Tucker, Jr., filed his Notice of Appearance as Employee's Counsel. On July 6, 2023, Employee submitted a Consent Motion to Extend the Discovery Deadline. This Motion was granted in an Order dated July 7, 2023. Employee filed an Amended Employee's Consent Motion to Extend the Discovery Deadline. This Motion was granted in an Order dated September 12, 2023. Subsequently, on October 4, 2023, the undersigned issued a second Order scheduling a Prehearing Conference for November 1, 2023. Both parties were present for the Prehearing Conference. On November 14, 2023, the undersigned issued an Order scheduling an Evidentiary Hearing for January 23 and January 24, 2024. On January 11, 2024, the parties filed a Joint Motion to Continue Evidentiary Hearing. This Motion was granted in an Order dated January 17, 2024, and the Evidentiary Hearing was rescheduled for March 27, 2024, and March 28, 2024. On March 19, 2024, the parties filed another Joint Motion to Continue Evidentiary Hearing. This Motion was granted in an Order dated March 20, 2024, and the Evidentiary Hearing was continued to May 15, 2024, and May 16, 2024. Employee filed a Motion for A Continuance on May 13, 2024, citing that the parties were engaged in settlement negotiations. Accordingly, on May 15, 2024, the undersigned issued an Order canceling the scheduled Evidentiary Hearing and required the parties to submit a written Status Update by June 7, 2024. The parties filed a Joint Status Report on June 24, 2024, noting that the parties were still in settlement negotiation and required additional time to submit another Status Report. On July 2, 2024, the undersigned issued an Order for Status Update, requiring the parties to submit a written status update by July 15, 2024. The parties filed a Joint Status Update on July 16, 2024, stating that the settlement negotiations were unsuccessful, and requested that the undersigned schedule a new Evidentiary Hearing date.

On August 6, 2024, the undersigned issued an Order scheduling the Evidentiary Hearing for November 12, 2024, and November 13, 2024. Both parties were present for the scheduled Evidentiary Hearing.[8] On February 5, 2025, the undersigned issued an Order requiring the parties to submit written closing arguments by March 21, 2025. Subsequently, on March 18, 2025, the parties filed a Joint Motion to Extend Time to File Written Closing Argument. This Motion was granted in an Order dated March 19, 2025. The parties were required to submit their written closing arguments by April 11, 2025. On April 11, 2025, the parties filed another Joint Motion to Extend Time to File Written Closing Argument. On May 2, 2025, the parties

[6] Employee was represented by attorney Catherine Watson of the Law Firms of Alan Lescht & Associates.
[7] Employee was now represented by attorney Arthur A. Elkins, Jr. of the DC Federal Employment Lawyers PLLC.
[8] Due to personal extenuating circumstances requiring the undersigned's absence, on December 11, 2024, AJ Harris issued a Notice Regarding Temporary Abeyance of Proceedings to the parties until my return.

submitted another Motion for Extension to File Written Arguments. The parties requested an extension of time until May 23, 2025. This Motion was granted in an Order dated May 5, 2025. While Agency timely filed its written closing argument, as of the date of this decision, Employee has not submitted his closing written arguments.[9] Nonetheless, the undersigned will accept Employee's May 30, 2025, electronic written closing argument as filed. 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 Employee's actions constituted cause for adverse action; and

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

SUMMARY OF MATERIAL TESTIMONY

The following represents a summary of the relevant testimony given during the Evidentiary Hearing as provided in the transcript (hereinafter denoted as "Tr.") which was generated following the conclusion of the proceeding.

Volume I ("Vol. I"): November 12, 2024.

Agency's Case in Chief

Estes Rodgers ("Mr. Rodgers") Tr. Vol. I. pgs. 32-193.

Mr. Rodgers has been employed by Agency for approximately eleven (11) years as an incident review specialist/investigator. He stated that his job responsibilities included reviewing incidents as they came in, he discussed the incidents with his supervisor, who in turn decides whether the incident would be investigated. Mr. Rodgers noted that he has worked in the field of administrative investigation for approximately sixteen (16) years Tr. Vol. I. pgs. 33-34.

Mr. Rodgers testified that he was the investigator assigned to the current matter. He was assigned this matter by Mr. Jason Carlock, the incident review manager at Saint Elizabeths'

[9] Employee emailed his written closing argument to OEA Official filing mailbox on May 30, 2025. OEA's Chief Operating Officer, Mr. Hemchand Hemraj**,** emailed the parties on June 2, 2025, stating that "Please note that all other documents must be filed directly with the OEA office by hand delivery or mail, as outlined in the agency's rules and regulations: OEA Rules and Regulations. Submissions outside the specified categories will not be received, date-stamped, or processed, and missed deadlines due to improper submission methods will not be honored."

Hospital. Tr. Vol. I. pg. 34. Mr. Rodgers stated that after he was assigned this matter, the first thing he did was review the incident video surveillance footage available between the hours of approximately 2:00 a.m. through 3:34 a.m. on the date of the incident. Tr. Vol. I. pg. 35.

Mr. Rodgers identified Agency's Exhibit AB as the video footage he reviewed as part of his investigation into this matter. He confirmed that the video footage was recorded by Saint Elizabeths' surveillance cameras. Mr. Rodgers affirmed that the top left camera, which is identified as Camera 3, is for Unit 1D. He described the various areas shown on the video footage. Mr. Rodgers confirmed that Agency's Exhibit AB, Part 1 is an accurate depiction and recording of the events in question on the night of the incident that led to Employee's termination. Tr. Vol. I. pgs. 36-42. Mr. Rodgers testified that as part of his investigation into the current incident, he also looked into the medical records of the patients who were involved in the matter; the training records of the involved staff members; the shift assignment forms that were used throughout that particular shift; Agency's and Saint Elizabeth's policies and procedures; and the police report of the incident. Tr. Vol. I. pgs. 44-45. Mr. Rodgers identified Agency's Exhibit P as his Investigative Report into the current matter. He also confirmed that Agency's Exhibit R was a diagram of Unit 1D, showing different corridors and nurses' station as they appeared on the date of the current incident. Tr. Vol. I. pgs. 46-48.

Mr. Rodgers acknowledged that Agency's Exhibit S was a Shift Assignment Sheet document which he reviewed as part of his investigation into this matter. Tr. Vol. I. pgs. 49. Upon reviewing part 1 of Exhibit AB, Mr. Rodgers identified Employee as the individual sitting at a desk and wearing a yellow shirt. Tr. Vol. I. pgs. 50-51. He noted that Employee conducted rounds or safety/security check around 2:03.43. Tr. Vol I. pg. 52. Mr. Rodgers stated that at 2:04.05, Employee is seen in the middle camera, marked as Corridor C, beginning his security check on Corridor C. Tr. Vol. I. pg. 53.

Mr. Rodgers testified that upon his review of the video of Employee's check of Corridor A, it appears as though Employee "is just brushing past the rooms, or just doing a quick check of the room, and policy mandates that he should be ensuring the whereabouts of the individuals in care. And once he can identify that they are in the room, to make sure that they are not being harmed and still breathing by seeing the sheets on the bed, or the chest, rise and fall to show that they are actually breathing inside of their rooms. But the checks that he just performed was just, like, a quick flash, and then he was away from … the doorways within a matter of seconds. So it didn't seem as if he was taking the proper time to do … each check accurately … per policy." Tr. Vol. I. pgs. 54-55. Mr. Rodgers explained that the staff is required per Agency policy to flash a flashlight inside the patient's room during the check to ensure that the patients were present and alive, in good health, and in good standing. Tr. Vol. I. pg. 56.

Mr. Rodgers testified that he observed Patient L in the video go in and out of his room several times between 2:00 to 3:00 am. At the 2:24.03 hour in the video, Mr. Rodgers identified Patient L outside of his assigned bedroom and in Hallway B. He confirmed that Patient L went to the restroom at 2:24 a.m., at 2:36 a.m., at 2:41 a.m., and again at 2:51 a.m. Mr. Rodgers noted that Patient L did not have any interaction with Employee or the other staff during that time. Tr. Vol. I. pgs. 56-59, 62.

Regarding the 2:43 a.m. check Employee conducted, Mr. Rodgers stated that "… it just felt as if he wasn't spending enough time at each of the doorways to ensure … that the individuals in care were where they should be, for one, and for two, that they were actually breathing or in good standards in terms of their health at that time." Tr. Vol. I. pgs. 59-60. Mr. Rodgers testified that "Based upon my observation, [Employee] at one point, enters the milieu, goes to Hallway C, engages in a conversation with a staff member there, and then returns back into the nurses' stations without completing full security checks throughout the entire milieu." Tr. Vol. I. 61.

Mr. Rodgers acknowledged that he observed Patient L in the video at 2:52 a.m. walking into Patient D's room. Tr. Vol. I. pg. 63. Mr. Rodgers testified that based on his understanding of Saint Elizabeth's policies, "It would be against policy for the individuals in care to enter into one another's room." Tr. Vol. I. pgs. 63-64.

Mr. Rodgers confirmed that as the charge nurse, Employee was responsible for making sure someone was at the front desk, monitoring the hallway. He affirmed that there were patients that were assigned one-to-one supervision in Hallway B and Employee was responsible for ensuring that the one-to-one was in the hallway outside of the patient's room. Mr. Rodgers affirmed that based on the layout of Hallway B, if a staff member was at their designated one-to-one location in Hallway B, they would have more easily observed Patient L walking into Patient D's room. Tr. Vol. I. pgs. 65, 67. Mr. Rodgers testified that at 3:00 a.m. on the day of the current incident, Employee was seated at the rear end of the nurses' station although according to the shift assignment form, Employee had assigned himself to work the front desk between the hour of 3:00 to 4:00 a.m. Tr. Vol. I. pgs. 68, 76. He noted that there were two staff members on their cell phones monitoring the front desk, instead of one staff member as required. Mr. Rodgers stated that employees assigned to Unit 1D can only utilize their cell phones in designated areas and not in areas where patient care is being taken. Tr. Vol. I. pgs. 69-70.

Mr. Rodgers acknowledged that Employee made security checks/rounds at approximately 3:09 a.m. Tr. Vol. I. pg. 69. He affirmed that at 3:10.13 a.m., Employee began his rounds on Corridor B, and he exited Corridor B at 3:10.51 a.m. Mr. Rodgers confirmed that based on the camera, Employee spent less than one (1) minute on Corridor B during this security check, which was concerning. Tr. Vol. I. pgs. 71-72. Mr. Rodgers testified that it was concerning because "As he passed [Patient L's] bedroom, it appears that he was initially just walking by, and then had to stop and back up to take a second look. And then takes a second look and just proceeds down the hallway. That was one thing that was pretty shocking, that he actually backed up to take a second look." Tr. Vol. I pgs. 72-73. Mr. Rodgers asserted that he was concerned because as Employee was walking towards the nurses' station pass Patient D's room on his right, Employee did not flash the flashlight into the room, instead, he was pointing the flashlight down towards the floor, with his head pointing down as well. He noted that Employee did not look into the room at that particular time. According to Mr. Rodgers, "…what was really concerning was that, per the video, we could see that [Patient L] was actually inside of the room with [Patient D] at this time." Tr. Vol. I. pgs. 72-73. Mr. Rodgers confirmed that from his review of the video, after Patient L went into Patient D's room at approximately 2:52 a.m., he does not leave the room again until he is discovered by staff. Tr. Vol. I. pg. 73.

Mr. Rodgers asserted that per the shift assignment form, Ms. Charlene Calvin ("Ms. Calvin") was assigned to do the 3:00 a.m. and the 3:30 a.m. security checks, and not Employee. Mr. Rodgers explained that Ms. Calvin stated during the investigation that she was going to attempt to complete the security checks, but she was instructed by Employee that "he would hang on to the clipboard and complete the next set of checks." Tr. Vol. pgs. 73-75. Mr. Rodgers reiterated that between 2:00 a.m. to 3:30 a.m., Employee was not consistent completing the 30 minutes or 15-minute checks. Tr. Vol. I. pg. 75.

Mr. Rodgers noted that Patient L was not in his room at approximately 3:28 in the morning. He stated that Employee did a second take again in what was [Patient L's] room at that time, during his 3:27 a.m. to 3:28 a.m. check. Tr. Vol. I. pgs. 78-79. Mr. Rodgers confirmed that Employee was outside of Patient D's room at 3:28.31 a.m. He also confirmed that at approximately 3:28.47 a.m., Employee put his head and upper body into Patient D's room after opening the door. Tr. Vol. I. pgs. 79-80. Mr. Rodgers identified Mr. Innocent Opara, Mr. Alex Colvin and Mr. Todd Lockhart as the staff members seen with Employee standing in front of Patient D's room. Mr. Rodgers confirmed that by 3:29.38 a.m., except for Mr. Colvin, all the other staff members had left the area outside of Patient D's room. Tr. Vol. I. pgs. 81-82. Mr. Rodgers confirmed that apart from Employee sticking his head into Patient D's room, as of 3:31.46 a.m., no other staff member had entered Patient D's room. Tr. Vol. I. pg. 84.

When asked if there was any indication in the video that Employee went into Patient D's room to render aid to Patient D from when he was discovered on the ground with Patient L in his room, until the 3:29.38 a.m. timestamp, Mr. Rodgers responded 'no'. Tr. Vol. I. pgs. 82-83. He identified the medical/crash cart (stored in the unit in case of medical emergencies) in Corridor B. Tr. Vol. I. pg. 83.

Mr. Rodgers affirmed that prior to Patient L walking out of Patient D's room, Mr. Colvin was seen walking into the room. Tr. Vol. I. pg. 87. He testified that Patient L walked out of Patient D's room on his own accord. He did not require any physical escort out. Tr. Vol. I. pg. 88. Mr. Rodgers confirmed that Employee walked into Patient D's room at 3:32.02 a.m. for the first time since he discovered Patient L in Patient D's room. Tr. Vol. I. pgs. 89-90. He stated that Employee brought the crash cart into Patient D's room for the first time at 3:32.20 a.m. Tr. Vol. I. pg. 91.

Mr. Rodgers asserted that from the time Patient L walked out of Patient D's room, Mr. Colvin stayed with him until 3:33.44 a.m. when Agency's Special Police Officer ("SPO") James Watson ("Mr. Watson") arrived. He noted that before Mr. Watson's arrival, Patient L took a few steps back down towards the hallway, but he was stationary for the majority of the time. He confirmed that restraints were placed on Patient L at approximately 3:35.33 a.m. and he was moved into his room. Tr. Vol. I. pgs. 93 -100.

Mr. Rodgers testified that he was concerned because Employee "did not attempt to render any immediate aid to [Patient D] which … policy mandates that the first nurse on the scene should immediately start to implement first aid, if necessary, CPR, to be a little more specific. And as the video just showed that [Employee] did not enter the room at all upon noticing what he described as …. [Patient L] standing… over a limp body. But yet he made no intervention to go

in to try to render any kind of medical aid." Tr. Vol. I. pg. 101. Mr. Rodgers noted that at one point, there were four (4) staff members by Patient D's room, and he expected Employee to at least facilitate Patient L's removal from Patient D's room. He also stated that all Saint Elizabeth staff members go through safety care training. He explained that waiting for a security officer is not required, rather, training mandates that they ensure the safety of all parties involved. Mr. Rodgers confirmed that as the charge nurse, Employee was responsible for coordinating the response effort to remove Patient L from Patient D's room. Tr. Vol. I. pgs. 101-103, 155-156. Mr. Rodgers confirmed that starting at 3:28.49 a.m. there were sufficient staff members to go into Patient D's room. Tr. Vol. I. pg. 193.

Mr. Rodgers testified that per policy because Employee was first nurse to arrive on the scene, he was responsible for coordinating the CPR efforts for Patient L. He testified that Employee should have "… tried to assess the vitals and started with CPR compressions until the necessary or proper authorities or medical response teams could have had a chance to come to respond to the scene." Tr. Vol. I. pgs. 103-104. Mr. Rodgers also testified that given Employee's role on that day, he should have been providing instructions to the other staff members to perform the duties that he left the scene of the incident to go perform himself. Tr. Vol. I. pg. 110.

Mr. Rodgers affirmed that he interviewed Employee after the incident. He cited that Employee stated during the interview that he saw Patient L standing over Patient D with one of his feet pressed up against Patient D's throat, rocking it back and forth and he observed some blood in the room. Per Mr. Rodgers, Employee stated during the interview that he told Patient L to back away from Patient D when he entered Patient D's room, and Patient L responded to this command. He also noted that Employee mentioned that at some point during the incident, Patient L lunged at him. Tr. Vol. I. pgs. 104 – 106, 152, 189. Mr. Rodgers stated that he uncovered during his investigation that "they were able to see blood on the floor and on [Patient L] and coming from [Patient D] as well." Tr. Vol. I. pg. 190.

Mr. Rodgers testified that at the end of his investigation, he found that Employee and "the staff members on duty that particular evening were negligent in their duties and failed to keep everybody within the milieu safe, including [Patient D]." Tr. Vol. I. pg. 112. He confirmed that he recommended that the matter be directed to the Nursing Director, Martha Pontes, for possible disciplinary action because of the lack of safety checks and the severity of the outcome of the incident. Tr. Vol. I. pgs. 113-114. Mr. Rodgers also confirmed that he recommended additional training. Tr. Vol. I. pgs. 114.

Mr. Rodgers asserted that he recommended a system for random safety checks of all units to ensure that the current issue was not a hospital-wide issue that was occurring. He explained that the evidence showed that the staff members were not being consistent in terms of the half-hour safety checks or the 15-minute checks. Tr. Vol. I. pgs. 114 -115.

Mr. Rodgers affirmed that he did not have the same medical training as Employee. Tr. Vol. I. pg. 134. He explained that he was well versed in Agency's policies and procedures that mandate what Employee should be doing and looking for. Tr. Vol. I. pg. 135. Mr. Rodgers affirmed that Employee was the only charge nurse on Unit 1D on the night of the incident and he was responsible for what happened on Unit 1D during his shift. Tr. Vol. I. pgs. 191-192.

Mr. Rodgers acknowledged that Employee started his check at 3:10 a.m., and another check 18 minutes later. Mr. Rodgers also affirmed that Employee was using his flashlight during those checks. Tr. Vol. I. pg. 146. He testified that while Employee did this check, another staff member was assigned to do the checks during this time frame. Mr. Rodgers affirmed that Employee discovered Patient L standing over Patient D during his 3:28 a.m. check. Tr. Vol. I. pgs. 146-147. He confirmed that at some point Employee called a Code Blue. Tr. Vol. I. pg. 163. Mr. Rodgers explained that when Employee called Code Blue, he conveyed whatever medical emergency was needed on the unit. After the Code Blue is called, it is announced over the PA system for additional assistance. He confirmed that by calling a Code Blue, Employee was seeking medical assistance for the incident. Tr. Vol. I. pgs. 164.

Mr. Rodgers testified that the fact that Patient L followed Employee's initial command to back away from Patient D while inside of the room displayed a level of compliance and responsiveness. Tr. Vol. I. pgs. 168-169. Mr. Rodgers asserted that at some point after the current incident, Agency's SPOs, and officers from the Metropolitan Police Department also arrived at the scene. Tr. Vol. I. pgs. 171-176. Mr. Rodgers asserted that he saw evidence suggesting that a weapon was recovered at the scene. Tr. Vol. I. pgs. 186-187.

Alex Colvin ("Mr. Colvin") Tr. Vol. I. pgs. 196 – 283

Mr. Colvin has been employed as a Behavioral Health Technician ("BHT") at Saint Elizabeth's Hospital for nine (9) years. In this role, Mr. Colvin helps the treatment planning team and nursing staff with patient care, aiding patients in adjusting to the unit, understanding the regulations, and engaging them to establish a connection. Mr. Colvin reports that he works the night shift and is currently assigned to the pretrial unit 1D. He characterized the pretrial unit as an intake area where individuals arrive at the hospital for forensic evaluation if they have violated a rule or have been arrested. As a BHT, Mr. Colvin mentioned that he performed security checks where he walks past patients' rooms every thirty minutes, usually overseeing about twenty-five to twenty-six rooms. Tr. Vol. I. pgs. 196-213.

Mr. Colvin confirmed that he worked the night shift from 11:00 p.m. to 7:00 a.m. on the evenings of March 8, 2022, and 9, 2022. He remembered that on the night of March 9, 2022, Employee served as the charge nurse for that unit. Mr. Colvin stated that Employee was responsible for making shift assignments and assigning employees to specific tasks. On the night of March 9, 2022, Mr. Colvin stated that he sprinted down the hallway after hearing Employee shouting. As he ran toward Employee, he saw one of the patients, Patient L, standing in the middle of the room while another patient, Patient D, was lying on the floor of his room, surrounded by blood. Mr. Colvin noted that Patient L was covered in blood and his socks were soaked in it. He observed that Employee was present with Todd Lockhart ("Mr. Lockhart") in front of Patient D's room door. Mr. Colvin recalled that instead of instructing him to enter Patient D's room to assist him, Employee shouted for someone to retrieve the crash cart. Tr. Vol. I. pgs. 224 – 229.

Mr. Colvin mentioned that Employee left his position near Patient D's room in search of a crash cart. He confirmed that while he was monitoring the incident, security guard James Watson arrived and took Patient L out of the room, putting him in handcuffs. Mr. Colvin indicated that

he then heard an alarm signal for another code in 1C, which prompted him to rush over since he was the designated responder for codes. Mr. Colvin clarified that he is trained in CPR, and everyone employed at the hospital has CPR training. He stated that while he was outside of Patient D's bedroom door, Employee never instructed him to perform CPR on Patient D. Tr. Vol. I. pg. 236.

Mr. Colvin confirmed that there were no concerns at the time of the incident regarding the implementation of safety checks due to COVID issues. He remarked that the COVID outbreak did not impact his ability to carry out his rounds in the hospital nor deter him from intervening in fights or responding to emergency situations. He stated that there had been no changes to the policy concerning COVID. Mr. Colvin noted that during the incident, Employee urged him to keep Patient L in Patient D's room prior to Patient L leaving the room independently. Tr. Vol. I. pgs. 251-262. Mr. Colvin stated that having additional staff outside of Patient D's door would have made the situation safer. Mr. Colvin emphasized that he felt most at risk when he was left alone in the hallway monitoring Patient L in Patient D's room, while Patient D was on the ground inside. Tr. Vol. I. pgs. 277-279.

Johnny Guy ("Mr. Guy") Tr. Vol. I. pgs. 283 – 337

Mr. Guy is employed as a Behavioral Support Technician ("BST") at Saint Elizabeth's Hospital. He explained his responsibilities as a BST, which include assisting the psychology team with creating best practice guidelines and individual recovery plans. He also mentioned that he provides support to three different units, delivering supplies to the residents there. Mr. Guy indicated that he has been a BST for one year and five months, and prior to that, he worked as a BHT for eight and a half months. Additionally, Mr. Guy serves as a safety care trainer for the hospital, and all staff members are required to come to him for recertification once a year. He stated that if staff members do not complete their training within the required timeframe, they must participate in an initial training session. Tr. Vol. I. pgs. 283-286.

Mr. Guy identified Agency's Exhibit M as the safety training manual that was in effect during his training in March 2022. He explained that the de-escalation techniques he teaches involve the triad tactic, utilized when a patient is in crisis. He described the triad tactic as having one staff member positioned in front of the patient as the leader, while two others stand on either side of the patient behind them, ready to intervene if the patient poses a danger to themselves or the counseling staff. In such cases, they can implement a safety care hold and escort the patient to a safer environment. Tr. Vol. I. pgs. 286-287.

Mr. Guy recalled observing the surveillance footage from the incident in March 2022 that involved Patient L and Patient D. He indicated that he saw several individuals outside of Patient D's room while Patient L was present inside. Mr. Guy stated that the staff members standing outside of Patient D's room should have requested that Patient L step out of the room and checked him before either restraining or placing him in seclusion, depending on the charge nurse's guidance. Additionally, Mr. Guy mentioned that if Patient L had refused to exit the room, the staff would be required to enter and use one of the safety care techniques to move Patient L into the hallway to a safer, secure location. Mr. Guy confirmed that during his review of the surveillance video, he did not observe Employee using a safety care technique to remove Patient

L from the room. He suggested that Employee should have instructed the BHT to enter the room and escort Patient L out, and that the BHT could have taken him to seclusion or restrained him, then searched for any contraband in Patient L's possession during that incident and secured it. Tr. Vol. I. pgs. 291-293.

Mr. Guy expressed that the top priority should have been to remove Patient L from the room since he posed a threat. He stated that one cannot provide lifesaving assistance to an individual while the person responsible for the issue remained present, especially if they may be armed, as any staff member could be at risk of being attacked. Mr. Guy identified Agency's Exhibit AB surveillance footage, pinpointing Employee in the clip along with two BHTs who were in the hallway. He confirmed that Employee and the BHTs constituted a sufficient number of personnel to enter the room and carry out a two-person stability hold on Patient L. He remarked that Employee should have directed the BHTs to enter the room and execute a two-person stability hold to safely remove Patient L. Additionally, Mr. Guy noted that the charge nurse is the unit leader and was tasked with managing the response to this incident on the 1D unit. He also indicated that any healthcare staff member who perceives a threat can call for a code or suggest that one be initiated. He stated that Employee could have assigned the necessary actions during the code protocol. Tr. Vol. I. pgs. 293-301.

Mr. Guy confirmed that staff members are unable to aid an injured patient in situations where there is a patient in need of medical assistance and the patient who poses the threat cannot be safely removed at that time. Tr. Vol. I. pg. 329. Mr. Guy stressed the urgency of quickly removing Patient L from Patient D's room, noting that Patient D could have survived if the staff had been able to enter the room promptly to remove Patient L and perform lifesaving procedures on Patient D. Mr. Guy pointed out that the four (4) minutes delay in administering CPR to Patient D was due to Patient L not being evacuated from the room. He confirmed that on the night of March 8 to March 9, 2022, there were errors made, as the staff failed to enter the room to remove Patient L and relocate him to a safer area, either through seclusion or restraint, to allow them to carry out lifesaving techniques on Patient D. Furthermore, Mr. Guy mentioned that as the charge nurse, Employee was accountable for ensuring that Patient L was moved so CPR could be administered to Patient D and that Employee erred by not ensuring that Patient L was removed from the room in a timely manner. Tr. Vol. I. pgs. 331 – 334.

Gregory Wilson ("Mr. Wilson") Tr. Vol. I. pgs. 337 - 390

Mr. Wilson is a Registered Nurse ("RN") and serves as a team leader at Saint Elizabeth's Hospital. He describes his position as involving numerous management responsibilities alongside his nurse manager, whom he assists. Wilson emphasized that it is the duty of the charge nurse and the team leader to ensure that all assignments are fulfilled before the end of each shift. He confirmed that in 2022, the protocol for completing security checks during the overnight shift, prior to the incident involving Patient L, required a single-person security patrol, which could be assigned by a charge nurse or team leader to either an RN or a BHT. Furthermore, Mr. Wilson explained that one individual is responsible for walking through Hallways A, B, and C while using a flashlight to check on each patient's room to ensure that the patient is breathing properly. Also, he mentioned that the staff conducting the security checks

must ascertain that no unauthorized individuals are present in the room unless assigned and that the environment remains secure. Tr. Vol. I. pgs. 337 – 343.

Mr. Wilson mentioned that on the night of the incident involving Patient L and Patient D, he was assigned to Unit 1C. He recalled hearing a Code Blue announcement, indicating that a patient was experiencing cardiac arrest. He also stated that he responded to the Code Blue in Patient D's room and upon entering, he found Patient D on the floor with a bluish tint to his skin, while Patient L was positioned over Patient D's head, against the wall. Mr. Wilson expressed his concern regarding Patient L's presence in Patient D's room, given that the patient was in distress. He also noted his worries about why a staff member from the unit had not started CPR, administered chest compressions, or initiated resuscitation efforts, and questioned the presence of a crash cart in the room. Mr. Wilson explained that as a nurse, when encountering a patient in cardiac arrest or one who appears to be non-breathing after a Code Blue is declared, the nurse should first assess for safety, ensure the environment is secure, then call out for someone to activate the emergency 911 system, and begin chest compressions and CPR. Tr. Vol. I. pgs. 343 – 347.

Mr. Wilson mentioned that once a patient is identified as being in distress and a Code Blue is activated, anyone is allowed to bring the crash cart to the location. Once the crash cart reaches the scene, the nurse assigned to it will be responsible for breaking the seal in order to administer the necessary cardiac medications to the patient. Mr. Wilson emphasized that CPR should begin immediately when a patient is found without a pulse or breathing, prior to the arrival of the crash cart. He also indicated that a person could perform CPR using chest compressions alone, without incorporating breathing techniques while waiting for the crash cart, as advised by the American Red Cross Association. Mr. Wilson pointed out that in the situation involving Patient L and Patient D, there was a delay of three (3) to four (4) minutes in delivering the crash cart to the room, whereas it should take no longer than ten (10) seconds given the short distance of the corridors to the treatment area. Mr. Wilson cited that when Employee noticed Patient D lying on the ground while Patient L had his foot on Patient D's neck, Employee should have promptly called code 13, indicating a patient is becoming highly agitated or violent, posing a risk to himself and others. Tr. Vol. I. pgs. 348 – 353.

Mr. Wilson testified that during the incident, Patient L exited Patient D's room voluntarily and that no staff members forcibly removed him. Mr. Wilson mentioned that once Patient L was found in another patient's room, he should have been taken out right away, emphasizing that unit policies prohibit any patient from being in another patient's room under any circumstances. Tr. Vol. I. pgs. 355-357. Mr. Wilson testified that when the incident occurred between Patient L and Patient D, he had just arrived at the scene and was on his way to retrieve the crash cart. By the time he stepped out of the room to get it, the crash cart was already being brought around the corner. Mr. Wilson mentioned that he exited the room as other responders entered to help. He added that he returned to Patient D's room but did not provide assistance to Employee or the other staff members with the patient. Mr. Wilson observed that upon entering the room, he did not notice any blood present at the scene, nor did he see any blood on either Patient D or Patient L. He confirmed that he told Officer James Watson ("Watson") during the investigation that Patient L should face murder charges. Mr. Wilson also stated that when he left Patient D's room, he was unaware of the patient's medical condition. Tr. Vol. I. pgs. 364-377.

Volume II ("Vol. II"): November 13, 2024.

Martha Pontes ("Ms. Pontes") Tr. Vol. II. pgs. 5 - 148

Ms. Pontes is the Chief Nursing Executive at Saint Elizabeth's Hospital. Her immediate supervisor is the CEO of Saint Elizabeth's Hospital, Mark Chastain. In this role, she is "responsible for the nursing care delivery and for the policies and procedures that impact the nursing department." She stated that she had "approximately 380 nurses and behavioral health technicians that work under me." She noted that her direct reports include the nurse managers of the various houses. Tr. Vol. II. pgs. 9- 12.

Ms. Pontes asserted that though Employee was employed at Saint Elizabeth's Hospital in 2022, he was not under her direct supervision. She stated that Employee was a team leader who worked on Unit 1D, which at that time was Dix House, and his direct nurse manager was Gladys Egwuatu ("Ms. Egwuatu"), who is Ms. Pontes' direct report. Tr. Vol. II. pgs. 12.

Ms. Pontes testified that in 2022, charge nurses at Saint Elizabeth's Hospital were responsible for the healthcare delivery of the unit they were assigned to. She noted that although charge nurses were not in management, they were like assistant head nurses on various units, and they were responsible for the delivery of care during their shift, to include delegation of assignments and ensuring that the delegation was done according to the person's skills and that the work was done appropriately. Ms. Pontes testified that since Employee worked night shift, he would have been responsible for tasks he assigned to the other staff on that night, and ensuring the assigned tasks were completed by the staff, which could be tracked with the assignment sheet. She affirmed that Employee was responsible ensuring that staff were at their designated posts and performing their designated duties. Tr. Vol. II. pgs. 12-14.

Ms. Pontes asserted that if one of the individuals in care is up and walking around, the front desk staff are required to alert the other staff. She stated that the front desk staff is also responsible for monitoring the hallways and they are not allowed to use their personal cell phone or read a book. Tr. Vol. II. pgs. 18. Ms. Pontes testified that "one-to-one is a special observation level that a physician would order for an individual in care. It can either be a one-to-one line of sight or a one-to-one arm's length. It would depend upon the reason why a person was assigned to be on a one-to-one whether it's going to be arm's length or if it's going to be line of sight. Either way, there's not to be any obstruction between the person and the patient because you need to be able to respond quickly." Ms. Pontes confirmed that a staff assigned to one-to-one is supposed to be seated directly outside the patient's bedroom or if at arm's length, inside the patient's bedroom. She cited that it was Employee's responsibility as the charge nurse to ensure that one-to-ones are in the correct location. Tr. Vol. II pgs. 20-22. Ms. Pontes identified Patient D's bedroom as 1D 45 and Patient L's bedroom as ID 39. She stated that the patient at room 1D41 was a one-to-one patient, and a staff member had to sit right outside the door where they could look through the door and see the patient. Tr. Vol. II. pgs. 22-23.

Referencing Agency's Exhibit S, Ms. Pontes, affirmed that Employee assigned himself to security check from 1:00 a.m. – 3:00 a.m. on the night of the incident and Employee assigned Ms. Calvin to take over security check from 3:00 a.m. – 5:00 a.m. She testified that Ms. Calvin

should not have been assigned to the front desk and also assigned to do the 30-minute security checks between 4:00 a.m. and 5:00 a.m. She confirmed that per Agency's Exhibit S, Employee assigned himself to the front desk from 3:00 a.m. to 4:00 a.m., so he should have been seated at the front desk during that time. Tr. Vol. II. pgs. 24 -26.

Ms. Pontes described the 30-minute security check to "entail the individual staff having their clipboard in hand, which has a listing of all of the individuals on it, and it's divided up in half hour increments; and taking a flashlight; and going from room to room down each corridor and back; and looking to make sure that the appropriate individual in care is in the room and that they are breathing; and if they are not in their room, where are they... if you're going to do it correctly, it should take you approximately 10 minutes … And you would go back to being in the milieu until the next 30-minute check should start. Now, it is possible to be assigned to do Q15 minute checks because you don't have that many individuals on. So the person doing the Q30s, the 15-minute time, could check the individuals on Q15 minute checks." Tr. Vol. II. pgs. 26-27. Ms. Pontes confirmed that "each of the staff members assigned from 11:30 p.m. to 7:15 a.m. to do security checks would be doing security checks every 30 minutes no matter what and then Q15 checks for the patients that are identified as needing 15-minute checks." Tr. Vol. II. pg. 27.

Ms. Pontes also testified that when performing a security check, the staff looks through the window on the individual in care's door to see the individual in care. She noted that the guidelines "are that, if the individual does not get upset, you are to open the door and actually see their chest rising and falling. You would have a flashlight. You're not to shine the flashlight in the person's face. You're actually to direct it to their chest to see it rising and falling. In some cases, looking through the door, you can't see the bed because the bed would be off to the side, in which case -- open the door." Tr. Vol. II. pgs. 33-34. Ms. Pontes confirmed that if a person performing the security check looking through the window could not see the patient, they are obligated to open the door and look at the patient. She confirmed that the protocol was to watch for three respirations. Tr. Vol. II. pg. 34.

When asked if the hospital changed its policy on security checks during the COVID pandemic, Ms. Pontes said "No." She explained that "the only thing that really changed at all was that everyone was wearing masks, and most people would wear gloves… and it was doing very frequent wipe downs as far as frequently touched areas." Tr. Vol. II. pg. 36. She affirmed that during Covid, staff were still expected to go into patient rooms to confirm that the patient was present, breathing, in good condition for each of the security checks. Tr. Vol. II pg. 37.

Ms. Pontes acknowledged that she reviewed the surveillance video of the current incident involving Employee. She stated that she was not at the unit when the incident occurred, but she immediately reported to Unit 1D between 4:15 a.m. and 4:20 a.m. Ms. Pontes stated that when she got to Unit 1D, Employee was at the back, working on a computer. She explained that some of the staff that were present during the incident were also in Unit 1D, "up by the front of the nursing station shaken. Safety was present on the unit. Some police were there, and the area was really, essentially, cordoned off." She testified that she spoke to Employee to ensure he was okay, as well as the rest of the staff. Tr. Vol. II. pgs. 37-39.

Ms. Pontes confirmed that she reviewed other documents related to either the incident or the shift at issue. She explained that whenever an incident occurs on the unit for whatever reason, "one of the first things we pull is the assignment sheet, the placement sheet of knowing who's supposed to be on for staff, and the security check sheets. Those we pull immediately to find out what actually occurred. So I reviewed those when I got ahold of those. We looked at the tape later in the morning and then spent a great deal of time reviewing the records." Tr Vol. II. pgs. 39-40.

Referring to the Agency's Exhibit S, Ms. Pontes confirmed that the night shift security checks sheet is supposed to be completed by the staff who performed the security check on that Q30-minute basis. Ms. Pontes stated that Q-15 checks would be on a separate sheet from the shift security check shift. She noted that everyone who was on a Q-15 had their own sheet. Tr. Vol. II. pgs. 40-42.

While still referring to Agency's Exhibit S, Ms. Pontes confirmed that starting at 1:30 a.m. on the day of the incident, the initials on the bottom row belong to the staff that performed the security check during that time period. She confirmed that the 1:30 a.m., 2:00 a.m., 2:30 a.m., 3:00 a.m., and the 3:30 a.m., security checks had Employee's initials. She also affirmed that room 1D-45 was Patient L's room. Ms. Pontes agreed that 'BR' was indicated on the security check sheet row for Patient L, room 1D-45, starting at 1:30 a.m. in the morning and continued to 3:30 a.m. in the morning. Ms. Pontes explained that the notation 'BR' was for 'bedroom' and anybody looking at the sheet that would know the individual in care was in his bedroom. Tr. Vol. II. pgs. 42-44.

Regarding the shift that started March 8, 2022, and that ended March 9, 2022. Ms. Pontes stated that she was concerned about Employee's supervision and delegation when she was reviewing the surveillance tape. She stated that "I was concerned with regards to the number of people who were sitting at the front desk. They weren't deployed out correctly. I was concerned about the fact that we had folks who were on one-to-ones, and they were being supposedly watched from the opposite end of the hallway, where you would not be able to see them in their room. The fact that, looking at the assignment sheets, many things had been assigned to him by him, and they were not carried out. There were other items that were assigned to other folk to do, such as the rounds. But was it -- he would take the clipboard, and he would do it himself. Watching the films, I did not see him go down Corridor A much at all, and we had two Q15 minute people down there. There was a fair amount of chatter or talking that was going on, so that folks were not focusing on what their job was. And I also saw folks that were … either on their iPad or on a telephone, which is not supposed to be taking place. Those were my initial concerns." Tr. Vol. II. pgs. 44-46.

Ms. Pontes testified that as a supervisor, she expected Employee to instruct his staff on what to do, where they were to be placed, and to ensure that they maintain the safety of the unit and account for where everybody was. Ms. Pontes stated that "that's not only our policies and procedures, but that's also required by his license under the Nurse Practice Act. That if you delegate, you delegate according to their skills, but you also monitor and make sure they carry out your delegation. And I did not see that happening when I was looking at the films." Tr. Vol. II. pgs. 46-47.

Ms. Pontes testified that Employee's security checks "were very cursory. That he was walking very quickly … down the corridor and back up again. I did not see the flashlight being flashed into any of the rooms. I didn't see any of the rooms being opened. … I didn't even see him go down a couple of the corridors, but they were signed off as having been checked." She asserted that that was a problem because "you don't know how the individuals in care are doing. Are they really sleeping? Are they in need of help? Are they having any difficulties at all? You're not following the process. When you're not following the process, things can happen." She confirmed that a properly conducted security check should take about 10 minutes. She agreed that from her review of the video, "there were times that the security checks done by [Employee] took just over one minute." Ms. Pontes affirmed that based on her review of the video, from 1:30 a.m. to 3:30 a.m. on March 9th, 2022, Employee was the only person making any type of security check. Tr. Vol. II. pgs. 47-49.

Ms. Pontes affirmed that based on the video and the security check forms, Employee falsified the records. She affirmed that there "were time periods where [Employee] indicated he made a security check on a particular wing or of a particular patient that he did not do." Tr. Vol. II. pgs. 48.

Ms. Pontes confirmed that she saw Patient L on the video recording come in and out of his room throughout that night shift. She stated that she found this concerning in that, when Patient L came out of the room, he would "stop in the middle of the hallway, he would walk down toward the nursing station, then he would go into the bathroom. Then he would come out, sometimes within a couple of minutes, sometimes within seconds. He repeated that activity four or five times in the course of a half hour." According to Ms. Pontes, a staff should have interacted with Patient L to find out if he was having any difficulties, if he needed something or why he was going into the bathroom as frequently as he did, but none of them did so. Ms. Pontes cited that while the ultimate responsibility was on Employee to ensure that the staff interacted with Patient L, "the staff do know that they are supposed to be in the milieu ready to engage with an individual at any time. And they weren't doing that." Tr. Vol. II. pgs. 50-51.

Ms. Pontes confirmed that she saw Patient L on the video leaving his room, going to the bathroom, coming out of the bathroom, then at approximately 2:52 a.m., Patient L went into Patient D's room, although patients are not allowed to go into other patients' rooms. Tr. Vol. II. pg. 51. Ms. Pontes testified that if staff had seen Patient L go into Patient D's room, they should have "stopped him, and they should have asked what was going on." She cited that the staff sitting at the front or any individual who was doing the one-to-one down at the end of the hallway would've been facing up toward the nursing station, and they should have seen him and spoken up and engaged." Tr. Vol. II. pgs. 52.

Ms. Pontes affirmed that based on the video recording, at approximately 3:10 a.m., Employee performed a security check of the unit and made rounds. She asserted that Employee "charted that [Patient L] was in his room, and he knew for a fact that he was not in his room at that time. And it was … was a cursory check. I believe he did step back to look in once during that time and then continued on down the hallway. When he went by [Patent D's] room, he did not flash the light. He did not look in." Ms. Pontes highlighted that Patient L was in Patient D's room at approximately 3:10 a.m., as Employee was walking by Patient D's room. He cited that

this was a problem because had Employee looked into Patient D's room then, he would have been able to see what was going on, direct Patient L out of Patient D's room, or provided assistance to Patient D, if he needed such. Tr. Vol. II. pgs. 52- 53.

Ms. Pontes confirmed that Employee is seen on the video at approximately 3:30 a.m. going out for another security check, even though he was assigned to the front desk and not supposed to be doing security checks at that time. She explained that during this check, Employee briefly looked into Patient L's room and then continued down the hallway, and he did not notice that Patient L was not in his room. Ms. Pontes affirmed that Employee looked into Patient D's room, as he walked pass the room. Tr. Vol. 53 -55. Ms. Pontes noted that by not conducting a thorough security check on the individuals in care and knowing whether any one of them was having difficulty or if somebody else was in their room, Employee endangered Patient D and other patients. Tr. Vol. II. pgs. 72-73.

Ms. Pontes testified that she was concerned about Employee's response when he found Patient D. She explained that Employee's response seemed slow to her. She noted that "… it did look like he had yelled for assistance, but I didn't see much else there initially. There was a delay in him opening the door. There was a delay in him going in." She cited that based on Saint Elizabeth's protocol and training, when a situation such as this occurs or when there's an incident in a room, the discovering "staff member should in fact be the one who yells for assistance, but stays in the area and … starts to take care of the situation." Ms. Pontes asserted that as the charge nurse and the staff member that discovered Patient L in Patient D's room, Employee "should have gone in." Tr. Vol. II. pgs. 56-57.

Referring to Agency's Exhibit AB, the four-panel view starting at timestamp 3:28.25, and stopping at timestamp 3:28.45, Ms. Pontes noted that during these 20 seconds, she did not see Employee go into Patient D's room. Instead, he steps back and yells for help. She affirmed that other staff members arrived at the scene by 3:28.49, and within seconds after Employee discovered Patient L in Patient D's room, there were three (3) staff members outside the door. Tr. Vol. II. pgs. 57 – 58. Ms. Pontes noted that based on Saint Elizabeth's protocol and training, "at this point the door should be open. They should be going in." She confirmed that Employee, Mr. Opara, and Mr. Colvin should all be going into Patient D's room. She explained that once in the room, Patient L should be asked to leave the room if he was still in there, then one of the staff should have been directed to get the crash cart, call for a code and ensure it is called. Tr. Vol. II. pgs. 59 -60. Ms. Pontes affirmed that as Chief Nursing Executive, her expectation was for Employee to facilitate both rendering the room safe and providing CPR and medical assistance to Patient D. Tr. Vol. II pg. 60.

As she reviewed the video, she confirmed that at 3:29.03 a.m., a fourth staff member, Mr. Lockhart, was outside of Patient D's room. She noted that she could not think of any medical reason preventing these four (4) staff members from going into Patient D's room to both render it safe and provide medical care to Patient D. Ms. Pontes stated that as the staff that identified the incident and as the registered nurse, Employee was responsible for directing the other staff members and the response to the incident. Tr. Vol. II. pgs. 60 – 62. Ms. Pontes stated that she was concerned about the delay in providing care to Patient D because at 3:29.34 a.m., Employee and Mr. Colvin were still outside of Patient D's room, Mr. Opara was at the end of the hallway

on his phone, and Mr. Lockhart is off camera. Ms. Pontes also noted that she was concerned when at the 3.29.37 a.m. timestamp on the video, Employee ran away from Patient D's room, leaving only Mr. Colvin outside of the room. She asserted that Employee "should have stayed there. If he needed something done, he should have advised Mr. Colvin. He should also advise Mr. Opara what else he wanted." Ms. Pontes confirmed that several minutes after discovery, no individuals had gone in to either make the room safe or render care to Patient D. She stated that this was problematic because "you're losing time if, in fact, you need to provide CPR. You're losing time as far as being able to help [Patient D]." Tr. Vol. II. pgs. 62 – 65.

Ms. Pontes confirmed that based on the video, Employee's departure from the area around Patient D's room violated Saint Elizabeth's policies and training. Ms. Pontes stated that based on the video, and as the Chief Nurse Executive, four (4) minute "is far too long a period of time for the crash cart to be brought." She again affirmed that Employee should have stayed outside of Patient D's room and ordered another staff member to get that crash cart over there right away. Ms. Pontes confirmed that a non-nurse could touch and roll a crash cart to the room. Tr. Vol. II. pgs. 68-69.

Ms. Pontes affirmed that Patient L was seen at the 3:31.56 video timestamp walking out of Patient D's room. She stated that four (4) minutes was too long a period to ask Patient L to step out of Patient D's room given the circumstance. Ms. Pontes reiterated that Employee "should have directed someone else to get the crash cart. He should have directed someone to make the call for the code… Security also arrives. If he was concerned about his safety or whatever, security would've been there to go in with him, … it was too long a delay. Tr. Vol. II. pgs. 70-71. Ms. Pontes confirmed that Employee's conduct in response to the incident place Patient D in potential danger. She explained that during the time Employee left Patient L in the room, Patient D was also in the room without being rendered any care. Tr. Vol. II. pgs. 72

Ms. Pontes testified that Unit 1D is the smaller of all the units at Saint Elizabeth's hospital, with a patient population of 20. She stated that the unit is an all-male pretrial admission unit, so it can be a little violent at times. Ms. Pontes explained that the basic staffing for that unit is six (6) people – two (2) RNs and four (4) BHT or three (3) RNs and three (3) BHTs. She testified that on the night of the current incident, two (2) staff members did not report to work. Ms. Calvin who had worked on the unit before, and Mr. Opara were floated to the unit for a total of six (6) staff members. Tr. Vol. II. pgs. 73- 74. Ms. Pontes cited that prior to the current incident; she did not receive any information from Employee that 1D was unsafe. Tr. Vol. II. pgs. 74-75.

Ms. Pontes cited that when Patient L was in unit 1D, she was not notified that Patient L was exhibiting problematic behavior on a regular basis. She described Patient L as "staying under the radar. He did have occasional episodes when he would be a little upset if another individual in care were -- that was very mouthy or very demanding or made racist remarks, but he didn't act out on them. He would withdraw." Tr. Vol. II. pgs. 75-76.

Ms. Pontes testified that she was the Deciding Official in this matter, and Kris McLoughlin ("Ms. McLoughlin") was the Proposing Official. Ms. Pontes stated that she thoroughly reviewed the Notice of Proposed Adverse Action and all the supporting materials that

were part of the notice when she received it. She confirmed that in making her final decision, she considered all the materials that she had reviewed as part of the Notice of Proposed Adverse Action. Ms. Pontes also confirmed that she considered the *Douglas* factors when making her decision to terminate Employee. Tr. Vol. II. pgs. 76-78, 81-85, 137.

Ms. Pontes acknowledged that Employee committed neglect of duty, made false statements, committed safety and health violations, and engaged in conduct prejudicial to the District Government. For the charge of neglect of duty, Ms. Pontes testified that this was Employee's "failure to adhere and comply to our policies and procedures. It was failure to act during the actual cardiac arrest, how he didn't do the levels of observation correctly, how he didn't guide the individual's care with staff. He failed to carry out his official duties and responsibilities that I would expect a reasonable nurse to do. I also looked at the Nurse Practice Act, which guides us also with regards to what we need to do and how we need to take care of our individuals." Tr. Vol. II. pgs. 78-79.

For the charge of conduct prejudicial to the District Government, Ms. Pontes testified that "I felt that his on-duty conduct wasn't what should reasonably have been done by another person or by another registered nurse. And consequently, I didn't have faith in him being able to continue to do his work." Tr. Vol. II. pgs. 79. For the Health and Safety violation charge, Ms. Pontes stated that Employee "didn't follow what he needed to do in making sure that Patient D was cared for immediately when the issues occurred." For the falsification charge, Ms. Pontes asserted that "checks were falsified on several times. The Q 15 minute checks were not done the way they should've been on … two of the individuals in here." She noted that the Unusual Incident Report and the statements made to the Metropolitan Police didn't coincide with what was seen on the video. She highlighted that Employee state to the police and in the Unusual Incident Report that they all did exactly what they needed to do, and that wasn't what happened. Tr. Vol. II. pgs. 79-80.

Ms. Pontes testified that although Employee had no previous disciplinary issues, the current incident was so egregious and the fact that an individual in care died was all considered. She also stated that per the guidelines, removal was warranted for each individual charge. Tr. Vol. II. pg. 81. Ms. Pontes confirmed that after the current incident, all the staff working that evening were placed on administrative leave, and Employee was not the only staff that was terminated because of this incident. Tr. Vol. II. pgs. 92 -94, 131.

Ms. Pontes affirmed that the individual conducting the safety checks must also consider their personal safety. She confirmed that there is nothing in the safety care policy that requires nurses to risk their own personal safety. Ms. Pontes averred that safety care is one of the trainings Agency has and it is "more of a de-escalation technique. When I'm talking, I'm talking about safety checks and one-to-ones. Those are a little different. But at any time an individual feels unsafe during those rounds, they could have another person with them. But it was never raised to any of us that [Employee] felt unsafe doing the checks." Ms. Pontes agreed that in an emergency, a person responding would be in the best position to make an assessment as to what action should be taken. Tr. Vol. II. pgs. 86-88. Ms. Pontes stated that prior to the current incident, she had no concerns about Employee's ability to respond. She stated that Employee is the only staff member seen in the video running to get the crash cart. Tr. Vol. II. pgs. 89 - 92.

Ms. Pontes acknowledged that what occurred on March 9, 2022, was an emergency situation and staff like Employee have to make split second decisions. She confirmed that the investigator, Mr. Rodgers, stated that Employee had advised him that he looked into Patient D's room, found Patient L standing above him. And at the time Employee gave Patient L a command to get off the neck of Patient D. Tr. Vol. II. pgs. 100 -104.

Ms. Pontes stated that while Employee had the right to make the call for a code, as the first responder on the scene, he should have stayed on the scene and directed someone from the front desk to make the call. She stated that Employee did not have the right to leave the patient unattended. Ms. Pontes reiterated that "it is his duty to yell down the hallway to get additional assistance and have them make the call. He was not to leave the individual in care." Tr. Vol. II pgs. 104-105. Ms. Pontes confirmed that as assistance arrived, Employee had a right to decide whether it was proper to enter Patient D's room. Tr. Vol. II. pgs. 106-107.

Ms. Pontes testified that Agency's Exhibit M was part of a training manual for safety care. Tr. Vol. II. pg. 107. When asked if it was within Employee's discretion to use the de-escalation process for the current incident, Ms. Pontes testified that "A de-escalation process is used primarily when you have individuals in care who are markedly agitated, or arguing with one another, and you're trying to separate them apart. I did not, in what I read and what I saw…that there was actually any verbal issues going on between [Patient L] and [Patient D] so de-escalation doesn't really fit the situation. This is more of a verbal activity." Tr. Vol. II. pg. 108. Ms. Pontes stated that Employee telling Patient L to take his foot off Patient D's neck was not de-escalation, rather, "a directive that was being given to Patient L." Tr. Vol. II. pgs. 109-112. Ms. Pontes explained that based on guidelines, each individual situation is different. She noted that "if you have a gentleman who is on the floor, unresponsive and bleeding, and another one is there and you're waiting to decide what you're going to do with the person standing up, you are losing valuable time in taking care of the person who's bleeding and on the floor." Tr. Vol. II. pgs. 114-115.

Ms. Pontes confirmed that Saint Elizabeth's hospital has a universal precaution policy. She stated that because they were still within the COVID phase, everyone had to wear masks and gloves. Ms. Pontes agreed that the camera was not able to capture what was going on in Patient L's room. When asked if Employee provided some assistance to Patient L after the crash cart arrived, Ms. Pontes agreed, but noted that the assistance was inappropriate. She affirmed that from her review of the investigative report, Employee and Mr. Adeyemo did chest compressions on Patient D after the crash cart arrived. Tr. Vol. II. pgs. 116-120.

Ms. Pontes affirmed that by calling Code Blue, Employee was seeking medical assistance and additional personnel for a patient. Tr. Vol. II. pgs. 122-123. Ms. Pontes noted that as the Code leader, Employee had a right to determine when it would be best to go into Patient D's room. Ms. Pontes affirmed that Employee's timing to enter the room could be influenced by any concerns he had about the presence of a weapon on the scene. She also noted that the presence of blood and the amount of blood on both Patent D and Patient L could influence the timing of entering the room. Tr. Vol. II. pgs. 125-126. Ms. Pontes noted that Employee did not report that Patient L was holding a weapon in his hand when he discovered him in Patient D's room. Ms.

Pontes affirmed that even if Patient L had a weapon, Employee and the staff on duty were obligated to go into the room and render that room safe. Tr. Vol. II. pgs. 144.

Ms. Pontes reiterated that "the policy as written is that the first responder or finder of the incident is to stay with the patient and delegate the other items to be brought so that the patient is not left alone during that time." She explained that in an emergency, Employee had to follow the same policy as with the 'Code Blue.' Ms. Pontes testified that "Code Blue specifically states that the first responder, the first R.N., stays with the patient and yells for the other stuff to be done and delegates it." Ms. Pontes again highlighted that Employee "is the nurse. He is the first responder. He should have stayed. Anyone of the other individuals could have gotten the cart, they could have gotten the gloves, they could have made the call. This was an emergency situation." Tr. Vol. II. pgs. 128-129.

Ms. Pontes testified that "[Patent D] was in respiratory distress. The waiting of up to four minutes to even get in there has already done damage, and it would be very difficult … to be able to resuscitate the gentleman. And even when they did go in, my understanding is that they did not apply the oxygen appropriately. There was a delay with regards to getting the crash cart going. According to [Employee's] statement, … [Patient D] actually had a pulse and blood pressure, which he did not, and that was clear when Dr. Frazier was in there. So there was a delay in providing care to a person who was in distress, and as a team leader and as the code leader, he could have directed other people to get things for him so they could start working sooner." Tr. Vol. II. pgs. 146-147.

Ms. Pontes confirmed that the safety training provided to Employee and other individuals instructed them on how to do a one-person hold, or a two-person hold. Tr. Vol. II. pg. 147. She stated that when Patient L was directed out of Patient D's room, there were at least two behavioral health technicians that were there. They should have "either with restrictions or without restrictions, removed [Patient L] from that particular area because there were other people coming in to respond. I do believe it was Mr. Colvin who finally stepped forward and moved [Patient L] out of the way, and then the lead security officer came on and did the actual arrest." Ms. Pontes acknowledged that when there were three people outside of Patient D's room, there were enough people to go in and render the room safe. Tr. Vol. II. pgs. 147 – 148.

Employee's Case in Chief

Employee – Tr. Vol. II. pgs. 151-343

Employee has been employed by Agency for approximately 20 years. He stated that he was a team lead and he was responsible for the staff on his shift. He noted that he also had other general duties and responsibilities that affected staff on the unit. Employee stated that his assignments were fixed. He explained that "there is a pre-printed assignment sheet that is fixed, and the number of staff, we used to fill in those various staffs, varied. Sometimes you will have enough staff to fill in the various tasks. Sometimes you don't. Another variable is the acuity of the unit." Employee stated that "a unit may have 10 patients and be very, very acute because of behavior of the patients. And on a different day, the same unit may have 20 patients, and the acuity may be low. So the primary driving force for acuity is the behavior of patients." Tr. Vol.

II. pgs. 151-153. Employee asserted that Unit 1D is an acute unit with a younger patient population, making it more likely to be violent. He noted that Unit 1D was facing a staff mismatch and staff shortage based on unit acuity. Tr. Vol. II. pgs. 154-155.

Employee noted that during his tenure at Agency, he did not have any disciplinary or performance issues. He also noted that he did not have any complaints from any of his supervisors regarding how he completed his assignments. Employee stated that Saint Elizabeth's Hospital is not responsive to complaints from supervisors about the behavior of staff they supervise. He provided an example of a situation where a staff under his supervision refused to complete the assigned task, and when he reported the incident to the supervisor, he, Employee was asked to complete an incident report, and Saint Elizabeth's Hospital did nothing about it. Employee stated that with that, he assessed that it was better he fulfilled that task than to leave it unfulfilled. Tr. Vol. II. pgs. 156-159.

Employee cited that he was working the night shift on March 9, 2022. He confirmed that was his standard shift. He noted that his shift started at 11:00 p.m., on March 8, 2022, and he was the charge nurse. He explained that as the charge nurse, he made and distributed assignments to each staff member on duty. He stated that he also reviewed the assignments with each staff member, and solicited their response, to ensure there were no conflicts and that the staff members did not have any issues with the assignment. Tr. Vol. II. pgs. 159-160.

Employee asserted that sometimes, as a charge nurse of the whole unit, your task is very fluid, meaning, "you go and fill in void where there is a need…. You have to tailor it with the patient's needs, with the need of the unit, with the need of the staff. It is a very fluid paper, and it's a very fluid type of work." Tr. Vol. II. pgs. 161.

Employee testified that on the day of the incident he did a regular security check at 2:43 a.m. Employee explained that "there is a written procedure you have to do security check. The same written procedure allows you to make adjustment based on what the patients present." He stated that on the night of the incident, before going for his 2:43 a.m. security check, there was an incident with some patients in the hallway who were concerned about the spread of COVID, and they did not want their doors opened, which he took into consideration. "So what I did was based on the social distancing that was in effect during that particular period, and the fact that there was no person during the night shift to do housekeeping or to clean the doorknobs, I used my flashlights and went from door to door and look. For most of it, doors were open. So you don't have to open it if the doors are open. You can go look through the crack of the door and see the patients were there. And then I did that. But that particular 2:43 a.m. was not able in relation to the incident, because as I was coming, I heard a noise, somebody saying dammit, shit, dammit, shit. I approached, and I find out that that cursing came from [Patient L]. So [Patient L] was inside his room, inside his bedroom." Employee asserted that because Patient L was still awake, he approached Patient L and asked him if he was okay, but Patient L did not respond. Employee cited that he took Patient L's nonresponse as a form of verbal communication and to imply that Patient L wanted to be left alone, so he continued down the hallway. Employee stated that on his way back, he looked into Patient L's room and Patient L was tucked in his bed asleep, so there was no reason for him to ask Patient L any more questions. Employee noted that he returned to

the rear of the nursing station, to continue his administrative work on the computer. Tr. Vol. II. pgs. 162-166.

Employee asserted that at 3:10 a.m., he did a check primarily to check on Patient L, to ensure he was able to stay in bed asleep. He stated that during this check-in, he "observed a bed that was in the form of a person who was asleep in bed. … Patient L appeared to be in bed. It was not a security check. It was a reevaluation. Many nurses do reevaluation if you think there was an issue with the patient… The checking is a normal procedure at Saint Elizabeth Hospital." Tr. Vol. II. pgs. 166-167.

Employee testified that he did a regular security check at 3:28 a.m., which was his next security check after the 2:43 a.m. security check. Employee noted that while this check was assigned to another staff, because the staff had gone to the bathroom, and Employee was the last person to do security checks, he decided to do the 3:28 a.m. check. Employee stated that "usually you need to hand over a procedure that is in sequence. Security check goes from one staff to the next. Ms. Calvin was still in the bathroom when I felt there was another need for security check, so I did it." Tr. Vol. II. pgs. 168 – 170.

Employee testified that when he got to Patient D's room during his 3:28 a.m. security check, he looked inside Patient D's room through the window, and he saw an image. He approached closer and flashed his flashlight into the room. Employee explained that he saw Patient L and as he looked down through the window, he saw Patient L's foot on Patient D's neck. Patient L was moving his foot back and forth on Patient D's neck. Employee cited that he pushed the door open, and he yelled at Patient L to take his foot off Patient D's neck and Patient L did that. Employee stated that he told Patient L to step aside and stay in the room. But as soon as he said that Patient L "leaped like a tiger over [Patient D] who was on the floor. I yelled, stop, stop. And then you saw me in the video stagger out, step back out, and then started yelling, yelling. What I yelled was, call a Code Blue. Call a Code Blue." Tr. Vol. II. pgs. 171-172.

Employee explained that he called a Code Blue because based on his assessment, the incident was an emergency of utmost importance and there was a need for additional help from medical doctors, psychiatrists, nurses, security etc. He stated that a Code Blue is designed to bring any and all available staff to assist. Employee stated that there was blood on both Patient L and Patient D. He noted that there was enough blood on Patient D to convince him that something terrible had occurred in the room. Employee testified that Patient L charged at him simply because he told Patient L to take his foot off Patient D's neck and stand aside. Employee cited that he was already threatened, and although they still had a victim on the floor, he was not about to become the next victim, so he had to retreat. He asserted that it was the most terrifying thing he had ever experienced in his life. Employee stated that the room was dark, the bed sheets were thrown all over the place, he did not know what the bed sheets were covering, and he could not make a complete assessment of the danger. Tr. Vol. II. pgs. 171-173, 175-178, 180-181, 325-332. Employee noted that he was also concerned about the safety of his staff. Tr. Vol. II. pgs. 202-204.

Employee confirmed that he had training in Safety Care. According to Employee, Safety Care requires a staff to assess the risk to himself, other staff members and the patient. He stated

that the Safety Care training recommends that "if a patient threatens a staff, the staff should immediately retreat." He cited that "Safety Care does not teach staff how to respond to a homicide or a possible homicide." Employee also asserted that Safety Care recommends that "based on the severity and dangerousness of an incident, you can contain a patient who is violent where he was, so that the violence would not spread." Tr. Vol. II. pgs. 181-183. Employee explained that based on the uniqueness of the situation and how dangerous he had assessed the situation to be, he concluded that he was not able to do a one-person safety hold as it was inappropriate for that situation. Employee stated that based on his assessment, the situation needed more staff than they had available, which was the reason he immediately called a Code Blue. Tr. Vol. II. pgs. 184.

Employee stated that when Ms. Calvin arrived at the scene, Patient L was no longer assaulting Patient D. He testified that even though he was physically present, he had already retreated so he was not available to enter the room with Ms. Calvin until more staff arrived. He stated that since he had retreated, he "had to make a decision of what to do, how to use my resource that is my physical being, how to use it. I had to do other things. I ran to get the crash cart." Employee asserted that before he retrieved the crash cart, he went to the nurses' station to call again because the response to the code was poor. Employee stated that he retrieved the crash cart because it is a primary tool for resuscitation and to prepare for other medical interventions. Tr. Vol. II. pgs. 185-186, 188-189.

Employee testified that when Mr. Colvin and Mr. Opara arrived, he instructed them to watch Patient L, and to ensure he did not come out of the room because based on his assessment, that was too risky as the hallway had more patients whose rooms were not locked. He noted that Safety Care recommended containing a dangerous patient in one. Employee cited that he made the decision to keep Patient L in one place so that the attack would not spread. Tr. Vol. II. pgs. 186-187, 236-237.

According to Employee, universal precaution requires a staff to wear gloves before coming in contact with blood. He stated that there was a lot of blood on the scene, and wearing gloves in that circumstance was basic. Employee noted that he did not have gloves on him and there were no gloves in the patient's room, so he had to go get gloves. He averred that the crash cart had gloves. He highlighted that "there was no way I could maneuver without getting blood, whether to bring Patient L out or to go start CPR." Tr. Vol. II. pgs. 189-190. Employee confirmed that Mr. Colvin's testimony that he saw Patient L dripping with blood was consistent with his observations on the night of the incident. Tr. Vol. II. pgs. 190-191. Employee stated that when Mr. Wilson arrived at the scene, he was pushing the crash cart in the hallway. Vol. II. pgs. 191-192.

Employee testified that he went into Patient D's room as soon as he brought the crash cart to the scene. He noted that he ran into Patient D's room and physically assessed him. Employee state that at that time, there were more people at that scene than when he first discovered the incident by himself. Employee testified that Patient L was still in the room when he brough the crash cart. He stated that he ran into the room and shook Patient D by the shoulder. Employee cited that while he was in the room, he told Patient L that "we are going to have you come out now. We want you to cooperate. And then I ran out quickly." Tr. Vol. II. pg. 192, 231-232, 256,

258-259. Employee affirmed that he facilitated Patient L's removal from Patient D's room. He noted that he did not put hands on Patient L. Tr. Vol. II. pg. 257.

Referring to Agency's Exhibit AB at 3:31.45 a.m., and stopping at 3:31.55.914.a.m., when Patient L is escorted out of Patient D's room, Employee acknowledged that he was the individual in the video wearing a yellow sweater, and standing in the hallway. When asked if he entered Patient D's room with his entire body after he retrieved the crash cart and while Patient L was still in the room, Employee stated that "It depends on what you mean by your entire body, but my … recollection was I went into his room." Employee also stated that "I went in there sufficiently to do what I needed to do." And that "based on that video there, I can only say that I entered the room… my answer will simply say I entered the room." Employee also stated that "And I don't think that this video is the original video." Tr. Vol. II. pgs. 260-269. When asked if Agency's Exhibit AB show him entering Patient D's room at time stamp 3:30 a.m. to 3:31.51a.m., Employee stated that "the one I'm looking at here now, … I'm in the hallway." He also noted that "I'm telling you I see myself out in the hallway…. I see myself in the hallway, yes." Tr. Vol. II. pgs. 271-273.

Employee testified that once Patient L was out of the room, Unit 1D-45, was safe. He stated that the threat was the presence of Patient L, and it prevented them from going into the room before then. He noted that he then put on gloves and went inside the room with the crash cart. Employee stated that he instructed Mr. Wilson while in the room to get the vital signs machine because the crash cart does not contain the vital signs machine. He explained that instead of Mr. Wilson doing as instructed, he pronounced Patient D dead. Employee cited that he did chest compressions on Patient D. Tr. Vol. II. pgs. 193-194. He noted that Mr. Adeyemo took over the chest compression when he was getting tired. Tr. Vol. II. pg. 196. Employee asserted that many of the staff members were doing different things such as taking vital signs at the scene as they were all trained in CPR and emergency interventions. Tr. Vol. II. pg. 197. Employee stated that he started CPR when it was safe to do, which is a basic requirement in any emergency - "provide care when it is safe to do." Tr. Vol. II. pg. 202.

Employee testified that the emergency training manual at Saint Elizabeth's Hospital is referred to as Safety Care. He noted that when you go through Safety Care from end to end, you will never see a scenario describing possible homicide in the hospital. Employee stated that Safety Care does not provide training for this type of incident and there is no training for this type of incident. He stated that "we followed Safety Care, where it was necessary." Tr. Vol. II. pgs. 211-215.

Employee testified that he had only seconds to make a judgment call of what to do, not only for himself, but for his team members and it was stressful. He stated that "sometimes you make decisions that somebody else will sit and say, he should have done that …but they were not in harm's way… Consider somebody being in harm's way. Consider somebody having responsibility for other people's life, for my staff life, for the life of other people. Consider that. Consider that I achieved the goal of minimizing the dangerousness of Patient L. …" Tr. Vol. II. pgs. 222 – 224.

Employee stated that he did not delay in rendering care to Patient D. He noted that it takes time to make a good decision, and he used the least amount of time to do it. Employee explained that this incident had never happened before and there was no preparation for it. Yet, he did what a reasonable nurse in that situation could have done. He stated that "I didn't freak out. When I was attacked, I recovered quickly enough to continue to do my job." Tr. Vol. II pgs. 243-244. Employee however, stated that Patient L never physically touched Employee. Tr. Vol. II. pgs. 254-255.

According to Employee, he did not neglect his duties. He stated that what happened was a very unusual circumstance, one Saint Elizabeth's Hospital has never recorded in the last 20 years. Tr. Vol. II. pg. 244. Employee testified that he complied with "Saint Elizabeths policy 107, which states that the first nurse on the scene shall assess the situation and determine the severity and then proceed from there. I assess[ed] the situation to be very dangerous, to be immediately threatening, to be immediately needing emergency care. I assess[ed] the situation to be too dangerous for me to go in. I assess[ed] the situation as needing more staff. That's what my assessment [was]. And the severity was very, very high, extremely risky. Based on those things, I activated the emergency code, and I took actions to prepare for other medical assistance. All the actions that I took calling a code was an intervention. Getting a crash cart was an intervention. Directing other staff to watch [Patient L] make sure that he didn't escape, was an intervention. All of those things made intervening in that situation a lot safe -- a lot safe." Tr. Vol. II. pg. 248.

Employee asserted that even with no prior disciplinary action, he was not given the option to resign. He testified that "termination was a harsh, unreasonable option. Look at the whole facts. Look at the whole facts. I didn't sit down and let something bad happen." Tr. Vol. II. pg. 249. Employee stated that he should have been given the same opportunity to retrain, the same suspension that the other staff on the unit on that day received." Tr. Vol. II. pgs. 254.

Employee affirmed that he did everything right as it related to the CPR provided to Patient D. Tr. Vol. II. pg. 273. When asked if he complied with Saint Elizabeth's policies when he conducted the security checks on March 9, 2022, from 1:00 a.m. to 3:28 a.m., Employee cited that he did not recall. He explained that "my memory doesn't allow me to say … it's been more than two years… I can't tell you that there was no mistake." Tr. Vol. II. pg. 274. Employee noted that Saint Elizabeth's policy requires 30-minute checks, for routine observation. He affirmed that some patients have 15-minute checks. Tr. Vol. II. pgs. 277-278.

Employee acknowledged that he assigned himself to do security checks from 1:00 a.m. to 3:00 a.m. on March 9, 2022. When asked if he did a security check at 2:03 a.m., Employee stated that he did not recall. Employee confirmed that he made no other security checks until approximately 2:43 a.m. Employee testified that the 30-minutes checks require at the minimum two checks within an hour. He agreed that security checks are important to ensure the patients do not need medical care. He noted that Saint Elizabeth requires staff to conduct security checks, and during these checks, the staff is supposed to put eyes on the patient. Employee affirmed that if the patient is sleeping, the staff must watch the patient's respirations to make sure they're breathing. Employee affirmed that they are supposed to log the security check they conduct for each patient on the night shift security checks form. Tr. Vol. II. pgs. 278-282.

Referring to Agency's Exhibit AB, at the top row middle panel, Employee identified himself as the staff holding the clipboard that had the night shift security checks on it. Employee affirmed that he walked around with the flashlight and the clipboard for the night security checks. Employee confirmed that Agency's Exhibit AB was the video of his 2:43 a.m. security check. The video was played from timestamp 2:43:27s to 2:43:32.946. Employee agreed that he is seen walking down Hallway B, on the bottom row left panel. Employee also agreed that at timestamp 2:43:35 he was coming up to the first room and at timestamp 2:43:37, he had already passed that first room. Employee agreed that while the video timestamp shows that he took two (2) seconds to complete his security check of the first patient, Employee stated that "we don't count seconds or time[when] we do [a] security check. It has never been said, you have to spend this amount of time doing security check. So whatever the camera shows, I don't dispute it. The interpretation is what is not accurate. We do not -- there is no policy that says you have to spend X amount of time. There isn't." Tr. Vol. II. pgs. 282-286.

Employee agreed that Saint Elizabeth required that they count three respiration per patient and that counting three respirations on a patient takes more than two seconds. Tr. Vol. II. pgs. 286-288. Employee confirmed that he had his flashlight on the lower part of the door of a patient's room at time stamp 2:43:39.152. Employee was asked if based on the video, he had already passed room number 2 at timestamp 2:43.40.47, and he responded that "I'm going -- again, I don't agree with your interpretation. I agree that I'm part -- I'm going ahead with the -- walking towards the end of the floor." When asked if he had already checked another room at timestamp 2:43:42, Employee stated that "… I see I'm moving forward. I see that." Employee confirmed that at timestamp 2:43:47.799, he had checked the room at the end of the hallway on the right side, and he was moving across the hall at this point. Employee agreed that he approached and passed another room between timestamp 2:43:51, and timestamp 2:43:54. Tr. Vol. II. pgs. 290-292.

Employee agreed that he left the corridor B Hallway at timestamp 2:44:08. Employee affirmed that he spent about a minute doing the 2:43 a.m. security check of Hallway B. Tr. Vol. II. pg. 292. When asked if he put eyes on every patient that was in the B hallway and watched for respirations while they were sleeping during this one (1) minute timeframe, Employee stated that "I could hear them breathing. Most of them smoke, the rooms were open. The reason for the breathing is to make sure that they are alive." Tr. Vol. II. pgs. 292-293.

Employee confirmed that at approximately 2:52 a.m., Patient L left his room, went to the bathroom, and then entered Patient D's room. He also agreed that he did not see that happen. Tr. Vol. II. pgs. 295-296. Referencing Agency's Exhibit S, Employee affirmed that he was assigned to sit at the front desk from 3:00 a.m. to 4:00 a.m. He confirmed that as the front desk resource staff member, it was his job to watch the A, B, and C Hallways from the front desk. Tr. Vol. II. pgs. 297-298. Employee stated that he did not recall if he sat at the front desk from 3:00 a.m. to 3:10 a.m. He noted that it was possible he was sitting in the rear office area during that time. Tr. Vol. II. pg. 299.

Employee stated that he did a security check at 3:10 a.m. Employee confirmed that Ms. Calvin was scheduled to do the security check between 3:00 a.m. and 4:00 a.m. Employee also affirmed that he had the clipboard with him when he did the 3:10 a.m. security check. He stated

that he did not recall where the clipboard was between 2:43 a.m. and 3:10 a.m. Tr. Vol. II. pgs. 300-302. Upon review of Agency's Exhibit AB between timestamp 3:08:15 and timestamp 3:09:09, Employee acknowledged that when he stood up from his chair, he had the clipboard in his left hand. Tr. Vol. II. pg. 303. Employee confirmed that he also had his flashlight in his right hand. He agreed that he left the nurse's station at timestamp 3:09:18.258 with the clipboard. Employee affirmed that the top left panel at timestamp 3:10:13.370 is a camera that covers Hallway B. Tr. Vol. II. pg. 304. However, when Employee was questioned at timestamp 3:10:17.773 if he pointed his flashlight onto the first doorway and if he was doing a security check of the patient, Employee stated that "No. I -- this run of going to the hallway was simply to do -- taking a welfare check. I -- the intent was not to do security check." When asked if he was doing a security check for the second room, Employee reiterated that it was not a security check. Employee explained that "the reason I went back to B Hallway at that time, at 2:43 there, [Patient L] had not gone to bed. I went back to make sure that he wasn't up and cursing… The thing that all alerted me and made me pay more attention to him at … 2:43 was because he was up… So that brought me to pay more attention because … for whatever reason, he was up, awake cursing. And then I needed to do a follow-up where I check, or a check in with him..." Vol. II. pgs. 305-308.

Employee confirmed that he completed his 'welfare' check of Patient L at timestamp 3:10:34.960. He noted that he did not look into the rooms of any of the patients on his right-hand side as he walked back towards the nurse's station. He affirmed that Patient D's room was one of those rooms. He cited that he did not recall if the 3:10 a.m. check was the only time that he walked down the B Hallway between 3:00 a.m. and 3:28 a.m. Tr. Vol. II. pgs. 309-310. Employee stated that he could not recall if apart from the 3:10 a.m. check, he did any other security checks between 3:00 a.m. and 3:28 a.m. He asserted that he was still within the 30-minute interval at 3:28 a.m. Tr. Vol. II. pgs. 314-315.

Referring to Agency's Exhibit AB at time stamp 3:11:12.882, bottom row, left panel, Employee confirmed that he was standing outside the nurse's station with a clipboard. He agreed that he was making notes on the clipboard at 3:11:49.003. Tr. Vol. II. pgs. 310-311. Employee testified that when he completed the 3:10 a.m. welfare check, he returned to the rear office to complete some administrative tasks, and he did not go to his assignment at the front desk. He cited that he was not watching television or videos on the computer in the rear office. He maintained that he does not watch videos on the job. Upon review of Agency's Exhibit AB from timestamp 3:18:57, Employee was asked if he was watching YouTube, to which he responded that "I don't recall it. I don't usually watch video on the job." Tr. Vol II. pgs. 321-324.

Referring to Agency's Exhibit S, at page DC OAG 442, the night shift security checks at the column starting with '03', Employee agreed that '03' indicated that the security checks were supposed to be done sometime between 3:00 and 3:30. Employee affirmed that all the patients except the patient in room 1D 57 had a notation of 'BR' on their census for the day, at 3:00 a.m., implying that they were in their bedrooms. He confirmed that he noted 'BR' for his 3:10 a.m. check and signed his initials to the bottom of the 3:00 security check as being the person that did that security check. Tr. Vol. II. pgs. 311 – 313. Employee later testified that this notation was for the 3:28 a.m. security check, and not the 3:10 a.m. welfare check. He affirmed that the only security check he made between the hours of 3:00 a.m. and 3:28 a.m. was the 3:28 a.m. check

where he found Patient L. Tr. Vol. II. pgs. 317-319. Employee stated that his notation for the 3:28 a.m. check stating that Patient L was in his room was an error because Patient L was not in bed. He testified that "that's the error because again, his bed was still in that same way that I had seen it at 3:10." Tr. Vol. II. pgs. 320.

Employee asserted that after he discovered Patient L in Patient D's room, he ran outside and yelled for help, and within seconds three (3) BHT arrived on the scene. He affirmed that these three (3) to four (4) staff members were an insufficient number of staff members to go in and remove Patient L from the room because the situation was too dangerous in the room. He explained that it wasn't simply a question of numbers, but also to give Patient L time to cool down. Employee testified that when Patient L was ultimately asked to step out of Patient D's room, he did so because he had cooled down and there were more staff at the scene, making it safe for Patient L to get out of the room safely. Employee highlighted that Mr. Colvin was the only staff member that physically went into Patient D's room to escort Patient L out. Tr. Vol. II. pgs. 333-342.

Barbara Bazron ("Dr. Bazron") – Tr. Vol. II. pgs. 346 -365

Dr. Bazron has been the director of the Department of Behavioral Health since 2019. Dr. Bazron did not have knowledge of any COVID related changes in how staff interacted with patients and still provided the level of care that was needed. She testified that the only policies at Saint Elizabeth that she considered fluid because of COVID were those related to patient safety, like making sure that people were vaccinated, making sure that people were isolated, making sure that any individual coming in to the hospital was checked to determine if they had COVID or not, and setting onsite testing opportunities for patients, as well as staff. Dr. Bazron cited that to her knowledge, the changes in policy were related to public safety issues. She asserted that staff were provided with gloves, sanitizer, and masks to maintain safety for the patients and staff. Tr. Vol. II. pg. 347-349.

Dr. Bazron testified that in an emergency situation, responding personnel have a duty to respond to the emergency according to the plan and procedure that has been established for emergency responses by the CEO. She agreed that it was within the discretion of the personnel making the call to determine when the appropriate policies and procedures can be properly implemented without harm to themselves or others, and in compliance with the policies. She highlighted that there are no specific policies that require a staff member to place themselves in harm's way when responding to an emergency. Dr. Bazron explained that policies are designed to ensure safety for the patients as well as for the staff. Tr. Vol. II. pgs. 358-360.

FINDINGS OF FACT, ANALYSIS AND CONCLUSIONS OF LAW[10]

Pursuant to OEA 631.2, 6-B District of Columbia Municipal Regulations ("DCMR") Ch. 600, et seq (December 27, 2021), Agency has the burden of proving by a preponderance of the

[10] 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").

evidence that the proposed disciplinary action was taken for cause. Furthermore, the District Personnel Manual ("DPM") regulates the manner in which agencies in the District of Columbia administer adverse and corrective actions. DPM § 1602.1 provides that disciplinary action against an employee may only be taken for cause. Agency terminated Employee pursuant to DPM §§ 1605.4(a)(3) and 1607.2(a); 1605.4(i) and 1607.2(1)(4); 1601.4(b)(3) and 1607.2(b)(3); and 1605.4(d) and 1607.2(e).

1) Whether Agency had cause to institute the current adverse action against Employee.

DPM §§1605.4(a)(3) and 1607.2(a)(4) – conduct that an employee should reasonable know is a violation of law or regulation and DPM Section 1605.4(i) and 1607.2(i)(4) – failure or refusal to observe and or enforce safety and health regulations or to perform duties in a safe manner

In the instant matter, Agency charged Employee with conduct that an employee should reasonably know is a violation of law or regulation, as well as failure or refusal to observe and or enforce safety and health regulations or to perform duties in a safe manner. Agency argued in its Advance Notice of Proposed Discipline - Removal[11] that Employee violated the District of Columbia Nurse Practice Act ("Nurse Practice Act") found at D.C. Official Code § 3-1201.01 et seq.; Title 17 of the District of Columbia Municipal Regulations ("DCMR") Chapter 54 – (Registered Nurses); Nursing Procedure Manual ("NPM") #1-3, #1-4, #2-4, and Saint Elizabeth Hospital's Polices ("SEH") #102-11.[12] Agency explained that the Nurse Practice Act and District regulations provide that the practice of registered nursing is designed to promote and maintain health, prevent illness and injury, and provide patient care to include delegating nursing interventions. Agency asserted that as the delegating registered nurse, Employee bore the responsibility for the adequacy of care provided to the hospital's patients on Unit 1D and retained accountability for the nursing tasks he assigned.[13]

Agency stated that on the March 8, 2022, night shift, Employee was required to delegate work and educate staff to promote safety and health of the patients in Unit 1D. However, he allowed Ms. Calvin to perform Patient D's one-to-one line of sight observation from the nursing station. Agency also stated that Employee allowed Mr. Opara to conduct a one-to-one Line of Sight observation away from the patient's room; he allowed Mr. Colvin to conduct a one-to-one Line of Sight observation of Patient C from the nursing station, and he allowed Ms. Sheila Benjamin, a Behavioral Health Technician to conduct a one-on-one observation from the nursing station. Agency cited that Employee's failure to require these staff members to perform their assigned duties was a violation of the Nurse Practice Act, the DCMR, NPM #1-3, #1-4, #2-4, and SEH #102-11. It stated that if Employee had ensured that these staff members performed their assigned duties, Patient L's movements in the hallway might have been observed and he would have been deterred from attacking Patient D.

Contrary to Agency's assertion, Employee argued that he was not his colleagues' supervisor and had no authority to ensure that they performed their assigned tasks. Employee testified that as the charge nurse, he made the assignments, distributed them to each staff

[11] Agency's Response to Employee's Petition for Appeal at Exhibit 36 (November 23, 2022).
[12] *See* D.C. Official Code § 3-1201.02(17) and 17 DCMR 5414, 541.
[13] Agency's Response to Employee's Petition for Appeal, *supra*, at Exhibit 36.

member on duty, and solicited feedback from the staff to ensure there were no conflicts and that the staff members did not have any issues with the assignment. Tr. Vol. II. pgs. 159-160. Employee asserted that Saint Elizabeth's Hospital is not responsive to complaints from supervisors about the behavior of staff they supervise. He provided an example of a situation where a staff under his supervision refused to complete the assigned task. He stated that when he reported the incident to the supervisor, he, Employee was asked to complete an incident report, and Saint Elizabeth did nothing about it.

Pursuant to 17 DCMR § 5415.4, "the delegating registered nurse shall be responsible for the adequacy of care provided and *shall retain accountability for the nursing task*." (Emphasis added). Ms. Pontes testified that charge nurses were responsible for the delivery of care during their shift, to include delegation of assignments and ensuring that the delegation was done according to the person's skills and that the work was done appropriately. Specifically, Ms. Pontes testified that since Employee worked the night shift, he would have been responsible for tasks he assigned to the other staff on that night, as well as ensuring the assigned tasks were completed by the staff. She affirmed that Employee was responsible for ensuring that staff were at their designated posts and performing their designated duties. She confirmed that a staff assigned to one-on-one is supposed to be seated directly outside the patient's bedroom or if at arm's length, inside the patient's bedroom. Ms. Pontes cited that it was Employee's responsibility as the charge nurse to ensure that one-to-ones are in the correct location. Further, Mr. Rodgers testified that Employee was responsible for making sure that each person assigned to a one-on-one implemented the one-on-one correctly. Additionally, Mr. Wilson testified that it is the duty of the charge nurse and the team leader to ensure that all assignments are fulfilled before the end of each shift. Employee does not deny that all the staff assigned to one-to-one did not perform their assigned tasks, and this is supported by the video recording of the current incident where no one-to-one staff members are seen in Hallway B. Accordingly, I find that Agency has cause to charge Employee with this cause of action, based on this specification.

Agency also stated in its Notice of Proposed Adverse action that Employee violated the Nurse Practice Act, the DCMR, NPM #1-3, #1-4, #2-4, and SEH #102-11 when he failed to properly conduct security checks during the night shift on March 8, 2022, from 2:00 a.m. to 3:00 a.m. on Hallway B where Patient L and Patient D were located. Agency asserted that security checks are performed to ensure that the patients are safe and accounted for. It explained that during bedtime, staff use flashlights to observe the rise and fall of the patient's chest, check if each patient is in the correct room, asleep, breathing and not in distress. Agency cited that Employee failed to observe during his security check that Patient L was not in his room, thereby violating the Nurse Practice Act, the DCMR, NPM #1-3, #1-4, #2-4, and SEH #102-11. Agency asserted that based on the video recording of the current incident, Patient L is seen entering Patient D's room at 2:52 a.m., and he does not leave the room until Patient D is discovered lying motionless on the floor approximately half an hour later. Agency asserted that had Employee properly conducted his assigned security check, he would have noticed that Patient L was absent from his room and possible have prevented the assault.

Mr. Rodgers stated that it is Saint Elizabeth's policy that the staff performing the security check must use their flashlight to shine inside of the room to look for chest respirations to verify that the patient is breathing. Ms. Pontes testified that if during bedtime a patient does not want

the door open or gets very upset when staff open the door during security checks, the staff would be able to look through the window on the patient's door. She explained that pursuant to the guidelines if a patient does not get upset, the staff must open the door, shine their flashlight on the patient's chest and see their chest rising and falling. Employee agreed that if a patient is sleeping, staff are required to watch the patient's respirations to ensure they're breathing.

I agree with Agency that had Employee properly conducted his assigned security check, he would have noticed that Patient L was absent from his room. A review of Agency's Exhibit AB shows Employee with his clipboard and flashlight at about 2:03 a.m., ready to conduct the security check. Per the video recording, it took Employee approximately two (2) minutes to conduct this security check. At no time is Employee seen shining his flashlight into the patients' rooms or observing the patients' respiration. Employee did another security check at 2:43 a.m., Again Employee is seen on the video recording rushing through the security check, spending about one (1) minute to complete the security check for the unit. Upon review of the video recording, I find that Employee did not shine his flashlight into most of the patients' rooms to check on their respiration while they were asleep. At one point, Employee had his flashlight on the lower part of his body while he was doing security checks, and he did not shine it into the patients' rooms as required by policy.

Additionally, I found it troubling that Employee did a check at 3:10 a.m. but he did not realize that Patient L had left his room to Patient D's room and had been there for over 30 minutes. Interestingly, Employee testified that he did not perform a security check at 3:10 a.m., but rather he performed a 'welfare check' of Patient L at 3:10 a.m., because he noticed during his 2:23 a.m. check that Patient L was agitated, and he wanted to ensure he had gone to sleep. Equally interesting is the fact that while Employee stated that Patient L was in his bedroom when he performed the 3:10 a.m. 'welfare check', per the video recording, Patient L entered Patient D's room at 2:52 a.m., and he did not leave Patient D's room until after Patient D was discovered on the floor at 3:28 a.m. Therefore, I conclude that if Employee had conducted a proper check, be it 'welfare' or security check at 3:10 a.m., he would have discovered that Patient L was not in his room, and that he was in another patient's room, and possibly have prevented the assault. Consequently, I find that Employee violated Agency's policies in this instance.[14]

Agency also asserted that Employee assigned himself to two (2) critical assignments – front desk resource person and security checks (previously delegated to Ms. Calvin) for the same time period. Agency noted that Employee failed to adjust the assignment sheet to reflect the change. Agency explained that by assigning himself both tasks, Employee could not provide appropriate monitoring for the unit or facilitate a safe environment. As a result, Employee violated the Nurse Practice Act, the DCMR, NPM #1-3, #1-4, # 2-4, and SEH #102-11. Ms. Pontes testified that the person assigned to the front desk does not have any other roles on the unit during the time they're supposed to be monitoring the front desk. Employee does not dispute

[14] Employee testified that at the end of his 2:43 a.m., security check, Patient L was in bed, and that the primary reason for his 3:10 a.m. check was to determine if Patient L was still in bed. Employee stated that "I observed a bed that was in the form of a person who was asleep in bed. The reason I went in there is to check whether he was still in bed within that short period of time. [Patient L] appeared to be in bed… I saw a figure that appeared that he was in bed." I find that if Employee had followed Agency's policies/procedure of observing the patient's respiration during this check, he would have realized at that point that the 'figure' he saw on Patient L's bed was not Patient L. He would have also realized that Patient L was not in bed or in his room at that point.

that he assigned himself to the front desk as the Front Desk Resource Person from 3:00 a.m. to 4:00 a.m. or that he delegated security checks from 3:00 a.m. to 4:00 a.m. to Ms. Calvin. He confirmed that as the front desk resource staff member, it was his job to watch the A, B, and C Hallways from the front desk. Tr. Vol. II. pgs. 297-298. Employee testified that when he completed the 3:10 a.m. 'welfare check', he returned to the rear office to complete some administrative tasks, and he did not go to his assignment at the front desk. This is also supported by Agency's Exhibit S, which is the Shift Assignment Sheet and the video recording where Employee is seen conducting a security check at 3:28 a.m., instead of sitting at the front desk monitoring the unit, in violation of the Nurse Practice Act and regulations. As such, I find that Agency has met its burden of proof with regards to this cause of action.[15]

Agency terminated Employee based on four (4) causes of action stemming from the March 9, 2022, incident. Agency asserted that termination was warranted for each of the four (4) causes of action levied against Employee. Therefore, because I have found that Employee violated DPM §§1605.4(a)(3) and 1607.2(a) – conduct that an employee should reasonably know is a violation of law or regulation, and DPM Section 1605.4(i) and 1607.2(i)(4) – failure or refusal to observe and or enforce safety and health regulations or to perform duties in a safe manner, I will not address in great detail the remaining two (2) causes of action levied against Employee.[16] Since Agency met its burden of proof for the charges of conduct that an employee should reasonably know is a violation of law or regulation, and failure or refusal to observe and/or enforce safety and health regulations or to perform duties in a safe manner, I further conclude that Agency was within its rights to discipline Employee.

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[15] This does not include a comprehensive list of the specifications contained within the Advance Notice of Proposed Removal Agency issued to Employee.

[16] Even *assuming* that Agency did not have cause to discipline Employee for cause number 1 and cause number 2, I find that Agency had cause to discipline Employee pursuant to cause number 3 - false statements, including misrepresentation, falsification or concealment of material facts or records in connection with an official matter. Agency explained that Employee documented that Patient L was in his room at 3:00 a.m., however, he had already entered Patient D's room by that time. Agency also noted that Employee documented that Patient L was in his bedroom at 3:30 a.m., when he indicated 'BR' on Agency Exhibit S (Security Check Sheet), although Patient L had not left Patient D's room. Employee argued that it was a mistake. I find Employee's statement to be self-serving and lacking credibility. Employee testified that he conducted a 'welfare' check of Patient L at 3:10 a.m. and that he saw Patient L in his bed during that 'welfare' check. However, the video recording contradicts this assertion as it showed Patient L going into Patient D's room at 2:53 a.m. Therefore, by documenting that Patient L was in his bedroom at 3:00 a.m. and at 3:30 a.m., I find that Employee provided a false statement of material facts in connection with an official matter and the penalty range for this cause of action is reprimand to removal for a first offense. Additionally, Agency also charged Employee under cause number 4 with Neglect of duty – failure to carry out official duties or responsibilities as would be expected of a reasonable psychiatric nurse in the same position. Agency argued that Employee did not perform his specific task properly. It stated that NPM Assignment of Nursing Care does not allow anyone designated as the Front Desk Resource Person to be given another task, yet Employee assigned himself to security check during the same time he was Front Desk Resource Person. Employee does not dispute that he was the Front Desk Resource Person from 3:00 a.m. to 4:00 a.m. He also does not dispute that he assigned himself to security check during that period. He only argued that Ms. Calvin who was assigned the 3:00 a.m. to 4:00 a.m. security check was unavailable during that time, so he decided to do the security check. Agency's assertion is supported by the record. Agency's Exhibit S shows that Employee was assigned to the front desk as the Front Desk Resource Person from 3:00 a.m. to 4:00 a.m. and the video recording also shows Employee doing security check during this period. Therefore, I find that Employee neglected his duty when he failed to carry out his official duties as expected of a reasonable psychiatric nurse in the same position. This cause of action also carries a penalty range of counseling to removal for a first offense.

Disparate Treatment

Employee argued that Agency engaged in disparate treatment in its decision to terminate him. Employee explained that three (3) other staff members who responded to the incident were initially placed on administrative leave alongside Employee. But all three (3) were retrained and they retained their positions while Employee was terminated. Employee asserted that Mr. Wilson abandoned his post during the emergency, left a patient he had assessed, and placed colleagues at risk, yet he was retained, retrained, and promoted. He also stated that Mr. Colvin passed Patient D's room multiple times without discovering the incident, yet he faced no discipline.[17]

OEA has held that, to establish disparate treatment, an employee *must* show that he worked in the same organizational unit as the comparison employees. They *must* also show that both the petitioner and the comparison employees were disciplined by the same supervisor for the same offense within the same general time period (emphasis added).[18] Further, "in order to prove disparate treatment, [Employee] *must* show that a similarly situated employee received a different penalty."[19] (Emphasis added). An employee must show that there is "enough similarity between both the nature of the misconduct and the other factors to lead a reasonable person to determine that the agency treated similarly-situated employees differently."[20] If a showing is made, then the burden shifts to the agency to produce evidence that establishes a legitimate reason for imposing a different penalty on the employee raising the issue.[21]

Here, I find that although Employee and Mr. Colvin were placed on administrative leave following the current incident, they did not have the same job title. Mr. Colvin was a BHT, while Employee was an RN at Saint Elizabeth's Hospital. Also, I find that Employee has not offered evidence to prove that he and Mr. Wilson were similarly situated – that they were disciplined by the same supervisor for the same offense, within the same general time period. While Employee and Mr. Wilson are both RNs at Saint Elizabeth's, I find that the record is void of any evidence to suggest that Mr. Wilson was disciplined for similar causes of action as Employee. Therefore, I find that Employee has not established a *prima facie* showing of disparate treatment and as such, I conclude that Employee has failed to prove that he was subjected to disparate treatment.

2) Whether the penalty of termination is appropriate under District law, regulations or the Table of Illustrative Action

Employee asserted that he was not given the opportunity to resign. Agency on the other hand argued that the penalty of termination was appropriate under District laws, regulations, and

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[17] Employee's Closing Argument, *supra*.
[18] *Mills v. D.C. Department of Public Works*, OEA Matter No. 1601-0001-09, Opinion and Order on Petition for Review (December 12, 2011), citing *Manning v. Department of Corrections*, OEA Matter No. 1601-0049-04 (January 7, 2005); *Ira Bell v. Department of Human Services*, OEA Matter No. 1601-0020-03, Opinion and Order on Petition for Review (May 6, 2009); *Frost v. Office of D.C. Controller*, OEA Matter No. 1601-0098-86R94 (May 18, 1995); and *Hutchinson v. District of Columbia Office of Employee Appeals*, 710 A.2d 227, 236 (D.C. 1998).
[19] *Metropolitan Police Department v. D.C. Office of Employee Appeals, et al.*, No. 2010 CA 002048 (D.C. Super. Ct July 23, 2012); citing *Social Sec. Admin. V. Mills*, 73 M.S.P.R. 463, 473 (1991).
[20] *Barbusin v. Department of General Services*, OEA Matter No. 1601-0077-15, Opinion and Order on Petition for Review (January 30 ,2018) (citing *Boucher v. U.S. Postal Service*, 118 M.S.R.P. 640 (2012)).
[21] *Id*.

the Table of Illustrative Actions. Agency cited that termination was an appropriate penalty for each of the four (4) charges against Employee. Agency maintained that termination was a within Agency's managerial discretion. Ms. Pontes testified that per the guidelines, removal was warranted for each individual charge. Agency also asserted that it carefully weighed the *Douglas* factors[22] and, after considering all options within its authority, it ultimately determined that termination was the best course of action.

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).[23] 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; 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 matter, I find that Agency has met its burden of proof for the charges of conduct that an employee should reasonably know is a violation of law or regulation, failure or refusal to observe and or enforce safety and health regulations or to perform duties in a safe manner, false statements and neglect of duty. Consequently, I conclude that Agency can rely on these charges to discipline Employee.

With regard to "conduct that an employee should reasonably know is a violation of law or regulation" charge; the record shows that this was the first time Employee violated this cause of action. Pursuant to the Table of Illustrative Actions ("TIA"), DPM §1607.2(a)(4), the penalty for a first offense ranges from 'Reprimand to Removal'. For the charge of "failure or refusal to observe and or enforce safety and health regulations or to perform duties in a safe manner", the record shows that this was the first time Employee violated this cause of action. The penalty for a first offense for violating DPM § 1607.2(i)(4) ranges from 'Reprimand to Removal'. Because the penalty of removal is allowable under both charges, I find that Agency was within its discretion to terminate Employee from his position.

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.[24] When an Agency's charge is upheld, this Office

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[22] *Douglas v. Veterans Administration,* 5 M.S.P.R. 313 (1981).

[23] *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).

[24] *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

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.

Penalty Based on Consideration of Relevant Factors

Employee argued that the *Douglas* factors require agencies to consider an employee's past record when determining appropriate discipline. He cited that he had no prior disciplinary actions, and his spotless record "should weigh heavily in favor of a lesser penalty or no penalty at all."[25] An Agency's decision will not be reversed unless it failed to consider relevant factors, or the imposed penalty constitutes an abuse of discretion.[26] Agency also provided a thorough analysis of the factors outlined in *Douglas v. Veterans Administration,* 5 M.S.P.R. 313 (1981), in reaching the decision to terminate Employee.[27] The *Douglas* factor analysis included in the record demonstrates that Agency considered all factors in imposing the penalty in this matter. Specifically, Ms. Pontes noted in Agency's Final Notice – Removal under Factor 3 – the employee's past disciplinary record that "A review of your work record reveals no disciplinary action within the past three years. Although your record is absent of disciplinary action this fact does not mitigate the seriousness of your misconduct. Therefore, this is a neutral factor." [28]

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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,* 5 M.S.P.R. 313 (1981).

[25] Employee's Closing Argument (May 30, 2025).

[26] *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).

[27] 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
12) the adequacy and effectiveness of alternative sanctions to deter such conduct in the future by the employee or others.

[28] Agency's Response to Employee's Petition for Appeal, *supra*, at Exhibits 36 and 40.

In *Douglas,* the court held that "certain misconduct may warrant removal in the first instance." In reaching the decision to remove Employee, Agency included the *Douglas* factors analysis in both the Advance Notice of Proposed Discipline – Removal and the Agency's Final Notice – Removal. Accordingly, I conclude that Agency has properly exercised its managerial discretion, and its chosen penalty of termination is reasonable. Consequently, I further conclude that Agency's action should be UPHELD.

ORDER

It is hereby **ORDERED** that Agency's action of removing Employee from service is **UPHELD**.

FOR THE OFFICE:

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