

THE DISTRICT OF COLUMBIA

BEFORE

THE OFFICE OF EMPLOYEE APPEALS

_____)	
In the Matter of:)	
)	
Darlene Nelson,)	OEA Matter No. 1601-0054-14
Employee)	
)	Date of Issuance: November 10, 2015
v.)	
)	Joseph E. Lim, Esq.
D.C. Fire & Emergency Medical Services,)	Senior Administrative Judge
Agency)	

Keisha Williams, Employee Representative
Eric Huang, Esq., Agency Representative

INITIAL DECISION

INTRODUCTION

On February 14, 2014, Darlene Nelson (“Employee”) appealed from D.C. Fire & Emergency Medical Services’s (“F&EMSD” or Agency”) final decision, effective January 14, 2014, suspending her from her position as Paramedic for one hundred and twenty duty hours for the cause of “neglect of duty.” This matter was assigned to me on July 18, 2014. I held a prehearing conference on August 8, 2014, and a hearing on December 15, 2014. The record closed at the conclusion of the hearing.

JURISDICTION

The Office has jurisdiction in this matter pursuant to D.C. Official Code § 1-606.03 (2001).

ISSUES

1. Whether Agency has proven, by a preponderance of the evidence, that Employee committed the acts of which she is accused.
2. Whether Employee's actions of “Any on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operations” constituted cause for taking an adverse action under 16 D.P.M. §1603.3(f)(3) (March 4, 2008) (inexcusable neglect of duty).
3. If so, whether Agency's penalty was appropriate under the circumstances.

BACKGROUND

Agency's Cause

By a letter dated October 8, 2013, Employee was notified by Assistant Fire Chief Coles of a proposal to suspend her from her position as Paramedic for one hundred and twenty duty hours for the cause of “Any on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operations. This misconduct is further defined as cause, to wit: Neglect of Duty.” The letter set forth the following allegations:

SPECIFICATION: On August 8, 2013, you failed to adhere to the requirements of D.C. Fire and Emergency Medical Services Department Order Book, Article XX, Section 15, which provides:

A check list will be provided for each piece of apparatus including the fireboats, reserve apparatus, chief cars and EMS units, alphabetically listing tools and appliances by compartment, or the location they are carried on the apparatus. The original copy will be kept on the apparatus and a copy in the company storeroom.

All EMS¹ personnel will utilize the tools and appliances check list and the F&EMSD Form 54.2 RS/EMS at the beginning of each shift and note the results thereof in the EMS journal. The member making the check will sign his/her name below and the on-duty platoon commander will sign his/her name under that of the member.

In addition, upon daily inspection of apparatus and EMS units to the foregoing, to ensure greater accountability and maintenance of the vehicles, equipment and supplies designated for the Emergency Medical Services Bureau, the 54.3 Daily equipment Check List, F&EMSD Form 54.3 will be executed by the on-duty crew members at the beginning of the shift. EMS units will not be placed out of service in order to comply with this policy, but will make every effort to complete the inspection as near to the prescribed hour as possible. The F&EMSD Form 54.3 EMS will be executed, original only, and will be retained at the unit level.

Moreover, on that same date, you failed to adhere to the requirements of D.C. Fire and Emergency Medical Services Department Order Book, Article XXIV, Section 6(1)(i), which provides that:

All equipment and supply levels will be thoroughly checked at the beginning of each shift, and maintained at acceptable levels and

¹ Emergency Medical Services.

ready for immediate use throughout the day. Deficiencies will be noted in the unit journal, reported immediately to the platoon commander, and recorded on the F.D. Forms 54.2 AMB Daily Apparatus Inspection Report Ambulance and/or the 54.3 EMS Daily Accountable Equipment Inventory Checklist, and the 54.5 Medication Bag Check List. Each of these forms shall be executed at the start of each shift.

Summary of Material Testimony

a. Nicole Renee Rust (“Rust”) testified as follows: (Tr. Pgs. 19 – 68)

Emergency Medical Technician (“EMT”) Rust, an 11-year veteran at Agency, testified that she was usually assigned to Medic 2. Typically, its ambulance unit had a longstanding defective fuel gauge. She noted that their duty hours were from 0700 hours to 2000 hours. She testified that although they had the responsibility of checking the fuel level of their vehicle, the gauge was broken. This fact had been noted in their daily equipment inventory checklist report.² Thus, to ensure that they had enough fuel, they simply filled up sometime during their shift in between ambulance emergency runs, due to the fact that Medic 2 is kept busy. Rust testified that most of the vehicles had defective fuel gauges. Even after reporting to management (the lieutenant in charge of the firehouse) that the fuel gauge was broken, it usually took three months before it was fixed.

On August 8, 2013, she and Employee were assigned to Medic 1, an ambulance unit normally detailed to escort the U.S. President. Typical of Agency’s vehicles, their unit also had a defective fuel gauge. Rust asked Employee if they needed to get more fuel. Employee responded that they had fueled yesterday. They were riding on the Medic Unit S542³ to line up for the motorcade when it ran out of fuel. Rust was then asked to write an incident report.⁴

b. John Donnelly (“Donnelly”) testified as follows: (Tr. I, Pgs. 70 – 106)

Battalion Chief John Donnelly authored the investigative report of the August 9, 2013, incident.⁵ His investigation revealed that the ambulance unit was completely out of fuel, needing 33 gallons to get it running, and that the fuel gauge was working intermittently. Since it was a relatively new unit, it was sent to the dealer for warranty repair. Donnelly testified that mechanical problems with Agency’s vehicles were to be reported via reports, phone calls, Google sheets, and emails.

He was the Deputy Fire Chief of the Apparatus Division at the time, which meant that he was in charge of fleet maintenance from March 23, 2013, to August 31, 2013. Donnelly found

2 Agency Exhibit 5, page 4.

3 An ambulance vehicle in Medic 1.

4 Agency Exhibit 1. Also see Agency Exhibit 7, Medic 1 Record which logs the crew’s notes.

5 Agency Exhibit 8.

that prior to August 9, 2013, there was no record of reported fuel gauge problem since March 23, 2013. Donnelly admitted that Agency's vehicular records were in disarray before March 23, 2013, citing news reports that Agency could not account for its vehicle inventory. He was sent to fix Agency's records problem but admitted that he was not able to completely fix the problem.

Donnelly claimed that during his tenure, there were only three units that had fuel gauge problems, and that the vendor took only a couple of days to fix them. He admitted that because of Agency's unreliable record system, there could have been more units with fuel gauge problems that he was not aware of.

Donnelly testified that using the Daily Apparatus Inspection Reports,⁶ employees should refuel their assigned vehicles every day and asserted that this instruction was in an Agency bulletin. However, he could not identify which bulletin. Donnelly also admitted that repairs of Agency vehicles could take months, a situation that he attributed to poor management, strapped budget, and insufficient personnel.

c. Ryan Frasier ("Frasier") testified as follows: (Tr. Pgs. 106 - 124)

Frasier worked in the Fuel Management Office Rations Program and Support at the time. He conceded that based on fuel pump usage reports, Agency's fuel pumps inexplicably and regularly shut off despite pumping out less than a gallon of biodiesel.⁷ When cross-examined about the instance when an individual appeared to give up after being unable to obtain sufficient fuel into his or her vehicle due to the pump shutting off after several tries, Frasier adamantly insisted that the vehicle's electronic device was the culprit, not the fuel pump.

d. Reginald Stowe ("Stowe") testified as follows. (Tr. Pgs. 124 – 139)

Chief Stowe authored the report on his interview with EMT Rust and Employee regarding the August 8, 2013, incident.⁸ Employee had fueled her vehicle the day before. When she reported to work the next day, she checked the journal and saw that the night crew only had a couple of runs. So Employee assumed they still had an adequate amount of fuel in the unit to last during her shift.

e. Donald Martin ("Martin") testified as follows. (Tr. Pgs. 140 – 171)

Battalion Fire Chief Martin investigated the August 8, 2013, incident and recommended disciplinary action for Employee. He testified that prior to that day, no mechanical problems were reported with Medic 1. However, he admitted that a defective fuel gauge would not necessarily be reported to him.

⁶ Agency Exhibits 2 and 3.

⁷ Agency Exhibits 10 to 12.

⁸ Agency Exhibit 13.

Martin felt that Employee was neglectful for not topping off the vehicle prior to her detail, especially since Employee was aware of the defective fuel gauge. His investigation revealed that Employee had a little over two hours to refuel before reporting for the presidential detail. In his view, relying on the number of runs the prior shift had did not take into account that the vehicle would still consume fuel while it was idling due to the use of either air-conditioning or heating.

Martin admitted that he later became aware that these new vehicles were reporting fuel gauge problems beforehand. He also admitted that even after a vehicular problem is reported to management, there was no guarantee that it would be fixed. Martin conceded that the regulation stating that the vehicle should be refueled when the fuel gauge indicator falls to half or less is inapplicable when the fuel gauge itself is faulty. He also conceded that there was no written regulation for instances when the fuel gauge is broken. Martin stated that broken fuel gauges were a common problem even back in the 1990's.

f. Kenneth Crosswhite ("Crosswhite") testified as follows. (Tr. Pgs. 171 – 203)

Deputy Fire Chief of Operations at the time of the incident, Crosswhite testified that according to Agency's Administrative and Operational rules,⁹ ambulance crew have a duty to ensure that their vehicle had adequate fuel and supplies throughout their shift. He opined that having a faulty fuel gauge did not relieve the operator of exercising due diligence in insuring adequate fuel levels by fueling up every day or even twice a day. As for the presidential detail, the Secret Service¹⁰ notifies Agency at least an hour before the event and thus, crewmembers have adequate time to get their equipment ready. Crosswhite testified that this incident was widely reported in the press and that other employees were disciplined as a result.

g. Tracye Weaver ("Weaver") testified as follows. (Tr. Pgs. 203 - 212)

Paramedic Weaver was assigned to Medic 1. She documented the faulty fuel gauge about a year before the incident on July or August 2012, but nothing was done. Since then, Weaver and her fellow crew members had been refueling every other day to avoid running out of fuel. She testified that other Agency vehicles had fuel gauge problems as well.

h. Jacqueline Pinnix ("Pinnix") testified as follows. (Tr. Pgs. 212 - 220)

EMT Pinnix testified that as a floater, she had been assigned to Medic 1. She explained that a floater was someone who is detailed to different medic units across the city. Pinnix testified that she knows crewmembers, including herself, who were not disciplined despite their vehicles breaking down on a presidential detail. She asserted that she herself had reported the fuel gauge

9 Agency Exhibit 18 and Employee Exhibit 3.

10 The Federal Agency entrusted with the security of the President and Vice President of the United States and also with various enforcement functions in the Treasury.

problem on the vehicle that Employee drove and then driving it to the repair shop for repairs. However, that failed to fix the problem.

i. Emory Crawford (“Crawford”) testified as follows. (Tr. Pgs. 220 - 229)

Heavy Equipment Technician Crawford worked at the fleet maintenance division and was aware of the fuel gauge problems with vehicles made from 2010 to 2012. Crawford also stated that due to the many mechanical problems coupled with the number of vehicles that were needed to be on the road for Agency’s mission, the vehicles did not often have regular maintenance.

j. James Dulling (“Dulling”) testified as follows. (Tr. Pgs. 230 - 232)

Fleet Manager Dulling testified that since the incident, Agency has revamped the reporting system for repairs.

k. Employee testified as follows. (Tr. Pgs. 233 - 248)

Basic Paramedic Employee had been assigned to Medic 1 for eight years. Employee testified that on August 8, 2013, she and her partner Rust performed their due diligence by checking out their vehicle, drugs, supplies, and performing the required paperwork. Employee asserted that they had reported the vehicle inexplicably shutting down a month before, but nothing was done. Employee also pointed out journal entries indicating that this particular vehicle had failed to start before on July 4, 2013.¹¹ When the vehicle shut down again on August 8, 2013, Employee thought it was an electrical problem so she instructed Rust to shut the engine off and turn it back on, in hopes that this would revive the engine. When it failed to do so, Employee notified radio communications to send them another unit.

The demands of the job are such that at times when there were a lot of ambulance runs, Agency’s Communications Unit would not give them permission to refuel at the time that she asked. Employee stated that she had refueled their vehicle the day before on August 7, 2013. The fuel pump quickly shut off with a click, which indicated to her that the tank must now be full despite the lack of notation on the journal by the prior crew.

FINDINGS OF FACT, ANALYSIS AND CONCLUSION

Title 1, Chapter 6, Subchapter VI of the D.C. Official Code (2001), a portion of the Comprehensive Merit Personnel Act, sets forth the law governing this Office. D.C. Official Code § 1-606.03 reads in pertinent part as follows:

¹¹ Agency Exhibit 9.

- (a) An employee may appeal a final agency decision affecting a performance rating which results in removal of the employee (pursuant to subchapter XIII-A of this chapter), *an adverse action for cause that results in removal*, reduction in force (pursuant to subchapter XXIV of this chapter), reduction in grade, placement on enforced leave, or suspension for 10 days or more (pursuant to subchapter XVI-A of this chapter) to the Office upon the record and pursuant to other rules and regulations which the Office may issue.

Chapter 16, Section 1603.3 of the District Personnel Manual (“DPM”) sets forth the definitions of cause for which disciplinary actions may be taken against Career Service employees of the District of Columbia government. Among the causes defined in the statute is Section 1603.3(f) any on-duty or employment related act or omission that interferes with the efficient and integrity of government operations; specifically, Neglect of Duty: Failure to follow instructions or observe precautions regarding safety; failure by a supervisor to investigate a complaint; failure to carry out assigned tasks; careless or negligent work habits.¹² In this matter, Agency had charged Employee for the cause of “Any on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operations, to wit: Neglect of Duty.”

This Office's Rules provide that an agency's action must be supported by a preponderance of the evidence, which is defined as "that degree of relevant evidence which a reasonable mind, considering the matter as a whole, would accept as sufficient to find a contested fact more probably true than untrue."¹³ OEA Rule 628.2 *id.* states: “The employee shall have the burden of proof as to issues of jurisdiction, including timeliness of filing. The agency shall have the burden of proof as to all other issues.”

The following findings of fact are based on the witnesses' demeanor during testimony and the documentary evidence of record.

The salient facts in this matter are not in dispute. Agency had a fleet of relatively new ambulance vehicles, of which many have faulty fuel gauges. Journal entries have documented the problem for Medic 1's vehicle for weeks before August 8, 2013. Employee and other crewmembers have reported this problem but Agency either took their time before fixing the gauges or, at least in this instance, failed to fix the problem. This occurred despite Agency's being on notice that this was a continuing problem. In addition, Agency's witnesses admitted that its records system was in disarray.

¹² Title 6B of the D.C. Municipal Regulations, Ch. 16 Table of Penalties 6(c)

¹³ OEA Rule 628.1, 59 DCR 2129 (March 16, 2012)

Agency regulation mandated that ambulance crewmembers refuel every time the fuel gauge falls to half or less. There is no regulation that covers instances where the fuel gauge is defective; presumably on the reasonable assumption that a defective gauge would or should be fixed promptly.

On August 8, 2013, Employee's ambulance unit ran out of fuel during a presidential detail, thereby generating negative media attention around the time there was already negative press coverage of Agency's performance. Embarrassed management thus charged Employee with negligence for what happened.

Agency does not take responsibility for insuring that their employees have fully functioning ambulance units to work with. Instead, it argues that since Employee was already aware that the fuel gauge was defective, then Employee should have refueled each and every time she was on her shift. Based on Agency's argument, Employee's failure to do so absolves Agency of any blame and shifts all blame and responsibility to Employee.

To look at this issue in another way, Agency charged Employee for the cause of "Any on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operations, to wit: Neglect of Duty."

Its specific allegations are that:

On August 8, 2013, you failed to adhere to the requirements of D.C. Fire and Emergency Medical Services Department Order Book, Article XX, Section 15, which provides a check list will be provided for each piece of apparatus... The original copy will be kept on the apparatus and a copy in the company storeroom. All EMS personnel will utilize the tools and appliances check list and the F&EMSD Form 54.2 RS/EMS at the beginning of each shift and note the results thereof in the EMS journal. The member making the check will sign and the on-duty platoon commander will sign his/her name under that of the member. In addition...the 54.3 Daily equipment Check List, F&EMSD Form 54.3 will be executed by the on-duty crew members at the beginning of the shift...and will be retained at the unit level.

Moreover, on that same date, you failed to adhere to the requirements of D.C. Fire and Emergency Medical Services Department Order Book, Article XXIV, Section 6(1)(i), which provides that: "All equipment and supply levels will be thoroughly checked at the beginning of each shift, and maintained at acceptable levels and ready for immediate use throughout the day. Deficiencies will be noted in the unit journal, reported immediately to the platoon commander, and recorded on the F.D. Forms 54.2 AMB Daily Apparatus Inspection Report Ambulance and/or the 54.3 EMS Daily Accountable Equipment Inventory Checklist, and the 54.5 Medication Bag Check List. Each of these forms shall be executed at the start of each shift."

In summary, the specific act or acts of negligence that Agency charged Employee with is not the failure to keep her ambulance unit fully fueled, but the failure to do the proper equipment checks and the keeping of the various log reports of their equipment.

Yet in their testimonies, Employee and her crew partner EMT Rust, asserted that they maintained all the required checklist and reports cited above in Employee's specifications. None of the witnesses credibly contradicted Employee's and EMT Rust's assertions. Indeed, the submitted documents, even those coming from Agency, lend credence to Employee's assertions.

I therefore find that Agency failed to prove Employee did not perform her equipment checks nor did it prove that Employee failed to maintain the necessary checklists and log reports. In short, I find that Agency had no credible evidence that Employee knowingly failed to follow her orders and neglected her duty.

Accordingly, I conclude that the agency has not met its burden of establishing cause for taking adverse action. Therefore, I conclude that Agency's action should be reversed.

ORDER

It is hereby ORDERED that:

1. Agency's action suspending Employee for one hundred and twenty duty hours is REVERSED.
2. Agency restore to Employee all pay and benefits lost as a result of its action; and
3. Agency file with this Office documents signifying compliance with the terms of this ORDER within thirty days from the date this decision becomes final.

FOR THE OFFICE:

JOSEPH E. LIM, ESQ.
Senior Administrative Judge