THE DISTRICT OF COLUMBIA

BEFORE

THE OFFICE OF EMPLOYEE APPEALS

In the Matter of:	)	
	)	
EMPLOYEE[1]	)	OEA Matter No. 1601-0040-21
	)	
v.	)	Date of Issuance: September 7, 2022
	)	
D.C. FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT, Agency	)	MONICA DOHNJI, Esq. Senior Administrative Judge
	)	

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

INITIAL DECISION

INTRODUCTION AND PROCEDURAL HISTORY

On August 9, 2021, Employee filed a Petition for Appeal with the Office of Employee Appeals ("OEA" or "Office") contesting the District of Columbia Fire and Emergency Medical Services Department's ("Agency" or "FEMS") decision to terminate her from her position as a Firefighter/EMT effective July 31, 2021. OEA issued a Request for Agency Answer to Petition for Appeal on September 28, 2021. Agency submitted its Answer to Employee's Petition for Appeal on October 27, 2021. This matter was initially assigned to Administrative Judge ("AJ") Cannon.[2] Thereafter, this matter was reassigned to the undersigned on April 5, 2022.

On April 18, 2022, the undersigned issued an Order Convening a Status/Prehearing in this matter on May 19, 2022. During the Status/Prehearing Conference, the undersigned was informed that there was an Adverse Action Panel Hearing in this matter. As such, OEA's review of this appeal was subject to the standard of review outlined in *Elton Pinkard v. D.C. Metropolitan Police Department,* 801 A.2d 86 (D.C. 2002). Thereafter, I issued a Post Status Conference Order on May 20, 2022, requiring the parties to submit briefs addressing the issues raised during the Status/Prehearing Conference. Both parties have complied. The record is now closed.

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

[2] AJ Cannon issued an Order scheduling a Prehearing Conference in this matter for March 24, 2022, and the parties were required to submit Prehearing Statements on March 17, 2022. Agency submitted its Prehearing Statement as requested.

JURISDICTION

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

ISSUES

1) Whether the Trial Board's decision was supported by substantial evidence;
2) Whether there was harmful procedural error;
3) Whether Agency's action was done in accordance with applicable laws or regulations.

BURDEN OF PROOF

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

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

OEA Rule 628.2 *id.* states:

> The employee shall have the burden of proof as to issues of jurisdiction, including timeliness of filing. The agency shall have the burden of proof as to all other issues.

STATEMENT OF THE CHARGE(S)

According to Agency's Answer to Employee's Petition for Appeal[3], Employee's adverse action was predicated on the following charges and specifications, which are reprinted in pertinent part below:

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

C. Position Responsibilities Continued – Medical Duties: …

Crewmember (Position No. 2): …

2. Duties at the Incident Scene:

[3] At Tab 21 (October 27, 2021).

- Stays with patient from the initial on-scene contact to release at the hospital.
- Obtains patient history and pertinent information from the patient, family and/or bystanders at the scene.
- Determines how the patient will be treated and transported. Request additional resources as may be necessary.
- Administers medications, as needed.
- Reassesses the patient's condition prior to and during the transport.

Further violation of D.C. Fire and Emergency Medical Services Department Bulletin No. 13, **Patient Bill of Rights** § 11, which states:

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

You may expect:

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

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

3. …

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

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

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

7. …

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

9. …

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

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

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

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

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

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

This morning at 1105 A32 was dispatched to 2323 Good Hope Court for a 6 year old male with a fever. When we arrived on scene we called the patient's mother to inform her that we were outside of her residence to evaluate her child whom she requested medical attention for. We were calling the parent to get clarity on what was going on and if we needed to get dressed in full PPE, because the notes did not indicate that information. Over the phone the patient's mother stated that she had previously to her son's primary care physician and that the doctor told her to call 911. The mother said she was unaware as to why the doctor advised her to call 911 because she hadn't given her son Tylenol yet and did not want her child to go to the emergency room or doctor's office because of the [C]ovid-19 situation. My partner and I stated to the mother that if she

> felt comfortable with giving her son over the counter medicine for now to try to break her son's fever that that was totally fine and up to her. She also stated that her friend was at her home to give her and the child a vehicle ride to whichever facility she [chose] to take her son to. We advised the mother that if she decided to give her child Tylenol and if it does not break the fever that she could always give EMS a call back and that an ambulance would transport with her consent. The patient's mother adamantly refused to go to the hospital and stated again that she would give her son Tylenol. The phone call ended and A32 made a radio transmission on Channel 11 that there were no EMS services required.

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

> Firefighter/EMT [Employee] was interviewed by me after being notified by EMS 3 Captain Moulton of a citizen complaint in reference to Run Number F200087160.
>
> Firefighter/EMT [Employee] admits in her Special Report that she did not make contact with [the] juvenile patient but rather chose to call the patient's mother and speak via personal cell phone advising her to administer over the counter medications to break a reported fever.
>
> Firefighter/EMT [Employee] failed to properly administer patient care and never did a face to face with the child in order to get a first impression or monitor vitals before choosing to place Ambulance 32 in service from the run, therefore grossly neglecting her duties and placing the juvenile patient in danger. Firefighter/EMT [Employee] also failed to properly fill in pertinent information into Patient Care Report.
>
> Upon arriving at the pediatric patient's home, both Order Book, Article XXIV and the Patient Bill of Rights required FF/EMT [Employee] to at least attempt to render competent, compassionate, and empathetic emergency medical service to the child. Yet FF/EMT [Employee] showed virtually no concern for this patient. Rather than initiate (or make an attempt to initiate) patient care FF/EMT [Employee] did nothing more than talk on her cell phone. FF/EMT [Employee] admitted discourteous treatment of the public, violation of department's customer service standards, failure to offer assistance when requested, failure to carry out assigned tasks, and careless work habits constitute both neglect of duty and unreasonable failure to give assistance to the public. Accordingly, this termination action is proposed.

Charge 2: Violation of D.C. Fire and Emergency Medical Services Department Manual and Pre-Hospital Treatment Protocols (2017), **Standard**

Operating Guidelines, **CONSENT / REFUSAL OF CARE POLICY**, which states:

V. **Refusal Procedures**:

…

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

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

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

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

D. Provide detailed explanation of possible risks and danger signs to patients or other designees.

E. …

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

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

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

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

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

> **Documentation Policy**:
>
> **Regardless of the outcome of an event, all units are required to provide a written account of their actions and findings on EMS related event.** An ePCR must be completed and include clear, concise and accurate documentation. The ACIC on the transport unit and the company OIC shall ensure the ePCR is completed on each dispatch, patient contact and/or transport.
>
> Narratives are required for each patient contact. The narrative section shall include any information that is pertinent to the assessment, treatment(s), decisions, response/outcome and disposition that is not covered in the drop-down menu. The narrative should include, but not limited to: rationale for the use/non-use of controlled medication; law enforcement badge number; condition of surroundings; especially when abuse is suspected; whether medical control was conducted; name of physician; when resuscitation is terminated in the field; patient refusal of treatment; transport to the closet or appropriate facility; and any other special considerations
>
> This misconduct is defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII, Section 2(f)(3) which states: "Any on-duty or employment-related act or omission that interferes with the efficiency or integrity of government operations to include: Neglect of Duty." *See also* 16 DPM § 1603.3(f)(3) (August 27, 2012).

Specification 1 In his first endorsement (dated 05/22/2020) Captain Brian McAllister describes Firefighter/EMT [Employee]'s misconduct as follows:

> Firefighter/EMT [Employee] failed to properly administer patient care and never did a face to face with the child in order to get a first impression or monitor vitals before choosing to place Ambulance 32 in service from the run, therefore grossly neglecting her duties and placing the juvenile patient in danger. **Firefighter/EMT [Employee] also failed to properly fill in pertinent information into Patient Care Report**.

Notwithstanding the clear directives outlined in both the Pre-hospital Treatment Protocols and the (**CONSENT / REFUSAL OF CARE POLICY**) and the Special Order No. 54, series 2012 (**Patient Care**

> **Reporting (ePCR) Directives**), FF/EMT [Employee] failed to perform any assessment of her pediatric patient, failed to follow the Department's Refusal of Care policy, and failed to properly complete the ePCR corresponding with her response on Incident No. F20087160. Accordingly, this termination action is proposed.

On June 7, 2021, Employee appeared before a Fire Trial Board. She was represented by counsel and pled not guilty to Charge 1, and Guilty to Charge 2.

SUMMARY OF THE TESTIMONY[4]

On June 7, 2021, Agency held a Trial Board Hearing. During the hearing, testimony and evidence were presented for consideration and adjudication relative to the instant matter. The following represents what the undersigned has determined to be the most relevant facts adduced from the findings of fact, as well as the transcript (hereinafter denoted as "Tr."), generated and reproduced as part of the Trial Board Hearing.

Agency's Case-In-Chief

Traes Ceasar – Tr. pgs. 27 – 75

Traes Ceasar ("Ceasar") is employed by Agency as a Firefighter/EMT. He has been in this role for about three (3) years. He was the driver of Ambulance 32 on May 22, 2020, and he was partnered with Employee. Tr. pgs. 27 -28. He recalled being dispatched to 2323 Good Hope Court on May 22, 2020, at about 11:00 am to provide care to a six (6) years old child. Tr. pg. 29.

Ceasar identified Agency's Exhibit 1, as a document for the Agency's CAD system. Tr. pg. 30. He explained that although the Computer Aided Dispatch system ("CAD") shows that they were dispatched to 2323 Good Hope Court at 11:06 a.m., and arrived at the address at 11:15 a.m., it does not take that long to get to the address on Ambulance (Engine) 32. Ceasar stated that the CAD system is accurate with regard to the timestamp. He further explained that once they were dispatched at 11:06 a.m., he immediately put Ambulance 32 en route, and they pulled off from the firehouse. He noted that generally, they have to hit the button on the CAD system when they are dispatched, when they are "en route", and when they arrive at the scene. Tr. pg. 31. Ceasar testified that the "at the scene" button could have been pushed late for multiple reasons such as faulty system or a mistake. He noted that Ambulance 32 probably arrived the scene at approximately 11:07 a.m. Tr. pg. 32.

Ceasar asserted that once they arrived at 2323 Good Hope Court, Employee called the mom on her personal cell phone to talk to her. Tr. pgs. 32-33. He explained that when they started their shift at 0700, they were unable to find the department phone because the previous employees on Ambulance 32 had the phone in a discreet location as required by the Order Book for Department Communication devices. They were later notified of the location of the department phone by a member of the previous Ambulance 32 crew, who had placed the phone in the discreet location. Ceasar noted that they did not notify a supervisor when they could not

[4] Agency Answer to Employee's Petition for Appeal at Tab 20 (October 27, 2021).

find the phone because they first wanted to talk to the previous Ambulance 32 crew. Tr. pgs. 33-36.

Ceasar testified that he worked with Employee frequently. Tr. pg. 36. He highlighted that May 22, 2020, was the first time he saw Employee use her personal cell phone to contact a patient. Ceasar noted that when they arrived 2323 Good Hope Court, Employee contacted the patient with her cell phone, and she placed the call on speakerphone. Tr. pgs. 36, 51. The patient's mother answered the call. Ceasar affirmed that he was able to clearly hear the entire conversation between Employee and the patient's mother. He stated that the call lasted for approximately three (3) to three and a half (3.5) minutes. Ceasar did not say anything while Employee was on the call. Ceasar testified that based on the call, he understood that the patient was a six (6) year old male with a fever. Tr. pgs. 36-37.

Ceasar asserted that when they talked to the patient's mother, she stated that she did not know why her child's doctor told her to call 911. The mother explained that her child had a fever and she had not yet given him the Tylenol as directed by the doctor. Tr. pgs. 39, 42. Ceasar identified Agency's Exhibit 4 as his Special Report. He explained that he was ordered by his supervisor to write the Special Report. Tr. pgs. 39-40. Ceasar affirmed that the content of the report was accurate to his knowledge. He noted that if they had gone inside to see the patient, Employee would have been the one to go inside and he would have remained outside the unit. Tr. pg. 41. When asked who made the decision to go back into service on May 22, 2020, Ceasar stated that Employee made the radio transcript to Communication placing them back in service. Tr. pgs. 41-42.

Ceasar testified that during the call with the mother, Employee inquired about the child's situation and a fever was the only symptom relayed to them. When asked if Employee asked how high of a fever the patient had, he stated that he could not recollect whether or not Employee asked. He stated that they asked the mother to bring the child downstairs to be evaluated and potentially be transported to the hospital, which would have been the best care for the patient. When asked if Employee asked the mother how long the child had had a fever, Ceasar stated that he does not think that was something that was relayed to them. Tr. pgs. 42 - 43. Ceasar could not recall if Employee asked if the mother is the child had any other symptoms. Tr. pg. 43.

Ceasar stated that they did not get any discussion about the incident after the call between Employee and the patient's mother. They were placed in service and Employee completed the patient care information on the tablet. Tr. pg. 44. Ceasar explained that the process of going back in service involves a radio transmission with Communications or other appropriate channel, and selecting the "In Service" or "Available" button on the CAD system. He averred that Employee made a radio transmission to Communications (Channel 11) stating "No EMS required", putting them back in service. Tr. pgs. 45-46, 52.

On cross-examination, Ceasar stated that Employee was one of the firefighters that trained him when he moved to the ambulance, and she signed off on his 502s and 503s forms, clearing him to ride the ambulance. Tr. pg. 46. He testified that Employee was a competent trainer and EMT; she was always willing to help patients; she went above and beyond; exuded confidence in her decision making; and he learned from Employee on both the fire and EMS

sides. He affirmed that he often rode the ambulance with Employee, and never had any problems working with Employee. Tr. pgs. 47 - 48.

Ceasar testified that when Employee got on the call with the patient's mother, she introduced herself, and asked the mother the nature of her call, to which the mother stated that her son had a fever and was not feeling well. He restated that the mother noted that she was asked to call 911 by her son's doctor, but she did not know why. Employee asked the mother if she could bring her son outside for evaluation and the mother stated that she did not want to have her son transported to the hospital by EMS, because she did not want him exposed to COVID. She also noted that she had not given the child Tylenol as directed by the child's doctor and that she would much rather monitor the child's fever. Employee asked the mother if she was sure about not wanting her child to be transported to the hospital. The mother adamantly refused stating she did not want to expose her son to COVID, noting that if she could not get the fever to break after administering Tylenol, she would have her friend transport her child to the hospital via personal vehicle. Tr. pgs. 48-51. Ceasar averred that Employee told the mother that if she felt comfortable giving the child Tylenol, had the right to do so, but she could always call back 911 if the fever did not break. Tr. pg. 51.

Ceasar acknowledge that Employee was completing the ePCR form around the time they went back in service. Tr. pg. 52. Ceasar affirmed that they responded to a call after the call at 2323 Good Hope Court. He explained that it was a COVID- related call. Tr. pg. 52. Ceasar and Employee went in dresses in PPE and assessed the patient since she was not able to come outside. The patient went through nurse triage line. Tr. pg. 53.

When asked by Member Edwards whether the Department directive that encouraged members to call patients to come outside stated that they use Department phones, Ceasar stated that the directive did not specify the type of phone to use. Tr. pg. 54. Ceasar stated that pre-COVID, they did not have to call patients when they were on call. Tr. 55. He explained that during the COVID pandemic, the ordinance specifically stated that they should call via cellular phone. Ceasar asserted that when he was trained by Employee, they had no Department cell phones, so they operated exclusively off radio communication. Tr. pg. 56.

Ceasar testified that for the 2323 Good Hope Court call, because of the pandemic, it was in the patient's best interest to be brought downstairs so they could conduct an evaluation while transporting the patient to the hospital. Ceasar noted that they did not know how many people were in the unit or whether it was a very hot environment. The patient could have been brought outside to a cooler environment and where there wasn't lots of people, since he could control who got in and out of the ambulance. He stated that getting the patient to the hospital was the best option for the patient. Tr. pgs. 57 -58. Ceasar asserted that their intention was not to go to 2323 Good Hope Court and not lay eyes or do anything for the kids. Instead, their intention was to get the kid to the hospital, and the mother stated that that was not something she wanted to do. Tr. pg. 60.

Ceasar stated his responsibilities as a driver and Ambulance Crew Member Aide ("ACA") according to protocol was to take vitals. However, it was different in the height of the pandemic. If he was driving, then Employee had control of the tablet and did patient care.

Employee would have also been the one to get dressed and make contact with the patient. He affirmed that he would have been responsible to drive the ambulance to the scene and the patient to the hospital, while Employee did patient care. Tr. pg. 61. Ceasar state that he was ordered to complete a special report because of a complaint from the patient's mother. Tr. pgs. 61-62.

When questioned by Chairperson Downs about her impression of the patient's mother based on the conversation she had with Employee, Ceasar stated that the mother was straightforward with her responses regarding what she wanted and what she did not want done. She did not want Ceasar and Employee to transport her child to the hospital because she was afraid of her child being exposed to COVID as this happened in the height of the pandemic. He stated that the mother might have been watching the new like everyone which advised people not to bring their children or themselves to the hospital unless they were experiencing trouble breathing. Tr. pgs. 63-64.

Ceasar averred that neither him nor Employee tried to coerce the patient's mother into not going to the hospital. Their sole intention was to get the patient to the hospital and they were not trying to duck a run or a call. The patient's mother adamantly refused having her son transported to the hospital, and she made this clear. Tr. pgs. 64 -65. When asked whose decision it was to put the ambulance back in service, Ceasar stated that he couldn't pinpoint who was responsible for making the decision, Employee simply placed them back in service. Tr. pgs. 66-68.

Ceasar testified that the 2323 Good Hope Court incident was a unique incident because he had never run a call during COVID wherein the patient did not want to come downstairs. Generally, the patient would come downstairs to be assessed and if they said they could not come down for one reason or another, they would go in and do an assessment. None of these happened in the current case. Instead, the mother adamantly refused to have her child transported to the hospital for fear of COVID exposure. She stated that she would rather give her child Tylenol and monitor the fever. Tr. pgs. 69-70.

On redirect, Ceasar stated that during the COVID pandemic, officers used the department cell phones to call patients to see if they could come outside to be evaluated. Tr. pg. 72. Referencing to Employee's Exhibit 13, on recross, Ceasar affirmed that the March 28, General Order Series 2020, number 25; expected employees to call patients prior to making contact with the patients. Tr. pgs. 72 – 75.

Employee's case-in-chief

Employee – Tr. pgs. 82 – 160

Employee has been employed with Agency since 2013. She started in the Cadet program after graduating high school. Tr. pgs. 82 - 83. Employee identified Employee's Exhibit 3, as a Leadership award she received as a cadet. Tr. pgs. 85-86. Employee stated that she served the public prior to joining Agency through community outreach programs. Tr. pg. 88. Employee identified Employee's Exhibit 5, as her 2015 Evaluation Report by Agency. She noted that she has not had an evaluation since 2015. She identified Employee's Exhibit 6, as a note from the previous fire chief, congratulating her on her nomination to receive Agency's Meritorious Pre-

Hospital Award. Tr. pgs. 89-90. Employee affirmed that Employee's Exhibit 8 was her Performance Evaluated for 2018, 2019, and 2022. Her supervisor at the time was Lieutenant John Connelly. Tr. pg. 94.

Employee testified that she loved running calls because she gets more experience with the different types of calls, especially on Ambulance 32. T. pg. 97. Referencing Employee's Exhibit 9, Employee stated that she had the most hours for riding the ambulance because as a senior member on the shift, she would step up to ride the ambulance when others were unavailable for whatever reason. Tr. pgs. 98-99. Employee testified that being a senior member, her role in training Ceasar was to ensure that he learned everything that he needed to know riding an ambulance such as the different calls, how to operate the ambulance, etc. Tr. pg. 100. She affirmed training other members of the fire department as well. Tr. pgs. 100-101.

Employee testified that she had COVID in March of 2020. She noted that she did not have any hesitation in responding to COVID calls. Employee highlighted that on May 22, 2020, while at the fire house in Engine 32, she responded to a call regarding a six (6) year old with high fever. Tr. pg. 103. The call came over the intercom system that they were being dispatched to Good Hope Court around 11:00 a.m. They got in the ambulance "en route" to the address which was about three (3) to four (4) minutes' drive down the street. Tr. pgs. 104 -105. She stated that when they arrived at the scene, she checked the CAD system to see what was going on. The CAD system stated that there was a six (6) year old with high fever. It also listed the mother's name and her phone number, no further information was provided. Tr. pgs. 105 - 106.

Employee asserted that she called the listed number with her personal cell phone because they did not possess the department cell phone at that time as the previous crew had put it somewhere they could not find. They became aware of the issue with the department cell phone early that morning. Tr. pg. 106. Employee asserted that she informed Lieutenant Connelly that they could not find the department phone. She and Lieutenant Connelly tried calling the crew from the previous shift but did not get a response. Lieutenant Connelly said he would give the crew a call at lunch time since they might be asleep at that time. After their run at Good Hope Court, Lieutenant Connelly informed Employee he had spoken to the crew and he knew where to find the department cell phone. Tr. pgs. 106 – 107, 123. When asked if she had used her personal cell phone before to contact a patient, Employee said "no". Tr. pg. 107, 124.

Employee explained that during COVID, the common practice was to call patients with COVID-related symptoms. Moreover, the notes did not specify the patient's unit number or advised on whether they had to wear PPE. Employee affirmed that the mother answered the phone when she called. Employee introduced herself and asked if the mother was able to bring her son outside for evaluation. The mother informed Employee that she spoke with the son's doctor already and he told her to give the son Tylenol and call 911. Tr. pg. 108, 125-126. Employee averred that the mother stated that she did not know why she was asked to call 911 because she had not yet given him the Tylenol. Tr. pgs. 108-109.

Employee stated that when she asked the mother what was going on with her son, the mother said the son had a high fever and he stated that he was not feeling good. Employee noted that she again asked the mother if she could bring her son outside to be evaluated and possibly

transported to the hospital to which the mother responded that she really did not want her son to go to the hospital because of COVID. Employee told the mother that she thought the mother should get the son some type of treatment. Tr. pg. 109. The mother then asked Employee what she thought she, the mother should do. Employee stated that she informed the mother that as a mother, she could follow the doctor's instructions of administering Tylenol to the child if the mother was comfortable doing so, and she, Employee did not have any issues with that. Tr. pg. 110, 145-146. The mother responded that she would rather give the son Tylenol and see if it breaks the fever before making any decision about taking the son to the hospital. Tr. pgs. 110 - 111, 129.

Employee testified that she asked the mother if she drove, and the mother stated that she did not drive, but her friend was available to take them to the hospital if they had to go in. Employee explained that she informed the mother that they were outside, and willing to transport the son to the hospital. Employee again asked the mother if she was certain that she did not want the ambulance to transport them to the hospital, and the mother said "Yes. I'm sure". Tr. pg. 111, 129. Employee asserted that she reiterated to the mother that it was fine if the mother was comfortable giving her son Tylenol, but if anything were to change, the mother could call 911 again and a unit would be dispatched to her to take the son to the hospital. The mother said okay and thanked Employee. Tr. pgs. 111 -112.

Employee affirmed that when the mother asked her what she should do, she told the mother she was also a mother and as a mom with a child of the same age, she administered Tylenol to her child whenever it was needed. Employee further explained that she was basically agreeing with what the doctor had recommended because she did it herself. Employee noted that the mother was the one who brough up the conversation about Tylenol. Tr. pg. 112, 128.

According to Employee, after the call entered, she used her tablet to document her findings. She then made the transmission to Communications via Channel 11. Tr. pg. 113. When asked if she had any discussions with Ceasar after the call, Employee said "no". Employee affirmed that the conversation with the mother was on speakerphone. Tr. pg. 113. She stated that Firefighter Ceasar chimed in when she was on the call with the mother, however, it was not to the mother's hearing. Tr. pgs. 113-114.

Employee identified Agency's Exhibit 1, as the first PCR he submitted. She noted that under disposition she stated that "No patient contact; canceled on scene" because she had not been able to physically assess or examine the patient. Tr. pgs. 114 -115. Employee stated that she did not introduce a narrative because the mother had stated that she did not want her son transported to the hospital and she wanted to try a different approach prior to deciding whether to transport the son to the hospital or not. Tr. pg. 115.

Employee identified Agency's Exhibit 2, as the ePCR that she submitted as an addendum to the first one. Tr. pg. 115. She explained that she submitted a second ePCR after they were place out of service that same afternoon, and they had learned of a citizen complaint. Since she thought it would be needed, she did a narrative on the phone. Tr. pg. 116.

Employee identified Agency's Exhibit 3 as her Special Report of the incident. She noted that she wrote the report after 1:00 p.m. on May 22, 2020. Tr. pg. 116. She affirmed that the report was accurate. Tr. pgs. 116-117.

Employee testified that from a professional standpoint and from being a mother, she could have done things differently. She would have made every attempt to exhaust all available options before leaving and not doing anything. Employee explained that although she could not administer medication, she could have at least done an assessment of everything else to determine whether she should have let it go or not. Tr. pg. 117. Employee stated that she should have gotten dressed in PPE, figured out what unit they were in, went in, did an assessment, checked his vital signs, made sure he was conscious and alert, and ask relevant questions. Tr. pg. 118.

For documentation, Employee stated that she should have done the narrative in the PCR report, and gather as much information as possible, to include the patient's demographic information. Tr. pg. 118.

Employee affirmed that she responded to other calls on May 20, 2022, including a COVID-related call and she got dressed in PPE for the call. She also affirmed getting into the patient's house, counseled and reassured the patient everything would be fine. Tr. pgs. 118-119. Employee affirmed calling the triage nurse on the department's cell phone. Tr. pg. 120.

Employee apologized for her error in judgment on May 22, 2020. She expressed that she took her job seriously and the incident on May 20, 2022, was a learning experience. She stated that in hindsight, she could have done more to ensure the patient was given appropriate care and attention. Tr. pgs. 120-121.

On cross examination, Employee testified that she arrived at the fire house on May 22, 2020, between 5:30 and 6:00 a.m. Tr. pg. 121. She stated that she checked all her work apparatus after she got her gear, and she informed Lieutenant Connelly of the missing Department cell phone. Tr. pg. 122. Employee noted that she had no excuse for not calling dispatch to contact the mother of the patient at Good Hope Court. She explained that the mother's number was listed on the CAD report, so she took advantage of the information already provided to her. Tr. pg. 124-125. Employee stated that she did not ask how long the child had had a fever or how high of a fever the child had because her main focus was to get the child evaluated and transported to the hospital. Tr. pg. 126. Employee noted that the mother did not specifically say she did not want to bring her child outside. Tr. pg. 126. Employee explained that based on her medical training, the condition of a child with high fever could change quickly and a child with a high fever could go into a febrile seizure. She agreed that a child with a high fever should be quickly evaluated by a medical professional. Tr. pg. 127. Employee was not aware if the mother was a medical professional. Tr. pg. 128.

When asked if she informed the mother that she could get dressed in PPE and come evaluate the child, and if necessary, transport the child to the hospital, Employee said no. Employee explained that she asked the mother multiple times to bring her child downstairs to be evaluates but the mother made it clear that she wanted otherwise, so she was simply respecting

the mother's wishes. Tr. pgs. 130, 142. Employee noted that in her seven (7) years of working at Agency, she has never had any incident with patient care or interacting with the public. Tr. pgs. 130-131.

Employee stated that she did not get any red flags during the call with the mother since the mother had a mild disposition. She thought everything was cool and calm. Employee also explained that she did not call a supervisor because she was used to EMS calls wherein patients stated that they did not need EMS services. Tr. pg. 131. Employee affirmed that the situation on Good Hope Court was not properly canceled. Tr. pg. 132.

Employee identified Agency's Exhibit 6 as a snippet of Agency's EMS protocol. Employee stated that she was trained in the protocols in 2013, and has since followed the protocols. Tr. pgs. 134-135. Employee acknowledged being familiar with the pre-hospital treatment protocol. Tr. pg. 135. Employee explained that there's no excuse for her action on May 22, 2022. She stated that what she did was out of respect for the mother's wishes with regard to COVID and all the information from the CDC and the media. Tr. pgs. 135-136. Employee noted that in hindsight, she could have done more and it was an error in judgement on her part that she regrets. Tr. pg. 136. Employee testified that it was her decision to put Ambulance 32 back into service after the Good Hope Court call. She explained that typically, when you finish with a call, you go back into service. Tr. pg. 141.

When asked by Member Edwards why she deviated from the Department's protocol, Employee stated that the mother had made it clear she did not need their assistance. She expounded that her failure to follow Department protocol was an honest mistake. She stated that she should have done everything she was supposed to do, instead of relying on what someone else wanted. Tr. pg. 145.

Employee explained that Agency protocol provides that they are supposed to render competent, compassionate care to everyone. Tr. pg. 148. Employee noted that she was the Ambulance Crew member in charge ("ACIC") and Firefighter Ceasar was the driver for the Good Hope Court call. Tr. pg. 149. She stated that as the ACIC, she had the ultimate control and decision authority for EMS care on the ambulance. Tr. pgs. 149-150.

When questioned by Member Bozarth, Employee stated that she pleaded not guilty for Charge No. 1 because she was dissatisfied with the way the charge was worded. Tr. pg. 151. She noted that she disputed Captain McAllister's description of the misconduct and their assumption about Employee's intentions. Tr. pg. 152, 159. Employee alluded that she was not satisfied with the performance of Ambulance 32 for the Good Hope Court run and that her performance was not consistent with EMS medical protocols and the Patient Bill of Rights. Employee acknowledged making an error in judgement on May 22, 2020 and that there are no excuses for her action. She noted that she was negligent to a certain degree but not grossly negligent. Employee explained that there was no legitimate reason for her not to carry out all her assigned duties and tasks. She reiterated that it was an error in judgement. She noted that they should have gotten the vitals and refusal to be transported if needed. Tr. pgs. 152 -153.

When asked by Member Troy if she thought appropriate care was given in the May 22, 2020, incident, Employee said "no". Tr. pg. 154.

Michael Dolby – Tr. pgs. 164 – 189

Chief Dolby ("Chief Dolby") retired from Agency a few days before this June 7, 2021, Trial Board Hearing. Tr. pgs. 164-165. He testified that while he was a captain on Engine 11 and Truck 16, he supervised Employee. Tr. pgs. 166 -167. Chief Dolby stated that Employee was an excellent firefighter, smart, and very energetic. She was available whenever Chief Dolby needed her. Tr. pg. 167. He asserted that Employee was an excellent EMT as she treated patients with compassion. He affirmed that he personally supervised Employee on EMS calls while on Engine 11 and Truck 16. Tr. pg. 168.

Chief Dolby averred that the current charges against Employee were exaggerated and did not warrant termination. If anything, it should be a reprimand or quality control issue. Tr. pg. 172. He stated that Employee's difficult work environment at Engine 11 did not affect the quality of her patient care. Tr. pg. 173. Chief Dolby stated that Employee studied hard. He explained that Employee's issues were not with her job performance, rather with the perception that because she was a woman, she could not do the job, but she proved them wrong. Tr. pg. 174.

On cross-examination, when asked if he thought the charges against Employee were brought because she was a woman or other improper reason, Chief Dolby stated that the history of what Employee went through at Agency, along with all what she had to deal with, led up to the current charges brought against Employee. Tr. pgs. 169-173, 76. He reiterated that the charges were excessive. He explained that there are Agency employees who have done worse and have not been terminated. 175-176. Chief Dolby noted that this was in the beginning of the COVID pandemic where everyone was trying to figure out the best approach and best practices. He explained that there were no procedures and nothing in writing on how to approach people in the middle of a pandemic that no one knew anything about. Tr. pg. 176.

Chief Dolby asserted that it's not uncommon for crew members to miss runs from being dispatched from the fire house and that they have had crew members asleep when runs come up for Code 1 calls, yet, none of them were fired. He reiterated that considering the fact that this happened in the middle of the pandemic, the current charges against Employee were exaggerated. Tr. pg. 181, 186. When questioned by Member Edwards, Chief Dolby stated that he personally stayed away from hospitals and everywhere that he thought he could get exposed to COVID. Tr. pg. 185.

Claude Brown – Tr. pgs. 189 – 202

Claude Brown ("Brown") is currently assigned to Truck 16, number 3, as a Tillerman. He has been at this assignment for 21 years. He stated that Employee was assigned to his unit, Truck 16, shift 3. He has worked with Employee for about six (6) to six and a half (6.5) years. Brown explained that he is the Tillerman, and Employee works on the back step – the truck fires, medical and rescue calls. He affirmed that he has responded to medical calls with Employee. Tr. pg. 190.

Brown stated that Employee was very efficient, effective and she knew her job. He noted that Employee follows protocols and does what she is supposed to do. He noted that Employee was a great EMT, she cares for the patients, does patient assessments and does whatever she is supposed to do. Tr. pg. 191. Brown affirmed that he was aware and had seen Truck 16 crew members calling patients on the radio during the pandemic. Tr. pg. 191. He affirmed that this practice was communicated to them by the officers in an effort to encourage the patients during the pandemic to come and meet them by the door. Tr. pg. 192. When questioned by Chairperson Downs, Brown stated that in a pandemic, he would use the cell phone to call the patient and ask if they could meet him outside. But if the patient cannot come outside, they will go inside the residence. Tr. pg. 199.

Gary Penny– Tr. pgs. 202 – 214

Gary Penny ("Lieutenant Penny") is currently assigned at Engine 19, Platoon number 2. He noted that Employee was his cadet about seven (7) years prior and he helped train her at the training academy for six (6) months. Lieutenant Penny explained that since leaving the training academy, he has supervised Employee in different capacities, such as on Truck 16. Tr. pg. 203. Lieutenant Penny was the officer in charge of the company on Truck 16. Tr. pgs. 203 – 204.

Lieutenant Penny stated that Employee was a hard worker; all around good and outgoing person; eager and always wanted to learn. Employee always had questions, and she was the first one in and the last to leave. Tr. pg. 204. Lieutenant Penny affirmed that he supervised Employee's medical calls and Employee knew her job. Employee was people oriented and she did not need mentoring. Tr. pg. 205.

Lieutenant Penny affirmed that he was aware of the practice of calling patients with the department cell phone to see if they could come outside for evaluation during the pandemic. He affirmed that this happened even in places where he acted as a supervisor. Tr. pg. 206, 207. Lieutenant Penny explained that he was not aware of any department order or directive about this practice, rather, it was a tool out of their toolbox to protect themselves from being exposed to the COVID virus. Tr. pg. 206. Lieutenant Penny asserted that he has used the department cell phone to call patients as a means of protecting his crewmembers and himself from being exposed to the COVID virus during the pandemic. Tr. pgs. 111-112. Lieutenant Penny noted that as one of Employee's instructors, he trained her to use common sense, better judgment and also to follow the rules. Tr. pg. 213.

Panel Findings

The Trial Board Panel made the following findings of fact based on their review of the evidence presented at the hearing:[5]

1) Pursuant to Order Book Article XXIV, § 2(4), FF/EMT [Employee] was the Ambulance Crewmember in Charge (ACIC) on Ambulance 32 during the incident in question and, as such, FF/EMT [Employee] was primarily responsible for patient care decisions made by the crew.

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

2) In direct violation of Department policies and practice, FF/EMT [Employee] called the patient's mother on the cell phone, rather than making face to face contact with the patient. FF/EMT [Employee]'s failure to assess the patient violates the Patient Bill of Rights.

3) FF/EMT [Employee] failed to contact an EMS Supervisor to assist in advocating for the patient.

4) FF/EMT[Employee] failed to obtain a proper refusal, which violates the Department's Patient Care Protocols.

5) FF/EMT [Employee] further violated Department's policy by failing to document appropriately (no narrative) on the first ePCR she prepared.

Upon consideration and evaluation of all the testimony and factors, The Trial Board Panel found that there was a preponderance of evidence to sustain the charges against Employee. The Panel found Employee guilty of Charge No. 1, Specification No. 1 and Charge No. 2, Specification No. 1. In addition to making the findings of fact, the Panel also weighed the offenses against the relevant *Douglas* factors[6] and concluded that termination for Charge No. 1, and 72-duty hours suspension for Charge No. 2, were the appropriate penalties for these offenses.[7]

---

[6] *Douglas v. Veterans Administration,* 5 M.S.P.R. 313 (1981). The *Douglas* factors provide that an agency should consider the following when determining the penalty of adverse action matters:

1) the nature and seriousness of the offense, and its relation to the employee's duties, position, and responsibilities including whether the offense was intentional or technical or inadvertent, or was committed maliciously or for gain, or was frequently repeated;
2) the employee's job level and type of employment, including supervisory or fiduciary role, contacts with the public, and prominence of the position;
3) the employee's past disciplinary record;
4) the employee's past work record, including length of service, performance on the job, ability to get along with fellow workers, and dependability;
5) the effect of the offense upon the employee's ability to perform at a satisfactory level and its effect upon supervisors' confidence in employee's ability to perform assigned duties;
6) consistency of the penalty with those imposed upon other employees for the same or similar offenses;
7) consistency of the penalty with any applicable agency table of penalties;
8) the notoriety of the offense or its impact upon the reputation of the agency;
9) the clarity with which the employee was on notice of any rules that were violated in committing the offense, or had been warned about the conduct in question;
10) potential for the employee's rehabilitation;
11) mitigating circumstances surrounding the offense such as unusual job tensions, personality problems, mental impairment, harassment, or bad faith, malice or provocation on the part of others involved in the matter; and

the adequacy and effectiveness of alternative sanctions to deter such conduct in the future by the employee or others.

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

FINDINGS OF FACT, ANALYSIS AND CONCLUSIONS OF LAW[8]

Pursuant to the D.C. Court of Appeals holding in *Elton Pinkard v. D.C. Metropolitan Police Department*,[9] OEA has a limited role where a departmental hearing has been held. According to *Pinkard*, the D. C. Court of Appeals found that OEA generally has jurisdiction over employee appeals from final agency decisions involving adverse actions under the CMPA. The statute gives OEA broad discretion to decide its own procedures for handling such appeals and to conduct evidentiary hearings.[10] The Court of Appeals held that:

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

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

> 1. The appellant (Employee) is an employee of the Metropolitan Police Department or the D.C. Fire & Emergency Medical Services Department;
>
> 2. The employee has been subjected to an adverse action;
>
> 3. The employee is a member of a bargaining unit covered by a collective bargaining agreement;
>
> 4. The collective bargaining agreement contains language essentially the same as that found in *Pinkard*, *i.e.*: "[An] employee may appeal his adverse action to the Office of Employee Appeals. In cases where a Departmental hearing [*i.e.*, Adverse Action Panel] has been held, any further appeal shall be based solely on the record established in the Departmental hearing"; *and*
>
> 5. *At the agency level, Employee appeared before an Adverse Action Panel that conducted an evidentiary hearing*, made findings of fact and conclusions of law, and recommended a course of action to the

[8] 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").
[9] 801 A.2d 86 (D.C. 2002).
[10] *See* D.C. Code §§ 1-606.02(a)(2), 1-606.03(a)(c); 1-606.04 (2001).

> deciding official that resulted in an adverse action being taken against Employee (emphasis added).

There is no dispute that the current matter falls under the purview of *Pinkard*. Employee is a member of the D.C. Fire and Emergency Medical Services Department and was the subject of an adverse action (termination); Employee is a member of the International Fire Fighters. Local 36, AFL-CIO MWC Union ("Union") which has a Collective Bargaining Agreement ("CBA") with Agency. The CBA contains language similar to that found in *Pinkard* and Employee appeared before an Adverse Action Panel on June 7, 2021, for an evidentiary hearing. This Panel made findings of fact, conclusions of law and recommended that Employee be terminated for the current charges. Consequently, I find that *Pinkard* applies in this matter. Accordingly, pursuant to *Pinkard*, OEA may not substitute its judgement for that of the Agency, and the undersigned's review of Agency's decision in this matter is limited to the determination of (1) whether the Adverse Action Panel's decision was supported by substantial evidence; (2) whether there was harmful procedural error; and (3) whether Agency's action was done in accordance with applicable laws or regulations.

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

Pursuant to *Pinkard*, I must determine whether the Adverse Action Panel's ("Panel") decision was supported by substantial evidence. Substantial evidence is defined as evidence that a reasonable mind could accept as adequate to support a conclusion.[11] If the Panel's findings are supported by substantial evidence, then the undersigned must accept them even if there is substantial evidence in the record to support findings to the contrary.[12]

After reviewing the record, as well as the arguments presented by the parties in their respective briefs to this Office, I find that the Panel met its burden of substantial evidence for Charge No. 1, Specification No. 1. Employee does not dispute she did not follow the proper patient care protocol in her interaction with the 6-year-old patient and his mother, in violation of the Patient Bill of Rights. Specifically, Employee admitted during the Trial Board Hearing to not having any contact with the patient prior to leaving the scene.

Employee testified that she could have made every attempt to exhaust all available options instead of leaving and without doing anything. Employee explained that she could have at least done an assessment of everything else to determine whether she should have let it go or not. Tr. pg. 117. Employee stated that she should have gotten dressed in PPE, figured out what unit they were in, went in, did an assessment, checked his vital signs, made sure he was conscious and alert, and ask relevant questions. Tr. pg. 118. Employee concluded that her actions on May 22, 2020, was an error in judgement on her part that she regrets. Tr. pg. 136. Employee further stated that she should have done the narrative in the PCR report, and gather as much information as possible, to include the patient's demographic information. Tr. pg. 118. Based on the aforementioned, I find that there was substantial evidence in the record to support the Panel's findings with regard to Charge No. 1., Specification No. 1.

---

[11] *Mills v. District of Columbia Department of Employment Services*, 838 A.2d 325 (D.C. 2003) and *Black v. District of Columbia Department of Employment Services*, 801 A.2d 983 (D.C. 2002).
[12] *Baumgartner v. Police and Firemen's Retirement and Relief Board,* 527 A.2d 313 (D.C. 1987).

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

The Panel further found that Employee violated the Patient Bill of Rights when FF/EMT [Employee]: 1) failed to assess the patient; 2) chose to call the patient's mother on the cell phone, rather than making face to face contact with the patient; and 3) failed to contact an EMS Supervisor to assist in advocating for the patient. In addition, the Panel also found that FF/EMT[Employee] violated the Department's documentation policy as she failed to include a narrative on the first ePCR she prepared. Employee did not get a signed refusal of service form from the patient's mother as required. Therefore, I find that there was also substantial evidence in the record to support Agency's findings in both Charge No. 1, Specification No. 1; and Charge No. 2, Specification No. 1.

2) Whether there was harmful procedural error

None of the parties raised an issue with the version of the DPM Agency used in the current matter. However, the undersigned notes that, Agency used the wrong version of the DPM in its administration of the instant adverse action. The District of Columbia Municipal Regulations ("DCMR") and the corresponding District Personnel Manual ("DPM') regulate the manner in which agencies in the District of Columbia administer adverse and corrective actions. The current and applicable DCMR and DPM versions (DCMR 6-B Chapter 16 and DPM Chapter 16) regulating the manner in which agencies administer adverse action went into effect in the District on May12, 2017. Consequently, all adverse actions commenced after this date were subject to the new regulation.

In the instant matter, Employee was terminated effective July 31, 2021, and the current version of the DPM was already in effect. Moreover, the incident occurred on May 22, 2020, after the current DPM version was already in effect. However, Agency levied an adverse action against Employee utilizing an older version of the DPM (2012 version of the DPM). Specifically, Agency charged Employee with violating 16 DPM §1603.3(f)(3) (March 4, 2012). Under the old DPM, this section correlated with "[a]ny on-duty or employment related act or omission that interferes with the efficiency and integrity of government operations, specifically neglect of duty". However, the new version of the DPM, moved all the adverse action charges to DPM § 1605. Thus, the charge of neglect of duty can now be found in DPM § 1605.4(e), with its corresponding penalty found in DPM § 1607.2(e).

Under the older version of the DPM, the specification for Neglect of Duty includes, but is not limited to: Failure to follow instructions or observe precautions regarding safety; failure by a

supervisor to investigate a complaint; failure to carry out assigned tasks; careless or negligent work habits. The penalty for the first offense for neglect of duty ranges from reprimand to removal. Under the new version of the DPM, the specification for Neglect of Duty includes, but not limited to: "Failing to carry out official duties or responsibilities as would be expected of a reasonable individual in the same position; failure to perform assigned tasks or duties; failure to assist the public; undue delay in completing assigned tasks or duties; careless work habits; conducting personal business while on duty; abandoning an assigned post; sleeping or dozing on-duty, or loafing while on duty." The penalty for the first offense is counseling to removal.

Here, Employee was charged with Neglect of Duty, for failing to carry out the essential functions of her position on May 22, 2020. This specification is captured in both the older and the new version of the DPM. Consequently, I find that in the current matter, the applicable DPM for the charge of neglect of duty is not substantively different from the older version utilized by Agency as both the charge and penalty range are similar. Both provide that the maximum range for penalty may be removal. Thus, I conclude that Agency's action constitutes harmless error.[13]

Agency also charged Employee with "unreasonable failure to give assistance to the public. *See also* 16 DPM § 1603.3(f)(9)." This cause of action which was also levied against Employee in this matter under Charge No. 1, Specification No. 1, does not have a corresponding provision in the May 12, 2017 or subsequent versions of the DPM. Further, there are substantive changes in the 2017 and subsequent versions of the DPM with regard to the charges and penalties such that the undersigned would be unable to ascertain which charges should have been levied against Employee had Agency utilized the appropriate version.[14] OEA has held that it is required to adjudicate an appeal on the "grounds invoked by agency and may not substitute what it considers to be a more appropriate charge."[15] Additionally, this Office has held that an employee must be aware of the charges for which they are penalized in order to appropriately address/appeal those charges.[16] Therefore, I find that Agency's failure to follow the appropriate laws, rules and regulation is harmful procedural error in this instance. Agency did not provide a breakdown of the penalty with respect to each cause of action or specification under Charge 1. Accordingly, it would be improper for the undersigned to essentially 'guess' or 'estimate' what the appropriate charge and/or penalty would have been had Agency used the appropriate DPM version. Based on the aforementioned, this charge will be dismissed.

---

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

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

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

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

Additionally, Employee argued that Agency violated the 180 days Trial Board Hearing deadline. Employee explained that the Trial Board held on June 7, 2021, was outside of the 180 days deadline to hold hearings. Agency asserted that Employee's timeliness argument is waived and meritless. It explained that Employee did not raise any argument about the timeliness of her hearing. Moreover, a hearing was timely scheduled for May 26, 2021, consistent with memoranda of understandings tolling Trial Boards in response to the Covid-19 pandemic. However, Employee, through counsel, requested that the Trial Board be continued and therefore, waived any argument as to timeliness for the period of the delay.[17]

In *Brown v. Watts*, 933 A.2d 529 (April 15, 2010), the Court of Appeals held that OEA is not jurisdictionally barred from considering claims that a termination violated the express terms of an applicable collective bargaining agreement. The court explained that the Comprehensive Merit Personnel Act ("CMPA") gives this Office broad authority to decide and hear cases involving adverse actions that result in removal, including "matters covered under subchapter [D.C. Code §1-616] that also fall within the coverage of a negotiated grievance procedure."[18] In this case, Employee was a member of a Union when she was terminated and governed by Agency's CBA with the Union. Based on the holding in *Watts*, I find that this Office may interpret the relevant provisions of the CBA between Employee's Union and Agency, as it relates to this adverse action.

Article 31 Section B (5) of the CBA between Agency and Employee's Union provides in pertinent part as follows:

> (5) ***if the case is to be heard by the Trial Board, the hearing shall begin within 180 days of the employee's receipt of the Initial Written Notification.*** When the employee requests a postponement or continuance of a scheduled hearing, the 180-day time limit shall automatically be extended by the length of the postponement or continuance granted by the Department. (Emphasis added)

Here, there is no dispute that the 180 days clock started on May 22, 2020. The Trial Board Hearing began on June 7, 2021. Agency stated that the Trial Board Hearing was initially scheduled for May 26, 2021, however, Employee through counsel, requested that the date be extended to June 7, 2021. There is no additional information in the record regarding this issue.

Assuming that Agency indeed violated the 180 Trial Board Hearing deadline as provided in Article 31 section B (5) of the CBA, the OEA Board and the Courts have held that, where there is no specific consequence to an agency's violation of a time limit, the time limit is construed to be directory in nature.[19] The OEA Board in *Kyle Quamina v. Department of Youth*

---

[17] Agency's Sur-Reply Brief (July 29, 2022).

[18] Pursuant to D.C. Code § 1-616.52(d), "[a]ny system of grievance resolution or review of adverse actions negotiated between the District and a labor organization *shall take precedence* over the procedures of this subchapter for employees in a bargaining unit represented by the labor organization" (emphasis added).

[19] *See Rodriguez v. District of Columbia Office of Employee Appeals*, 145 A.3d 1005 (D.C. 2016). Although the CBA provision at issue in *Rodriguez*, as well as the outcome of *Rodriguez* are different from that of the current matter, the D.C. Court of Appeals in *Rodriguez* echoed the premise that a violation of a time limit CBA provision that does not provide a specific consequence to an agency's violation of a time limit is considered harmless error. The Court in *Rodriguez* noted that *"[w]e also can agree that application of harmless error review might warrant a ruling in favor of the Agency if Article 24, Section 2.2 of the CBA provided only that the Union was to be notified in*

Rehabilitation Services,[20] cited to *Teamsters Local Union 1714 v. Pub. Employee Relations Bd.*[21], wherein, the D.C. Court of Appeals held that "[t]he general rule is that [a] statutory time period is not mandatory unless it both expressly requires an agency or public official to act within a particular time period and specifies a consequence for failure to comply with the provision. In *Watkins v. Department of Youth Rehabilitation Services*[22], this Board adopted the reasoning provided in *Teamsters* when examining a forty-five-day regulation which also addressed the time limit in which an agency was required to issue a final decision in cases of summary removal. The Board in *Watkins* noted that the personnel regulation regarding the forty-five-day rule did not specify a consequence for the agency's failure to comply; therefore, the regulation was construed to be directory in nature.[23]

Unlike a mandatory provision, a directory provision requires a balancing test to determine whether any prejudice to a party caused by agency delay is outweighed by the interest of another party or the public in allowing the agency to act after the statutory time period has elapsed."[24] Here, although Article 31 section B (5) provides a clear time limit for when to begin a Trial Board Hearing, it does not provide a consequence for failing to strictly adhere to this provision. Consequently, I find that based on the aforementioned, that the CBA language of Article 31 section B (5) should be considered directory, rather than mandatory in nature. I further conclude that based on the record, this does not constitute a harmful procedural error.

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

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

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

---

writing within forty-five days "after the date that the Employer knew or should have known of the act or occurrence[,]" without specifying any consequence of the failure to give the requisite notice." (Emphasis added).

[20] OEA Matter No. 1601-0055-17, Opinion and Order on Petition for Review (April 19, 2019).

[21] 579 A.2d 706, 710 (D.C. 1990).

[22] OEA Matter No. 1601-0093-10, Opinion and Order on Petition for Review (January 25, 2010).

[23] In distinguishing mandatory statutory language from directory language, the Board in *Watkins* highlighted the *holding in Metropolitan Police Department v. Public Employee Relations Board,* 1993 WL 761156 (D.C. Super. Ct. August 9, 1993), wherein the Court found statutory language mandatory, not directory, where it provided that no adverse action shall be commenced 45 days after an agency knew or should have known of the act constituting the charge.

[24] *See JGB Property v. D.C. Office of Human Rights,* 364 A.2d 1183 (D.C. 1976); and *Brown v. D.C. Public Relations Board,* 19 A.3d 351 (D.C. 2011). See also *Quamina*, *supra*.

government operations to include: unreasonable failure to give assistance to the public." *See also* 16 DPM § 1603.3(f)(9).

Neglect of Duty is defined as "Failing to carry out official duties or responsibilities as would be expected of a reasonable individual in the same position; failure to perform assigned tasks or duties; failure to assist the public; undue delay in completing assigned tasks or duties; careless work habits; conducting personal business while on duty; abandoning an assigned post; sleeping or dozing on-duty or loafing while on duty."[25]

Employee has admitted that her conduct on May 22, 2020, did not conform with the Patient Bill of Rights and proper patient care protocol. She also admitted that Ambulance 32 did not have a face-to-face contact with the patient and they did not do an assessment of the patient as required. Based on the record, I find that Agency's decision to levy the current charge of Neglect of Duty against Employee was done in accordance with applicable laws and regulations.

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

Brown affirmed that he was aware and had seen Truck 16 crew members calling patients on the radio during the pandemic. Tr. pg. 191. Chief Dolby noted that this was in the beginning of the COVID pandemic where everyone was trying to figure out the best approach and best practices. He explained that there were no procedures and nothing in writing on how to approach people in the middle of a pandemic that no one knew anything about. Tr. pg. 176. Employee and her partner testified that the mother was concerned about potential COVID exposure, and she decided to transport her son to the hospital by herself. In addition, the mother of the patient was not present at the Trial Board Hearing to provide testimony regarding the incident.

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

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

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

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

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

Whether the Penalty was Appropriate

In determining the appropriateness of an agency's penalty, OEA has consistently relied on *Stokes v. District of* Columbia, 502 A.2d 1006 (D.C. 1985).[26] According to the Court in *Stokes,* OEA must determine whether the penalty was within the range allowed by law, regulation, and any applicable Table of Illustrative Actions ("TIA"); whether the penalty is based on a consideration of the relevant factors; and whether there is a clear error of judgment by Agency. An Agency's decision will not be reversed unless it failed to consider relevant factors or the imposed penalty constitutes an abuse of discretion.[27]

In this case, I find that Agency's action was taken for cause with regard to Charge No. 2, Specification No. 1. When an Agency's charge is upheld, this Office has held that it will leave the Agency's penalty undisturbed when the penalty is within the range allowed by law, regulation or guidelines, is based on consideration of the relevant factors and is clearly not an error of judgment.[28]

Here, I find that Agency has met its burden of proof for the charge of "[a]ny on-duty or employment-related act or omission that interferes with the efficiency or integrity of government operations to include: Neglect of Duty" as it applies to Charge No. 2, Specification No. 1. According to the Table of Illustrative Action ("TIA"), the penalty for a first offense for Neglect

---

[26] *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).

[27] *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).

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

of Duty is Counseling through Removal.[29] The record shows that this is the first time Employee is being charged with this cause of action. Additionally, Agency did a thorough *Douglas* factors analysis in this matter. Therefore, I conclude that Agency had sufficient cause to suspend Employee for 72 duty hours for Charge No. 2., Specification No. 1.

As provided in *Love v. Department of Corrections*, OEA Matter No. 1601-0034-08R11 (August 10, 2011), selection of a penalty is a management prerogative, not subject to the exercise of discretionary disagreement by this Office.[30] When an Agency's charge is upheld, this Office has held that it will leave the agency's penalty undisturbed when the penalty is within the range allowed by law, regulation or guidelines, is based on consideration of the relevant factors, and is clearly not an error of judgment. I find that Agency has properly exercised its managerial discretion and its chosen penalty of suspension is reasonable and is clearly not an error of judgment. Accordingly, I conclude that Agency was within its authority to suspend Employee for 72- duty hours for Charge No. 2, Specification No. 1.

For Charge No. 1, Specification No. 1, because Agency failed to utilize the appropriate version of the District Personnel Manual in its administration of this action, as well as the fact that Agency failed to provide a breakdown of the penalty with respect to each cause of action as listed in Charge No. 1, Specification No. 1, I find that Agency engaged in harmful procedural error against Employee. Consequently, I further find that the penalty of termination levied against Employee for Charge No. 1, Specification No.1 was inappropriate under the circumstances.[31]

Disparate Treatment

Employee alleged that the penalty of termination for Charge No. 1, Specification No. 1, was too excessive and not in line with the *Douglas* factors. Employee cited to an incident (F200089827) which occurred on May 26th, 2020, involving Employee as the patient and another Agency employee as the comparable employee. There is nothing in the record in its

---

[29] The Trial Board noted that it relied on the DPM Chapter 16 in administering the penalty for Charge 1, Specification 1. See Agency's Answer, *supra*, at Tab 20 (Douglas Factors No. 6 and 7).

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

[31] *Assuming arguendo* that Charge 1, Specification 1, was sustained, I find that the penalty of termination in this instance was unduly excessive. Chief Dolby, a retired Agency Fire Chief testified that the current charges against Employee were exaggerated and did not warrant termination. Tr. pg. 172. He reiterated that the charges were excessive. He explained that there are Agency employees who have done worse and have not been terminated. Tr. pg. 175-176. Chief Dolby asserted that it's not uncommon for crew members to miss runs from being dispatched from the fire house and that they have had crew members asleep when runs come up for Code 1 calls, yet, none of them were fired. He reiterated that considering the fact that this happened in the middle of the pandemic, the current charges against Employee were exaggerated. Tr. pg. 181, 186.

present state of an adverse action associated with this incident. For Charge 1, Specification 1, the Trial Board noted under Douglas factor number 6 - Consistency of the penalty with those imposed upon other employees for the same or similar offenses that "there were no other cases in the previous three years that resulted in a guilty verdict; therefore, the Panel could not use consistent penalties from within the organization. Thus, the Panel referred to Chapter l6 of the District Personnel Manual to render its penalty decision."[32] Since the undersigned has concluded that Agency engaged in harmful procedural error for this charge, the issue of disparate treatment will not be addressed.

ORDER

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

1. Agency's action of suspending Employee for 72 duty hours for Charge No. 2, Specification No. 1 is hereby **UPHELD**.

2. Agency's action of terminating Employee for Charge No. 1, Specification No. 1 is hereby **REVERSED.**

3. Agency shall reimburse Employee all pay and benefits lost as a result of the termination.

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

FOR THE OFFICE:

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

[32] Agency Answer, *supra*, at Tab 20.