THE DISTRICT OF COLUMBIA

BEFORE

THE OFFICE OF EMPLOYEE APPEALS

In the Matter of:	)	
	)	
EMPLOYEE[1]	)	OEA Matter No. 1601-0025-22
	)	
v.	)	Date of Issuance: January 10, 2023
	)	
D.C. FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT,	)	MONICA DOHNJI, Esq.
Agency	)	Senior Administrative Judge
	)	

Marc Wilhite, Esq., Employee Representative
Rahsaan Dickerson, Esq., Agency's Representative

INITIAL DECISION

INTRODUCTION AND PROCEDURAL HISTORY

On December 2, 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 him from his position as a Firefighter/EMT effective November 6, 2021. OEA issued a Request for Agency Answer to Petition for Appeal on December 6, 2021. Agency submitted its Answer to Employee's Petition for Appeal on January 5, 2022. This matter was initially assigned to Administrative Judge ("AJ") Hochhauser. Thereafter, this matter was reassigned to the undersigned in March of 2022.

On March 29, 2022, the undersigned issued an Order Convening a Status/Prehearing Conference in this matter on April 20, 2022. During the Status/Prehearing Conference, the undersigned was informed that an Adverse Action Panel Hearing was convened 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 April 21, 2022, requiring the parties to submit briefs addressing the issues raised during the Status/Prehearing Conference. After several requests for extensions, the parties submitted their respective briefs. Upon review of the record, the undersigned, via email dated October 10, 2022, requested additional documentation in this matter. Both parties have now complied. The record is now closed.

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

JURISDICTION

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

ISSUES

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

BURDEN OF PROOF

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

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

OEA Rule 628.2 *id.* states:

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

STATEMENT OF THE CHARGE(S)

According to Agency's Answer to Employee's Petition for Appeal[2], 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 Services Department Bulletin No. 3, **Patient Bill of Rights**, which states:

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

[2] Agency Answer at Tabs 26 & 27 (January 5, 2022).

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.***

***

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*.

***

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

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:

- 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 Emergency Medical Services Manual and Pre-hospital Treatment Protocols (2017), **Standard Operating Guidelines**, **CONSENT REFUSAL OF CARE POLICY**, which state:

II. Guidelines:

***

2. Patient Assessment

A. Providers should attempt to obtain a history and perform a physical assessment in as much detail as is permitted by the patient.
B. Conduct three assessments: *Providers should attempt to assess the following three major areas prior to permitting a patient to refuse* care and/or transportation.

***

Mental Capacity to Refuse Care

- ***Ensure that patient is oriented to person, place, time and purpose***.
- Establish that patient is not a danger to himself or others.
- ***Ensure that patient is capable of understanding the risks of refusing care or transportation*** and any proposed alternative.

Medical or situational Capacity

- Ensure that patient is suffering from no acute medical conditions that might impair his or her ability to make an informed decision to refuse care or transportation.
- ***Check to be sure that the patient is exhibiting no other signs or symptoms of potential mental incapacity including, drugs or alcohol intoxication***, unsteady gait, slurred speech, post ictal period after seizure, cognitive deficits after hypoglycemia or drug intoxications. etc.
- If possible, rule out conditions such as hypovolemia, hypoxia, head trauma, metabolic emergencies (diabetic shock); hypothermia, hyperthermia, etc.
- Attempt to determine is patient lost consciousness for any period of time.

III. Who May Refuse Care

1. The Patient:
   A. If patient has legal, mental, medical and situational capacity to understand the risks and alternatives to treatment and transportation, the patient has the right to refuse care. ***Obtain refusal signature***.

B. Implied consent – *if patient is unconscious lacks capacity* and/or is seriously injured or in need of further medical attention, ***treat and transport patient*** *despite patient's inability to consent or the unavailability of another person to provide consent*.

***

IV. Managing Incompetent Patients and Patients who lack Medical and Situational capacity

1. Take all reasonable steps to secure treatment or transportation for a patient who is legally or mentally incompetent to refuse care, but do not put yourself or your crew in jeopardy.
2. ***The Metropolitan Police Department should be summoned to the scene to assist with patients that you believe may be mentally incompetent and refusing services.*** A Battalion EMS Supervisor will also be requested to the scene to facilitate the FD 12 process with the responding law enforcement officer.
3. ***If a patient lacks medical or situational capacity, and no other authorized individual is available to provide a refusal signature, the patient may be treated and transported*** as long as you act in good faith and without knowledge that the patient or authorized individual would refuse case. Patients may be transported against their objections if they lack medical or situational capacity to refuse care.

Further violation of D.C. Fire and Emergency Medical Services Department Order Book Article XXIV, § 9, **Patient Transport Guidelines**, which states:

7. EMS Providers, specifically the members designated as the ACIC, assigned to EMS units, should not hesitate to contact the EMS Battalion Supervisor, on-duty platoon commander or EMS Chief Supervisor of any requests or issues arising during the tour of duty that requires clarification or immediate resolution. **Do Not Hesitate to Seek to Assistance Necessary – Ask for Help**!!!!

This misconduct is defined as caused 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 operation, to include: Neglect of Duty." See also 16 DPM §1603.3(f)3. (August 27, 2017).

This misconduct is further defined as cause in D.C. Fire and Emergency Medical Services 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 operation, to include: unreasonable failure to give assistance to public." See also 16 DPM §1603.3(f)9. (August 27, 2017).

Specification 1 In his Special Report (date 07/20/2022), FF/EMT[Employee] describes his misconduct as follows:

> On Monday June 23, 2020 at 0455, A13 responded to a call at 301 G St. SW reporting of a Migraine. We entered the building due to security and proceeded up the appropriate floor. Once at the door, we had difficulty entering the apartment, when a little voice started trying to open the door. The door opened and it was a little girl, she said her mom, called for help. We go back to the Mother's room to find her laying on the floor, naked with a pillow under her head. We covered up and started to arouse the lady and proceeded with vitals. After getting her Blood Pressure, she told us "get off me". Her vitals seemed to be within normal ranges, and we asked for her to sign but she dismissed us. We returned to A13 and due to the reporting of a Migraine we determined at the time that she was sleeping initially. We then returned to service. Once back at the firehouse I added an addendum to the report because I forgot to add the vitals (97% rm air, 158/91 BP, 78 HR, no blood sugar).
>
> Approximately 10-15 mins later, the alarm went off for the same address, upon arrival we noticed that MPD arrived before us, as we got to the apartment, we went back to the room and this time she was unresponsive, we took her vitals and her Sp02 dropped down to 41% rm air, I started to bag her, my partner then went to get the stretcher, and I tell him to call ALS too. ***As I was bagging her, I noticed a medium sized bottle of Hennessy and a bottle of Benadryl both with the caps off and empty***. The medics arrived and we helped to load the patient on the stretcher, ***as we picked her up, we noticed a small amount of fecal matter smudged on the floor as we lifted her***.

Further, in her 1st Endorsement (dated 07/23/2020), Deputy Fire Chief Queen A. Anunay describes FF/EMT[Employee]'s misconduct as follows:

> I have reviewed the special report submitted by FF/EMT[Employee] regarding incident F200106421 at 0433 hours & incident F200106429 at 0540 hours. On F200106421 at 0433 hours, FF/EMT[Employee] responded

> to a call on Ambulance 13 for a female in her 40s experiencing headache. Upon arrival FF/EMT[Employee] stated in his report that the door was answered by a little girl who stated that her mom called 911 for help. The assessment conducted by the crew describes and unresponsive and combative female not alert but responsive to pain stimuli. ***The statement in the report submitted by FF/EMT[Employee] stating the patient said "get off me" is inconclusive and unacceptable as a refusal of care. The care required is further supported under "Implied Consent" by the initiation of 911 to solicit medical assistance in addition to the described mental status assessment. The patient was in no condition to be left alone or to refuse care.*** The circumstances presented requires that the Emergency Medical Technician has a "Duty to ACT". ***The patient was abandoned and left with an unaccompanied minor without notification to law enforcement***.

Upon arriving at this patient's home, Department policy (including the Patient Bill of Rights, Order Book Article XXIV, and the Emergency Medical Services Manual and Pre-Hospital Treatment Protocols) required FF/EMT[Employee] to at least attempt to render competent, compassionate, and empathetic emergency medical services. Yet, FF/EMT[Employee] showed virtually no concern for the patient. Rather than perform an assessment and determine an appropriate course of treatment and transportation, FF/EMT[Employee] did nothing more than conclude that his patient was asleep and left the scene – without following any of the Department's refusal protocols. FF/EMT[Employee]'s admitted discourteous treatment of the public, violation of department customer service standards, failure to offer assistance when requested, failure to carry out assigned tasks, careless work habits constitutes 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**:
>
> ***
>
> 2. ***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. ***Inform the patient to call 911***, call their doctor or go to an emergency department if the symptoms persist or get worse or any of the danger signs you inform them appear.

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

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.

Further violation of D.C. Fire and Emergency Medical Services Department Bulletin No. 3, Patient Bill of Rights, which states:

> As our patient, you have the right to expect competent and compassionate service from us.
>
> ***
>
> You may expect:
>
> 5. ***To have your vital signs checked and documented*** whether or not you are transported to the hospital.
> 6. ***To have you 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.***

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).

This misconduct is further defined as cause in D.C. Fire and Emergency Medical Services 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 operation, to include: unreasonable failure to give assistance to public." See also 16 DPM §1603.3(f)9. (August 27, 2012).

Specification 1 In contrast to the narrative recited in FF/EMT[Employee]'s Special Report (dated 07/20/2020), the electronic Patient Care Report for Incident No. F200106421 recites the following "Disposition" information that illustrates FF/EMT[Employee]'s misconduct:

Disposition: **No Patient Contact (Canceled on Scene)**

Notwithstanding clear directives set forth by Department policy – including the Patient Bill of Rights, Special Order No. 54 (Series 2012) and the Emergency Medical Services Manual and Pre-Hospital Treatment Protocols – FF/EMT failed to properly assess his patient, failed to follow the Department's Refusal of Care protocols, and failed to properly complete the ePCR corresponding with his response on Incident No. F200106421 (i.e., it appears FF/EMT[Employee] closed out his ePCR as "No Patient Contact" to cover up his multiple refusal of care protocol deviations). Accordingly, this termination action is proposed.

On June 25 and August 4, 2021, Employee appeared before a Fire Trial Board. He was represented by counsel and pled Not Guilty to Charge 1 and Charge 2.[3]

SUMMARY OF THE TESTIMONY[4]

On June 25 and August 4, 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

Deontre Gigger Tr. Vol. I. pgs. – 27 -108

Deontre Gigger ("Gigger") has been employed with Agency for four (4) years. He was assigned to Ambulance 13 in June of 2020. He noted that two (2) members typically ride on an ambulance. He explained that one (1) crewmember is the driver and the second crewmember is responsible for ePCR. Tr. Vol. I. pgs. 27 -29.

Gigger noted that he was the night shift driver on Ambulance 13, and ePCR crewmember during the morning hours on June 23, 2020. Tr. Vol. I. pg. 29. When asked what his tour of duty was, Gigger said 24 hours. Tr. Vol. I. pgs. 29-30. He affirmed that his tour of duty started at 07:00 hour on June 22, 2020. Gigger acknowledged that he responded to a 911 call at Capitol Park Towers Apartment, in the early hours of June 23, 2021. Tr. Vol. I. pg. 30.

[3] *Id*.
[4] *Id*. at Tab 24.

Gigger explained that on June 23, 2020, they responded to a "headache at 301 G Street Southwest. When they knocked at the door of the apartment, they heard a little girl behind the door. Gigger called communications to find out who made the call. The little girl opened the door as Employee took the radio from Gigger to speak with Communications. Tr. Vol. I. pgs. 31 – 32, 34. When they got into the apartment, they notice a naked lady laying on the ground with a pillow under her head. They covered her up with a sheet. Gigger assessed the lady to see if she still had a pulse. Tr. Vol. I. pgs. 31, 34. He affirmed that he and Employee attempted to take the lady's vital – SpO levels, heart rate, blood pressure and blood sugar. Tr. Vol. I. pgs. 33-35, 78-79.

Gigger testified that while checking the patient's carotid pulse, he asked the lady if she was okay, and she gave him a moaning grunting noise. He was able to get the oxygen level, heart rate and blood pressure. Tr. Vol. I. pg. 36, 38. He did not take the blood sugar. Tr. Vol. I. pg. 47. Gigger stated that after he got the blood pressure, and while still taking the vitals, the lady told him to get off of her. Gigger said he and Employee looked at each other in shock. Tr. Vol. I. pgs. 36-37, 39-40, 80, 82.

When asked if he has had a patient refuse service before or say anything along the lines of "get off me" when he was attempting to assess the patient, Gigger said yes. Tr. Vol. I. pg. 40. Gigger stated that when the patient said "get off me", he was shocked and he asked Employee what they should do since Employee was the senior crewmember. Gigger asserted that Employee initially stated that it appeared the patient was just sleepy so they should just let her sleep. Gigger asked if Employee was sure, that's when Employee proceeded to have a conversation with the patient. Employee tried to talk to the patient as well as wake her up. Tr. Vol. I. pgs. 40 -42, 82-82. He stated that the lady ended up talking to Employee. Gigger said he did not hear the conversation between Employee and the lady. But when he asked if all was good, Employee stated that he got it under control. Gigger averred that Employee told him to get the bag and wait by the stretcher. He followed Employee's instruction and went by the stretcher, which was by the door, while waiting on Employee's decision on whether they were transporting her to the hospital or getting a refusal. Tr. Vol. I. pg. 43, 46, 83. Gigger testified that Employee came out a few minutes later and asked the little girl – patient's daughter to lock the door behind him, and they left for the firehouse. Gigger noted that he did not think to ask Employee questions because as the senior crewmember, he assumed Employee had taken care of everything. Tr. Vol. I. pg. 44, 46-47, 51-52, 84.

When asked if the patient said anything else to him other than "get off me" and moaning, Gigger said no. When asked if the patient ever got up while they were on the scene, Gigger stated that he did not see her wake up before he left the room. Tr. Vol. I. pg. 45.

When asked who was responsible for completing the ePCR on the day of the incident, Gigger noted that it was Employee's responsibility. Gigger affirmed that he told Employee the vital sign information as he collected them since Employee was right there in the room with him. Tr. Vol. I. pgs. 48-49. Gigger acknowledged knowing the Department's policy regarding the accuracy of the information contained in an ePCR. He asserted that the policy requires the ePCR to have the name, vitals, narrative, signatures, names of designees, and refusal of service. Tr. Vol. I. pg. 50.

Gigger testified that for refusal of service, both the patient and crewmember have to sign it, include an explanation in the narrative and explain the risk factors of leaving to the patient. He also noted that if the patient is not able to provide a refusal, they call the EMS supervisor. Tr. Vol. I. pg. 51.

According to Gigger, about 10-15 minutes after they cleared the scene and went back to the firehouse, they got called back to the same address. They did not hear the 911 call but got the information through the computer. When they got to the ambulance, notices started popping up, and Employee said the patient is going to the hospital this time and Gigger said 'okay'. When they got to the scene, they were approached by MPD. Tr. Vol. I. pgs. 52, 55-56, 58-59, 77, 85, 86. Gigger noted that they got in with MPD. They put the pulse oximeter on the patient's finger and realized that her SpO level had dropped down. Employee immediately got the BVM (a device that helps the patient to breathe) and connected it to oxygen and it was breathing for the patient. Then, Employee told Gigger to call Advance Life Support ("ALS") – the Medic Unit. Gigger explained that the ambulance crewmembers have Basic Life Support ("BLS") skills. ALS got to the scene pretty fast. Tr. Vol. I. pgs. 53-55, 88. Gigger was getting prepared to load the patient into the ambulance but decided to go get the blood sugar level that he could not get the first time around. Thereafter, the medics came in as he was giving the patient some Narcan. Gigger testified that during this second trip to the patient's apartment, he noticed a bottle of Hennessy and Benadryl that was sitting on the nightstand, that he had not noticed during their first visit. Tr. Vol. I. pgs. 55-56.

Gigger asserted that when the ALS medics arrived, he did not have any communication with them or MPD as Employee was the one relaying what happened to medics. Tr. Vol. I. pg. 57. The medics took the patient's vitals, and she was put on the stretcher and transported in the back of the medic unit. Gigger noted that when they picked the patient up from the ground to put on the stretcher, they noticed some fecal substance on the ground. Employee went in the back of the medic unit with the medics and Gigger followed behind alone in Ambulance 13 to GW Hospital. He did not have a conversation with Employee at the hospital about what happened. Tr. Vol. I. pgs. 57-58, 88.

Gigger affirmed that, once a patient is turned over to the care of the hospital, they are done with the patient. Tr. Vol. I. pg. 60. He noted that as they were getting ready to leave from GW Hospital, Employee asked him for the vitals again, and he provided him with the vitals from the first scene from his recollection. He estimated that about 40 minutes had elapsed from when he collected the vital during the first scene, to when Employee asked him about it again as they were leaving GW Hospital. Tr. Vol. I. pgs. 60-67.

Gigger testified that he has had the responsibility of preparing an ePCR while someone else gives him the vitals. He explained that everyone is different, and he usually inputs the information as he receives it. Tr. Vol. I. pgs. 66-67.

Gigger affirmed that he was asked to prepare a Special Report. He noted that they were taken off the run and asked to write a Special Report. Tr. Vol. I. pg. 68. Gigger identified Agency's Exhibit 8, as the July 21, 2020, Special Report for the current incident. He affirmed that he completed the special report about three (3) to four (4) weeks after the incident. He also

affirmed his memory of the incident was fresher at the time he wrote the special report than it was on the day of the Trial Board Hearing. He explained that Employee did not input the patient information and history in the ePCR. Tr. Vol. I. pgs. 68-73. Gigger asserted that he wished he had called for a supervisor or made better judgement instead of relying on the senior crewmember at the time. He stated that he wished he had made his own judgement. Tr. Vol. I. pg. 73.

On cross examination, Gigger affirmed that he had worked with Employee prior to the incident on June 22-23, 2020. In the morning, he was crewmember number 2, and Employee did the driving and they switched roles during the second half of the day. He affirmed that at times he has the responsibility to write the ePCR. Whoever is not writing the ePCR is responsible for taking the vitals at the scene. Tr. Vol. I. pgs. 75 -76. Gigger stated that he was in the backroom when he got the information about the nature of the call – headache/migraine. He said the bells went off and it came up on the CAD system when he was in the ambulance. Tr. Vol. I. pgs. 76-77. His first impression when he saw the patient on the floor was that she was sleeping. He checked her pulse and found that she had a pulse. Gigger explained that the patient's blood pressure was 158/91; her blood Oxygen lever was 97 %; her heart rate was 78%. The vitals were in the normal range. Employee was standing next to him while he was taking the vitals and Employee wasn't saying anything when Gigger was taking the vitals. Tr. Vol. I. pgs. 79-80.

Gigger affirmed that the patient woke up and her eyes opened when she said "get off me". He stated that he did not use his penlight to observe the patient's eyes. Tr. Vol. I. pgs. 81-82. He also affirmed that the firehouse was a minute away from the scene. He does not recall if Employee was working on the ePCR while he was driving to the firehouse. Tr. Vol. I. pg. 84. Gigger does not recall if Employee stayed in the ambulance when they got to the fire house. Tr. Vol. I. pg. 85. He stated that the only vital signs he was able to collect during the second visit were the SpO, the heart rate and blood sugar – blood oxygen level and blood glucose. They did not obtain the blood pressure. Tr. Vol. I. pgs. 86 -87. Gigger affirmed that Employee made a decision at that time to initiate life saving measures. Tr. Vol. I. pgs. 87-88. When asked if Employee's action was consistent with training, Gigger responded in the affirmative. Explaining that it's like a fight or flight. Tr. Vol. I. pg. 88. When asked if Employee directed him to administer the Narcan, he said no. He said he decided to do so on his own because he saw the alcohol and Benadryl and he thought it was an overdose. Gigger does not recall what the patient's cause of death was. Tr. Vol. I. pg. 89.

When questioned by Member Wright, Gigger stated that the stretcher was inside the apartment during the first visit to the scene. He could not recall how far it was from the room. Tr. Vol. I. pg. 90. He stated that the four (4) year old was in her own room at the time, by herself. The only thing they said to the daughter when they were leaving was to lock the door. Tr. Vol. I. pgs. 90-91.

On redirect, Gigger stated that when they returned to the scene the second time, the patient was still on the floor, but on her side. The Hennessy bottle and the Benadryl were on the nightstand, with less than half of liquor remaining in the bottle. He did not check the Benadryl. Tr. Vol. I. pg. 93. Gigger explained that the patient was about four (4) to six (6) feet away from her bed, and the nightstand was next to her bed. He did not notice the alcohol and Benadryl the

first time they were at the scene and Employee did not make any mention of it either, during their first visit. Tr. Vol. I. pgs. 93-94.

When questioned by Member Banks if the patient used fluent speech and was able to make rational decisions when she spoke to Employee, Gigger stated that he was not in the room. When asked if the patient told Gigger and Employee that she had a headache, Gigger said she never said anything to him. When asked if the patient signed a release form, Gigger said no. Tr. Vol. I. pg. 97. Gigger asserted that he has not seen the ePCR for both scenes, so he is unsure of what is contained in the ePCR. Tr. Vol. I. pg. 98.

When questioned by Chairperson Brooks, Gigger stated that he left the room while Employee spoke to the patient because Employee said he had it under control. Tr. Vol. I. pg. 101. He was waiting on the final decision on whether they were taking the lady to the hospital or Employee was getting a refusal. Gigger averred that he never had the tablet as it was with Employee. Tr. Vol. I. pg. 102. Gigger stated that Blood Pressure, heart rate, Blood Sugar and SpO are all vital signs. However, he answered "no" when asked if level of consciousness was considered a vital sign. He affirmed that they get one set of vital signs for each patient. Tr. Vol. I. pgs. 103-104. When questioned if he asked the patient if she knew where she was, Gigger said "no". He noted that he did not ask her anything. Tr. Vol. I. pgs. 104-105. To assess the patient's level of consciousness, Gigger testified that he asked her if she was okay and gave her a little rub. When asked if he suspected a reduced level of consciousness when he gave the patient the starter rub, Gigger said "no". Tr. Vol. I. pg. 105. Gigger said "no" when asked if the patient's response was satisfactory to prove she was okay. Tr. Vol. I. pg. 106.

On recross, referencing the bottle of Hennessy and Benadryl that was found next to the patient's bed during the second scene, Gigger stated that his focus was on the patient during the first visit. Tr. Vol. I. pgs. 106-107.

Queen Anunay Tr. Vol. I. pgs. 112 – 141

Queen Anunay ("DFC Anunay") is a Deputy Fire Chief ("DFC") with Agency. She has been with Agency for about 30 years. Her duties and responsibilities include creating processes for EMS administrations such as training processes, protocol review and any special projects and operations that require scheduling. She also works directly with the medical directors and the assistant fire chief of EMS. Tr. Vol. I. pgs. 112-113.

DFC Anunay testified that she was promoted to her current position around April or May of 2020, and they were involved in covert operations during that time. She received a call from Assistant Fire Chief Mills, informing her of the June 23, 2020, incident involving Employee, and requested that she collect special reports from Employee. She affirmed that she collected the special reports as requested. Tr. Vol. I. pgs. 113 -114. DFC Anunay explained that prior to meeting with Employee and Gigger, she spoke to both of them to be apprised of the situation since she had no prior knowledge of the incident. Moreover, she wanted to explain to them what she would be asking of them and make herself available to speak to them about the incident. Tr. Vol. I. pg. 115. She spoke to both Employee and Gigger at the Logistic section where they had been detailed to. Tr. Vol. I. pgs. 115-116.

DFC Anunay affirmed that Grigger and Employee submitted Special Reports. She explained the process to Gigger and Employee and asked them to include everything that occurred on June 23, 2020. She also had them ask questions if they had concerns about her request. She also spoke with Gigger and Employee individually and they were both aware of the process. Tr. Vol. I. pg. 115. DFC Anunay also stated that she knew Gigger and Employee would be speaking to Assistant Fire Chief Mills and the Medical Director about their certification. Tr. Vol. I. pgs. 115-116.

DFC Anunay testified that she conducted an investigation after receiving the special reports from Gigger and Employee. She contacted Paramedic DeLima, who was the ALS provider that arrived on the second scene after Ambulance 13, to get a perspective of what ALS found on the scene on arrival. DFC received an email from Paramedic DeLima, which she took into consideration as she started doing her endorsement. Tr. Vol. I. pg. 116.

DFC Anunay acknowledged preparing an endorsement. Tr. Vol. I. pg. 117. She identified Agency's Exhibit 5, Bates page 17, as her endorsement of the special report from Employee. DFC Anunay explained that after she received the special report from Employee, she focused on the actions taken from the time of dispatch to the engagement with the young child who answered the door. She also focused on the care provided to the decedent, and Employee and Gigger's efforts in trying to establish consciousness. Tr. Vol. I. pgs. 117-120. DFC Anunay asserted that somethings stood out in the report with regard to (1) the response to pain stimuli where Employee was unable to awake the patient; (2) that she had a motion of swaying her hand and (3) the special reports from Employee and Gigger also stating that the patient request they get off her. DFC Anunay stated that the reports did not indicate that the decedent established an acceptable baseline of consciousness. She noted that they normally respond to calls involving people who need their help but are not medically able to consent to their help. Tr. Vol. I. pg. 120. DFC Anunay testified that based on her investigation, she found it necessary to cite Employee for neglect of duty and abandonment of a patient that needed care. Tr. Vol. I. pg. 125.

When asked what Department policies were violated, DFC Anunay stated that an attempt to establish whether or not the patient was conscious, and Employee went back to service without obtaining a refusal of service from the patient. Tr. Vol. I. pg. 127. She explained that the patient telling the crewmembers to leave her alone was not admissible as a refusal, as there's a process that needs to occur. DFC Anunay stated that there were no vital signs for glucose reading. She noted that the crewmembers should have called ELO at communications as a step towards obtaining a refusal on a recorded line; and assess the mental status of the patient to establish if they were capable of making a refusal. DFC Anunay explained that she did not see anything in the report which led her to conclude that there was any attempt to awake the decedent and Employee and his partner decided to leave and were satisfied with what they saw. Tr. Vol. I. pg. 128.

DFC Anunay explained that her endorsement alluded to the required protocol and referenced resources available to firefighters who are perplexed or have not received enough diagnostic resources from the scene at patient assessment. Tr. Vol. I. pg. 129. She also testified that her endorsement referenced the fact that the crewmembers on the scene should have at least

requested the assistance of MPD to accompany the minor, since based on their reports, they were not able to establish that the mother was conscious. Tr. Vol. I. pg. 131.

DFC Anunay identified Agency's Exhibit 6 as an email she received from firefighter DeLima after a phone call to him, requesting that he submit a statement of what he found on arrival on the scene. Tr. Vol. I. pg. 133.

On cross-examination, DFC Anunay affirmed that she did a thorough investigation of the alleged incident which consisted of collecting special reports from Employee, Gigger and an email from Firefighter DeLima. Tr. Vol. I. pg. 135. She noted that she did not have a conversation with, or follow-up questions for Employee after she received his report. Tr. Vol. I. pgs. 135-136. DFC Anunay did not listen to any of the relevant 911 calls in the course of her investigation. Tr. Vol. I. pg. 138. She affirmed that her endorsement was based solely on her review of the special reports from Employee, Gigger and the email from firefighter DeLima. Tr. Vol. I. pg. 139.

On redirect, DFC Anunay affirmed that she spoke to Employee and Gigger prior to completing her endorsement, and she took into account what they said and wrote in their reports when drafting the endorsement. Tr. Vol. I. pgs. 139 -140.

On recross, DFC Anunay explained that the conversation she had with Employee and Gigger did not just include the procedures and what to expect, but it was also an opportunity for them to thoroughly explain what happened. Tr. Vol. I. pg. 140. When asked if she discussed with Employee the facts of what occurred prior to writing his special report, DFC Anunay said "no". Tr. Vol. I. pgs. 140-141.

Leonardo Delima Tr. Vol. I. pgs. 145 -191

Leonardo Delima ("Delima") has been a Firefighter Paramedic with Agency for about five (5) years. He is assigned to Engine 9. Tr. Vol. I. pg. 145. As a paramedic, Delima is designated as an ALS. He recalled working the morning of June 23, 2020. He affirmed responding to a call on 301 G Street, Southwest, during the early morning hours of June 23, 2021. His was assigned to a Transport ALS Unit, Medic 2, that morning. Tr. Vol. I. pg. 146.

Delima testified that he and his partner responded to the call at 301 G Street, following a request from Ambulance 13, for an ALS Transport Unit. He was at Engine 2, which is about ten (10) minutes away, when they were dispatched to the location. Tr. Vol. I. pgs. 147, 179. Delima stated that prior to their arrival at the scene, they had the CAD notes which referenced an unconscious person. The notes also stated that it was a second call, and it referenced a little girl. Tr. Vol. I. pgs. 147-148. Delima asserted that upon their arrival at the scene, they found several police officers in the living room with a little girl, and the ambulance crew in the room providing patient care. Tr. Vol. I. pg. 148. He headed to the room and had a conversation with Ambulance 13 crewmembers on what was going on. He was informed by the crewmembers that there was an unconscious patient. He asked for the patient's vitals and took it from there. Tr. Vol. I. pg. 149.

Delima affirmed preparing an email regarding the June 23, 2020, incident. He stated that he was approached by DFC Anunay requesting that he give a brief email of what happened that morning. Tr. Vol. I. pgs. 150, 175. Delima identified Agency's Exhibit 6, as the July 21, 2020, email he sent to DFC Anunay upon her request. Tr. Vol. I. pg. 150. Upon refreshing his recollection from Agency's Exhibit 6, Delima stated that the only thing that stuck out to him was the fact that the Ambulance 13 crewmembers had been at the scene before. They confirmed being at the scene before and they also mentioned something about alcohol. He asked a few questions about what happened at the scene during their first visit. He then proceeded to doing a thorough assessment to figure out what was going on. Tr. Vol. I. pgs. 151 -152. Delima affirmed having a conversation with Ambulance 13 crewmembers. They mentioned the presence of alcohol and the fact that they initially thought the patient was asleep. Tr. Vol. I. pgs. 153, 176. Delima noted that after his conversation with Ambulance 13 crewmembers, he started getting the patient's vitals, and he quickly realized that they had a priority one critical patient. As the person in charge, Delima made the decision to wrap things up and transport the patient to the hospital as quickly as possible since there was nothing beneficial to the patient that they could accomplish at the scene. The ambulance crew assisted in transporting the patient to the hospital. Tr. Vol. I. pgs. 158, 164, 167, 169, 172, 180.

Delima noted that he did not think too much about the fact that Ambulance 13 had been at the scene before, because he had a lot to deal with at that moment. He asked them about what vitals they had since he was expecting to have the full set of vitals as he walked into the room, but that was not the case. He affirmed that some vitals had been collected prior to his arrival at the scene. Tr. Vol. I. pgs. 153-154., 169-170. When asked what the use of the blood sugar reading was, in terms of the overall assessment of a patient, Delima explained that it fits within the unresponsive person protocol. He further noted that the blood sugar was the first vital sign he collected if someone was unconscious. Tr. Vol. I. pgs. 154 -155.

Delima testified that based on his training, the first thing he does when he arrives at a scene is to ensure it is safe. Thereafter, he tries to gather as much information as possible by scanning the scene for things like drug paraphernalia, alcohol etc. He noted that since they are the triage department, they have a tiered system with a lot of things to do such as transport BLS, ALS, call nurse triage or get a refusal. He stated that once they get past the safety check, they now move to complete the vitals and patient assessment to help decide their next step. Tr. Vol. I. pg. 1556-158. Delima affirmed that he was familiar with the term 'situational awareness'. He understood this to mean being able to read the scene by walking into it. Tr. Vol. I. pg. 158.

Delima identified Agency's Exhibit 7 as the ePCR he completed after the incident on June 23, 2020. Tr. Vol. I. pg. 160. He noted that they got the patient's blood pressure and blood sugar using the LIFEPAK 15 monitor, which is only available to ALS. He also checked her pupils to make sure there was no trauma. Tr. Vol. I. pgs. 161, 170-171. He explained that the narrative section of the ePCR includes all the vitals taken, procedures, or medications give, and anything they did with the patient. Tr. Vol. I. pgs. 161-162.

Delima stated that he would not dispose of the incident on June 23, 2020, as a "no patient contact." He asserted that "no patient contact" means there was no contact with the patient at all. Tr. Vol. I. pg. 163. Delima testified that a full patient care assessment is important, so you don't

categorize a call incorrectly. He noted that without a full assessment, you will not have all the questions answered, and would not be able to take the next step in the decision process. Tr. Vol. I. pg. 168. Delima does not recall having a conversation with Ambulance 13 crewmembers while at GW hospital. Tr. Vol. I. pg. 173.

On cross examination, Delima affirmed that his email to DFC Anunay did not include every single word he had with the crew of Ambulance 13 on June 23, 2020, but he tried to be accurate with what happened. Tr. Vol. I. pg. 175. He affirmed that Ambulance 13 crew provided him with vitals they collected from their first trip. He noted that they gave him the blood pressure and another vital that he could not recall. When asked if Employee told him that the patient refused care, he said "no". Tr. Vol. I. pg. 177. He stated that Ambulance 13 crew had not collected the blood sugar when he arrived at the scene. He explained that that was something he was expecting to get, giving its importance for the protocol of unresponsive patients. Tr. Vol. I. pgs. 177 – 178. Delima also explained that if the first vital sign collected indicates that the patient is not doing well, and they will need an ALS crew, they should go ahead and request ALS care, while completing the rest of the vitals. Tr. 179.

Delima explained that, before he obtains a refusal from a patient, he has to complete a full set of vitals and do an assessment of the patient's level of consciousness because you cannot get a refusal from a patient who is not able to give a refusal. His goal is to ensure the patient is alert and capable of making an educated decision on their own health. He also noted that it really depends on the type of call. Tr. Vol. I. pg. 183. Delima also asserted that the patient was wrapped up in a sheet when he arrived the scene, and he did not realize the patient was naked until he unwrapped her. Tr. Vol. I. pg. 184, 191.

Delima testified that what constitutes a full set of vitals varies, based on the situation. But generally, it includes blood sugar, level of consciousness, assessment of the scene, heart rate, respiratory rate, and pupil check. Delima explained that the ALS crew expect to receive level of consciousness, blood sugar, blood pressure, heart rate, respiratory rate whether the lungs are clear or not, suspicion of trauma, suspicion of drug use, and any other history pertaining to the call. He noted that the ALS crew get at least two (2) sets of vital signs, per patient, depending on how long they are with the patient. Tr. Vol. I. pgs. 185 - 186. They typically get a set of vitals if the patient refuses. Tr. Vol. I. pg. 187. Delima testified that they do get calls where people are sleeping and they don't want to be touched, but you have to ensure that that's exactly what is going on. This can be achieved by doing a pain stimulus -nudging the person or give them a sternum rub. Next, the person's vitals are collected, to include a blood sugar level test. Tr. Vol. I. pg. 188.

When asked if there's a protocol of what vital signs should be collected first, Delima stated that he does not think there is a dictation on what signs you are supposed to collect first. But protocols routinely list them the same way – assess level of consciousness, assess blood sugar, heart rate, respiratory etc. He also noted that since there is more than one (1) person on scene, more than one set of vitals can be taken at the same time. Tr. Vol. I. pg. 190.

Edward Mills Tr. Vol. I. pgs. 193 - 232

Edward Mills ("Chief Mills") has been employed by Agency for 25 years. He is currently the Assistant Fire Chief of EMS. Tr. Vol. I. pgs. 193-194. Chief Mills stated that he prepares endorsements for disciplinary actions, as well as acts as the deciding official on penalty for disciplinary actions. He explained that he cannot be both the charging official and the deciding official in the same case. Tr. Vol. I. pg. 195. Chief Mills asserted that he was the Deciding Official in the current case.

Chief Mills was tasked to review the information provided by DFC Anunay after review by the medical director, in its entirety, to make a determination on any potential penalty for Employee. He was provided with the information collected by DFC Anunay, which included the patient care reports for both incidents on June 23, 2020; the special reports submitted by the crew; and the endorsement, along with other relevant documents. He noted that he reviewed these documents in reaching his conclusion/endorsement in this matter. Tr. Vol. I. pgs. 195-198. Chief Mills explained that in his role as a deciding official, there have been times when he would review information and determine that the charges levied were not appropriate or the reviewed information might have an impact on his final penalty decision. Tr. Vol. I. pgs. 198-199.

Chief Mills affirmed preparing an endorsement in the current case. Tr. Vol. I. pg. 199. He identified Agency's Exhibit 4, as the endorsement he prepared after reviewing the information package. He explained that after he prepared the endorsement, he forwarded the information to the Office of Compliance, and they prepared the official notification documents to Employee. Tr. Vol. I. pg. 200. Chief Mills explained that he was the official at the end of the process and the person that made the decision on the outcome of the process. Tr. Vol. I. pg. 203. He asserted that he found that there was abandonment of the patient in the current matter, a failure to perform appropriate patient care, and that Employee and his partner could have performed in such a manner that the patient would have received the appropriate patient care as expected from any prudent, trained EMT. He did not feel that those elements of the job had been met. As a result, the patient suffered an unfavorable outcome which could have been prevented had she received medical care in a timely manner. Tr. Vol. I. pgs. 204 -205.

Chief Mills testified that the National Highway Transportation Safety Administration sets the guidelines for EMT standards. These standards are for the delivery of patient care, and they also lay out the ethical responsibilities of care providers and their responsibility to have a duty to act. It also addresses providers not performing these functions, thus breaching their duty to act. Tr. Vol. I. pg. 205. Chief Mills stated that the patient in the current matter was left in a state of medical need, and the members had a duty to act by providing care to the patient, and they breached that duty by leaving the patient in that state. Tr. Vol. I. pg. 206.

Employee's case-in-chief (August 4, 2021)

Employee – Tr. Vol. II. pgs. 11 – 113

Employee has been a Firefighter with Agency since October 2012. He has been an EMT since 2001 and has worked in Pennsylvania and Maryland. While at Agency, he has been

assigned to Engine 6, No. 2, and most recently to Truck 10, No. 2. He was on Engine 6 for eight and a half (8.5) years. He switched to Truck 10 on March 17, 2020. Tr. Vol. II. pgs. 11-13. Employee stated that he loved driving the ambulance because that's where he was going to help the most people. Tr. Vol. II. pgs. 13-14. He explained that the ambulance was basically all about patient care. Tr. Vol. II. pg. 14. Employee testified that when approaching a patient, it does not matter to him whether the patient is the President of the United States or a guy sleeping on the concrete with a bottle of 'Velikoff' next to him. Everyone gets treated the same and they receive the best treatment he can offer. Tr. Vol. II. pg. 15.

Employee identified Employee's Exhibit 1, as his EMS evaluations received during his time at Agency. Tr. Vol. II. pgs. 15-16. He noted that the evaluation provided that his EMS skills were acceptable and consistent. He affirmed that he last received an EMT evaluation on June 14, 2014. Tr. Vol. II. pg. 16. Employee acknowledged that he received annual performance evaluations. He was evaluated by Lieutenant Christopher Moreland, and he was rated 'Excellent' for 2018 and 2019. Tr. Vol. II. pgs. 17-18.

Employee affirmed that he was assigned to Ambulance 13 on June 23, 2020. His shift began at 0700 on June 22, 2020. It was a 24-hour shift from June 22 to June 23, 2020. His partner on that shift was Firefighter Gigger. Tr. Vol. II. pgs. 18. Employee had only recently begun working at the firehouse. He acknowledged working with Gigger before. Employee averred that he did not have any problems working with Gigger. They get along well, but they were still figuring out each other's working styles and how their teamwork would be best suited. Tr. Vol. II. pgs. 18-19. Employee stated that Gigger was the ACIC in the morning from 0700 to 1900, and Employee was the ACIC overnight from 1900 to 0700 the next day. As the ACIC, he rode in the back of the ambulance with the patient, conducted assessments and wrote reports. Gigger was the driver. Employee noted that it was not a busy shift and they had somewhere between 12 and 15 runs during the 24-hour shift. Tr. Vol. II. pgs. 20, 62.

Employee asserted that he was in bed when he received the call at 4:30 a.m. on June 23, 2020. He explained that he heard the bells go off and saw the light for the ambulance. He got up, slid down the pole, and went to the ambulance. He did not have any information about the nature of the call before he got to the ambulance. Tr. Vol. II. pgs. 21. Employee provided that when he got to the ambulance, he received additional information on the CAD system about the call, such as the location of the call, and information indicating that migraines were the possible nature of the call. Employee noted that he heard a radio dispatch after he pressed en route. Tr. Vol. II. pg. 22. Employee responded in the negative when asked if he received the actual 911 call that prompted the ambulance request. Tr. Vol. II. pg. 23. Employee averred that once his partner got to the ambulance, they proceeded to the address. Tr. Vol. II. pg. 24.

Employee affirmed that Employee's Exhibit 3 showed the route they took to get to the call on G Street. He also affirmed that the map showed that it took approximately one (1) minute by car to get to G Street from Employee's location. He acknowledged that it took him approximately one (1) minute to get to the location on June 23, 2020. Tr. Vol. II. pg. 24.

Employee averred that when they got to the apartment building on June 23, 2020, they knocked on the door for at least two (2) minutes, but no one came to the door. His partner then

started to initiate a call for help to get into the apartment. Tr. Vol. II. pg. 25. Employee affirmed that his partner spoke to someone at the Office of Unified Communications ("OUC"), but Employee could not recall exactly what was said. Employee explained that while his partner was on the radio with OUC, Employee heard someone trying to open the door. He noted that it took the child who was approximately four (4) or five (5) years old a while to open the door. The child told Employee that her mother was sick. Tr. Vol. II. pgs. 26, 64-65. Employee stated that the child did not say anything else when they entered the apartment. Employee affirmed that they scanned the scene when they entered the apartment. He explained that he noticed a small kitchenette on the left-hand side, a little round table with mail on it on his left leading into the living room area, the child's bedroom was outside the kitchenette, and then there was the mother's bedroom. The mother's bedroom door, like the child's was open, with the lights on. Tr. Vol. II. pgs. 27, 64-65.

Employee testified that they found the patient laying on the floor, perpendicular to her bed, with a pillow under her head. Tr. Vol. II. pg. 27. Employee stated that the patient appeared unconscious when they found her. He asserted that the patient was breathing and had a normal rise and fall of her chest. Employee noted that he asked the child if she put the pillow under her mother's head, and she said 'no'. The patient was naked, and they covered the patient up with a sheet they took off the bed, to preserve her modesty. Tr. Vol. II. pg. 28. Employee explained that he proceeded to try to arouse the patient with painful stimuli such as a sternum rub and pressure points between her clavicles and her shoulders. He also tried squeezing the patient's fingers and earlobe. Employee instructed his partner to start taking the patient's vitals. Employee stated that the patient responded to the stimuli with moans. Employee asserted that he checked the patient's eyes with a pen light by opening the patient's eyelids and checked the reactiveness of her eyes to light. Tr. Vol. II. pgs. 29, 68-69. Employee stated that the patient's eyes were equal and reactive to light, which indicated that there was no brain trauma. Employee recalled that his partner took the following vitals – 97% room air, 78% heartrate, and the blood pressure was 150/90. The vitals indicated that they were within normal limits. Tr. Vol. II. pg. 30.

Employee asserted that he started assessing the patient's level of consciousness as he walked into the room. Tr. Vol. II. pg. 30. He explained that the patient appeared unconscious, and the pillow indicated that she might have just been able to go to sleep. Employee found this weird. He stated that you do not put a pillow under your head unless you intentionally laid somewhere. Employee was not writing down the vitals as his partner took them because he was focused on trying to arouse and wakeup the patient. When asked if he recorded vitals during examination of other patients, Employee responded in the affirmative. He explained that it would depend on what is going on with the patient. If the patient was unconscious, more than likely, he focuses on trying to arouse the patient and have his partner take the vitals. Tr. Vol. II. pgs. 31, 68.

Employee acknowledged that there came a time during the examination when the patient spoke. Tr. Vol. II. pg. 31. Employee testified that as Gigger was taking the blood pressure, the patient yelled out "get off of me", which is when she finally woke up. Employee and his partner both took a step back because it was in the middle of the night, the patient was naked, even though there was a sheet over her at that time. Employee averred that he tried to explain who they were, identify themselves to the patient and let her know they were responding to a medical

call. Employee stated that they could see she was in the fuzz of waking up. He asked the patient if Gigger could continue taking her blood pressure, which she allowed. Employee assisted in helping the patient sit up and he began to talk to her. Tr. Vol. II. pg. 32. Employee noted that while he was talking to the patient, he asked Gigger to take the bag to the stretcher and bring in the stretcher. He thought they were going to go to the hospital because it took so long to wake the patient up, and the patient called for a reason. Tr. Vol. II. pgs. 32-33.

Employee stated that he was on the patient's left-hand side when he was talking to her. He noted that his leg was next to the patient so she wouldn't fall in case she felt a little woozy. Employee affirmed that the patient could see his face and vice versa. Tr. Vol. II. pg. 33. He explained that he asked the patient questions to assess her mental acuity. He asked the patient how many quarters were in a dollar; if she knew what section of the city she was in; what date it was; and who the president of the United States of America was. The patient responded that there were four (4) quarters in a dollar; she was in Southwest; that it was Sunday; and that the president was Biden. Employee also affirmed that the patient made a political joke against Trump, when she said "… because that other guy is not my president." Tr. Vol. II. pg. 34. Based on the patient's responses, Employee concluded that she was alert and oriented. The patient's tone was clear, she was not gasping for air, and she did not struggle to speak. Employee testified that he asked the patient about the nature of the call – why she called the ambulance, and if she wanted to go to the hospital. The patient stated that she had a migraine and just wanted to go back to sleep. Tr. Vol. II. pg. 35. Employee asserted that he explained to the patient that she called them for a reason, so they should go to the hospital and get her checked out. The patient refused, stating that she was okay. Employee averred that he told the patient that it was in the middle of the night, and he did not know how long she had had a migraine, so they should take her to the hospital to check it out, but the patient refused saying she was okay. He explained to the patient that if she did not want to go to the hospital, she had to sign his book. Employee stated that he informed the patient of the risks of refusing treatment and not going to the hospital. As he kept prodding the patient to go to the hospital, the patient became irritated and asked them to leave. Tr. Vol. II. pgs. 35-36. They left the apartment after the patient told them to leave. The patient was awake and still sitting up when they left, and the little girl was in the hallway. Tr. Vol. II. pgs. 37-38. Employee asked the little girl to lock the door behind them, and he made sure the door was locked. Tr. Vol. II. pg. 38.

Employee testified that apart from her blood sugar that they did not get, they finished taking the patient's baseline vitals on the initial call. Tr. Vol. II. pg. 36. He was not sure if Gigger asked to take the patient's blood sugar. Tr. Vol. pg. 37. Employee concluded that as far as the patient's vitals, she was within normal limits. He noted that the patient was overweight, so he did not think the patient was that healthy. Tr. Vol. II. pg. 38. Employee stated that he thought the patient had a migraine and she would go back to sleep. Tr. Vol. II. pgs. 38-39.

When asked if he abandoned the patient, Employee responded no. He explained that they did everything they were supposed to do, as far as patient care and checking vitals. Employee stated that in hindsight, he could have called a supervisor or persuaded the patient to go to the hospital. Tr. Vol. II. pg. 39. Employee noted that after they got to the ambulance, he told Gigger that he did not understand why people did not want to go to the hospital. He mentioned that the patient called for a reason and that if she called again, she's definitely going to the hospital. Tr.

Vol. II. pgs. 39-40. Employee asserted that he started working on the PCR in the ambulance as Gigger drove to the firehouse which was about a minute away from where the call took place. Tr. Vol. II. pg. 40. When they got to the firehouse, he went to use the bathroom, after which he returned to the ambulance to complete the report. When he got to the ambulance, the computer was off. He plugged it in, and turned it back on, but the report was gone, so he had to start over. Tr. Vol. II. pgs. 40-41.

Employee identified Employee Exhibit 4 as the PCR he was working on after he got his computer back on. He affirmed that he began working on a PCR on their way back from the call to the firehouse, but he lost that PCR because the Toughbook was not working. Tr. Vol. II. pgs. 41-42. So, he started a second PCR, which he described as Employee's Exhibit 4. He noted that the second PCR was incomplete as it only recorded his observations. Employee explained that the second PCR did not have the vital because Gigger collected the vitals, and as he was trying to get Gigger to collect that information, they got called out for another call. The ambulance was not back in service when they got the call and he had not completed the second PCR when they got another call. Tr. Vol. II. pgs. 43, 45. Employee noted that the disposition of the first call as stated in the PCR should have been a "refusal" and not "no patient contact" as it stated. He stated that he dropped the ball in his documentation. Tr. Vol. II. pgs. 44-45.

Employee acknowledged that the second call they received was to return to the apartment they had just been at. Tr. Vol. II. pgs. 45-46. Employee stated that it took them less than one (1) minute to get to the apartment the second time. He told Gigger on their way back to the apartment that the patient was definitely going to the hospital. Tr. Vol. II. pg. 46. Employee asserted that when they arrived at the apartment, MPD officers were in the living room; the little girl was with the security guard; the lady was laying down on her side, and she was unconscious. Tr. Vol. II. pg. 46. He explained that the lady was barely breathing. They put the pulse oximeter on her finger and noticed that it was at 41 percent. Employee grabbed the VVM out of the bag and told Gigger to call ALS, as Employee began assisting the lady with her breathing. Employee noted that they only collected her pulse and heart rate before the ALS arrived. He explained that the patient was at a life-or-death state, and he had to correct her breathing. This took the patient's blood oxygen level to 97 percent. ALS arrived within ten (10) minutes. Tr. Vol. II. pgs. 47-48.

Employee averred that after placing the call to ALS, Gigger came back to the patient's right side and told Employee that he would administer Narcan to the patient. Employee explained that while he was assisting the patient to breathe, he was panning around the room and he noticed an empty bottle of Benadryl and an almost empty bottle of Hennessy on the patient's nightstand next to her bed, about four (4) feet away. He did not know if there was some type of interaction with the two (2). Employee also asserted that sometimes, patients on some types of opiates such as heroine or fentanyl have compromised breathing and the current patient's breathing was low. He mentioned something to Gigger and these probably prompted Gigger to administer Narcan. Tr. Vol. II. pgs. 48-49.

Employee acknowledged that Paramedic Delima was one of the ALS providers who responded to the call. Employee informed Delima that they were at the patient's apartment earlier and her vital signs were within normal ranges. Tr. Vol. II. pg. 49. Employee further explained to Delima that the patient noted that she just wanted to go to sleep, and she berated

them until they left and now, they are back. He provided Delima with the patient's oxygen level when they arrived the second time, and what they got it back up to. They pulled the stretcher and used her sheet to get her on the stretcher. Then they noticed that there was fecal matter on the floor. Employee testified that there was no fecal matter the first time they were at the patient's apartment. He explained that he would have noticed the fecal matter during the first call because his foot was pretty much right behind the patient. Moreover, he would have probably smelled it. Tr. Vol. II. pgs. 49-50.

Employee noted that he did not tell Delima that they had been at the apartment an hour earlier. He provided that he told Delima that they were literally just at the patient's apartment. Employee stated that after the patient was put on the stretcher, Delima asked him to ride with him and to continue to assist with the patient's breathing, which he did. The patient was transported to the George Washington Hospital Center No. 8. When they got to the hospital, Employee continued helping the patient breathe until they got to Trauma Room No. 2 where they took over the breathing responsibilities. Tr. Vol. II. pgs. 50-51. Employee was done at this point. Gigger followed him to the hospital in the ambulance. Employee then returned to the ambulance. As they were driving back to the firehouse, he tried to do the PCR reports. He recalled that the vitals were not on the first report, so he tried to do an addendum. Tr. Vol. II. pg. 52.

Employee identified Employee Exhibit 5 as the addendum to the first PCR. He noted that the addendum contained vitals from the first visit, but he had some typos when he entered them. He explained that Gigger told him that the patient's heart rate was 78, but he wrote down 48. He also did not add the updated Glasgow Comma Scale ("GCS") before they left. Employee further explained that the GCS helps to describe the patient's alertness. He noted that the GCS of six (6) as stated in the report indicated that the patient was unconscious or asleep, which was the initial state they found the patient in. He did not input the updated GCS at the time they left, which was thirteen (13) at the time they left. He also pointed out that the pulse oximetry was initially 41, but they got it up to 97. He was attempting to complete the addendum and the report from the second call at the same time. Tr. Vol. II. pgs. 52-55.

Employee identified Agency's Exhibit 2, as the PCR for the second call that he completed at the same time he was completing the addendum. He noted that he mixed up the vitals in the addendum PCR and the PCR for the second call. Employee provided that the patient's pulse oximetry during the second call was 41. Employee asserted that they typically collect a patient's vitals at least twice during a normal patient encounter. He explained that, depending on the patient and the severity of the levels, they collect the vitals every five (5) minutes. But, if it is not serious, they collect the vitals every fifteen (15) minutes. Tr. Vol. II. pgs. 55-56. Employee averred that they collect vitals once for patients that refuse care especially if they become combative, irate and won't allow the crew to touch them. Tr. Vol. II. pgs. 56-57.

Employee asserted that about four and a half (4.5) weeks after the June 23, 2020, incident, he was asked by DFC Anunay to write a special report on the June 23, 2020, run at issue. Employee was not provided with any documentation (such as the PCRs Employee drafted) by DFC Anunay about the run when he was asked to do the special report. Tr. Vol. II. pg. 57. The dispatch call for the current incident was not made available to Employee and he was not asked to comment on any aspect of the run. DFC Anunay requested that Employee provide her

with everything that happened, and he provided DFC Anunay with that information. Employee noted that he was not interviewed or received any follow-up questions about what he wrote in his report about the June 23, 2020, run from DFC Anunay or Chief Mills. Tr. Vol. II. pg. 58. Employee maintained that he had no communications with DFC Anunay about what happened on the June 23, 2020, run. Tr. Vol. II. pg. 59.

Employee testified that in hindsight, he would have called the supervisor to convince the patient to go to the hospital because they would not be having the current Trial Board hearing if he had done that. He also noted that he would have written the report as a refusal like it should have been. Apart from these, Employee remarked that they did everything they were supposed to do in the patient's house. They checked the patient, and her vitals were within normal range. Tr. Vol. II. pgs. 59, 61.

On cross examination, Employee provided that as of June 23, 2020, he had worked with Agency for about eight and a half (8.5) years. Tr. Vol. II. pg. 62. Employee affirmed that he had more years of experience than Gigger. Employee agreed that the ePCRs are considered legal documents by Agency. He also affirmed that there's a written order that indicates that accuracy is of great importance in terms of completing the ePCRs. Tr. Vol. II. pgs. 62-63. Employee noted that he made typos in the two (2) ePCRs he completed for the June 23, 2020, runs to Capital Park Towers apartments. Tr. Vol. II. pgs. 63-64. Employee highlighted that one of the typos he made was his entry of the pulse oximetry reading of 48 percent.

Employee testified that he scanned the apartment during their first visit on June 23, 2020. He noted that he did not see the Hennessy and Benadryl during the first visit. Tr. Vol. II. pg. 66. Employee explained that he did not observe the nightstand during the first visit, as his focus was on the patient. He affirmed that when they got into the apartment, the patient appeared unconscious. Tr. Vol. II. pg. 67. Employee affirmed that the kid stated that she did not put the pillow under the mother's head. Tr. Vol. II. pg. 68. Employee asserted that the narrative in the first ePCR was incomplete. Tr. Vol. II. pg. 71. Employee affirms that his disposition in the ePCR makes no reference to the patient refusing service and the narrative in the ePCR does not reference the patient refusing service. Employee explains that the ePCR referenced was technically his second ePCR generated for his first trip to the Capital Park Towers on June 23, 2020, as the initial ePCR that he started working on got lost. He affirmed that the ePCR also stated that there was no patient contact. Tr. Vol. II. pgs. 72-73.

Employee averred that he prepared the report for both the first and second visit simultaneously because he had to get things done so that the next crew could start their shift. He stated that he did not like to leave reports open into the next shift. Tr. Vol. II. pgs. 74-75. Employee noted that he did not recall Gigger asking him during the first visit if he was sure about not transporting the patient to the hospital when he informed Gigger that the patient was not going to the hospital. He noted that the patient was not transported to the hospital during the first visit because her vitals were in the normal limits. Tr. Vol. II. pgs. 76. Employee affirmed that Gigger was not immediately present when he had the conversation with the patient to determine her consciousness. When asked if he shared his conversation with the patient and the patient's refusal with his partner Gigger, Employee said he did not share the patient's responses to his questions with Gigger. He affirmed that he shared with Gigger that the patient refused

service. Employee stated that Gigger should have been within close enough proximity to hear his conversation with the patient. Tr. Vol. II. pgs. 77-78. Employee explained that after Gigger got the blood pressure during the first visit, he asked Gigger to get the stretcher located in the hallway within the apartment, about six (6) feet from the patient. Tr. Vol. II. pgs. 79-81. Employee also stated that the ePCR did not contain information about his conversation with the patient. Tr. Vol. II. pg. 81.

Referencing Agency's Exhibit 9, Employee averred that his Special Report to DFC Anunay stated that he requested that the patient sign the ePCR but she refused. Tr. Vol. II. pgs. 81-82. Employee affirmed that the specific of his conversation with the patient during the first visit was not included in his Special Report to DFC Anunay. Employee affirmed that he added an addendum to the report when he returned to the firehouse to include the blood pressure. He stated that a blood pressure reading of 158/91 was still within the normal limit based on the patient's age and weight. Tr. Vol. II. pgs. 83-84. Employee acknowledged that he informed the patient of all the risk factors, but that is not mentioned in the ePCR or the Special Report. Tr. Vol. II.pg. 84.

Employee affirmed that when a patient refuses treatment, he has the option to call the supervisor for help. However, they are not under any obligation to call in every situation. Employee stated that he did not do so on June 23, 2020, because the patient's vitals were within range, thus, he was not required to call the supervisor. But given the outcome, he should have called the supervisor to convince the patient to go to the hospital. Tr. Vol. II. pgs. 84-87. Employee maintained that he wants everyone who called 911 to go to the hospital. Tr. Vol. II. pg. 86.

Employee affirmed that Agency's Exhibit 9, was his Special Report, completed on July 20, 2020, in connection with the June 23, 2020, incident. Tr. Vol. II. pg. 88. Employee acknowledged that the only proof of his conversation leading up to the patient's refusal is Employee's testimony at the Trial Board. He also affirmed making mistakes on the reports relating to the first visit. Employee also affirmed that the pulse oximetry was at 41% during the second visit, and he got it up to 97%. Employee stated that he was responsible to get the patient's history at the scene, but in speaking to the patient, he was more concentrated on the patient's state of mind. Tr. Vol. II. pgs. 89-90. Employee later noted that he did ask the patient some questions, but that did not make it into the ePCR. Tr. Vol. II. pgs. 90-91.

Employee asserted that he was familiar with the OPQRSTI[5], and he explained that it is how they follow pain during patient assessment. Employee affirmed that he followed OPQRSTI, but the patient got irate when he was talking to her. Tr. Vol. II. pg. 91. Employee also averred that he was familiar with the acronym SAMPLE. He explained that that's how they obtain the medical history. Tr. Vol. II. pg. 91. Employee provided that the patient's GCS was about six (6) when they arrived at the scene. The patient was semi-conscious, and she responded to painful stimuli through moaning and inflection. Employee stated that a higher GCS meant more consciousness. Tr. Vol. II. pg. 92. Employee affirmed that his success in rousing the patient, having her sit up, and her saying she wanted to go back to sleep contributed to his conclusion that she was just sleeping at the time. Tr. Vol. II. pg. pg. 93.

[5] The parties did not provide the full meaning of this acronym.

When questioned if he thought his performance was consistent with the Patient Bill of Rights and the D.C. Fire Department Medical Protocol, Employee affirmed that it did. He noted that he had no explanation for why he recorded "no patient contact" in the ePCR. Tr. Vol. II. pg. 94.

Employee testified that he would treat the president in the exact same way as he treated the patient in this matter. He stated that apart from calling his supervisor, he would have checked his vitals. Employee asserted that if the president told him to leave and he became belligerent, and if the vitals were within normal range, he would probably leave, just as he did with the current patient. Tr. Vol. II. pg. 96. Employee acknowledged that he dropped the ball with regards to documentation for the current incident. Tr. Vol. II. pg. 98.

Employee stated that the patient did not show any symptoms of nausea or vomiting while they were in the house. Tr. Vol. II. pg. 100. Employee averred that he did not do a stroke scale for the patient. Tr. Vol. II. pg. 101. Employee affirmed prior to the incident on June 23, 2020, he had completed an ePCR after taking another run. Employee also affirmed that he normally gets a witness to sign a refusal. He explained that if there was no witness available, he gets his EMT partner to sign the refusal. Tr. Vol. II. pg. 103.

Employee explained the procedure for a refusal of service. He noted that the level of consciousness must be ascertained; the consequences of the refusal read to the patient and the patient is informed that Agency will respond to any future calls, even if they refuse the current service. He also noted that both the patient and a witness must sign the refusal. If the patient refuses to sign, a supervisor should be called. Tr. Vol. II. pgs. 103-104. Employee asserted the patient's respiratory rate was 20 respirations per minute. Tr. Vol. II. pg. 104.

Employee testified that he spoke to the ELO on the night of the incident and told them that the patient wanted to sleep, and they asked him to use his judgment as to whether to let the patient sleep. Employee explained that he failed to notify 0-14 to make a refusal, after the patient refused treatment. Tr. Vol. II. pgs. 105-106. When asked if Employee would have left the patient if their GCS remained at six (6) at the time they were leaving, he said 'no' because that would have been considered implied consent to transport to the hospital. Tr. Vol. II. pgs. 107-108.

On re-direct examination, Employee stated that the first ePCR was missing information because he did not have time to finish it. He explained that once they returned to the firehouse, he went to the bathroom and thereafter, started completing the report. However, they were called back out to the same address five (5) minutes after they got to the firehouse. Tr. Vol. II. pg. 109. Employee acknowledged that his special report to DFC Anunay indicated that he had a conversation with the patient when he noted that they asked the patient to sign the refusal and she refused. He noted that he was not asked any follow-up questions by DFC Anunay or anyone else. Tr. Vol. II. pg. 110. Employee affirmed being disciplined in 2019 for discourteous conduct involving another Agency employee. Tr. Vol. II. pg. 111. It had nothing to do with patient care and he has never been disciplined for patient care. Tr. Vol. II. pg. 111.

<u>Mark Lucas– Tr. Vol. II. pgs. 116 - 121</u>

Lieutenant Mark Lucas ("Lt. Lucas") retired from Agency in 2018, after 32 years at Agency. He worked with Employee at Engine 6. Tr. Vol. II. pg. 116. Lt. Lucas explained that he was the officer in charge of the truck, and Employee was assigned to it. He worked with Employee for about six (6) to seven (7) years. Tr. Vol. II. pg. 117.

Lt. Lucas noted that Employee's work as a Firefighter was excellent. He provided that Employee was a good and dependable employee. He showed up to work on time every day and did not have any complaints. Lt. Lucas asserted that he rode the truck with Employee and Employee was an exemplary EMT. Employee was respectful, he knew how to address people on the streets, and he had confidence in Employee. Tr. Vol. II. pg. 117.

Lt. Lucas asserted that he observed Employee do patient care several times. Employee was polite, treated everyone the same, took their vitals and entered all the information into the computer system for Lt. Lucas, since he was not computer savvy. Tr. Vol. II. pg. 118. He never observed Employee take shortcuts with his job. Employee did everything by the books. Lt. Lucas explained that for patient care as an EMT, they emphasized documentation – "if you don't document it, you didn't do it." Employee was aware of this, and he always did it. Tr. Vol. II. pg. 118. Employee was partnered with Curtis Bryan for four (4) years, and during that time, Lt. Lucas did not receive any complaints and he did not have to supervise them. Tr. Vol. II. pg. 120.

Lt. Lucas noted that he never encountered any documentation issues with Employee. He explained that he trusted Employee to document his information. Tr. Vol. II. pg. 121.

Chris Moreland – Tr. Vol. II. pgs. 123 – 132

Lieutenant Chris Moreland ("Lt. Moreland") is assigned to Engine 6, Platoon 2. He supervised Employee on the ambulance after he was assigned to Engine 6 in December of 2017. Lt. Moreland noted that Employee was a good Employee, who went above and beyond when it came to EMS calls. Tr. Vol. II. pg. 123. Lt. Moreland averred that he never had a problem with Employee checking vitals or any other EMS related duties. Lt. Moreland testified that Employee had a way of convincing homeless people to be transported to the hospital. Employee was placed in charge of all EMS equipment because he was very thorough. Tr. Vol. II. pgs. 123-125, 126-127.

Lt. Moreland provided that Employee was also thorough with patient care. He noted that he went on EMS calls with Employee, and while on the scene, he never asked Employee to do anything, as he did everything he needed to do. He treated all the patients in the city with utmost respect and he did not receive any complaints about Employee for the three (3) years he supervised Employee. Tr. Vol. II. pgs. 125, 126-127. Lt. Moreland affirmed that he did Employee's 2018 and 2019, performance evaluation, but does not recall his rating. He stated that there was nothing in Employee's evaluation that pointed to incompetence or inefficiency. He did not know what happened to the performance evaluation as he sent them via email through the chain of command to Chief Dobie. Lt. Moreland stated that Ms. Sharita asked for the performance evaluation or the email, but he did not have them. She noted that she would ask Chief Dobie, and he wasn't able to locate them either. Tr. Vol. II. pgs. 125-126, 128-130. Lt.

Moreland acknowledged that he reviewed Employee's documentation of his EMS calls, and he never saw anything that was alarming or not done correctly. Tr. Vol. II. pg. 127.

Lt. Moreland stated that he has never had his blood pressure checked by Employee, but Employee checked Jay Hart's blood pressure. Thereafter, Medic 2 was called to the firehouse to check Jay Hart. When they arrived, they rechecked Jay Hart's blood pressure, and the reading was almost identical to the reading Employee got. Tr. Vol. II. pgs. 130-131. Lt. Moreland testified that Employee went above and beyond, connected with the people in the city and loved what he did. Tr. Vol. II. pg. 132.

Curtis Bryan – Tr. Vol. II. pgs. 133 – 145

Curtis Bryan ("Bryan") is a firefighter at Agency, currently assigned at Truck Company 12, Number 2 Platoon. He has worked for Agency for over twenty (20) years. He worked with Employee for several years while he was assigned to Truck 4 and Employee to Truck 6. Tr. Vol. II. pg. 134. Bryan asserted that he liked working with Employee and they had worked out a pretty good working system. They both got to work at 0500, although their shift did not start until 0700. Tr. Vol. II. pg. 135. Bryan stated that Employee went above and beyond; he was very professional; proficient; knowledgeable on the job; he was good at what he did as an EMS; and Bryan did not feel like he needed to keep an eye on Employee like he did with others he worked with. Bryan averred that Employee was very customer service oriented. He testified that Employee was thorough in interviewing and getting information from the patients such as what happened, how it happened, history, medications, and allergies. Tr. Vol. II. pgs. 136-139, 141.

Bryan asserted that Employee completed paperwork for runs on several occasions, and occasionally, he would be asked by Employee if he wanted to review the paperwork. He would provide Employee with any feedback he had. Bryan testified that the quality of Employee's documentation was good. He never received any complaints about the care they provided while working with Employee. People were happy to see them, and they had a good rapport with them. Tr. Vol. II. pgs. 139-141.

Bryan affirmed that Employee was a detailed-oriented person and he never questioned Employee's dependability in terms of his accuracy in documentation. He noted that he did not get to read all Employee's documentation, he only did so if he was asked. Tr. Vol. II. pgs. 142-143.

Bryan affirmed that Employee knew the difference between 'no patient contact' and a refusal. He expressed that the current matter might be a case of improper documentation, but that was not in Employee's character. Tr. Vol. II. pg. 144.

Panel Findings[6]

The Trial Board Panel made the following findings of fact based on their review of the evidence presented at the hearing:[7]

[6] *Id*. at Tab 26.

Charge 1

1) In direct violation of the Patient Bill of Rights, FF/EMT[Employee]:

    a. Did not give medical services that were timely and appropriate;
    b. Did not perform a timely medical assessment, and did not determine an appropriate level of medical care;
    c. Did not inform his patient of the potential consequences of her refusal; and
    d. Was neither compassionate nor considerate or empathetic.

2) In direct violation of Order Book Article XXIV FF/EMT [Employee]:

    a. Did not obtain a patient history or pertinent information from the patient (§10); and
    b. Did not contact the EMS Liaison Officer or a Battalion EMS Supervisor (§ 9).

3) In direct violation of the Department's EMS Protocols, FF/EMT[Employee]:

    a. Did not determine the patient's mental capacity to refuse care.
    b. Did not establish the patient's medical or situational capacity to refuse care.
    c. Did not obtain a refusal, nor did he treat and transport the patient; and
    d. Did not summon the Metropolitan Police Department to assist with a patient who might have been mentally incompetent.

Charge 2

4) In direct violation of the Department's EMS Protocols, FF/EMT [Employee]:

    a. Did not properly inform the patient in relation to the refusal of services;
    b. Did not review the form with the patient;
    c. Did not provide an explanation of risks or danger signs to the patient;
    d. Did not inform the patient to call 911 if symptoms persisted or worsened;
    e. Did not obtain the signature of a witness; and
    f. Did not contact the EMS Liaison Officer or a Battalion EMS Supervisor.

5) In direct violation of Special Order No. 54, series 2012, FF/EMT[Employee] did not properly document the patient's refusal of treatment.

6) In direct violation of Bulletin No. 3 (**Patient Bill of Rights**), FF/EMT[Employee] did not check the patient's vital signs or thoroughly and truthfully document:

    a. His patient's vital signs;
    b. His patient's medications;
    c. His patient's current complaint(s) of illness or injury;
    d. His assessment of his patient; and

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

e. His interventions and treatment of the patient.

Upon consideration and evaluation of all the testimony, 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[8] and concluded that termination for Charge No. 1, and Charge No. 2, was the appropriate penalty for these offenses.[9]

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

Pursuant to the D.C. Court of Appeals holding in *Elton Pinkard v. D.C. Metropolitan Police Department*,[11] 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.[12] 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

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[8] *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.

[9] Agency Answer, *supra*, at Tab 26.

[10] Although I may not discuss every aspect of the evidence in the analysis of this case, I have carefully considered the entire record. *See Antelope Coal Co./Rio Tino Energy America v. Goodin*, 743 F.3d 1331, 1350 (10th Cir. 2014) (citing *Clifton v. Chater*, 79 F.3d 1007, 1009-10 (10th Cir. 1996)) ("The record must demonstrate that the ALJ considered all of the evidence, but an ALJ is not required to discuss every piece of evidence").

[11] 801 A.2d 86 (D.C. 2002).

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

> 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 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 25 and August 4, 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.[13] 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.[14]

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 and Charge 2, Specification No. 1. Employee stated that he should have called a supervisor when the patient refused to sign. Tr. Vol. II. pg. 39, 84-87. He explained that he was aware that if a patient refuses to sign a refusal, a supervisor should be called. Tr. Vol. II. pgs. 103-104. Gigger asserted that if a patient is not able to provide a refusal, they call the EMS supervisor. Tr. Vol. I. pg. 51. Agency provided that Employee violated Order Book Article XXIV, § 9 when he failed to contact the EMS Liaison Officer or a Battalion EMS Supervisor.

Additionally, Agency alleged that Employee did not obtain a refusal, nor did he treat and transport the patient to the hospital. Agency also provided that Employee did not properly document the patient's refusal of treatment, in violation of Special Order No. 54, series 2012. Gigger asserted that the policy requires the ePCR to also have the refusal of service, signed by both the patient and crewmember, along with an explanation in the narrative. Tr. Vol. I. pgs. 50 - 51. DFC Anunay testified that Employee went back to service without obtaining a refusal. She explained that the patient telling the crewmembers to leave her alone was not admissible as a refusal. Tr. Vol. I. pgs. 127-128. Employee explained that he failed to notify 14 to make a refusal, after the patient refused treatment. Tr. Vol. II. pgs. 105-106. Employee explained that, to get a refusal of service, the level of consciousness must be ascertained; the consequences of the refusal read to the patient and the patient is informed that Agency will respond to any future calls, even if they refuse the current service. He also noted that both the patient and a witness must sign the refusal. If the patient refuses to sign, a supervisor should be called. Tr. Vol. II. pgs. 103-104. Employee acknowledged that he asked the patient to sign the refusal and she refused, but he did not get a signature from the patient or a witness. Tr. Vol. II. pg. 110. Employee noted that the disposition of the first call as stated in the PCR should have been a "refusal" and not "no patient contact" as it stated. He stated that he dropped the ball in his documentation. Tr. Vol. II. pgs. 44-45.

Employee averred that the patient was not transported to the hospital during the first visit. Tr. Vol. II. pgs. 76. Furthermore, Employee stated that he was responsible to get the patient's history at the scene, but in speaking to the patient, he was more concentrated on the patient's state of mind. Tr. Vol. II. pgs. 89-90. Employee later noted that he did ask the patient some questions, but it did not make it into the ePCR. Tr. Vol. II. pgs. 90-91.

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[13] *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).
[14] *Baumgartner v. Police and Firemen's Retirement and Relief Board,* 527 A.2d 313 (D.C. 1987).

Further, Agency stated that Employee did not perform a timely medical assessment and did not determine an appropriate level of medical care. Agency stated that Employee did not check the patient's vital signs or thoroughly and truthfully document the vital signs, in violation of Bulletin No. 3 of the Patient Bill of Rights. Employee testified that they did not collect the patient's blood sugar during the initial call. Tr. Vol. II. pg. 36. DFC Anunay stated that there were no vital signs for glucose reading. Tr. Vol. I. pg. 128. Employee stated that the addendum to his PCR contained vitals from the first visit that had some typos when he imputed them. Employee noted that he made typos in the two (2) ePCRs he completed for the June 23, 2020, runs to Capital Parks Towers apartments. Tr. Vol. II. pgs. 63-64. Employee highlighted that one of the typos he made was his entry of the pulse oximetry reading of 48 percent. 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 and Charge No. 2, Specification No. 1.

2) Whether there was harmful procedural error

Upon review of the record, the undersigned noticed that Agency used an older version of the DPM in this matter. Accordingly, the undersigned held a Status Conference with the parties wherein, the aforementioned issue was discussed, and the parties were required to supplement the record. Both parties complied. In its October 26, 2022, submission, Agency noted that it charged Employee relying on Order Book Article VII because that is the procedure for which Agency and Employee's Union bargained. Agency explained that the Order Book, which is expressly incorporated in the (CBA) by Article 31, defines the causes of action for which Agency may charge bargaining-unit employees. Accordingly, Employee was charged pursuant to Order Book Article VII, § 2. Agency maintained that because the 2012 DPM was in effect at the time the Order Book was published, the Order Book relied upon the 2012 DPM. Citing to *Fraternal Order of Police/MPD v. Metropolitan Police Department*,[15] 47 D.C. Reg. 1449, Slip Op. No. 607, PERB Case No. 99-U-44 (2000). Agency averred that it relied on the 2012 DPM because absent impacts and effects bargaining, doing otherwise would have violated labor law. Agency explained that, when the 2012 DPM was amended, Employee's Union demanded assurance from the Office of Labor Relations and Collective Bargaining ("OLRCB")[16], on behalf of Agency that the disciplinary causes and procedures for members of Local 36 would not change. Without completed impact and effects bargaining designed to identify, for instance, the amendments to Chapter 16 of the DPM that would be incorporated into Order Book Article VII, Agency was precluded from implementing the new DPM regulations as to employees represented by Local 36.[17]

Employee filed an objection to Agency's stipulation on October 28, 2022, noting that utilizing the current version of the DPM would not violate the principles of labor law as alleged by Agency. Employee noted that at the time he was charged with the current misconduct, the 2012 version of the DPM was not in effect, as it had been replaced by the 2017 version of the DPM. Therefore, he was improperly charged under the wrong version of the DPM. Employee

[15] "[A]n employer may not unilaterally implement regulatory changes to procedures governed by both regulation and bargaining without completing impact and effects bargaining as to the regulatory changes)."
[16] OLRCB has authority to represent Agency in bargaining proceedings. Mayor's Order 2001-168 (November 14, 2001).
[17] Agency's Stipulation (October 26, 2022).

argued that the Order Book makes it clear that discipline proposed by Agency is not limited to the 2012 version of the DPM. Employee explained that the language in the Order book is not limited to a particular version of the DPM, rather, it states that all discipline shall be governed by Chapter 16 of the DPM.

Employee additionally stated that contrary to Agency's assertion that the Union and Agency agreed in the December 23, 2015 memo to OLRCB to rely on the 2012 DPM, the text of this letter makes it clear that the Union expected the proposed changes to be implemented.[18] Employee argued that both the CBA Article 31 and the Order Book provide that all adverse actions should be taken pursuant to the applicable provision of Chapter 16 of the District Personnel Manual and the current DPM is the applicable provision, not the 2012 DPM version. Accordingly, Employee concluded that Agency had no basis to rely on the old DPM in this matter and as such, both charges levied against Employee should be dismissed.[19]

It is undisputed that Agency used the 2012 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 June 12, 2019. Consequently, all adverse actions commenced after this date were subject to the new regulation.

In the instant matter, Employee was terminated effective November 6, 2021, and the current version of the DPM was already in effect. Moreover, the incident occurred on June 23, 2020, after the current DPM version was already in effect. However, Agency argued that Employee was charged pursuant to Order Book Article VII, § 2. Agency maintained that because the 2012 DPM was in effect at the time the Order Book was published, the Order Book relied upon the 2012 DPM.

A review of Order Book Article VII, Section 1, provides that:

> *Disciplinary actions against firefighters at the rank of captain and below shall be governed by the collective bargaining agreement between the Department and D.C. Fire Fighters' Association Local 36 and Chapter 16 of the D.C. Personnel Manual (DPM).* In the event of a conflict between the collective bargaining agreement and Chapter 16, the collective bargaining agreement shall prevail. (Emphasis added).

Furthermore, Article 31, Section A of the CBA between Employee's Union and Agency provides:

> Disciplinary procedures are governed by *applicable provisions of Chapter 16 of the District Personnel Manual, and the Department's Rules and Regulations and Order Book*, except as amended/abridged by this Article. Disciplinary procedures

[18] Employee's Objection to Agency's Proposed Stipulation (October 28, 2022).
[19] *Id*.

> are also governed by applicable sections of the District of Columbia Official Code, of which such sections shall supersede the provisions of this Article. (Emphasis added).

Citing to *Fraternal Order of Police/MPD v. Metropolitan Police Department*,[20] 47 D.C. Reg. 1449, Slip Op. No. 607, PERB Case No. 99-U-44 (2000), Agency argued that it relied on the 2012 DPM because absent impacts and effects bargaining, doing otherwise would have violated labor law. In *Fraternal Order of Police/MPD v. Metropolitan Police Department*, the Fraternal Order of Police/Metropolitan Police Department Labor Committee ("FOP") filed an Unfair Labor Practice Complaint against the District of Columbia Metropolitan Police Department ("MPD") asserting that MPD refused to bargain in good faith, upon request, over the impact of a proposed change to police officers' "watch" and "days off" schedules. FOP conceded that MPD's management rights permitted it to adopt the policy. However, FOP requested amongst others, that the PERB Board grant preliminary relief which would prohibit MPD from implementing the proposed schedule changes until it engaged in impact bargaining with FOP over the proposed changes. Citing to *American Federation of Government Employees, Local 383 v. D.C. Dept of Human Services*, Slip Op. No. 418, PERB Case No. 94-U-09 (1992), the PERB Board noted that "[w]e have held that an employer does not violate its duty to bargain when it merely unilaterally implements a management right decision. The violation of the duty to bargain arises from the employer's failure to provide an opportunity to bargain over the impact and effects *once a request to bargain is made, not from the unilateral exercise of its sole management right.*" (Emphasis added). The PERB Board also noted that "*a request to bargain need not be made and a violation of the duty to bargain will lie when an employer unilaterally implements a change in mandatorily negotiable terms and conditions of employment subject to mandatory duty to bargain (not contained in an effective collective bargaining agreement) without first providing notice and an opportunity to bargain*." (Emphasis added)

Agency provided that when the 2012 DPM was amended, Employee's Union, in a December 23, 2015 memo demanded assurance from the OLRCB that the disciplinary causes and procedures of its members would not change. Agency added that without completing impact and effects bargaining designed to identify the amendments to Chapter 16 of the DPM that would be incorporated into Order Book Article VII, it was precluded from implementing the new DPM regulations to employees represented by Local 36. Employee on the other hand stated that contrary to Agency's assertion that the Union and Agency agreed in the December 23, 2015, memo to OLRCB to rely on the 2012 DPM, the text of this letter makes it clear that the Union expected the proposed changes to be implemented.

On December 23, 2015, Employee's Union addressed a memo with the subject "NPRM: Chapter 16 – District Personnel Manual Impact on IAFF, Local 36 to the OLRCB, wherein, it provided a recap of a December 7, 2015, discussion regarding the Union's concerns to the proposed changes to Chapter 16 of the DPM. Employee's Union noted that:

> "[T]o the extent that the proposed revisions purported to relegate to second-class status or supplant entirely any collectively bargained arrangements regarding

[20] "[A]n employer may not unilaterally implement regulatory changes to procedures governed by both regulation and bargaining without completing impact and effects bargaining as to the regulatory changes)."

> discipline, …eliminating provisions and purporting to employ a three prong approach to reconciling DPM provisions with CBA provisions, and requiring that there be conflict between a "specific provision" of the labor agreement and the DPM for the labor agreement to prevail, … those revisions are without legal effect. Similarly, to the extent that the revisions purports to relieve the District of its burden of proof in disciplinary proceedings …, or permit the District to initiate disciplinary action for conduct that has no nexus whatsoever to employment …, the revisions runs afoul of basic tenet of due process. The District may not use the regulatory process to dilute collectively-bargained procedures and rights…or to opt out of then entirely.
>
> Notwithstanding our concerns, *I understood you to confirm during our conversation that no changes to the disciplinary or grievance process applicable to the Local 36 bargaining unit was intended by these proposed revisions*. It is therefore unclear to us what impact, if any, the revisions – assuming they are adopted – would have on the Union's members. We reserve our rights under Article 9 should the District identify any such impact on the unit in the future…"[21] (Emphasis added).

In this instance, I find that the matter at hand is distinguishable from *Fraternal Order of Police/MPD v. Metropolitan Police Department,* in that, *Fraternal Order of Police/MPD* made a request to bargain over the impact of MPD's proposed schedule change, whereas Employee's Union, Local 36 did not make a request to bargain over the proposed Chapter 16 DPM changes. On the contrary, the current Employee's Union had a discussion about the proposed changes with Agency on December 7, 2015, wherein, the Union was assured by Agency's representative (OLRCB) that no changes were made to *the disciplinary or grievance process applicable to the Local 36 bargaining unit in the proposed revisions*. The content of the discussion was included in the December 23, 2015, wherein, Employee's Union concluded that "[i]t is therefore unclear to us what impact, if any, the revisions – assuming they are adopted – would have on the Union's members. We reserve our rights under Article 9 should the District identify any such impact on the unit in the future…" (Emphasis added). The record as-is, is void of any such request under Article 9.

Although the PERB Board in *Fraternal Order of Police/MPD,* also provided that "*a request to bargain need not be made and a violation of the duty to bargain will lie when an employer unilaterally implements a change in mandatorily negotiable terms and conditions of employment subject to mandatory duty to bargain (not contained in an effective collective bargaining agreement) without first providing notice and an opportunity to bargain*", this is not applicable to the current matter. Here, Agency provided Employee's Union with notice of the proposed changes to Chapter 16 of the DPM in 2015, approximately one and a half (1.5) years before the proposed changes to Chapter 16 of the DPM were implemented in August of 2017 and an opportunity to bargain. Moreover, Chapter 16 of the DPM was again updated in 2019, and there is no evidence in the record of any request from the Union to engage in impacts and effects bargaining.

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[21] Agency's Stipulation, *supra*.

Accordingly, I conclude that the parties were not engaged in impacts and effects bargaining when the current cause of action was levied against Employee. Moreover, Employee's Union did not make a request to bargain over the proposed changes to Chapter 16 of the DPM. Further, Agency assured Employee's Union that the proposed changes to Chapter 16 of the DPM would not impact members of Employee's Union, but it did not provide that it would continue using the old DPM. Thus, it can be reasonably assumed that the changes did not touch on the mandatorily negotiated terms and conditions of employment subject to the mandatory duty to bargain. The Union also informed Agency that it reserved its rights to request to bargain in the future if the proposed changes when adopted impacted its members. The proposed changes to Chapter 16 of the DPM were adopted in August of 2017. Chapter 16 of the DPM was again revised in 2019, however, this revision did not affect the adverse action/disciplinary section. The record is void of any indication that Employee's Union invoked its rights to bargain or made a request to bargain the changes in Chapter 16 of the 2017 or 2019 DPM. Therefore, I further conclude that the applicable DPM at the time of the current disciplinary action was the 2019 DPM.

In this matter, Employee was charged with Neglect of Duty and unreasonable failure to give assistance to public pursuant to the Order Book and the 2012 version of the DPM for Charge 1, Specification 1, and Charge 2, Specification 1. Since the undersigned has concluded that the applicable DPM at the time of the current action was the 2019 DPM version, I additionally find that Agency used the incorrect DPM version.

Neglect of Duty:

Here, Employee was charged with Neglect of duty pursuant to the Order Book Article VII, Section 2(f)(3)[22] and 16 DPM §1603.3(f)(3)[23] in compliance with Order Book Article VII, Section 1 and Article 31, Section A of the CBA, which required that all disciplinary actions against firefighters at the rank of captain and below be governed by the CBA and Chapter 16 of the DPM. However, in the current matter, because the cause of action occurred in 2020, and Employee was disciplined in 2021, the applicable DPM is the 2019 DPM. Moreover, 16 DPM §1603.3(f)(3) does not exist in the current DPM, as the 2017 version of the DPM, moved all the adverse action charges to DPM § 1605. Thus, in the current DPM, there is no 16 DPM §1603.3(f)(3) and 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).

Unreasonable failure to give assistance to the public:

Agency also charged Employee with "unreasonable failure to give assistance to the public pursuant to the Order Book Article VII, Section 2(f)(9) and 16 DPM §1603.3(f)(9) in compliance with Order Book Article VII, Section 1 and Article 31, Section A of the CBA, which required that all disciplinary actions against firefighters at the rank of captain and below be governed by the CBA and Chapter 16 of the DPM. This cause of action does not have a

[22] Order Book Article VII, Section 2(f)(3), defines cause as "[a]ny on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operations, to include: (3) Neglect of duty."
[23] Under the 2012 DPM version, this section correlated with "[a]ny on-duty or employment related act or omission that interferes with the efficiency and integrity of government operations, specifically neglect of duty".

corresponding provision in the 2017 version of Chapter 16 of the DPM 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.[24] 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."[25] 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.[26]

Upon review of the record, the undersigned concluded that there were substantive changes in the 2012 DPM related to the charges and penalties as compared to the current 2019 DPM version. The undersigned can only adjudicate the current appeal based on the grounds invoked by Agency in the Final Agency Decision. Agency disciplined Employee under an incorrect DPM version. Thus, I am unable to determine which cause of action could have been levied against Employee had Agency utilized the appropriate version. The only similar charge found in the 2012 DPM version and the 2019 DPM version of the DPM is the charge of Neglect of Duty, however, Agency failed to identify the charge under the applicable DPM.

Moreover, the D.C. Superior Court in *D.C. Office of the Attorney General v. Office of Employee Appeals,* 2019 CA 5286 P(MPA) (July 2, 2020), found that the Advance Notice and Final Decision issued by OAG failed to adequately identify the charges underlying [employee's] proposed removal. It concluded that "… OAG's failure to provide [employee] with adequate notice of the charges underlying her proposed termination prevented her from knowing "the allegations . . . she w[ould] be required to refute or the acts . . . she w[ould] have to justify, thereby [depriving her of] a fair opportunity to oppose the proposed removal.""[27] The D.C. Superior Court agreed with the OEA Board and AJ Harris's decision in *Rachel George v. D.C. Office of the Attorney General, supra,* that OAG's failure "to identify the charges underlying [employee's] proposed termination in the Final Agency Notice deprived [employee] of the notice to which she is entitled, as well as an opportunity to adequately defend herself." Citing to case law, the D.C. Superior Court further opined that "[A]n employer is required to provide an employee, against whom an adverse action is recommended, with advance written notice stating any and all causes for which the employee is charged and the reasons, specifically and in detail, for the proposed action."[28]

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[24] *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).

[25] *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).

[26] *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).

[27] Citing to *Office of the D.C. Controller v. Frost*, 638 A.2d 657, 662 (D.C. 1994), at 662.

[28] *Id.* (internal quotations and citations omitted); see also 6B DCMR § 1618(c)-(d) (requiring an employer to provide the employee with written notice of "[t]he specific performance or conduct at issue;" and "[h]ow the employee's performance or conduct fails to meet appropriate standards."). "The purpose of requiring a specification of the

Similarly, here, I find that Agency's failure to provide Employee with the specific charges underlying the proposed termination under the appropriate DPM provision deprived Employee of a fair opportunity to oppose the proposed removal. Because the wrong version of the regulation was used, Employee could not adequately defend himself against the charges levied against him. Additionally, Agency did not provide a breakdown of the penalty with respect to each cause of action or specification under Charge 1 and Charge 2. It would be improper for the undersigned to essentially 'guess' or 'speculate' what the appropriate charge and/or penalty would have been had Agency used the appropriate DPM version.[29] Unlike the 2012 version, the 2019 version does not include a charge for unreasonable failure to give assistance to the public". Agency disciplined Employee for "unreasonable failure to give assistance to the public" under the same charge as that of "neglect of duty". Accordingly, I find that Agency's failure to follow the appropriate laws, rules and regulation amount to harmful procedural error. Based on the aforementioned, these charges will be dismissed.

180 days Trial Board Hearing deadline

Employee argued that Agency violated Article 31 section B (5) of the CBA which required Agency to begin a Trial Board Hearing within 180 days of the Employee's receipt of the Initial Written Notification. Employee explained that even considering the period of tolling under the COVID-19 Memorandum of Agreement ("MOA") between Agency and the Union, the Trial Board Hearing was untimely. Therefore, the charge against him should be dismissed. According to Employee, the Union and Agency executed a COVID-19 MOA on April 15, 2020, whereby, the parties decided to toll the 180-day period for all new and pending disciplinary matters because of the pandemic. Thereafter, on November 20, 2020, the parties executed an Addendum to the MOA, which ceased the tolling of the 180-day deadline and provided for trial board hearings to take place virtually. Employee asserted that he received his initial written notification on August 13, 2020, during the MOA tolling period. Consequently, the 180-day period to commence the trial board began on November 20, 2020, when the MOA was lifted and 180 days later was May 19, 2021. However, Agency did not attempt to schedule the trial board proceeding in this matter within the requisite 180-day period. Employee asserted that Agency requested to set the trial board proceeding for May 27, 2021, a date outside of the 180-day period. Ultimately, the trial board proceeding was held on June 25, 2021, well outside of the 180-day period. Employee concluded that Agency was mandated to comply with the 180-day period negotiated and agreed to by the parties. Employee maintained that it can be reasonably deduced that the mandatory language in Article 31, Section B (5) of the CBA, read in conjunction with Article 31, Section F of the CBA prevented Agency from submitting a disciplinary matter that

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details is to apprise the employee of the allegations he or she will be required to refute or the acts he or she will have to justify, thereby affording the employee a fair opportunity to oppose the proposed removal." Frost, 638 A.2d at 662.

[29] Assuming *arguendo* that this cause of action was based solely on the Order Book Article VII, Agency will not meet its burden of proof here because the Order Book does not provide a table of penalty or list of potential penalties associated to the different causes of actions outline in section 2, on which the undersigned can rely on in determining the appropriateness of the penalty. Hence, the reason both the Order Book Article VII and the CBA provide that disciplinary action shall be based on **both** the Order Book and Chapter 16 of the DPM, as the DPM provides a Table of Illustrative Actions for the various causes of actions (emphasis added).

proposes terminated to the Trial Board if Agency failed to comply with the established procedures applicable to the Trial Board.[30]

Agency on the other hand argued that there was no harmful procedural error during Employee's disciplinary proceedings since Employee's Trial Board Hearing was scheduled within 180 days of service of the Initial Written Notification. Agency noted that it contacted Employee on April 20, 2021, to schedule the Trial Board Hearing, and several postponement requests followed. Agency argued that pursuant to the April 15, 2020, MOA, it could not unilaterally schedule a Trial Board Hearing, instead, it worked collaboratively with the charged Employee's counsel to schedule the Trial Board Hearing. Agency maintained that it could have scheduled Employee's Trial Board Hearing for the 180th day, however, doing so would have simply been a symbolic gesture that would not serve the parties' interest as the parties would have undoubtedly requested a continuance.[31]

Agency however asserted that, assuming that it did not comply with the 180 days scheduling requirement, that contractual agreement is directory, and Agency's interests in imposing discipline outweighs any prejudice to Employee. Agency cited to *Kyle Quamina v. Department of Youth Rehabilitation Services,*[32] in support of its assertion. Agency explained that the logic in *Quamina* applies to the current case as the CBA in this case did not set forth a penalty for failure to schedule a Trial Board Hearing within 180 days. Agency averred that the directory nature of CBA Article 31 section B (5) renders the purported failure to bring the case within 180 days harmless error. Accordingly, its discipline should stand.[33]

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."[34] In this case, Employee was a member of a Union when he 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 MPD, as it relates to the adverse action in question in this matter.

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

[30] Employee's Brief (August 1, 2022).
[31] Agency's Brief (May 25, 2022).
[32] OEA Matter No. 1601-0055-17, Opinion and Order on Petition for Review (April 19, 2019).
[33] Agency Brief, supra. See also Agency's Sur-Reply (September 9, 2022).
[34] 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).

> 180-day time limit shall automatically be extended by the length of the postponement or continuance granted by the Department.[35] (Emphasis added)

Here, there is no dispute that the current cause of action commenced after the clock was tolled on April 15, 2020, when the MOA between Agency and Union went into effect. The parties also agreed that the clock restarted on November 20, 2020, pursuant to the terms of the amended MOA. From November 20, 2020, when the clock started, to June 25, 2021, when the Trial Board Hearing began is a total of 217 days.[36] This is outside of the 180-day deadline to commence a Trial Board Hearing. Therefore, I agree with Employee's assertion that Agency violated the terms of Article 31, section B (5) of the CBA as stated above.

While Article 31 section B (5) of the CBA was a bargained-for provision that Agency and the Union negotiated, 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.[37] The OEA Board in *Quamina*, *supra*, cited to *Teamsters Local Union 1714 v. Pub. Employee Relations Bd*., 579 A.2d 706, 710 (D.C. 1990), 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*, OEA Matter No. 1601-0093-10, Opinion and Order on Petition for Review (January 25, 2010), 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.[38] 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."[39]

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[35] Agency's Answer, *supra*, at Tab 21, Exhibit B.

[36] Agency's first proposed Trial Board Hearing date in this matter was May 27, 2021. November 20, 2020, to May 27, 2021, is 188 days. This date is also outside of the 180-day deadline to commence a Trial Board Hearing. See Agency's Answer, *supra*, at Tab 25, Exhibit 6.

[37] *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 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).

[38] 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.

[39] *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*.

Here, although Article 31 section B (5) provides a clear time limit for when to begin a Trial Board Hearing, it, however, does not provide a consequence for failing to strictly adhere to this provision. Employee attempts to argue that Article 31 section F of the CBA provides a consequence for failing to strictly adhere to Article 31 section B (5) when read together. Article 31 section F of the CBA provides in pertinent part as follows:

> All cases in which an employee is charged with an infraction for which the penalty that may be imposed is termination, demotion or a 120-hour suspension or greater shall be submitted to a Trial Board. The previously established procedures applicable to Trial Boards shall continue to be followed…[40]

I disagree with Employee's assertion. Article 31 Section F simply directs Agency to refer all adverse actions of termination, demotion and suspensions greater than 120 hours to the Trial Board and to follow the applicable Trial Board procedures. Consequently, I find that based on the aforementioned, Agency correctly asserted that the CBA language of Article 31 section B (5) should be considered directory, rather than mandatory in nature.

When weighed against the prejudice to Employee, it is clear that the public interest in adjudicating this matter on its merits outweighs Agency's procedural delays.[41] Although Employee was aware of Agency's refusal policy, Employee did not call a supervisor when the patient refused to sign. Gigger also noted that if a patient is not able to provide a refusal, they call the EMS supervisor. Tr. Vol. I. pg. 51. Agency provided that Employee violated Order Book Article XXIV, § 9 when he failed to contact the EMS Liaison Officer or a Battalion EMS Supervisor. Also, Employee did not obtain a refusal, nor did he treat and transport the patient; he did not properly document the patient's refusal of treatment, in violation of Special Order No. 54, series 2012; Employee went back to service without obtaining a refusal; Employee explained that he failed to notify 14 to make a refusal, after the patient refused treatment; the patient was not transported to the hospital during the first visit; he did not collect the patient's history at the scene; and Employee testified that they did not collect the patient's blood sugar during the initial call; the addendum to his PCR from the first visit had some typos when he imputed them. Employee admitted that the disposition of the first call as stated in the PCR should have been a "refusal" and not "no patient contact" as it stated. He stated that he dropped the ball in his documentation. Tr. Vol. II. pgs. 44-45. Employee noted that he had no explanation as to why he wrote "no patient contact" on the ePCR. Accordingly, the undersigned agrees with Agency's assertion that Agency's failure to comply with the above referenced CBA section is considered harmless error.

OEA Rule 631.3 provides that, "[n]otwithstanding any other provision 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: 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 the action."

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[40] *See* Agency's Stipulation, *supra*, at Attachment 2.
[41] *Watkins at 5.*

Moreover, the OEA Board in *Quamina*, addressed this issue of harmless error. It noted that "… an agency's violation of a statutory procedural requirement does not necessarily invalidate the agency's adverse action. Thus, the facts in this matter warrant the invocation of a harmless error review. In determining whether Agency has committed a procedural offense as to warrant the reversal of its adverse action, this Board will apply a two-prong analysis: whether Agency's error caused substantial harm or prejudice to Employee's rights *and* whether such error significantly affected Agency's final decision to suspend Employee."[42] In applying this two-prong analysis to the current matter, the undersigned finds that Agency's failure to schedule the Trial Board Hearing within the 180 days required time period did not cause substantial harm or prejudice to Employee. The Union and Agency signed an MOA addressing the interaction between the Union and Agency during the pandemic. Prior to the expiration of 180-day deadline, Agency contacted Employee and his representative on April 20, 2021, to schedule the Trial Board Hearing, which was eventually held on June 25, 2021, and August 4, 2021. Both parties were present for the virtual hearing, along with their witnesses. Agency's failure to comply with the 180 days requirement did not significantly affect Agency's decision to terminate Employee. Accordingly, I conclude that Agency's failure to comply with the 180 days requirement as provided in the CBA is harmless error.

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

Employee was charged with Neglect of Duty for both Charge No. 1, Specification No.1, and Charge No. 2, Specification No. 1. Neglect of Duty is defined as "[f]ailing 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."[43]

Employee provided inaccurate information on the PCR report he completed on June 23, 2021. He did not accurately document the patient's vital signs in violation of the Patient Bill of Rights. Further, Employee did not properly document the patient's refusal of treatment, in violation of Special Order No. 54, series 2012. Employee noted that the disposition of the first call as stated in the PCR should have been a "refusal" and not "no patient contact" as it stated. He stated that he dropped the ball in his documentation. Tr. Vol. II. pgs. 44-45. Employee had no explanation as to why he wrote "no patient contact" on the ePCR. Employee did not get a signed refusal from the patient; and he did not get a witness signature or call the EMS Liaison Officer or Battalion EMS Supervisor to inform them of the patient's refusal, in violation of Order Book Article XXIV, § 9. Apart from Employee's testimony, there is nothing in the record to suggest that Employee informed the patient of the potential consequences of her refusal in violation of the Patient Bill of Rights. There is also no information in the record to support Employee's assertion that he obtained a patient history from the patient, in violation of Article XXIV, § 10. Based on the record, I find that Agency had cause to levy the current charge of Neglect of Duty against for both Charge 1, Specification 1; and Charge 2, Specification 1. However, because Agency combined the cause of action of neglect of duty with another cause of action that does not exist in the applicable DPM, I find that this is harmful procedural error.

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[42] *Quamina*, *supra*.
[43] District Personnel Manual ("EDPM") section 1607.2(e).

Employee was also charged with unreasonable failure to give assistance to the public under Charge No. 1, Specification No. 1, and Charge No. 2, Specification No. 1. This cause of action does not exist in the current DPM. The undersigned previously found that pursuant to the CBA and the Order Book, the applicable DPM was the 2019 version of Chapter 16 of the DPM. Since the cause of action for unreasonable failure to give assistance to the public is not listed as a charge under the current version of Chapter 16 of the DPM, the undersigned cannot adjudicate this issue. OEA may not substitute the current cause of action as presented by Agency to what it considers to be a more appropriate charge. Therefore, Agency cannot rely on this cause of action to discipline Employee.

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).[44] 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.[45]

In this case, 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 under both Charge No. 1, Specification No. 1, and 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.[46]

In this matter, although Agency had cause for the charge of Neglect of Duty under both Charge No. 1, Specification No. 1, and Charge No. 2, Specification No. 1, I however find that Agency engaged in harmful procedural error against Employee. Agency brought two charges against Employee, both of which do not exist in the applicable version of the DPM. This created substantial harm and severely prejudiced Employee's rights. As previously noted, the 2017, and

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[44] *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).

[45] *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).

[46] *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).

subsequent versions of the DPM eliminated DPM section 1603 and moved all adverse actions to DPM section 1605. Moreover, Agency failed to provide a breakdown of the penalty with respect to each of the two (2) causes of action under Charges 1 and 2. It would be improper for the undersigned to essentially 'guess' what the appropriate charge and/or penalty would have been had Agency used the appropriate DPM version. Consequently, I conclude that the penalty of termination levied against Employee for Charge No. 1, Specification No.1 and Charge No. 2, Specification No. 1 was inappropriate under the circumstances.

ORDER

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

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

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

3. 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