

Notice: This decision may be formally revised before it is published in the *District of Columbia Register* and the Office of Employee Appeals' website. Parties should promptly notify the Office Manager of any formal errors so that this Office can correct them before publishing the decision. This notice is not intended to provide an opportunity for a substantive challenge to the decision.

**THE DISTRICT OF COLUMBIA
BEFORE
THE OFFICE OF EMPLOYEE APPEALS**

In the Matter of:)	
)	OEA Matter No. J-0049-16
GUY VALENTINE,)	
Employee)	
)	Date of Issuance: January 2, 2018
v.)	
)	Michelle R. Harris, Esq.
D.C. FIRE AND EMERGENCY FIRE AND)	Administrative Judge
MEDICAL SERVICES DEPARTMENT,)	
Agency)	
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Brian R. Bregman, Esq., Employee Representative		
Rahsaan Dickerson, Esq., Agency Representative		

INITIAL DECISION

INTRODUCTION AND PROCEDURAL BACKGROUND

On May 23, 2016, Guy Valentine (“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 assess a five thousand dollar (\$5,000.00) penalty in lieu of demotion pursuant to D.C. Official Code § 5-1051, *et.seq.*, *Firefighter Retirement While Under Disciplinary Investigation*.¹ On July 22, 2016, Agency filed its Answer to Employee’s appeal. On August 5, 2016, I issued an Order scheduling a Status/Prehearing Conference for September 14, 2016. On September 9, 2016, Employee filed a Consent Motion to Reschedule the Status/Prehearing Conference. On September 13, 2016, I issued an Order granting Employee’s Motion and rescheduled the Status Conference for November 4, 2016. During the Status/Prehearing Conference held on November 4, 2016, an issue regarding OEA’s jurisdiction in this matter was discussed.

As a result, on November 7, 2016, I issued an Order requiring the parties to submit briefs addressing whether OEA has jurisdiction over this appeal. Employee’s brief was due on or before December 12, 2016. Agency’s response was due on or before January 12, 2017. On January 11, 2017, Agency filed a Consent Motion for an Enlargement of Time to file its brief. On January 13, 2017, I issued an Order granting Agency’s Motion. Both parties filed their respective briefs by the prescribed deadlines. On March 21, 2017, I issued an Order Regarding Jurisdiction wherein I held that OEA has jurisdiction over the instant appeal. Accordingly, because there was a Fire Trial Board hearing in this matter, I also found that OEA’s review of this appeal is subject to the standard of review outlined *Elton Pinkard v. D.C. Metropolitan Police Department*, 801 A.2d 86 (D.C. 2002). As a result, the parties were ordered to submit briefs addressing whether: (1) the Fire Trial Board’s

¹ See D.C. Official Code §§ 5-1051 through 5-1056 (2017).

decision was supported by substantial evidence; (2) whether there was a harmful procedural error and (3) whether Agency's action was done in accordance with all laws and/or regulations.

Agency's brief was due on or before April 21, 2017, and Employee's brief was due on or before May 22, 2017. On April 20, 2017, Agency filed a Consent Motion for an enlargement of the briefing schedule. On April 21, 2017, I issued an Order granting Agency's Motion. As a result, the Agency's Brief was now due on May 31, 2017, and Employee's brief was due on or before June 30, 2017. Agency had the option to submit a sur-reply brief on or before July 17, 2017. Agency submitted its brief by May 31, 2017. On June 30, 2017, Employee filed a Consent Motion for an Enlargement of the briefing schedule. On July 5, 2017, I issued an Order granting Employee's Motion. Employee's brief was now due on or before July 19, 2017, and Agency had the option to submit a sur-reply brief on or before August 4, 2017. Employee submitted his brief by July 19, 2017. Agency did not submit a sur-reply brief. The record is now closed.

JURISDICTION

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

ISSUES

1. Whether the Fire 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 all 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 CHARGES

In a Final Agency Decision dated April 25, 2016, Agency assessed a \$5,000 penalty² to Employee based on the following:

Charge No 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... You may expect (1) To receive timely and appropriate medical services without regard to age, race religion, gender, sexual orientation or nation origin. [and]... (10) That all of our personnel will be polite, compassionate, considerate, *empathetic*, respectful and well mannered.” Further violation of D.C. Fire and Emergency Medical Services Department Rules and Regulations Article VI §2, which states: “Members shall devote proper attention to service, exert their greatest energy and full ability in the performance of their duties, not perform their duties in a spiritless, lax, surly or careless manner, not neglect or fail to perform any portion of their duties as required by rule, regulation, order, common practice, or the necessities of the situation involved; avoid connection with any clique tending to interfere with good order; be efficient, exercise proper judgement in the performance of their duties.” This misconduct is defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII §2(f) (3), which states: “Any on-duty or employment-related act or omission that interferes with the efficiency or integrity of government operations, to include: Neglect of Duty.” *See also* 16 DPM §1603.3(f) (3). 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 relations, to include: Unreasonable failure to give assistance to the public.” *See also* 16 DPM §1603.3(f) (9)

Specification No 1: In his Final Investigative Report (dated 5/28/2015), MPD Captain Hilton Burton describes Lieutenant Guy Valentine’s misconduct as follows: At approximately 0836:20 hours the Office of Unified Communications (OUC) received a call for an unconscious one year old male not breathing at 4246 Warrant Street, N.W. The Event Chronology F150039200 was created for this call for service. At approximately 0838:21 hours OUC received a second call for an unconscious one year old male choking at 4246 Warren Street, N.W. The Event Chronology for F150039202 was created for this call for service. A third Event Chronology F150039203 for 4246 Warren Street, N.W. shows that at 0844:58 hours an [sic] event was created for an unconscious one year old male not breathing at 4246 Warren Street, N.W. At 0845:23 there was a request for EMS by a member of the Metropolitan Police Department and this event was closed. It was determined from their Unit Histories that both Paramedic Engine 20 and Ambulance 20

² The findings of the Trial Board warranted demotion to sergeant, however, given Employee’s conditional retirement status, a \$5,000 penalty was assessed pursuant to D.C. Official Code § 5-1054.

were in quarters at the firehouse during this incident and were not dispatched and did not respond to 4246 Warren Street, N.W. It should be noted that the firehouse for Engine 20/Truck 12 is located at 4300 Wisconsin Avenue, N.W. at the corner of Warren and Wisconsin Avenue N.W. approximately 0.3 miles away from 4246 Warren Street, N.W. On Monday, April 6, 2015, Lieutenant [Edward] Winslow responded to the Office of Internal Affairs to be interviewed regarding this matter. When asked what should happen if a run comes out in a unit's first due area three blocks from their station, Lieutenant Winslow related that he thinks it's up to the officer to come up and say something if he knows he is available. When asked what did he mean when he told Lieutenant Valentine that it was his call, Lieutenant Winslow stated that if he knew he was in a service and it was his first due area, he should have come up on the air and advise that he is available to respond. On Thursday, April 12, 2015, Sergeant Paramedic [Matthew] Woolston responded to the Office of Internal Affairs to be interviewed regarding this matter. When asked if he heard any concerns about Paramedic Engine 20 not responding to this assignment, Sergeant Paramedic Woolston related that he did and that he heard Lieutenant Valentine say "if OUC wants us to go on a call they would dispatch us." On Thursday, April 12, 2015, Lieutenant Guy Valentine responded to the Office of Internal Affairs to be interviewed about this matter. When asked if he asked [sic] the officer in charge of the Engine Company could he notify the dispatcher that he was in the vicinity of a call and that he could get there before other units and be placed on the call. Lieutenant Valentine stated it could not be done in the firehouse.

Charge No. 2: Violation of D.C. Fire and Emergency Medical Services Department Rules and Regulations, Article VI §3, which states that: "Commanding officers are charged with responsibility for requiring the general observance of all provisions of Section 2 hereof, and failure of members to maintain the standards required of personnel shall be reported by special report to the Fire Chief." Further violation of D.C. Fire and Emergency Medical Services Department Rules and Regulations, Article II §K which states that: "Lieutenants shall: (b) be responsible for all the efficient operation in quarters and on the fireground of their respective commands, discipline and for the maintenance and protection of all departmental property in, or assigned to, the unit with which they serve during their periods of duty." Further violation of D.C. Fire and Emergency Medical Services Department Order Book Article 3 §3 which states: "Members charged with command responsibilities (divisional and unit) shall take appropriate action to insure efficient, safe, orderly, uniform, and economical operation, and shall maintain all property and records in their charge or under their control in an efficient manner." This misconduct is further defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII §2 (f) (3), which states: "Any on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operations, to include: Neglect of Duty." See also 16 DPM §1603.3 (f) (3). 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 operations, to include: Unreasonable failure to give assistance to the public.” See also 16 DPM §1603.3. (f)(9).

Specification No. 1: In his Final Investigative Report (dated 05/28/2015), MPD Captain Hilton Burton describes Lieutenant Valentine’s misconduct as follows: On the Audio recording from the Emergency Liaison Officer’s phone line at 0914:16 hours Lieutenant Guy Valentine called the ELO and spoke with Lieutenant [Edward] Winslow. Lieutenant Winslow advised Lieutenant Valentine that it was his call if he thought he was closer. Lieutenant Valentine replied, “I don’t know man, I heard the call come out man, I mean, I’m not, I’m like a fish out of water...” On Thursday, [sic] April 2, 2015, Lieutenant Guy Valentine responded to the Office of Internal Affairs to be interviewed about this matter. When asked if he was familiar with the location of the 4200 block of Warren Street, N.W., Lieutenant Valentine stated that he was not. When asked if he was familiar with Warren Street, Lieutenant Valentine advised that he was not. When asked if he knew that Warren Street ran right beside Engine 20, Lieutenant Valentine advised that he was not and that he did not pay attention to it. When asked if he knew that the 4200 block of Warren Street was three blocks away from his station, Lieutenant Valentine responded that he was not. Lieutenant Valentine was then played the part of the Audio recording from the Emergency Liaison Officer’s phone line where he says that he heard the call come out but that he is like a fish out of water. When asked what he meant by that, Lieutenant Valentine stated that he meant that he did not know the address. Lieutenant Valentine then related that if he had known it was three blocks away maybe he would have called in and gone on it.

Charge No. 3: Violation of D.C. Fire and Emergency Medical Services Department Rules and Regulations Article VI §5 which states: “Members shall conduct themselves in a respectful manner, be just, impartial, firm and dignified in their relations with others: be respectful and obedient to their superior officers; accord proper respect to members and others; refrain from harsh, violent, abusive, coarse, or insolent language; not unnecessarily disturb other members; refrain from unnecessary altercations; refrain from giving unauthorized orders or directions to other members.” This misconduct is defined as case in D.C. Fire and Emergency Medical Services Department Order Bok Article VII §2(g) which states: “Any other on-duty or employment-related reason for corrective or adverse action that is not arbitrary or capricious.” See also 16 DPM §1603.3(g)

Specification No. 1: In his Final Investigative Report (dated 5/28/2015), MPD Captain Hilton Burton describes Lieutenant Valentine’s misconduct as follows: On the Audio recording from the Emergency Liaison Officer’s phone line at 0903:18 hours, Lieutenant Guy Valentine called and spoke with Lieutenant Winslow about the red X in the CAD system that showed the GPS for Paramedic Engine 20 as [unavailable]. Lieutenant Winslow was explaining that the GPS system works on the fact that units are moving. Lieutenant

Valentine responds by saying “oh shit” and starts laughing. It [sic] is further concluded that Lieutenant Valentine was not knowledgeable that all calls to dispatch are recorded and require appropriate language as they become public record. Your use of coarse/harsh/undignified language and failure to follow instructions constitutes both neglect of duty and any other employment-related reason for corrective or adverse action that is not arbitrary or capricious. Accordingly this action is proposed.

Specification No 2: In his Final Investigative Report (dated 5/28/2015), MPD Captain Hilton Burton describes Lieutenant Valentine’s misconduct as follows: On the Audio recording from the Emergency Liaison Officer’s phone line at 0903:18 hours, Lieutenant Guy Valentine called and spoke with Lieutenant Winslow about the red X in the CAD system that showed the GPS for Paramedic Engine 20 as [unavailable].... Lt. Valentine advised that he had already rebooted the system. Lt. Winslow told Lt. Valentine that they would monitor it and if the problem continued that Lt. Valentine would have to contact IT about the problem. Lt. Valentine then stated, “The situation was the 4200 whatever blocks of Warren, the wagon driver, like I was telling Sgt., the wagon driver from 31 called here yelling and screaming like how come y’all didn’t take that run. I said well shit they didn’t put us on it.” If [sic] is further concluded that Lieutenant Valentine was not knowledgeable that all calls to dispatch are recorded and require appropriate language as they become public record. Your use of coarse/harsh/undignified language and failure to follow instructions constitutes both neglect of duty and any other employment-related reason for corrective or adverse action that is not arbitrary or capricious. Accordingly this action is proposed.

Charge No. 4: Violation of D.C. Fire and Emergency Medical Services Department Rules and Regulations, Article VI §8, which states: “Members shall refrain from immoral conduct, deception, violation or evasion of law or official rule, regulation, or order; and from false statements.” Further violation of D.C. Fire and Emergency Medical Services Department Order Book VI § 4, which states: “Any member who willfully and knowingly makes untruthful statements of any kind, or who refuses or fails to make truthful statements in a verbal or written report pertaining to his official duties as a Fire and EMS Department employee is subject to disciplinary action, including dismissal.” This misconduct is defined as cause in D.C. Fire and Emergency Medical Services Department Order Book Article VII § 2(f) (6), 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).

Specification No. 1: In his Final Investigative Report (dated 5/28/2015), MPD Captain Hilton Burton describes Lieutenant Valentine’s misconduct as follows: On Thursday April 12, 2015, Lieutenant Guy Valentine responded to the Office of Internal Affairs to be interviewed about this matter. When asked if as the officer in charge of the Engine Company could he notify the dispatcher that he was in the vicinity of a call and that he could get there before the other units

and be placed on the call. **Lieutenant Valentine stated that it could not be done in the firehouse.** Lieutenant Valentine was then played the part of the Audio recording from the Emergency Liaison Officer's phone line where he says that he heard the call come out but that he is like a fish out of water. When asked what he meant by that, Lieutenant Valentine stated that he meant he did not know the address. **Lieutenant Valentine then related that if he had known it was three blocks away maybe he would have called in and gone on it.** Lieutenant Valentine's provision of misleading, deceptive and contradictory information to superiors constitutes both misfeasance and neglect of duty. Accordingly, this action is proposed.

Following the Final Investigative Report dated May 28, 2015, Agency scheduled a Fire Trial Board hearing in this matter for September 9, 2015, however Employee requested a continuance. Thereafter, Employee submitted a request for optional retirement, effective February 20, 2016.³ In a letter dated January 26, 2016, Agency acknowledged receipt of Employee's request, and notified him therein that he would be placed on "Conditional Retirement" due to a pending investigation for serious misconduct pursuant to D.C. Official Code § 5-1051. On February 5, 2016, Agency informed Employee of its intention to sustain the "serious misconduct allegations" and informed Employee that a Fire Trial Board Hearing would be held on February 24, 2016.

SUMMARY OF THE TESTIMONY

On February 24, 2016, and February 25, 2016, Agency held a Fire Trial Board Hearing. During the hearing, testimony and evidence was 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 a part of the Fire Trial Board Hearing.

Captain Hilton Burton ("Capt. Burton") (Tr. Volume 1- Pages 53 –172)

Captain Hilton Burton testified that he is a member of the Metropolitan Police Department ("MPD"), and was detailed to the Department of Internal Affairs for DCFEMS. As a result, he was assigned to conduct the investigation into allegations of misconduct by Lt. Guy Valentine. Capt. Burton indicated that he issued the final investigative report into the matter. Capt. Burton testified that his report consisted of audio interviews with DCFEMS members, and recordings of communication from the Office of Unified Communications (OUC) the Emergency Liaison Officer (ELO), and Fire Liaison Officer (FLO). Capt. Burton said that this case was forwarded to his division by the Deputy City Administrator for investigation. Capt. Burton noted that this investigation began with gathering information regarding the March 13, 2015 call for service to the address of 4246 Warren Street, NW. Following that, Capt. Burton revealed that they started with OUC chronology, and also reviewed which units were assigned to the call. Capt. Burton cited that during his investigation he found that Engine 20 was located closest to the call address. Further, Capt. Burton testified that Lt. Guy Valentine was in charge of that same Engine. Capt. Burton indicated that during the course of his investigation he

³ Agency's Answer at page 14 (October 28, 2016).

reviewed the calls and the chronology of the event and noted that the Paramedic Engine 20 and Ambulance 20 were technically the closest units to the scene.

Capt. Burton also testified that he found that Engine 20 was closest to the call address, as it was approximately 0.3 miles away or about three blocks away from address. Capt. Burton testified that he also found that there were three (3) calls placed to OUC regarding this incident. Capt. Burton testified that the calls were for a “Delta” call – unconscious child. Capt. Burton cited that in reviewing the chronology, that the initial call came in 0839 hours, and Medic 31 and Paramedic 31 were dispatched. Capt. Burton cited that at the time of the calls Medic 31 and Paramedic 31 were near their quarters, roughly a mile and a half away from the address site. Capt. Burton noted that Engine 20 and Ambulance 20, along with Truck 12 were in quarters at this same time. Further, Capt. Burton testified that Lt. Valentine was the officer in charge of Engine 20. Capt. Burton indicated that at 0843 hours, the Computer Aided Dispatch (CAD) recommended that Truck 12 and EMS 5, which were stationed at Engine 20, were recommended for dispatch, but that this was almost disregarded as a duplicate call. Then again at 844 hours, Capt. Burton testified that Truck 12 was dispatched again to the address location to assist Paramedic 31 and Medic 31. During this time, Capt. Burton explained that EMS 5 was also dispatched which was a part of Engine 20. Burton testified that EMS 5 was out of service and that Lt. Valentine had contacted the FLO to let OUC know that EMS 5 was not in service. Capt. Burton testified that Lt. Valentine had heard the dispatch, but indicated that EMS 5 was not in service. Capt. Burton indicated that through his investigation, he found that the first unit, Paramedic 31, arrived at the address at 0847 hours and Medic 31 at 0848 hours. Capt. Burton said that at that time he reviewed the arrivals, but continued to note that Engine 20 and Ambulance 20 were the closest to the scene. Capt. Burton testified that he reviewed all of the recordings from OUC with regard to this investigation/assignment.

Upon his review of the audio, Capt. Burton testified that he heard a call at 0844 hours from Lt. Valentine to the ELO line. Capt. Burton testified that Lt. Valentine spoke to Lt. Winslow to advise that EMS 5 was not in service. Capt. Burton also indicated that Lt. Valentine also made a call to the FLO, Sergeant Jon Connelly, at 0857 hours in which they spoke about the status of Paramedic Engine 20. Capt. Burton said that the audio reflected that Lt. Valentine was calling to ask the status of Engine 20 because someone had called in and complained that they had not responded to the 4246 Warren Street call for the child in need of CPR. During this conversation, the FLO told Lt. Valentine that the CAD showed their unit GPS as “not receiving”. Capt. Burton explained that Valentine was asked many times about why he contacted the OUC about Paramedic 20 not being dispatched, but that his answers were vague. Capt. Burton indicated that during his interview with Lt. Valentine, that he was evasive in answering questions regarding these calls until he was played some of the recorded calls. Specifically, Capt. Burton noted that Lt. Valentine acknowledged his call with Technician Veney about them not responding. Capt. Burton said that he interviewed other officers in charge of the responding units that were involved with this matter and asked what their response would be in a similar circumstance. Capt. Burton indicated that their responses indicated that if there was a dispatch in their first due area, that they would notify dispatch and say that they were in service.

During the course of the investigation, Capt. Burton concluded that Valentine heard the original dispatch of Truck 12 and Medic 5 and contacted the ELO to notify that EMS 5 was out

of service. He also found that Lt. Valentine was not aware (by his own admission) that the 4246 Warren Street address was three blocks away and that he did not know the streets in his first due area. Capt. Burton also concluded that Lt. Valentine failed to acknowledge and act appropriately when notified by Sergeant Woolston that the incident was one in which he should have responded to. Further, Capt. Burton noted that Lt. Valentine (by his own admission) could have notified OUC that Paramedic Engine 20 and Ambulance 20 were available to respond to the incident, but failed to do so. Additionally, Capt. Burton indicated that Lt. Valentine told him he would not have responded even if he had known the location was close because he felt he was not dispatched. Capt. Burton also concluded that Lt. Valentine was aware that the GPS/tablet system had issues that could have caused his unit not to be dispatched. Capt. Burton also cited that OUC failed to dispatch the closets units due to CAD and human error.

On cross examination, Captain Burton was asked about his investigative process. Capt. Burton testified that at the time of the incident, the G-Tech tablets (GPS) had been in use since the fall of 2014. Captain Burton also testified that he did not make any recommendations for charges, but sustained allegations and that in the matter of Lt. Valentine, he ultimately sustained the allegation that Lt. Valentine failed to ensure there was a timely response to a medical emergency that was only three blocks away from his location. Capt. Burton also maintained on cross-examination that while human and technological errors were a part of this incident, that Lt. Valentine failed to act appropriately under the circumstances. Capt. Burton also testified that he did not interview OUC personnel in the course of this investigation because he was limited to investigating D.C. Fire and EMS. Capt. Burton indicated that OUC conducted its own investigation regarding this incident.

Lieutenant Anthony Lytton (“Lt. Lytton or Lytton) (Tr. Volume 1- Pages 173-196)

Lt. Anthony Lytton testified that he has been a member of DCFEMS since 1987. On the day of the incident, March 13, 2015, Lytton testified that he was assigned to Engine 31. Lytton indicated that he was the “OIC” or Officer in Charge on that day for Engine 31. Lt. Lytton testified that it was his responsibility to turn out that unit and send them out. Lt. Lytton testified that on the morning of March 13, 2015, that he was dispatched to a called at 4246 Warren Street. Lt. Lytton testified that during the course of the call it was upgraded to “CPR in progress.” Lt. Lytton testified that upon arrival the members of Engine 31 took over administering CPR at the residence. Lt. Lytton also testified that during the course of the call he was not aware of the status of Paramedic Engine 20 or Ambulance 20. Lt. Lytton explained that he was interviewed regarding the incident at 4246 Warren Street. Lt. Lytton cited that he recalled that Lt. Veney had called Lt. Valentine afterwards, but did not see him place the call. Lt. Lytton testified that he was aware of some of the issues with the G-tech (GPS) tablets that were in use. Lt. Lytton also testified that as an OIC, if he heard a call in his first due area and he wasn’t dispatched to it, he would call communications and notify that they were closest unit.

On cross-examination, Lt. Lytton testified that the highest level of certification of the EMS personnel on the Engine on the day of the incident was a Paramedic and that they had all ALS equipment on board. Additionally, Lt. Lytton noted that Medic 31 and Engine 31 arrived at the residence simultaneously. Lt. Lytton indicated that there was an MPD police officer on the scene administering CPR when they arrived.

Lieutenant Ronald Bobo Jr. (“Lt. Bobo”) (Tr. Volume 1- Pages 196 - 219)

Lt. Bobo testified that he was employed by DCFEMS, and that as of July 2016, he would have been a part of DCFEMS for 20 years. On March 13, 2015, Lt. Bobo testified that he was typically assigned to Truck 14, Platoon 1, but on that day he was working a day off trade with Captain Steen and he was shifted to Truck 12. On March 13, 2015, he was serving as the Officer in Charge (OIC) for Truck 12. Lt. Bobo testified that he was dispatched to a call at 4246 Warren Street. He said that upon dispatch he went to look at the tablet (GPS) and found it was not displaying the address, so he went verbal on Channel 2. Lt. Bobo said he went to Channel 2 and informed that they were responding and then he switched to Channel 12, upon which time they were told they were in service. However, they were subsequently taken off that run. Lt. Bobo then testified that few minutes later, they were re-dispatched again with EMS 5, but that he later heard that EMS 5 was out of service. Lt. Bobo indicated that they arrived at the same time with Medic 31 and Engine 31. Lt. Bobo said that upon arriving at the residence, they followed the medics in and were attending to the male child. Lt. Bobo said that he spoke with a female child at the residence who said the male child had picked up a grape, swallowed it and turned blue. Lt. Bobo indicated that upon leaving the residence, he noted that Engine 20 and Ambulance 20 were in quarters, but that he was not aware of their status. Lt. Bobo indicated that as an OIC that if he was aware of a call in his first due area and his unit was not dispatched, he would get on Channel 2 and tell them to put them on the run. Lt. Bobo said that they (dispatch) rely on technology, but if he knows that a unit is closer in an area that they're running, they would take the run.

On cross-examination, Lt. Bobo testified that it probably took less than 60 seconds for them to get out of the station once they were alerted to the call. Lt. Bobo maintained that he saw Ambulance 20 and Engine 20 in quarters on the day of the incident.

Lieutenant Edward Winslow (Lt. Winslow) (Tr. Volume 1 Pages 219- 268)

Lt. Winslow is employed by the DCFEMS as an OUC Emergency Liaison Officer (ELO). At the time of this hearing, Lt. Winslow testified that he had been an employee of DCFEMS for 24 years, and had been an OUC ELO for five (5) years. Lt. Winslow testified that his primary responsibilities as an ELO is similar to that of air traffic control, but calls them an ambulance traffic controller. He indicated that he monitors the hospitals and sending units; but was not responsible for dispatching units. On the day of March 13, 2015, Lt. Winslow indicated that he received maybe three or four calls from Lt. Valentine. Lt. Winslow indicated that the first call in the morning was with regard to EMS 5 being out of service. Lt. Winslow said that a second call from Lt. Valentine came regarding what the CAD system was showing at that time. (*Lt. Winslow was played an audio recording of a call made at 844am on March 13, 2015, and then was asked subsequent questions.*) Lt. Winslow testified that while he does not dispatch units, that if there is help needed, he can do so.

Lt. Winslow indicated that he could not recall whether Lt. Valentine inquired about Ambulance 20. (*Another audio recording of calls was played*). Lt. Winslow recalled a call from the medic unit on the scene of the 4246 Warren Street that indicated that a child was choking. Lt. Winslow testified that this call was to follow up to indicate that they were not able to connect with the hospital to let them know that they had a priority patient. (*Lt. Winslow was then played an additional audio recording of a call between him and Lt. Valentine.*) Lt. Winslow testified that during the call he made a comment indicating that “it was your call Val”. Lt. Winslow explained that what he meant was that in talking to Lt. Valentine, it was his (Lt. Valentine) call on whether he

would respond to a call that he wasn't dispatched to if he believed he was a closer unit. Lt. Winslow explained that Lt. Valentine could have come up on the radio and advised the "OU" dispatcher that he may be closer. Lt. Winslow indicated that this was departmental common knowledge. Lt. Winslow testified that there were ongoing issues with the "tablets" and the tracking/tablets (GPS etc.)

On cross-examination, Lt. Winslow testified that ELO position where he was answering the phone was the normal station. Lt. Winslow indicated that depending on what channel he was on the OUC dispatcher may be close by. Lt. Winslow indicated that he did not have the authority to "override steps" if an officer called saying that they had been passed over for a call. Lt. Winslow testified that the company supervisor would have to resync with the GPS. Lt. Winslow testified that situations involving this incident where tablets and GPS weren't functional was not a common occurrence. Lt. Winslow testified on redirect that he has very rarely been called by a unit and told that they were not picked up for a run. Lt. Winslow also explained that when he received the first call from Lt. Valentine on March 13, 2015, that he was not initially aware of what was happening with regard to the incident at 4246 Warren Street.

Lieutenant Matthew Woolston⁴ (Lt. Woolston) (Tr. Volume 1 Pages 269 - 319)

Lt. Matthew Woolston is a Lieutenant Paramedic with DCFEMS and had been with DCFEMS for 11.5 years. Lt. Woolston testified that his current assignment is to Engine 3 Platoon Number 1. On March 13, 2015, Lt. Woolston recalled that he was working at Engine Company 20 and at that time he was a Sergeant Paramedic and was riding Engine 20 as the paramedic. Lt. Woolston testified that he had ALS (advanced life) training, and on March 13, 2015, he was detailed to be a firefighter paramedic on Engine 20. Lt. Woolston testified that in the morning hours of March 13, 2015, he was doing his regular assignments when a station alert went off for Truck 12 and Medic 5. Lt. Woolston testified that he thought he heard it was for an address on Warren Street. Lt. Woolston indicated that he heard the alert over the electronic voice "Siri" while he was in the mop closet preparing to clean the fire house. Shortly thereafter, Lt. Woolston testified that he saw members of Truck 12 walking to their fire truck as if they were about to respond to the dispatch. Following this, Lt. Woolston said he heard another alert for Truck 12 to respond on the same call. Lt. Woolston indicated that he later found out that this was a call for CPR in progress for a delta choking. Lt. Woolston indicated that on the day of the incident he was familiar with the surroundings and knew that Engine Company 20 was located on Wisconsin Avenue and Warren Street.

Lt. Woolston testified that he had heard the call and knew that Truck 12 had been dispatched and also believed that Medic 5 transported to the hospital. Lt. Woolston indicated that he felt something was going on, and says that later, he was in contact with the crew in the kitchen area and they wanted to know why Engine 20 didn't come up or take the run. Lt. Woolston testified that Lt. Valentine and the wagon driver, Technician Brian Palmer, said that they were not dispatched and there was no need to go. When asked what he would do if he were an OIC and heard a call assignment come out in his first due area that he was not dispatched to, Lt. Woolston said that he would check the status of the unit to make sure the computer had them listed as available. Lt. Woolston said he would also come up on his radio and tell the dispatcher that they were available in quarters and could take the run. Lt. Woolston testified that Lt. Valentine and Technician Brian Palmer's excuse with regard to them not being dispatched was "lazy."

⁴ Lieutenant Woolston was listed as a Sergeant, but it was clarified during the hearing that his rank at the time of the hearing was in fact, Lieutenant.

Lt. Woolston testified that he believed that if you're the officer in charge, "that you should know the neighborhood like the back of your hand or are supposed to". Lt. Woolston indicated that he believed that they knew they were three blocks away, so that meant they had the responsibility to investigate further as to why you were not assigned to a run. Lt. Woolston testified that during the course of the discussion regarding the call, Lt. Valentine was arrogant. Lt. Woolston also indicated that several days later a similar incident happened when they were not dispatched on a call in which they were close to, which resulted in the Battalion Chief doing a lineup and telling everyone that they need to be paying attention and that if they hear something that should be their run that they need to "come up" on the radio and tell someone.

On cross-examination, Lt. Woolston testified that he had experienced problems with the tablet device and GPS. Lt. Woolston also indicated that he did not find it unusual that on March 13, 2015, that a ladder truck was responding instead of a paramedic engine because the system is fluid and units could be anywhere. Lt. Woolston reiterated that he was bothered by the answer that Lt. Valentine provided with regard to not going on the call. He also indicated that he did not hear anyone ask Captain Partridge why Ambulance 20 did not go on the run. Lt. Woolston indicated that he did not speak to or ask Lt. Valentine about what his concerns were. Lt. Woolston maintained that Lt. Valentine, as company officer was responsible for making that notification that they were in service and available in quarters.

Firefighter Lamont Veney ("FF. Veney") (Tr. Volume 2 Pages 4 –66)

Firefighter Veney testified that he was a fire technician and had been with DCFEMS for 29 years at the time of the hearing. FF. Veney indicated that he was with Engine 31 located at 4930 Connecticut Avenue, NW. FF. Veney testified that the 4246 Warren Street address was not far from his engine, though he was unsure of the exact location. Following a review of information, FF. Veney testified that the residence was roughly 2 miles away from Engine 31. FF. Veney testified that on March 13, 2015, he was working with Engine 31 and that his responsibilities included to check the apparatus of the fire truck and make sure all tools are in order and if a call comes out, then he is responsible for driving to the scene. FF. Veney confirmed that on March 13, 2015, he was the assigned driver for Engine 31, but did not drive that day. FF. Veney indicated that Paramedic Engine 31 was dispatched to a call at 4246 Warren Street and that the call came in as an unresponsive person. FF. Veney testified that when they went out to the call, he had one of his backups, Firefighter Ward drive to the 4246 Warren Street call. FF. Veney said he could not recall, but based on a report, the call was eventually upgraded to a red CPR.

FF. Veney indicated that it probably took them a couple of minutes to get to the address, perhaps three to six minutes. FF. Veney indicated that he thought that Paramedic 31 and Medic 31 arrived at the scene at the same time and that Truck 12 was a few minutes after, or closely thereafter. FF. Veney indicated that upon arrival at the scene a police officer ran out indicating that a child was in the house, but that he stayed outside at that time. FF. Veney testified that once the units left, the child was transported to Georgetown hospital. FF. Veney indicates that he drove the ambulance to the hospital, but did not recall what time they arrived there. FF. Veney testified that during the course of this, he contacted Lt. Valentine. He explained that he and Lt. Valentine (referred to him as "Val") had a good relationship over the years and that since he was at 31 and Lt. Valentine was at 20, that he would call if he was going into Lt. Valentine's area. FF. Veney could not recall exactly when he made the call on March 13, 2015, but thought that it was likely before the upgrade was made to the run. *(Veney is made to listen to an audio recording from his interview with Capt. Burton of*

MPD). FF. Veney then testified that he did make the call to Lt. Valentine to inquire as to why he had not taken that call. FF. Veney said he called the firehouse and that Lt. Valentine answered and that during the course of the call he didn't think Lt. Valentine was being rude or "smart" with him.

On cross-examination, FF. Veney testified that he had once worked at Engine 20. He also testified that he did not contact Communications (OUC) after being referred to communications by Lt. Valentine because it was not his responsibility to do so. FF. Veney maintained that in the time he has known Lt. Valentine that he has not been one to miss his calls or avoid going out on calls. FF. Veney also testified that they listen in on calls and if there is one in their first due area that they have not been dispatched to, that a supervisor or Lieutenant will call Communications to let them know they're available. On redirect, FF. Veney testified that he did not think he was "hollering" as reported by Lt. Valentine to the FLO during the call with Lt. Valentine on March 13, 2015.

Trial Board Findings

On April 7, 2016, Agency's Fire Trial Board issued its findings from the February 24- 25, 2016⁵, hearing. The Panel made the following findings of fact based on their review of the evidence presented at the hearing. With regard to Charge, Specification 1, the Panel found the following:

1. At 0839:46, Engine 31 and Medic 31 were dispatched to 4246 Warren Street N.W. on a Medical Local that is in Engine 20's local alarm district.
2. Engine 20 was in service and in quarters at the time of dispatch.
3. At 0841:04, Truck 12 and EMS 5 were dispatched to 4246 Warren Street N.W. for a Delta choking.
4. In his interview with Internal Affairs, Lieutenant Valentine admitted that he heard the dispatch to 4246 Warren Street N.W. for Truck 12 and EMS 5 but did nothing.
5. Lieutenant Valentine failed to contact communications and place Engine 20 on the response. He did call the ELO to notify them that EMS 5 was out of service.
6. FF/EMT Lamont Veney stated during his testimony that he called the quarters of Engine 20 and spoke to Lieutenant Valentine to let him know that Engine 31 was responding on a Medical Local in Engine 20's alarm district.
7. FF/EMT Lamont Veney stated that during his testimony, that in the past, when Engine 31 was responding into Engine 20's area, Lieutenant Valentine would call communications and respond on the run.
8. It was made clear during testimony – and after reviewing audio tapes from the interviews that were conducted – that the Patient Bill of Rights was violated due to Lieutenant Valentine's failure to act.

With regard to Charge 2, Specification 1, the Panel found the following:

1. At 0914:16 Lieutenant Valentine called the ELO and spoke with Lieutenant Edward Winslow, who advised Lieutenant Valentine that the Medical Local was in Engine 20's area and that he should have taken the response.
2. Lieutenant Valentine stated during the conversation, "I don't know man, I heard the call come out man, I'm not, I'm like a fish out of water."

⁵ The findings reflect the dates of February 25, 2016 through February 26, 2016, however the transcript reflects the dates of February 24, 2016 through February 25, 2016.

3. In his interview with Internal Affairs, Lieutenant Valentine stated that he did not know the address.
4. In his interview with Internal Affairs, Lieutenant Valentine stated that – had he known that the Medical Local was three (3) away – maybe he would have called in and gone on it.
5. In addition to failing to give assistance to the public, Article III, Section 10 of the Rules and Regulations state the following: Members shall acquire and maintain a general knowledge of the streets, roadways, major buildings and installations in the District of Columbia, and shall thoroughly familiarize themselves with their respective unit districts, including buildings, streets, roadways, alleys, water, [sic] mains, hydrants routes thereto, and other pertinent factors and conditions. With that being said, Lieutenant Valentine had been assigned to Engine 20 for eight (8) months and should have been well aware that Warren Street was the street that ran adjacent to the quarters of Engine 20, and should have known where the 4200 block of Warren Street was.
6. Even though Lieutenant Valentine was made aware by FF/EMT Lamont Veney that the response was in his area, he failed to act accordingly.

With regard to Charge 3, Specification 1, the Panel found the following:

1. The panel collectively agreed that the phone conversation that Lieutenant Valentine had with Lieutenant Edward Winslow was neither harsh, violent, abusive, coarse nor insolent.
2. During his testimony, Lieutenant Winslow stated that he and Lieutenant Valentine were “boys” and at no time during the conversation did he feel threatened.

Lastly, with regard to Charge 4, Specification 1, the Panel found the following:

1. During the interview with Internal Affairs, Lieutenant Valentine stated that he could not place Engine 20 on the response from the firehouse.
2. Later during the interview with Internal Affairs, Lieutenant Valentine stated that – had he known the response was three (3) blocks away from the firehouse – maybe he would have called communications and responded on it.
3. During his testimony, FF/EMT Lamont Veney stated that prior to this incident; he would call Lieutenant Valentine and make him aware that Engine 31 was responding to a call in Engine 20’s area. When FF/EMT Veney was asked if Engine 20 would take the response in the past after the phone call, FF/EMT Veney replied that he doesn’t play, he takes his calls.
4. Lieutenant Valentine was well aware that this response was in Engine 20’s local alarm district by virtue of the following: (a) the dispatch of Engine 31 and Medic 31, (b) the dispatch of Truck 12 and EMS 5, (c) the phone call from FF/EMT Veney, and (d) the address that was displayed on the reader board in the firehouse.

In addition to making the aforementioned findings of facts, the Panel weighed the offenses according to the relevant *Douglas*⁶ factors. The Panel weighed the following factors: the nature and

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

- 1) the nature and seriousness of the offense, and it’s 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;

seriousness of the offense; Employee's job level and type of employment; employee's past disciplinary record, employee's past work record; the consistency of the penalty with those imposed upon other employees for the same or similar offenses; consistency of the penalty with applicable Table of Penalties; the notoriety of the offense or its impact on the reputation of the Agency; the clarity with which employee was on notice of any rules that were violated; and the adequacy and effectiveness of alternative sanctions to deter such conduct in the future by employee or others. The Panel found that in relation to nature and seriousness of the offense in relation to the employee's duties position and responsibilities etc., that Employee, as a Lieutenant in Agency, is "held to the highest standard of conduct and is expected to conduct himself in a manner consistent with Department policy."⁷

Accordingly, the Panel found that as an Officer with Agency, serving in a command position that Employee was held to the highest standard of conduct. Employee had no disciplinary history for the previous three (3) years and was a 29-year veteran of the department. The Panel also determined that the penalty was consistent with that imposed upon other employees for the same or similar offenses and was also consistent with any applicable Table of Penalties. Further, the Panel determined that the notoriety of the offense, given that it was made public through local television media outlets, became very damaging to the Agency's reputation. Additionally, the Panel found that employee should have "known his actions were in direct violation of Department policy, and that through the course of entry and continual training, that there was no evidence to suggest that Employee was not made aware of the regulations."⁸ Lastly, the Panel considered that the recommended penalty would deter, and even prevent future occurrences with other members of the Agency.

Upon consideration and evaluation of all of the testimony and factors, the Panel found that there was sufficient evidence to find Employee Guilty on Charge 1, Specification 1, Charge 2, Specification 1 and Charge 4, Specification 1. With regard to Charge 3, Specification 1 and 2, the Panel found Employee to be Not Guilty. Finally, the Panel recommended that the penalty of "Demotion to Sergeant" was an appropriate penalty for the offenses. On April 25, 2016, Agency issued its Final Agency Decision. The Agency held that Employee was guilty of the charges, and the Trial Board recommendation of demotion to Sergeant was warranted, but given Employee's

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

⁷ Trial Board Findings and Recommendations dated April 7, 2016.

⁸ *Id.*

conditional retirement, and pursuant with D.C. Official Code § 5-1054, that Employee be assessed a \$5,000 penalty.

ANALYSIS AND CONCLUSIONS

This Office's review of this matter is limited pursuant to the D.C. Court of Appeals holding in *Elton Pinkard v. D.C. Metropolitan Police Department*.⁹ According to the *Pinkard* decision, OEA has a limited role where a departmental hearing has been held. The D.C. Court of Appeals held that while OEA generally has jurisdiction over employee appeals from a final agency decision involving adverse actions under the CMPA¹⁰, that in a matter where a departmental hearing has been held that:

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

Further, the Court of Appeals held that OEA's power to establish its own appellate procedures is limited by the agency's collective bargaining agreements. As a result, and in accordance with *Pinkard*, an Administrative Judge of OEA may not conduct a de novo hearing in an appeal before them, but rather, must base their decision on the record 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 and Emergency Medical Services Department;
2. The employee has been subject 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 has been held, any further appeal shall be based solely on the record established in the Department hearing; and
5. At the agency level, employee appeared before a panel that conducted an evidentiary hearing, made findings of fact and conclusions of law, and recommended a course of action of the deciding official that resulted in an adverse action being taken against employee.

In this case, Employee is a member of the D.C. Fire and Emergency Medical Services Department (DCFEMS) and was the subject of an adverse action; DCFEMS collective bargaining agreement contains language similar to that found in *Pinkard*; and Employee appeared before a Fire Trial Board Panel, which held a hearing. Based on the documents of record, and the position of the parties as stated during the Status Conferences held in this matter and in the briefs submitted herein, the undersigned finds that all of the aforementioned criteria are met in this instant appeal. Accordingly, pursuant to *Pinkard*, OEA may not substitute its judgment for that of the Agency, and the undersigned's review of Agency's decision in this matter is limited to the determination of whether the Fire Trial Board's findings were supported by substantial evidence, whether there was

⁹ 801 A.2d 86 (D.C. 2002)

¹⁰ See D.C. Code §§ 1-606.02 (a)(2), 1-606.03(a)(c); 1-606.04 (2001).

harmful error, and whether the action taken was done in accordance with applicable laws or regulations.

Whether Fire Trial Board Panel's Decision was supported by Substantial Evidence

Pursuant to *Pinkard*, the undersigned must determine whether the Fire Trial Board Panel's findings were supported by substantial evidence.¹¹ "Substantial evidence" is defined as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."¹² If the [Fire Trial Board] 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.¹³

After reviewing the record, and the arguments presented by the parties in their briefs submitted before this Office, the undersigned finds that the Fire Trial Board met its burden of substantial evidence. The parties had an opportunity to present testimonial and documentary evidence and had the ability to call witnesses and to cross-examine witnesses during the Fire Trial Board hearing. Employee elected not to call any witnesses or appear for the hearing, but was represented by his counsel who cross-examined Agency's witnesses. Further, a review of the transcript indicated that the Fire Trial Board Panel was engaged in the hearing, asked relevant questions and made credibility determinations for the witnesses, supported by sufficient evidence in making those determinations. Additionally, the Fire Trial Board considered and reviewed the *Douglas* factors in making its determinations and findings and in sustaining the charges. The Fire Trial Board Panel unanimously found Employee guilty on three of the four charges that were levied against him, and considered the evidence and also decided unanimously not to sustain Charge 3, Specifications 1 and 2, and found Employee Not Guilty with regard to that charge. The Board considered the actions of Employee in relation to the events that led to the charges of misconduct, as well as his time and experience with Agency. As a result, the undersigned finds that there was substantial evidence in the record to support the Panel's findings, as well as its recommended penalty of demotion to Sergeant, which given the conditional retirement, ultimately resulted in assessment of the \$5,000 penalty.

Whether there was harmful procedural error.

In accordance with *Pinkard* and OEA Rule 631.3, the undersigned is required to evaluate and make a finding of whether or not Agency committed harmful error. OEA Rule 631.3 provides that "notwithstanding 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 an error in the application of the agency's procedures, which did not cause substantial harm or prejudice to the employee's rights and did not significantly affect the agency's final decision to take action."

In the instant matter, Employee argues that the undersigned should reverse Agency's decision because Agency committed procedural error by: (1) admitting written statements without being read in the open hearing, (2) admitting the "178-page written investigative report" and (3) including all the audio recordings of Departmental interviews.¹⁴ Further, Employee also avers that the

¹¹ *Elton Pinkard v. DC Metropolitan Police Department*, 801 A.2d at page 91. (2002).

¹² *Black v. District of Columbia Department of Employment Services*, 801 A.2d 983 at 985 (D.C. 2002).

¹³ *Metropolitan Police Department v. Baker*, 564 A.2d 1155, 1189 (D.C. 1989).

¹⁴ Employee's Brief at Page 14 (July 19, 2017).

investigation was not completed within 25 days of Employee's request for retirement. Agency contends that there was no harmful procedural error present. Agency argues that Employee's Fire Trial Board hearing was "scheduled to commence on September 9, 2015; however, Employee requested and was granted a continuance."¹⁵ Agency argues that subsequent to this request for a continuance, Employee submitted a request for optional retirement, to be effective February 20, 2016. Agency argues that it appropriately invoked the "Firefighter While under Disciplinary Investigation Amendment Act of 2014", which made Employee's retirement conditional "pending the outcome of the disciplinary investigation."¹⁶ Agency argues that in a letter dated January 26, 2016 it acknowledged Employee's request for retirement, and informed Employee of the conditional retirement status pending the investigation. Agency also contends that its February 5, 2016 letter, also notified Employee of the decision to sustain the allegations and proceed with a Fire Trial Board hearing, well in advanced of Employee's requested February 20, 2016 retirement date. As a result, Agency argues that Employee was afforded all of his due process procedural rights and that there was no harmful procedural error. The undersigned agrees with Agency.

Based on a review of the record, the undersigned finds that Employee was provided notice of the allegations and charges that were assessed against him and was provided appropriate notice regarding the Fire Trial Board Hearing. Further, it should be noted that, Employee elected not to bring forth any witnesses (or appear personally) during the Fire Trial Board hearing (his counsel appeared and cross-examined witnesses and gave opening and closing statements), but instead argued that the Panel hearing was inappropriate since Employee had retired. However, the undersigned finds that the February 5, 2016 letter was an indication of the end of the investigation, and notice of the Fire Trial Board hearing. Accordingly, I find that there was no harmful procedural error.

Whether Agency's action was done in accordance with applicable laws or regulations.

Employee contends that Agency's final action was "contrary to law and regulation, as there was deficient statutory and regulatory authority."¹⁷ Further, Employee argues that Agency had no jurisdiction over Employee when he gave notice of his retirement and no valid regulatory or statutory authority to act in this case.¹⁸ Employee argues that a board had cleared him for "full retirement", before making his retirement "conditional" and that the Agency failed to follow the law in administering the subsequent Fire Trial Board hearing and final penalty of demotion to Sergeant and fine of \$5,000. Employee also argued that the "...conditional retirement statute, which the FEMS so handily implemented with its emergency rulemaking on the exact same day it sent Mr. Valentine his notice of conditional retirement, forces Mr. Valentine to stay with FEMS systems and procedures."¹⁹ Further, Employee argues this action by Agency meant that Agency had jurisdiction over the Fire Trial Board hearing and as a result, Mr. Valentine was entitled to have his appeal heard at OEA." Employee also argues that the Emergency legislation of this Firefighter Retirement while under disciplinary investigation" was not appropriate in leveraging the investigation against him because (1) a previous board had approved his "full retirement" without conditions, and (2) that the

¹⁵ Agency's Brief at Page 10 (May 31, 2017).

¹⁶ *Id.* at Page 11.

¹⁷ Employee Brief Page 15 (July 19, 2017).

¹⁸ *Id.* at Page 22.

¹⁹ Employee Brief on Jurisdiction at page 6 (December 12, 2016).

Firefighter Retirement While Under Disciplinary Investigation Amendment Act of 2014, would have to have been applied retroactively given his previously “fully-vested” retirement.²⁰

Employee goes on to argue that the application of the legislation was “nothing more than a self-created rush by the Employer to correct its previous lack of diligence, and an attempt to do a quick fix that really was only designed to prevent a single person, the Employee, from retiring unconditionally.”²¹ Employee argues that emergency legislation is generally disfavored and that Agency failed to follow the Act which “requires the promulgation of valid regulations to effectuate the Act.”²² Additionally, Employee argues that these regulations were required to have been made within “60 days of the effective date of the Act, which did not occur.”²³

Agency argues that its actions were done in accordance with all applicable laws and regulations. Agency argues that Employee’s Trial Board hearing was initially scheduled to be held on September 5, 2015, but following a request by Employee, the hearing was continued. Subsequently, Employee requested optional retirement to be effective February 20, 2016. Agency avers that it invoked the Firefighter Retirement While under Disciplinary Investigation Amendment of 2014 (“Act of 2014 or Act”), which made Employee’s retirement conditional pending the outcome of the disciplinary investigation.²⁴ Further, Agency argues that the Act of 2014 became law on January 6, 2015, as D.C. Official code §§ 5-1051 through 5-1057.²⁵ Agency argues that the Act provides authority to the Agency to place employees on conditional retirement pending a disciplinary investigation. Agency argues that in a letter dated January 26, 2016, that Agency acknowledged Employee’s December 2015 request to retire on February 20, 2016. Agency argues that it also informed Employee that he would be subject to conditional retirement due to the disciplinary investigation in accordance with the Act. Agency contends that on February 5, 2016, it informed Employee of the decision to sustain the allegations and that a Fire Trial Board hearing would be held. Agency argues that the February 5, 2016 notice “confirms that Agency completed its serious misconduct investigation well in advance of Employee’s retirement date of February 20, 2016.”²⁶ Additionally, Agency argues that Employee was on notice of the charges since he received a Proposed Notice in the summer of 2015. Agency argues that although Employee elected not to personally appear for the Fire Trial Board hearing, (as he was only represented by counsel), that he was afforded his full due process under the law.

The undersigned finds that Agency’s actions were done in accordance with all applicable laws, rules and regulations. The Firefighter Retirement While under Disciplinary Investigation Amendment (“Act”) makes clear that if a member of the DCFEMS retires or resigns while under disciplinary investigation, the retirement will be deemed as conditional pending the outcome of the investigation.²⁷ Here, Employee was given notice of the investigation and was scheduled for a Fire Trial Board hearing in September of 2015, to which he asked for a continuance and was granted. Employee subsequently requested to retire in December 2015, with the effective date of retirement of February 20, 2016. On January 26, 2016, Agency responded to Employee’s request for retirement and informed him that since he was currently under investigation that his retirement would be

²⁰ Employee Brief at Page 16 (July 19, 2017).

²¹ *Id.* at Page 18.

²² *Id.* at 17

²³ *Id.*

²⁴ Agency’s Brief at page 11 (May 31, 2017).

²⁵ *Id.*

²⁶ *Id.* at page 12.

²⁷ See. D.C. Code §§ 5-1051 – 5-1057.

conditional pending the outcome of that investigation. Additionally, on February 5, 2016, Agency provided notice that the allegations against Employee would be sustained, and that the Fire Trial Board hearing would take place on February 24, 2016. While Employee argues that his retirement had already been “fully vested”, and that the Fire Trial Board had no jurisdiction because Employee had retired, the undersigned finds that the Act clearly outlines that this retirement would be conditional pending the completion of the investigation.²⁸ Further, the undersigned finds that the legislative history of the Act reflects that it was introduced by the D.C. Council and was adopted on first and second readings on November 18, 2014, and December 2, 2014, respectively. Following that, the Act was signed by the Mayor on January 6, 2015, subsequently transferred to Congress for its review and became law on March 11, 2015.²⁹ As a result, I find Employee’s arguments regarding the efficacy of the legislation, and its inability to be applied to Employee to be unpersuasive and unsupported by the record and legislative history of the Act.

Additionally, I find that the February 5, 2016 notice indicated the end of the investigation, and that this notice was in advance from the February 20, 2016, date of retirement requested by Employee. As a result, I find that Agency’s actions were done in accordance with the applicable Firefighter Retirement While under Disciplinary Investigation Act. Following the hearing, Agency sustained the allegations and noted the recommendation to demote Employee to Sergeant, but given his conditional retirement in accordance with the Act, Agency assessed a \$5,000 penalty. As previously mentioned, the Fire Trial Board Panel found Employee guilty on three of the four charges that were levied against him. The undersigned finds that the Board considered the actions of Employee in relation to the events that led to the charges of misconduct, as well as his time and experience with Agency and considered the *Douglas* factors in making its decision.

OEA has consistently held that the primary responsibility for the management and discipline of Agency’s workforce is a matter entrusted to the Agency, not this Office.³⁰ As a result, when determining the appropriateness of a penalty, this Office is not to substitute its judgment for that of the Agency, but is simply to ensure that “managerial discretion has been legitimately invoked and properly exercised.”³¹ Accordingly, when an Agency charge is upheld, this Office will “leave 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 judgement.”³² Based on the aforementioned, the undersigned finds that Agency acted in accordance with all applicable laws, rules and regulations. Consequently, the undersigned concludes that the Agency’s action should be upheld.

²⁸ D.C. Code §§5-1051 – 5-1057.

²⁹ See D.C. Code § 5-1051 Legislative History (2017). On January 26, 2016, Agency adopted and made effective an emergency rulemaking to implement the Act See 6B DCMR §§ 878 and 879. (January 26, 2016).

³⁰ See. *Wilberto Flores v Metropolitan Police Department*, 1601-0131-11 (August 18, 2014), citing *Huntley v Metropolitan Police Department*, 1601-0111-91, *Opinion and Order on Petition for Review* (March 18, 1994).

³¹ *Stokes v. District of Columbia*, 502 A.2d 1006, 1010 (D.C. 1985).

³² *Id.* See also *Sarah Guarin v Metropolitan Police Department*, 1601-0299-13 (May 24, 2013) citing *Stokes supra*.

ORDER

Based on the foregoing, it is **ORDERED** that the Agency's action of assessing a \$5000 penalty is hereby **UPHELD**.

FOR THE OFFICE:

MICHELLE R. HARRIS, Esq.
Administrative Judge