Fire Dep't v. Prosper

OATH Index No. 2885/10 (Dec. 16, 2010), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD-11-52-A (Aug. 9, 2011), appended

Emergency medical technician charged with false reporting and other violations with regard to an emergency call and two acts of insubordination. ALJ found that 11 of the 12 charges should be sustained and recommended that the technician be terminated.

NEW YORK CITY OFFICE OF ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
FIRE DEPARTMENT
Petitioner
-against-
RODRIGUE PROSPER
Respondent

REPORT AND RECOMMENDATION

JOHN B. SPOONER, *Administrative Law Judge*

This case involves disciplinary charges initiated by petitioner, the Fire Department, against respondent, Rodrigue Prosper, an emergency medical technician (EMT), pursuant to section 75 of the Civil Service Law. The 12 charges allege that respondent failed to deal properly with an emergency call, falsified reports about the call, and was insubordinate on two occasions.

A hearing was held before me on October 15 and 19, 2010. Petitioner called as witnesses respondent and two supervisors. Respondent testified, denying most of the charges, and called two other EMT's, one of whom was his partner on the emergency call.

For the reasons given below, I recommend that 11 of the 12 charges be sustained. As a penalty for this misconduct, I recommend that respondent be terminated.

ANALYSIS

Incident of June 8, 2009

The most serious charges against respondent, who has been employed as an EMT since 1989, assert that, in responding to a 911 call from an elderly patient, he violated multiple Department rules. During the call, he allegedly failed to do a proper patient assessment, gave

misleading information to the dispatch regarding not making contact with the patient, failed to transport the patient to his hospital of choice, and failed to contact medical control regarding the patient's transport request. After the call, respondent allegedly failed to complete the proper form for a contacted patient, failed to make accurate and timely log entries, and gave false statements during an investigative interview. As a consequence of respondent's mistakes in reporting the incident to his dispatcher, firefighters broke into the patient's apartment after he had left.

The incident came to the attention of Emergency Medical Services (EMS) management on June 9, 2009, when a caller named Mr. Williams made a telephone complaint. He stated that workers who responded to his emergency medical call the previous day never examined him, refused to transport him to his hospital of choice, and had his apartment lock broken while he was away. Mr. Williams was interviewed by telephone by Lieutenant Fields later that day and, in a tape-recorded conversation (Pet. Ex. 26), provided further details regarding his contact with two EMS workers. Mr. Williams stated that two EMT's came to his door, in response to his emergency call, and asked whether he wanted to go to the hospital. In refusing to transport him to Community Hospital, the female EMT was "abusive" and "smiling and grinning." Mr. Williams stated that, other than asking for his insurance card, the EMT's did not ask him any questions. Mr. Williams also stated that, after walking out of his apartment building, he spoke again with the two EMT's who were in the ambulance. He told them that he was taking the bus to Community Hospital and walked to the bus stop. He took the bus to the hospital and was there most of the night. The following morning, when Mr. Williams arrived home from the hospital, his apartment door lock had been broken and a security guard posted outside. Mr. Williams was told that Fire Department personnel had broken into his apartment, under the impression that he was inside and might need medical attention. Mr. Williams was charged $360 to repair the door and lock (Pet. Ex. 28; Tr. 181-85).

Respondent testified at the hearing and also offered the testimony of Ms. Alleyne, his partner on the date of the incident. In their testimony, respondent and Ms. Alleyne confirmed much of Mr. Williams's account. They indicated that, on June 8, 2009, they were working together, with respondent driving and Ms. Alleyne acting as the recorder. Ms. Alleyne had been working for only seven months as an EMT and was on probation (Tr. 52, 238). At around 10:53 p.m., they were assigned to a call regarding a 72-year-old male with difficulty breathing at 1305

Delmar Loop, apartment 7D, in the Bronx, a housing complex known as Starrett City. The EMT's parked in front of the building, removed their equipment, and rang the bell to 7D. After being buzzed in, they took the elevator to the seventh floor (Tr. 56-57).

From this point on, respondent and Ms. Alleyne offered conflicting accounts of how they came upon Mr. Williams, whether they recognized him as the patient who called for help, and whether they saw him leave the building. According to respondent, when the EMT's reached the seventh floor, they were met by a black man in front of apartment 7D who complained to them of breathing problems. The man told Ms. Alleyne that he had called 911 because there was a smell in his apartment (Tr. 58). Ms. Alleyne, who also happened to reside in Starrett City, conversed with the man about air quality. The man told her he wanted to be taken to a specific hospital, which she indicated was too far away (Tr. 62). The man became upset, went inside apartment 7D, and closed the door (Tr. 64). The EMT's knocked on the apartment door but the man did not respond (Tr. 66).

Respondent testified that, at this point, even though the EMT's had just spoken with an elderly man in apartment 7D with breathing complaints, respondent radioed the dispatcher that the EMT's could not gain access. From outside the building they asked dispatch for a callback to the patient. Dispatch replied with a code to stand by for more resources and respondent said "10-4" (Tr. 69).

The transcript (Pet. Ex. 23) of respondent's transmissions from the Delmar Loop location shows that respondent conveyed the impression that the EMT's could not gain access to the apartment and had had no contact with the patient. The transcript shows that, at 11:18 p.m., respondent reported, "Do you have a call back? There is no one at the apartment." The dispatcher twice asks, "You're at 7D right now?" Respondent first replies, "39 EDDIE 10-5" and then "Yes, 10-4." The dispatcher asks, "Do you hear the phone ringing?" Respondent answers, "Negative." The dispatcher says, "I have to send you fire for entry" and confirms the address as 105 Delmar Loop. Respondent replies, "10-4." At no time did respondent tell the dispatcher that the EMT's had had contact with the patient or that, at the time of the transmission, they were not close enough to the apartment door to hear a telephone.

Respondent testified that, after calling dispatch, the EMT's sat in their ambulance and filled out paperwork. Respondent did not remember if anyone knocked on the ambulance window prior to the arrival of the firefighters (Tr. 80). After the firefighters found no one in the

apartment, respondent reported to dispatch that the call was a code 90, meaning it was "unfounded" (Tr. 91). Ms. Alleyne also wrote on the ambulance activity log (Pet. Ex. 18) that the call ended in a code 90.

Ms. Alleyne's account was much closer to that of Mr. Williams and inconsistent with that of respondent as to several crucial details. She testified that, after reaching the seventh floor of the building, she knocked on the door of an apartment and an elderly man answered. The man said someone was trying to kill him because fumes were coming through the vents. Ms. Alleyne told the man to retrieve what he needed so he could go with them in the ambulance. When the man returned to the door, he asked if he would be taken to Beth Israel Hospital. Ms. Alleyne said they would "check you out downstairs and then we'll make the decision." Ms. Alleyne confirmed respondent's statement that, at this point, the man slammed the door and refused to answer the EMT's repeated knocks (Tr. 243).

Ms. Alleyne testified that respondent called the dispatcher from the ambulance, not from inside the building (Tr. 244). Ms. Alleyne also testified that, while they were seated in the parked ambulance, both EMT's saw the elderly man come to the ambulance window and recognized him as the patient they had encountered upstairs (Tr. 244-45). She stated that the man again refused her offer to transport him in the ambulance and walked away. She insisted she could not tell whether he walked back toward the building or in another direction (Tr. 246).

The evidence indicates that, after communicating to dispatch that no one answered the door at apartment 7D, respondent and Ms. Alleyne watched silently as the door lock was broken by firefighters. On June 22, 2009, Lieutenant Fields interviewed one of the firefighters who responded to the building. In a written summary of that interview (Pet. Ex. 28), the lieutenant wrote that the firefighter recalled responding to 1305 Delmar Loop and speaking with the EMT's, who were sitting in their ambulance. The firefighters asked the EMT's "what they had" and they did not seem to understand what the fire crew was talking about. The firefighters told the EMT's that, because they had not made contact with the patient, the firefighters were going to "gain entry" to the apartment. Firefighter Viverito stated, "The EMT crew never told us they had spoken with the patient and we were operating under the assumption that EMS hadn't seen the patient." The EMT's seemed "reluctant" to follow the firefighters into the building, but did so. The EMT's watched as the firefighters broke the lock to force open the apartment door and stood outside in the hallway for a couple of minutes. Then the EMT's left.

Lieutenant Fields testified that, even in respondent's version of the incident, the EMT's violated a number of EMS protocols. Where EMT's encounter an uncooperative patient, they should notify a supervisor to report to the location. Where patient contact is made and a patient refuses medical attention, they also need to request guidance from supervisors as to whether the patient is sufficiently alert and oriented to make medical decisions (Tr. 200-01). Where patient contact is made and the patient will not be transported in the ambulance, the EMT's should call in a code 93. A code 10-90, or unfounded call, should be made only where no contact is made and a patient cannot be found at the location (Tr. 202-03). When patient contact is made, EMT's are also required to complete a form (*see* Pet. Ex. 22) with information about the patient (Tr. 207). It was undisputed that none of these procedures were followed.

Respondent admitted to only one violation of EMS protocol. He admitted that, where patient contact is made, EMT's are obliged to fill out a form as to the patient's condition and identity and that this was not done here (Tr. 94). Based upon this admission, charge two of the June 8, 2009 specifications must be sustained.

Charge one of the June 8, 2009 specifications alleges that respondent failed to perform a patient assessment and "provide emergency care in accordance with BLS patient care protocols." Respondent admitted that no assessment was done but offered two excuses. First, he contended that he was uncertain that the elderly man in the seventh floor hallway was, in fact, the patient who had called 911. Second, respondent contended that no assessment was possible because Mr. Williams refused medical attention.

As to the first excuse, respondent's statements that he did not know that the man in the hall was the caller were contrary to the other evidence and incredible. Both Mr. Williams and Ms. Alleyne agreed, and I find, that after the EMT's knocked Mr. Williams came to the door of apartment 7D and identified himself as the 911 caller. There was no question that the EMT's knew that Mr. Williams was the man who had called for emergency assistance and respondent's testimony to the contrary was transparently false.

Respondent's second explanation as to why no medical treatment was given is credible, but does not absolve him of violating the required protocol. According to Lieutenant Fields, where a patient refuses medical attention, EMT's are obliged to call a supervisor but are not required to force medical attention upon a patient against his will. Respondent offered no excuse as to why he failed to call a supervisor in accordance with these protocols. Based upon

respondent's failure to contact a supervisor before leaving the patient in violation of "patient care protocols," I find that charge one of the June 8, 2009 specifications should be sustained.

Charge three of the June 8, 2009 specifications alleges that respondent provided false information as to making patient contact, as to coding the call a 10-90 or "unfounded," and as to making a log entry of no patient contact. Respondent admitted this charge by acknowledging that he and his partner made patient contact but never notified dispatch and that he called in the 10-90 code indicating no contact. Respondent's testimony that the code 10-90 was correct because Mr. Williams had, in fact, departed was specious. Respondent was aware that, at the time he transmitted the unfounded code, the EMT's had made contact with Mr. Williams in the apartment and that a code 10-90 would communicate to dispatch that no one answered at the apartment and no patient contact made. For respondent to transmit a code to dispatch indicating that there was no one at the address of the call was false. Both EMT's were equally responsible for the inaccurate transmission of code 10-90 to dispatch and the parallel inaccurate entry in the activity log (Pet. Ex. 18). Charge three of the June 8, 2009 specifications should be sustained.

Charge eight of the June 8, 2009 specifications alleges that respondent's "action and inaction" caused unnecessary damage and expense to the patient due to the forcible entry. As to respondent's actions, this charge is duplicative of charge three and does not allege an independent violation. Respondent's inaction, consisting of his failure to tell the firefighters about prior interactions with the patient and the patient's departure from the apartment, was also misconduct, in violation of the general requirement that he perform his duties responsibly and avoid bringing "the Department into disrepute." OGP No. 101-01 § 4.2.48. This charge should be sustained.

Charge five of the June 8, 2009 specifications alleges that respondent failed to transport the patient to the hospital of the patient's choice, in violation of EMS rules. Charge seven of the June 8, 2009 specifications alleges that respondent failed to contact on-line medical control as to transporting the patient to a specific hospital. As testified by Lieutenant Fields, EMS procedures require that EMT's confronted with a patient's request for a specific hospital seek guidance from a supervisor before taking action. Respondent, a 20-year employee, was aware that EMT's may go to a requested hospital so long as their supervisor approves transport (Tr. 63-64), a procedure respondent had, in fact, followed a week before for this same patient. Respondent's failure to

notify a supervisor about Mr. Williams's request to go to a specific hospital violates EMS rules and charges five and seven must be sustained.

Charge six of the June 8, 2009 specifications alleges that respondent failed to submit an accurate log entry until the following day. Although the unit activity log (Pet. Exs. 18 and 19) for respondent's 9:00 p.m. to 9:30 a.m. tour was admitted at trial, no proof was offered to show that the log was submitted late. The inaccuracy of the log entry as to the coding of the Williams call was sustained as misconduct under charge three. Insofar as no other misconduct with regard to the log was established, charge six must be dismissed.

As to charge four of the June 8, 2009 specifications, petitioner contends that respondent made false statements in his June 17, 2009 investigative interview as to two facts: (1) that he did not recognize the man he encountered on the seventh floor as the man who had called for an ambulance and (2) that he was not aware he had transported the same man only two weeks before. The audio recording of respondent's interview (Pet. Ex. 26) contains the following statements with regard to whether respondent knew the man in the hall was the patient who had made the emergency call:

> Q The CAD job that you received was for a male patient 70 years of age?
> A Around that age.
> Q So when this man stepped out of apartment 7 David, because that's what it says in the CAD, so he steps out of apartment 7 David, he's elderly, and he's in his seventies. Right?
> A I believe so.
> Q All right. Did you assume that this was the patient?
> A I – my partner was talking to him. I don't know whether he is the patient or not.

As discussed twice above, the hearing evidence established that Mr. Williams answered the door of apartment 7D, the location of the 911 caller, and identified himself as the caller. Respondent's statements to the contrary were incredible, made in order to conceal the fact that the EMT's made contact with the patient. I find that respondent's interview statements that he did not recognize the elderly man as the patient were false.

It is a much closer issue as to whether respondent was also lying when he denied recognizing the patient from the week before. It was undisputed that respondent had transported Mr. Williams by ambulance on May 29, 2008, only a few days before, as demonstrated by a

form (Pet. Ex. 1) signed by respondent. Respondent made the following statements as to whether he recognized Mr. Williams as the patient he had transported the week before:

> Q Had you ever had this patient before?
> A I don't remember. I really didn't get a good look at this patient. I've been in the building so many times so I couldn't . . .
> Q The patient never made you aware that you transported him to Long Island College Hospital?
> A No.

On the one hand, the prior transport of Mr. Williams to a hospital of his choice had occurred only 10 days before and seemed to be the type of call that most EMT's would remember. Respondent also had the same motive to deny recognizing Mr. Williams from a prior visit as he had to deny recognizing that Mr. Williams was the patient on the day of the incident. To admit that he had transported the man in the hall only a few days before would have undermined respondent's statements that he did not know the man was from apartment 7D who had called 911.

On the other hand, Mr. Williams's statement that he spoke exclusively with Ms. Alleyne, not respondent, was consistent with respondent's statement that he paid little attention to the call generally. It was also likely true that respondent had had other recent calls in the same building and may not have remembered specific apartment numbers or patients. Prior to asking these questions, Lieutenant Fields apparently did not attempt to refresh respondent's recollection by showing him the log detailing the prior transport of Mr. Williams on May 29, 2009.

Ultimately, because the prior call was so recent and respondent had a compelling motive to lie about recognizing Mr. Williams, I found it more likely than not that respondent remembered that he had transported Mr. Williams the week before and falsely denied this fact to Lieutenant Fields in order to conceal the falsity of his dispatch transmissions. On this basis, charge four should be sustained.

Insubordination

Respondent was charged with two acts of insubordination: (1) refusing an order to work mandatory overtime and (2) refusing an order to clean an ambulance.

Respondent admitted that he refused to work overtime on May 21, 2009, when ordered to do so by his supervisor. He insisted that he believed he was exempt from the overtime

requirement because he was in the "12-hour program" (Tr. 30). He acknowledged signing a notification of mandatory overtime form (Pet. Ex. 1), which stated that he was ordered to report for overtime at 9:00 a.m. and declined the order (Tr. 35). According to respondent, a supervisor is required to "exhaust" all resources before ordering overtime. Respondent therefore told his supervisor that if, at the end of his tour, the supervisor could not find anyone else to work respondent would do so (Tr. 33).

Under Department rules, EMT's are obliged to participate in the "mandatory overtime pool" unless exempt. Pet. Ex. 29, EMS Command Order 2006-014 § 6.1. The only exemption under the rules are for participants in the voluntary overtime program; there is no exemption for being in a 12-hour program. Pet. Ex. 29, EMS Command Order 2006-014 § 3.2.1. Respondent admitted that he did not participate in the voluntary overtime program (Tr. 30) and offered no support for his assertion that enrollment in a 12-hour program relieved him of the overtime requirement. Insofar as he suggested that he did not refuse overtime but instead sought to delay compliance until the end of his tour, his testimony is contradicted by his signature on the overtime form expressly stating that he refused the mandatory overtime order. The charge that respondent refused to work mandatory overtime should be sustained.

Lieutenant Robbins testified that, on September 23, 2008, respondent and three other EMT's were assigned to the division headquarters on light duty. That morning she sent an EMT to direct the four light duty EMT's to clean some spare trucks in the garage, trucks which were not currently being used. A few minutes later the EMT told Lieutenant Robbins that respondent was refusing to wash any vehicles. Lieutenant Robbins directed the EMT to again deliver the same order to wash the trucks and again he reported that respondent complained that he was wearing "nice clothes and shoes" and didn't want to get contaminated or wet.

Lieutenant Robbins then spoke with respondent directly, ordering him and the other EMT's to begin washing the vehicles. Respondent said, "I'm not going to wash the vehicles." The lieutenant pointed out that he had been offered a special material called Tychem to protect his clothes, a material which two of the other EMT's had already slipped into. Respondent stated yet again that he would not wash the vehicles (Tr. 264-67). Lieutenant Robbins reported to Captain Baughman that respondent was refusing the order to wash the vehicles. Later she overheard the captain tell respondent that he was relieved of duty (Tr. 268).

In a detailed memorandum (Pet. Ex. 6), dated September 26, 2009, Captain Baughman wrote that, upon hearing from Lieutenant Robbins of a "situation," the captain went to lounge and asked respondent why he was refusing the order to clean. Respondent said that he wasn't required to perform this type of work while on restricted duty and that he was not appropriately dressed. The captain told respondent he could clean the inside only of the vehicles and would be provided with a protective gown and mask if he wished. After respondent twice refused to comply with Captain Baughman's order, respondent was relieved of duty. Captain Baughman later spied respondent washing a vehicle. She again told him to leave the facility.

Lieutenant Robbins and two other EMT's wrote reports about the incident. In a report (Pet. Ex. 11) dated September 23, Lieutenant Robbins wrote that she asked respondent to wash several ambulances and that he refused to do so. She reported the incident to Captain Baughman.

Captain Baughman completed two other reports about the incident. In an unusual occurrence report (Pet. Ex. 7), dated September 23, she wrote that she directed respondent and three other EMT's to clean the station's spare vehicles. Respondent stated he would not clean the vehicles because he had no change of clothes in case his clothes got wet. Captain Baughman ordered him to clean the inside of the vehicles, but respondent refused again saying he had never had to work like this before while on restricted duty. After Captain Baughman ordered respondent a third time to clean and he refused to do so, respondent was relieved of duty and told to leave. When the captain saw respondent about 20 minutes later washing a vehicle, she repeated that he was relieved and ordered him out of the station.

Two other EMT's also wrote reports (Pet. Exs. 12 and 13) indicating that they heard respondent refuse to obey Captain Baughman's order to clean.

Respondent admitted that, on September 23, 2009, he was assigned to light duty at the division headquarters. He and three other employees were directed to wash the interior and exterior of some parked buses (Tr. 39, 44-45), although he insisted that there was never a "direct order" to do so by anyone other than another EMT (Tr. 39, 45). Respondent also insisted that he had "street clothes" on which were not appropriate to wash vehicles (Tr. 45). He therefore delayed in following the order until some 10 minutes after it was given, after placing plastic over his clothing (Tr. 40). Even after he donned protective gear and started cleaning, he was sent

home and not paid for the day (Tr. 40-41). The following day he brought in "extra clothing" and, when ordered to clean buses, immediately complied (Tr. 41).

Respondent called a co-worker to corroborate his assertion that he, in fact, complied with the order to clean. Mr. Campbell testified that, as respondent, Mr. Campbell, and two other EMT's were "having breakfast," an EMT ordered them to report downstairs to the lounge. In the lounge, the EMT's discovered they were being assigned to clean ambulances and discussed not being prepared to do so because of their regular street clothes. No one offered the EMT's protective gear. Nonetheless, respondent put on a gown and began washing the ambulances. Later a captain told respondent that he should go home because he had refused to wash ambulances. Mr. Campbell told the captain that he himself was "unprepared" to clean ambulances in his street clothes. Mr. Campbell insisted that he did not hear respondent refuse to wash the ambulances.

Lieutenant Robbins's testimony that she ordered respondent to clean the ambulances and that he refused was entirely credible. I also found credible her testimony that respondent was expressly offered protective gear to cover his clothes, in response to his concerns about his clothing. The lieutenant, unlike respondent, had no discernable interest in the outcome of the proceeding. Lieutenant Robbins's account was corroborated by the written statements from two other EMT's and from Captain Baughman, who stated that she repeated the order and that respondent refused yet again.

Respondent's version, in which he contended that he was never given an order by anyone other than an EMT and that he, in fact, complied, was not credible. No motive was offered to explain why two supervisors and two EMT's would all provide false statements about this issue, while respondent's motive to falsely deny misconduct was obvious. Respondent's contention that, without a supervisor telling him, he was unaware that protective gear was available was unbelievable, coming from an employee who had been an EMT for 20 years. Likewise, his assertion that he was sent home for no reason by Captain Baughman seemed highly implausible.

In his testimony, respondent contended that a major reason for his refusal was that he feared being exposed to all manner of medical waste, such as blood and feces. It is apparent this was an after-the-fact excuse, concocted to avoid taking responsibility for his disobedience. The statements of the other witnesses demonstrate that respondent never articulated this concern to his supervisors and that, in fact, he was offered adequate protective clothing to ensure his safety.

Based upon the testimony of Lieutenant Robbins and the statement of Captain Baughman, I find that, after being given orders to clean ambulances by another EMT and subsequently by two supervisors, respondent announced to both of the supervisors, including a captain, that he was refusing to obey and was then ordered by the captain to leave the workplace. Instead of leaving, respondent remained at the work site for approximately 20 minutes, when he began cleaning ambulances. Respondent's disobedient defiance of a lawful order violated OGP 101-01 § 4.2.54, and his belated compliance, after he had been ordered to leave the EMS work site due to his misconduct, did not exonerate him or prevent him from being disciplined. *See Dep't of Homeless Services v. Chappelle*, OATH Index No. 1918/07 (Aug. 30, 2007); *Dep't of Buildings v. Cortes*, OATH Index No. 577/90 (Feb. 9, 1990). The charge that respondent refused an order to clean ambulances should be sustained.

In sum, I find that the proof here was sufficient to sustain 11 of the charges, as discussed above.

FINDINGS AND CONCLUSIONS

1. Charges 1 and 2 of case #258/09D should be sustained in that, on May 21, 2009, respondent refused to obey an order to work mandatory overtime in violation of OGP No. 101-01 §§ 4.2.50 and 4.2.54.

2. Charges 3 and 4 of case #258/09D should be sustained in that, on September 23, 2009, respondent refused to obey an order to clean ambulances in violation of OGP No. 101-01 § 4.2.54.

3. Charge 1 of case #18/10D should be sustained in that, on June 8, 2009, respondent failed to properly evaluate and care for an elderly patient in violation of OGP No. 106-02 § 4.1.2.

4. Charge 2 of case #18/10D should be sustained in that, on June 8, 2009, respondent failed to complete a patient care report in violation of OGP No. 106-02 § 4.1.3.

5. Charge 3 of case #18/10D should be sustained in that, on June 8, 2009, respondent falsely reported that he had not made patient contact by reporting that a patient call was code 10-90 (unfounded) in violation of OGP No. 101-01 § 4.2.48.

6. Charge 4 of case #18/10D should be sustained in that, on June 17, 2009, respondent falsely stated that he did not realize that the elderly man he encountered was the patient who had called 911 and was also a patient he had transported 10 days before, in violation of OGP No. 101-01 § 4.2.48.

7. Charges 5 and 7 of case #18/10D should be sustained in that, on June 8, 2009, respondent failed to properly facilitate a patient's

request for transport to a specific hospital and refusal of medical aid in violation of OGP No. 106-04 §§ 4.9.3(A) and 5.31.

8. Charge 6 of case #18/10D should be dismissed in that petitioner failed to prove by a preponderance of the credible evidence that respondent failed to complete an activity log by the end of his tour.

9. Charge 8 of case #18/10D should be sustained in that on June 8, 2009, respondent failed to tell firefighters crucial information about prior interactions with a patient, resulting in the patient's door lock being broken, in violation of OGP No. 101-01 § 4.2.1.

RECOMMENDATION

Upon making the above findings, I requested and received a summary of respondent's personnel history. He was appointed in 1989 and has an extensive disciplinary history. In 1991 he was fined $100 for insubordination. In 1993 he was suspended 3 days and lost 3 days of annual leave for failure to perform his duties. In 1994, he was suspended for 5 days for insubordination and failure to safeguard equipment. In 1994 he was suspended for 7 work days for insubordination and providing an improper signal status. In 1995 he was reprimanded for improper patient care and for failing to prepare documentation. In 1997 he was suspended for 30 days and put on a one-year probation for insubordination and conduct unbecoming. In 2000 he accepted a penalty of 5 days' suspension and forfeit of 10 days' annual leave for failure to safeguard property. In 2002 he accepted a penalty of 5 days' suspension and forfeit of 10 days' annual leave for failure to maintain radio availability and conduct unbecoming. In 2006 he was reprimanded and placed on probation of one year for excessive lateness. Finally, in 2007, he was suspended for 20 days for failing to respond promptly to an assignment and for failing to report his departure from his assigned area, after a trial before this tribunal. *See Fire Dep't v. Prosper*, OATH Index No. 294/08 (Nov. 28, 2007). Respondent's extremely poor disciplinary record must serve to increase the penalty for the misconduct here.

Respondent's past evaluations have generally been poor. In 1990, his earliest evaluation, he was rated as needs improvement due to problems with his "judgment and reliability." In 1992 he was rated satisfactory, but in 1994 he was again rated needs improvement due to excessive absence and lateness. In 1997, 1998, 2000, 2002, and 2003 he was rated as good, although several supervisors commented on continuing problems with excessive absence and lateness. In 2004 respondent was rated as conditional due to problems with attendance and punctuality. At

the beginning of 2005 he was rated conditional due to poor attendance and lateness. In part of 2005 he was rated as good and very good as to starting his tour promptly and for maintaining his ambulance and equipment. In 2006 he was again rated as conditional due to his failure to respond to calls, providing improper radio signals, poor attendance, and lateness. In 2007 he was rated as very good in most categories, although he was initially rated as conditional due to pending disciplinary charges and to excessive absences. He was rated as outstanding with regard to maintaining his vehicle and his uniform. In 2008 he was rated as generally good, and very good as to being in his assigned area and operating his vehicle safely. He was rated conditional for not completing proper paperwork and for not going into service promptly at the beginning of his tour.

Other than the smattering of good and very good ratings in his evaluations, which are more than outweighed by other very poor ratings, respondent's file contains one other positive statement. In 1992, a patient's daughter praised respondent and his partner for going "beyond their usual routine" in transporting her father.

Both the record here and respondent's generally dismal personnel history demonstrate that respondent is, at best, an indifferent employee and, at worst, a vindictive one. In fact, petitioner's counsel coined the oxymoronic phrase "malicious indifference" to capture respondent's peculiar mix of hostility and apathy. Certainly respondent's refusal to obey the two orders concerning overtime and cleaning, without any rational justification, shows him to be unreliable and largely indifferent to the consequences of this unreliability both to his co-workers and to his own career. Respondent's insubordination seemed to be due, in part, to considerable resentment he harbored against his employer. This anger was apparent in his insistence that, despite his alleged certification as a paramedic, the Department refused to promote him.

Respondent's treatment of Mr. Williams displayed equal parts of inattention and nastiness. Respondent was apparently content to stand by silently while Ms. Alleyne refused to transport Mr. Williams to his hospital of choice, perhaps feeling that Mr. Williams might be abusing the 911 system in order to get free transportation for non-emergency care. Respondent's resentment of Mr. Williams seems to have led him to deliberately convey false information to dispatch, causing an unnecessary break-in to Mr. Williams's apartment.

Petitioner has requested that respondent be terminated for the misconduct which occurred here. For the two acts of insubordination alone, a penalty of at least 40 days would be

appropriate under the principle of progressive discipline, since respondent has already been suspended for 20 days in 2007 for similar misconduct. When compounded with the multiple violations which occurred during the incident involving Mr. Williams, there is little doubt that respondent should be dismissed. His sorry work history demonstrates conclusively that he cannot be depended upon to observe fundamental rules of his work, despite being disciplined repeatedly. In similar cases involving persistent patterns of unacceptable work performance or insubordination, termination has been found appropriate. *See, e.g., Short v. Nassau County Civil Service Comm'n*, 45 N.Y.2d 721, 723 (1978) (termination appropriate for employee's "persistent unwillingness to accept the directives of his supervisors"); *Dep't of Health & Hospitals Corp. (Coler-Goldwater Specialty Hospital & Nursing Facility) v. Ramsay*, OATH Index No. 1248/05 (Nov. 9, 2005) (maintenance worker terminated for numerous acts of insubordination and discourtesy); *Admin. for Children's Services v. Lin*, OATH Index No. 1812/01 (Nov. 9, 2001) (termination appropriate for defiance of multiple supervisory directives, after prior 20-day penalty and demotion for similar misconduct).

Accordingly, I recommend that respondent be terminated.

John B. Spooner
Administrative Law Judge

December 16, 2010

SUBMITTED TO:

SALVATORE J. CASSANO
Commissioner

APPEARANCES:

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NYC Civ. Serv. Comm'n Decision, Item No. CD 11-52-A (Aug. 9, 2011)

THE CITY OF NEW YORK CIVIL SERVICE COMMISSION

In the Matter of the Appeal of:
RODRIQUE PROSPER
Appellant
-against-
NYC FIRE DEPARTMENT
Respondent

Pursuant to Section 76 of the New York State Civil Service Law

PRESENT:

NANCY G. CHAFFETZ, **COMMISSIONER**
CHAIR

RUDY WASHINGTON, COMMISSIONER
VICE CHAIR

MATTHEW W. DAUS, COMMISSIONER

CHARLES D. MCFAUL, COMMISSIONER

ALINA A. GARCIA
DIRECTOR/GENERAL COUNSEL

AMANDA M. WISMANS
ATTORNEY FOR THE COMMISSION

JESSE GRIBBEN, ESQ.
REPRESENTIVE FOR APPELLANT

TYRONE HUGHES, ESQ.
REPRESENTATIVE FOR RESPONDENT

APPELLANT PRESENT

STATEMENT

On Thursday, June 30, 2011 the City Civil Service Commission heard oral argument in the appeal of RODRIQUE PROSPER, Emergency Medical Technician, NYC Fire Department, from determination by the NYC Fire Department, finding him guilty of charges of incompetency or misconduct and imposing a penalty of TERMINATION following an administrative hearing conducted pursuant to Civil Service Law Section 75.

COMMISSIONERS' FINDINGS

After a careful review of the testimony adduced at the departmental hearing and based on the record in this case, the Civil Service Commission finds no reversible error and affirms the decision and penalty imposed by the New York City Fire Department.

NANCY G. CHAFFETZ, *Commissioner/Chair,* Civil Service Commission
RUDY WASHINGTON, *Commissioner/Vice Chair,* Civil Service Commission
MATTHEW W. DAUS, *Commissioner,* Civil Service Commission
CHARLES D. McFAUL, *Commissioner,* Civil Service Commission

August 9, 2011