Health & Hospitals Corp. (Bellevue Hospital Ctr.) v. Ogbonna

OATH Index No. 165/17 (Jan. 17, 2017), *adopted*,
HHC Personnel Review Bd. Dec. No. 013/17 (June 13, 2017)

Patient care technician charged with sleeping on duty on three occasions. ALJ found testimony of supervisor and hearsay statements of other staff sufficient to sustain the charges. Penalty of termination recommended.

NEW YORK CITY OFFICE OF
ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
HEALTH AND HOSPITALS CORPORATION
(BELLEVUE HOSPITAL CENTER)
Petitioner
- against -
YOUNG OGBONNA
Respondent

REPORT AND RECOMMENDATION

SUSAN J. POGODA, *Administrative Law Judge*

This disciplinary proceeding was referred to me pursuant to section 7:5 of the Personnel Rules and Regulations of the Health and Hospitals Corporation by petitioner Bellevue Hospital Center. Respondent, Young Ogbonna, a patient care technician ("PCT"), is charged with sleeping on duty on three occasions and other related misconduct.

During a one-day trial petitioner presented testimony from respondent's supervisor and a medical fellow. Respondent testified on his own behalf, denying that he was asleep or inattentive to his duties.

For the reasons set forth below, I find that all of the charges should be sustained and recommend that respondent be terminated.

ANALYSIS

Respondent is employed as a PCT at Bellevue Hospital. On all of the charged dates, respondent was assigned to monitor patients who required special attention and were at risk of falling out of their beds and injuring themselves (Tr. 62). Hospital rules (Pet. Ex. 8) require that

PCT's placed on close observation assignments must complete observation flow sheets every 15 minutes. The three charges allege that on May 4 and 5, 2015 and on August 11, 2015, respondent was observed sleeping on duty, failed to perform various aspects of his patient monitoring assignments, and compromised patient safety. Charge 2 also alleges that, on May 5, respondent failed to respond when a patient got up from the bed, while charge 3 also alleges that respondent failed to record patient data on a flowsheet (ALJ Ex. 1).

Ms. Martin-Rodgers, the assistant director of nursing, testified that she had been respondent's supervisor for ten years (Tr. 101). On May 4, 2015, respondent was assigned to provide noon meal relief for a staff member who was monitoring a patient in a hospital room (Pet. Ex. 2). Shortly after 12:00 p.m., during Ms. Martin-Rodgers daily rounds, she looked into respondent's assigned room and observed respondent sitting in a chair beside the door with his eyes closed and his head leaning to the right, appearing to be asleep (Tr. 28, 36, 38). He did not open his eyes when Ms. Martin-Rodgers entered the room. Ms. Martin-Rogers stated that respondent appeared to be sleeping and she thought he was sleeping (Tr. 122). She walked in front of respondent and called out to him, "Ogbonna," and respondent jumped out of his chair and stood up. Ms. Martin-Rodgers told respondent he needed to wash his face or stand up if he was feeling sleepy (Tr. 39-40). Respondent said that he wasn't sleeping (Tr. 40). Respondent repeated this denial to Ms. Martin-Rodgers later during his shift (Tr. 41).

The following day, May 5, 2015, respondent was assigned to provide 11:00 a.m. meal relief in the same room for a nurse's aide monitoring two patients (Tr. 45; Pet. Ex. 3). Dr. Lee, an oncology fellow, testified that on the same morning, he performed a bone marrow biopsy on one of the patients in the hospital room where respondent was assigned. A medical student, Mr. Minhas, was standing at the foot of the patient's bed observing the biopsy and respondent was watching the patient in the adjacent bed who was in the end stages of cancer and in a weakened condition (Tr. 17-18, 20). In the middle of the biopsy, which involved driving a large 10 centimeter needle into the hip bone of the patient and extracting bone marrow, the patient in the adjacent bed fell through the curtain onto the back of Dr. Lee's right knee (Tr. 10, 14; Pet. Ex. 4). As Dr. Lee completed the biopsy, Mr. Minhas and respondent helped the other patient get up from the floor and back into bed. According to Dr. Lee, Mr. Minhas later told him that respondent, who had been assigned to monitor the patient, was "asleep" (Tr. 11, 15). Dr. Lee

completed a written statement (Pet. Ex. 1) describing being struck by the other patient while performing the biopsy.

Ms. Martin-Rodgers testified that she was made aware of the May 5 incident with Dr. Lee on the following day. She spoke with both Dr. Lee and Mr. Minhas (Tr. 46, 48). Mr. Minhas told Ms. Martin-Rodgers that he had observed respondent from the foot of the bed "in and out of sleep" (Tr. 98 - 100). Mr. Minhas also completed a written statement (Pet. Ex. 4) stating that the patient in the adjacent bed "got up from his bed and fell sideways" against the curtain and into Dr. Lee's leg. He also stated that respondent, the PCT on duty, "was drifting in and out of sleep on the chair situated across the feet [sic] of the bed."

When Ms. Martin-Rodgers questioned respondent about the May 5 incident, he denied being asleep and indicated that doctors lied about him because he is "African" and "black" (Tr. 54). According to Ms. Martin-Rodgers, this was the only occasion when respondent had ever accused medical staff of treating him unfairly (Tr. 100).

The third incident occurred on August 11, 2015. Ms. Martin-Rodgers testified that on this date, respondent was on a 7:00 a.m. to 3:30 p.m. shift and assigned to monitor three patients sharing a hospital room (Tr. 66-67; Pet. Ex. 6). The assignment included observing the patients in the room and taking vital signs. Every 15 minutes the PCT's were required to fill out a flow sheet indicating whether the patient was asleep, awake, or moving about (Tr. 35-36; 70 ; Pet. Ex. 7). At around 1:30 p.m., during her daily rounds, Ms. Martin-Rodgers entered respondent's assigned room and observed respondent sitting in a chair with his head leaning to the right, apparently sleeping. She remained watching him for three minutes, checking the time on her phone, and then called out his name. When respondent did not reply, she tapped him on the shoulder and called his name again. She tapped two or three more times and respondent opened his eyes. Ms. Martin-Rodgers told him she would have to report the incident as it was the second time she had observed him sleeping on duty (Tr. 56-58). Respondent got up and said he had not been sleeping (Tr. 58).

Ms. Martin-Rodgers spoke to the director of nursing and reported what she had seen (Tr. 111-114). She then found another staff member to replace respondent and, after speaking with the director, respondent was relieved from duty at 2:45 p.m. (Resp. Ex. B) and sent home (Tr. 204-205).

Ms. Martin-Rodgers summarized the incident in an e-mail (Pet. Ex. 5) sent to her supervisor later that day, stating that respondent's eyes had been closed. Ms. Martin-Rodgers also examined the flow sheet (Pet. Ex. 7) prepared by respondent for the patients he was assigned to monitor on August 11 who were at risk of falling. Although there were entries on the sheet from 7:15 a.m. to 1:00 p.m. indicating that the patients were awake, there are no entries from 1:15 to 2:15 p.m. (Tr. 75).

In his testimony, respondent denied sleeping on any of the dates charged. Respondent testified that, on May 4, "nothing happened that day" and he did not see Ms. Martin-Rodgers during his meal relief assignment (Tr. 149). He denied that he had fallen asleep (Tr. 150). He testified that he first heard about the May 4 sleeping-on-duty accusation at a conference at Bellevue Hospital (Tr. 151).

As to the second date, respondent initially stated that, on May 5, an "agency employee" asked respondent to relieve him for a break at 12:00 p.m. (Tr. 152). He then testified that he recalled Dr. Lee and some students coming into the room where there were "about three patients." Dr. Lee went to the wrong patient and respondent told them, "This is not the patient you is supposed to do" (Tr. 153). Dr. Lee pulled a curtain around the patient who was receiving the procedure, preventing anyone around the bed from seeing respondent (Tr. 155-56).

Another patient told respondent he had to "urinate" and respondent also pulled the curtain around that patient's bed to provide privacy, as required by hospital policy (Tr. 157, 212). After the patient stood and finished urinating into a portable urinal, respondent saw "the leg of the patient on the ground" and "on the edge of the curtain" (Tr. 158). Respondent moved "quick" and opened the curtain, asking the patient what happened. The patient spoke only "Chinese" (Tr. 158). Respondent called a Chinese nurse who indicated that the patient said, "Sit, sit" (Tr. 161). When the nurse asked the patient if he fell, he indicated that he had not (Tr. 163). The nurse also spoke to Dr. Lee. Dr. Lee told her he was doing a procedure (Tr. 159). Respondent insisted that Dr. Lee was not struck by the patient's leg, but merely saw the leg (Tr. 161). Respondent and another PCT pulled the patient up and put him back in bed (Tr. 160, 163). A medical student tried but was unable to assist (Tr. 168). When asked if he was sleeping on May 5, respondent stated, "Not at all" (Tr. 166).

Respondent recalled being questioned about the May 5 incident by Ms. Martin-Rodgers. He repeatedly denied that the patient fell (Tr. 173). Respondent also denied that he ever told Ms. Martin-Rodgers that the hospital staff was prejudiced against him due to his race (Tr. 174-75).

Respondent, who appeared at the trial wearing a sling on his left arm, stated that he was injured on the job a few weeks after the May 5 incident, on May 28, 2015, when a patient struck him in the eye and shoulder with a door. The incident resulted in a loss of vision requiring him to use eye drops 3 times per day (Tr. 145, 180).

As to the August 11 incident, respondent stated that he saw Ms. Martin-Rodgers as he was returning from his break. At 1:00 pm, he was putting in his eye drops, which would take 10 to 20 minutes to coat his eye, when Ms. Martin-Rodgers entered the room (Tr. 181-82, 184, 188). Respondent stated that Ms. Martin-Rodgers came into the room, said nothing, walked up behind him, and "hit" him in the shoulder which he had injured some six months before, causing him to "start crying" because he was "in serious pain" (Tr. 189). Ms. Martin-Rodgers escorted respondent to see the director, via the elevator and not the stairs (Tr. 201), and told her that respondent had been sleeping (Tr. 190). Respondent denied this. The director asked Ms. Martin-Rodgers if there were any other witnesses, and she said there were not (Tr. 193). The director gave respondent a letter (Resp. Ex. B) relieving him from duty for the remainder of the day (Tr. 203).

Analysis of all three charges depends upon assessing the credibility of petitioner's witnesses and hospital staff statements indicating they observed respondent with his eyes closed, and respondent, who denied sleeping. To evaluate credibility, this tribunal has looked to "witness demeanor, consistency of a witness' testimony, supporting or corroborating evidence, witness motivation, bias or prejudice, and the degree to which a witness' testimony comports with common sense and human experience." *Dep't of Sanitation v. Menzies*, OATH Index No. 678/98 at 2-3 (Feb. 4, 1998), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 98-101-A (Sept. 9, 1998) (citation omitted).

Ms. Martin-Rodgers, who testified as to her May 4 and August 11 observations, gave every appearance of being a truthful witness. Her testimony was clear, straightforward and professional. As to the August 11 incident, her observations were corroborated by a contemporaneous written report. The fact that the flowsheet that respondent was supposed to complete has no entries for 1:15 or 1:30 is consistent with Ms. Martin-Rodgers's observation that

respondent was either daydreaming or asleep at around this time, and contradicts respondent's testimony that he was alert and doing his job. Although respondent testified that Ms. Martin-Rodgers was biased against him, he offered neither a reason for bias nor any evidence to support his accusation.

Respondent, on the other hand, was a thoroughly incredible witness. Much of his testimony was disjointed, difficult to understand, and implausible. His insistence that, for some reason, he was aware of which patient was scheduled for the May 5 biopsy and had to correct a misidentification by medical staff seemed unlikely. Respondent's testimony that the patient he was assigned to monitor, called respondent " to urinate" and told respondent "to close the curtain and give him privacy" is contradicted by the contention that the patient only spoke Chinese and did not understand English (Tr. 158, 160-161). His account of a Chinese nurse, who translated for the patient who fell into Dr. Lee and, stated that the patient denied falling and insisted he just sat on the floor, was equally improbable, and contradicted by the testimony of Dr. Lee. Furthermore, by his own admission, respondent recognized that "something went wrong" when he saw the patient's leg on the floor (Tr. 161).

Respondent's contention that Ms. Martin-Rodgers hit him on the arm on August 11, causing him pain to the point that he wept, was highly suspect. Despite respondent having made complaints of workplace injury, he apparently made no complaint as to being injured on this date and never indicated that he told the director that he had been struck by Ms. Martin-Rodgers.

Respondent's testimony was peppered with inconsistencies. He initially stated that, on August 11, Ms. Martin-Rodgers walked up behind him (Tr. 189), but seconds later he testified he could see her approaching (Tr. 190). In one breath he testified that, on August 11, Ms. Martin-Rodgers said nothing to him because the two of them had not spoken in some time (Tr. 191), and seconds later testified that Ms. Martin-Rodgers said, "Oh, you're sleeping" (Tr. 191). He stated that Ms. Martin-Rodgers has a "personal problem" with him (Tr. 191). Yet, when asked what the nature of the problem was, he stated only that she had complained about his work performance by making "false allegations on me" and threatening to make sure he loses his job (Tr. 195), strongly suggesting that any problems that existed between them are largely his, not hers.

Respondent testified that he saw Ms. Martin-Rogers at 1:00 p.m. because he was putting eye drops in his eye and his head was back (Tr. 181-182, 184). Respondent later stated that Ms. Martin-Rodgers came to him as he was putting in the eye drops at 1:30 p.m. (Tr. 188).

Respondent did not mention the eye drops to Ms. Martin-Rodgers (Tr. 189). This testimony is not only inconsistent but demonstrates that respondent, by his own account, would have been unable to properly monitor and assist his assigned patients or document their activity every 15 minutes, since he was obliged to keep his head back for between 10 to 20 minutes for the eye drops to coat his eye (Tr. 181-182, 184).

Based upon Ms. Martin-Rodgers's credible testimony, I find that, on May 4, 2015, respondent was assigned to monitor patients to ensure, among other things, that they did not fall from their beds. A few minutes after 12:00 p.m., he was seen by his supervisor with his eyes closed and his head leaning to one side, appearing to be asleep. Likewise, on August 11, 2015, respondent was again seen by his supervisor, at around 1:30 p.m., with his eyes closed and his head leaning to one side. The supervisor watched for three minutes as respondent remained in this position. The supervisor spoke to and tapped respondent on the shoulder three times before he opened his eyes and answered her.

The May 5 allegations, which are based upon the hearsay statements of Mr. Minhas, requires weighing of additional factors. Hearsay is generally admissible in administrative proceedings and may form the sole basis for a finding of fact. *See* Charter § 1046(c)(1) (Lexis 2016); 48 RCNY § 1-46(a) (Lexis 2017); *Gray v. Adduci*, 73 N.Y.2d 741, 742 (1988); *People ex. rel. Vega v. Smith*, 66 N.Y.2d 130, 139 (1985); *Dep't of Correction v. Jackson*, OATH Index No. 134/04 at 4-5 (May 5, 2004), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 05-67-SA (Sept. 14, 2005); *Police Dep't v. Ayala*, OATH Index No. 401/88 (Aug. 11, 1989), *aff'd sub nom., Ayala v. Ward*, 170 A.D.2d 235 (1st Dep't 1991). However, hearsay must have probative value and bear some indicia of reliability in order to be given significant weight. *See Dep't of Housing Preservation & Development v. Davron*, OATH Index No. 1533/11 at 16 (Dec. 21, 2011).

In order to ascertain the probative value and reliability of hearsay evidence, courts and this tribunal have relied on several factors, including "the identity of the hearsay declarant, the availability of the declarant to testify, the declarant's personal knowledge of the facts, the independence or bias of the declarant, the detail and range of the hearsay, whether the statements were oral or written, signed and sworn or unsworn, the degree to which the hearsay is corroborated, the centrality of the hearsay evidence to the agency's case, and the magnitude of the administrative burden should the hearsay be excluded." *Dep't of Environmental Protection v. Cortese*, OATH Index No. 1613/06 at 7 (Sept. 12, 2006).

Here there are a few factors buttressing the reliability of Mr. Minhas's statements that respondent was "drifting in and out of sleep." Mr. Minhas was an unbiased observer. He made consistent contemporaneous statements to Dr. Lee and later to Ms. Martin-Rodgers. Mr. Minhas made the statements three times -- to Dr. Lee, to Ms. Martin-Rodgers, and in a handwritten report. The statements that respondent was inattentive are corroborated, to a degree, by the fact that the patient's leg came into contact with Dr. Lee as the doctor was performing a biopsy and the patient was found sitting on the floor by his bed. Based upon these factors, I found the hearsay statements by Mr. Minhas to be credible and reliable.

Respondent's account of the May 5 incident, as discussed above, was particularly unbelievable. Respondent's insistence that Mr. Minhas could not have observed him because the curtain around the bed of the biopsied patient was closed was not persuasive. Ms. Martin-Rogers credibly testified that she was familiar with the room and believed that from the foot of the biopsied patient's bed, Mr. Minhas could have observed respondent at the adjacent bed (Tr. 99-100). Based upon Mr. Minhas's and Dr. Lee's statements, I find that, on May 5, a patient whom respondent had been assigned to monitor fell out of bed against the leg of a doctor who was performing a bone marrow biopsy. At this time, respondent either fell asleep or intermittently closed his eyes.

The evidence supports a finding that respondent was sleeping on duty based on the observation on August 11, 2015, that respondent had his eyes closed and head inclined for three minutes and required multiple efforts to reply to his supervisor. On May 4 and May 5, the evidence indicated that, while possibly not completely asleep, respondent was inattentive and not monitoring the patients he was assigned to observe.

Respondent's conduct on all three dates violated a number of hospital rules. While the various rules offered by petitioner (Pet. Ex. 9), including the Corporation Personnel Rules and various Bellevue directives, do not expressly mention sleeping on duty, HHC Code of Conduct section (B)(1) requires that all employees perform their duties "in a satisfactory manner." HHC Code of Conduct section E defines "unprofessional conduct" as including "acts of gross incompetence or gross negligence on a single occasion, or negligence or incompetence on more than one occasion." As a general matter, employees who sleep on duty or otherwise avoid work are found to have committed misconduct on the theory that they are failing in their obligation to perform their duties. *Health and Hospitals Corp. (Kings County Hospital Ctr.) v. Delapara,*

OATH Index No. 349/01 at 8 (Apr. 6, 2001). In order to timely note his observations of the patients assigned to him as required by hospital policy, respondent was required to be awake and not sleeping or closing his eyes (Tr. 82-83). Respondent's failure to provide close observation and complete the flowsheet violated the Bellevue Hospital Close Observation Policy (Pet. Ex. 8). It was also clear that PCT's were trained that a primary purpose of being assigned to the hospital rooms was to observe the patients' movements and prevent them from falling (Martin-Rodgers: Tr. 77-78).

The August 11 charge that respondent failed to record patient data is based upon the flowsheet (Pet. Ex. 7), which is missing 5 entries from 1:15 p.m. to 2:15 p.m. It is true that the evidence indicated that, after Ms. Martin-Rodgers found respondent sleeping at 1:30 p.m., respondent was relieved of duty and sent home. It was unclear exactly when respondent was sent home, but it was obviously after 1:30 p.m. when Ms. Martin-Rodgers saw him sleeping. Respondent would therefore have been obliged to do entries for 1:15 and 1:30 p.m. and his failure to do so was misconduct.

In sum, all of the charges should be sustained.

FINDINGS AND CONCLUSIONS

1. Charge 1, specifications 1, 2, and 3 should be sustained in that, on May 4, 2015, respondent was asleep on duty or failed to attend to his assignment of observing a patient, compromising patient safety, in violation of HHC Code of Conduct sections (B)(1) and E and Bellevue Hospital observation policy.

2. Charge 2, specifications 1, 2, 3, and 4 should be sustained in that, on May 5, 2015, respondent was asleep on duty or failed to attend to his assignment of observing a patient, and failed to stop a patient from getting out of bed, compromising patient safety, in violation of HHC Code of Conduct sections (B)(1) and E and Bellevue Hospital observation policy.

3. Charge 4, specifications 1, 2, 3, and 4 should be sustained in that, on August 11, 2015, respondent was asleep on duty, failed to attend to his assignment of observing a patient, and failed to record patient data on a flowsheet, compromising patient safety, in violation of HHC Code of Conduct sections (B)(1) and E and Bellevue Hospital observation policy.

RECOMMENDATION

Upon making the above findings, I requested and received a summary of respondent's personnel history in order to make an appropriate penalty recommendation. Respondent was appointed as a PCT in 2002 and has a significant disciplinary record. In 2007, he was suspended for 10 days, with a 15-day penalty for the record, for excessive absence. In 2010, he was suspended for 60 days and placed on probation for sleeping on duty, failing to respond when a patient fell from a bed to the floor and leaving a patient sitting in urine for two hours. In 2014, he was again suspended for 20 days, with a 60-day penalty for the record, for refusing an assignment, using inappropriate language to a supervisor, and abandoning a work assignment.

While four of respondent's last six evaluations have been "satisfactory," the evaluations for 2012-13 and 2015-16 were "unsatisfactory" or "needs improvement." The 2012-13 evaluation notes that respondent is repeatedly late for work and has unscheduled absences. The 2015-16 evaluation notes that respondent falls asleep during close observation assignments.

In this case, respondent's failure to perform his observation assignments and sleeping while on duty, despite being previously disciplined for similar misconduct, constituted a serious infraction and placed patients at risk. By far the most egregious act of misconduct occurred on May 5, 2015, when respondent not only permitted a patient he was assigned to monitor to fall from his bed but, by failing to prevent the fall, it could have interfered with an invasive surgical procedure being conducted in the adjacent bed by a doctor. It is fortuitous that no one involved was injured.

Petitioner's attorney recommended that respondent be terminated for the misconduct here. Employees with a history of sleeping on the job have been terminated. *Triborough Bridge and Tunnel Auth. v. Perkins*, OATH Index No. 1571/02 (May 22, 2002); *Dep't of Correction v. Hyman*, OATH Index No. 219/83 (Sept. 6, 1983). While some hospital employees have received suspension penalties for sleeping on duty, *see Health and Hospitals Corp. (Harlem Hospital Ctr.) v. Henry,* OATH *Index* No. 2196/13 (Dec. 9, 2013)*; Health and Hospitals Corp. (Metropolitan Hospital Ctr.) v. Williams,* OATH Index No. 386/98 (Dec.8, 1997), *aff'd,* HHC Personnel Review Bd., Decision No. 923 (Oct.26, 1998)*; Health and Hospitals Corp. (Kings County Hospital Ctr.) v. Delapara,* OATH Index No. 349/01 (Apr. 6, 2001*),* hospital employees found to have slept on duty have been terminated under exacerbating circumstances, such as compromising hospital security, *Health and Hospitals Corp. (Metropolitan Hospital Ctr.) v.*

Santana, OATH Index No. 1962/04 (Apr. 19, 2005), or threatening patient safety, *Health and Hospitals Corp.* (*Henry J. Carter Specialty Hospital & Nursing Facility*) v. *Williamson*, OATH Index No. 986/16 (Oct.7, 2016).

Based on respondent's prior disciplinary record coupled with the severe safety risks posed by this misconduct, I find that the only appropriate penalty here is termination, and I so recommend.

Susan J. Pogoda
Administrative Law Judge

January 17, 2017

SUBMITTED TO:

STEVEN R. ALEXANDER
Executive Director

APPEARANCES:

BRIAN MITCHELL, ESQ.
Attorney for Petitioner

MICHAEL COVIELLO, ESQ.
Attorney for Respondent

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JS → NVG → BM

PERSONNEL REVIEW BOARD
NEW YORK CITY HEALTH+HOSPITALS

In the Matter of the Appeal of	:	**Decision No.: 013/17**
YOUNG OGBONNA	:	**Date: June 13, 2017**
Patient Care Technician **Bellevue Hospital Center**	:	**DOCKET NO.: 1000/17**

This is an appeal to New York City Health+Hospitals Personnel Review Board ("Board") by Young Ogbonna ("Appellant") from the decision by Bellevue Hospital Center ("Facility") to terminate him, pursuant to Rule 7.5 of the Personnel Rules and Regulations of New York City Health+Hospitals, from his position as a Patient Care Technician. As explained below, the Appeal is denied.

BACKGROUND

New York City Health+Hospitals ("NYCH+H"), charged Appellant with sleeping on duty on three occasions and other related misconduct. NYCH+H charged that on May 4 and May 5, 2015 and on August 11, 2015 Appellant was observed sleeping on duty, failed to perform various aspects of his patient monitoring assignments and compromised patient safety. Charge 2 also alleges that on May 5, 2015 Appellant failed to respond when a patient got up from the bed, while charge 3 also alleges that Appellant failed to record patient data on a flowsheet. On January 17, 2017 the Office of Administrative Trials and Hearings (OATH), Administrative Law Judge Susan J. Pogoda presiding, conducted a Rule 7.5 hearing on all of the charges. In a Report and Recommendation

dated January 17, 2017, Judge Pogoda recommended that all of the charges be sustained and that the appropriate penalty is termination.

In the case before Judge Pogoda, testimony was given by the Assistant Director of Nursing, Ms. Martin-Rogers, who stated that, when she entered the patient's room on May 4, 2015, Appellant appeared to be sleeping and she thought he was sleeping and when she called out his name "he jumped out of his chair". Appellant denied that he had been sleeping. On the following day, May 5, 2015, the patient that the Appellant was assigned to monitor had fallen out of bed and struck the knee of the doctor on the other side of the curtain who was extracting bone marrow for a biopsy from the patient in the next bed. A medical student who was with the doctor performing the biopsy helped the patient up from the floor and back into bed and subsequently told the doctor that the Appellant was "asleep". After being confronted about the incident, Appellant denied he was asleep. On August 11, 2015, Ms. Martin-Rogers entered Appellant's assigned room and watched him for approximately three minutes observing that he was apparently sleeping. She called his name but he did not respond. She called his name again and tapped him on the shoulder several times before he opened his eyes. Appellant denied he had been sleeping. Ms. Martin-Rogers also examined the flowsheet which was prepared by the Appellant for the patients he was assigned to monitor who were at risk of falling. Ms. Martin-Rogers noted that no entries were made for approximately one hour. Appellant stated that relating to the August 11 incident he had put eye drops in his eyes and he had closed them to allow the drops to coat his eyes. Judge Pogoda found that Appellant's testimony was "peppered with inconsistencies" and that the evidence supports a finding that appellant "was sleeping on duty based on the observation on August 11, 2015". Regarding the incidents on May 4 and May 5, Judge Pogoda

determined that the evidence indicated that "while possibly not completely asleep,... [he] was inattentive and not monitoring the patients he was assigned to observe." Judge Pogoda also noted that Appellant's most recent evaluation, 2015-2016 noted that Appellant "falls asleep during close observation assignments." Based on the severe safety risks noted by Judge Pogoda, her recommendation was termination. This recommendation was forwarded to the Facility which, by letter dated February 10, 2017, and on behalf of the Chief Executive Officer of the Facility, Ms. Shamelle Watkins-Harcum, Senior Associate Director, Human Resources, agreed with the findings of fact and recommended penalty. Appellant was terminated as a Patient Care Technician effective February 10, 2017.

Appellant, through his attorney, Michael Coviello, Esq., appealed the Judge Pogoda's recommendation and Appellant's termination pursuant to Rule 7.5 to this Board on March 16, 2017.

DECISION AND ORDER

On May 3, 2017, this Board held a hearing on this appeal. Michael Coviello, Esq. appeared for Appellant and Brian Mitchell, Esq. appeared for NYCH+H. Mr. Coviello argued that the record does not support the findings of misconduct and that the record does not support the penalty of termination. Mr. Coviello reiterated the issue of eye drops in the Appellant's eyes and just closing them to coat the eye. Appellant failed to offer convincing defenses of the charges brought against him. He denied he was sleeping at any point. Furthermore, Mr. Coviello argued that termination was excessive as "at no point was any patient injured." Mr. Mitchell argued that the appeal should be denied as "the decision of the administrative law judge had a rational basis". It was neither "arbitrary or capricious and there is substantial evidence supporting the

determination." Mr. Mitchell further indicated that Appellant received two 60-day suspensions which predated these charges and which involved similar issues of conduct and performance of duties.

After a review of the testimony presented and of the record, the Board finds no reason to overturn the determination of Judge Pogoda or the decision of the Facility to terminate the Appellant. For the foregoing reasons, this Appeal is denied.

[redacted]

Gayle A. Gavin
Chair

[redacted]

Jonathan L. Kimmel
Board Member

[redacted]

Pamela G. Ostrager
Board Member

JLK: jams
cc: Brian P. Mitchell, Esq., Labor Relations, NYCH+H
Michael Coviello, Esq., Counsel for Appellant