STATE OF NEW JERSEY

In the Matter of Randy Kelly, Ancora Psychiatric Hospital, Department of Health CSC Docket No. 2021-1815 OAL Docket No. CSV 05208-21	**DECISION OF THE CIVIL SERVICE COMMISSION**

ISSUED: JUNE 14, 2024

The appeal of Randy Kelly, Human Services Technician, Ancora Psychiatric Hospital, Department of Health, removal, effective September 28, 2020, on charges, was heard by Administrative Law Judge Joan M. Burke (ALJ), who rendered her initial decision on May 13, 2024. Exceptions were filed on behalf of the appointing authority and a reply to exceptions was filed on behalf of the appellant.

Having considered the record and the attached ALJ's initial decision, and having made an independent evaluation of the record, including a thorough review of the exceptions and reply, the Civil Service Commission (Commission), at its meeting on June 12, 2024 adopted the ALJ's Findings of Facts and Conclusions of Law and her recommendation to reverse the removal.

Upon its *de novo* review of the ALJ's thorough and well-reasoned initial decision as well as the entire record, including the exceptions and reply filed, most of which do not require extensive comment, the Commission agrees with the ALJ's determinations regarding the charges, as they were predominantly based on the ALJ's credibility determinations of the testimony of the witnesses and how that testimony compared to the video of the incident. In this regard, the Commission acknowledges that the ALJ, who has the benefit of hearing and seeing the witnesses, is generally in a better position to determine the credibility and veracity of the witnesses. *See Matter of J.W.D.*, 149 *N.J.* 108 (1997). "[T]rial courts' credibility findings . . . are often influenced by matters such as observations of the character and demeanor of the witnesses and common human experience that are not transmitted by the record." *See also, In re Taylor,* 158 *N.J.* 644 (1999) (quoting *State v. Locurto,* 157 *N.J.* 463, 474 (1999)). Additionally, such credibility findings need not be explicitly enunciated if the record as a whole makes the findings clear. *Id.* at 659

(citing *Locurto, supra)*. The Commission appropriately gives due deference to such determinations. However, in its *de novo* review of the record, the Commission has the authority to reverse or modify an ALJ's decision if it is not supported by sufficient credible evidence or was otherwise arbitrary. *See N.J.S.A.* 52:14B-10(c); *Cavalieri u. Public Employees Retirement System,* 368 *N.J. Super.* 527 (App. Div. 2004). In this matter, most important was the ALJ's finding that, after her detailed review of the video, the appellant's testimony that he did not push the patient but rather the patient dropped to the ground while the appellant attempted a restraint technique, was credible. The exceptions filed arguing that the ALJ's above assessment was inaccurate is not persuasive. In this regard, based on its review of the record, the Commission finds nothing to demonstrate that the ALJ's assessment of the credibility of the witnesses was so off base as to meet the standard for reversal of such findings enunciated above. As such, since the appointing authority's exceptions have not demonstrated that the ALJ's credibility determinations, or her findings and conclusions based on those determinations, were arbitrary, capricious or unreasonable, the Commission has no reason to question those determinations, or the findings and conclusions made therefrom. Therefore, the Commission finds that the appointing authority has not sustained its burden of proof in this matter and the appellant's removal is reversed.

Since the removal has been reversed, the appellant is entitled to be reinstated with mitigated back pay, benefits, and seniority pursuant to *N.J.A.C.* 4A:2-2.10 from the first date of separation without pay until the date of reinstatement. Moreover, as the removal has been reversed, the appellant is entitled to reasonable counsel fees pursuant to *N.J.A.C.* 4A:2-2.12.

This decision resolves the merits of the dispute between the parties concerning the disciplinary charges and the penalty imposed by the appointing authority. However, per the Appellate Division's decision, *Dolores Phillips v. Department of Corrections*, Docket No. A-5581-01T2F (App. Div. Feb. 26, 2003), the Commission's decision will not become final until any outstanding issues concerning back pay or counsel fees are finally resolved. In the interim, as the court states in *Phillips, supra*, if it has not already done so, upon receipt of this decision, the appointing authority shall immediately reinstate the appellant to his position.

ORDER

The Civil Service Commission finds that the action of the appointing authority in removing the appellant was not justified. The Commission therefore reverses that action and grants the appeal of Randy Kelly. The Commission further orders that the appellant be granted back pay, benefits, and seniority from the first date of separation without pay until the date of reinstatement. The amount of back pay awarded is to be reduced and mitigated as provided for in *N.J.A.C.* 4A:2-2.10. Proof of income earned, and an affidavit of mitigation shall be submitted by or on behalf of

the appellant to the appointing authority within 30 days of issuance of this decision.

The Commission further orders that counsel fees be awarded to the attorney for the appellant pursuant to *N.J.A.C.* 4A:2-2.12. An affidavit of services in support of reasonable counsel fees shall be submitted by or on behalf of the appellant to the appointing authority within 30 days of issuance of this decision. Pursuant to *N.J.A.C.* 4A:2-2.10 and *N.J.A.C.* 4A:2.12, the parties shall make a good faith effort to resolve any dispute as to the amount of back pay and counsel fees. However, under no circumstances should the appellant's reinstatement be delayed pending resolution of any potential back pay or counsel fee dispute.

The parties must inform the Commission, in writing, if there is any dispute as to back pay or counsel fees within 60 days of issuance of this decision. In the absence of such notice, the Commission will assume that all outstanding issues have been amicably resolved by the parties and this decision shall become a final administrative determination pursuant to R. 2:2-3(a)(2). After such time, any further review of this matter shall be pursued in the Superior Court of New Jersey, Appellate Division.

DECISION RENDERED BY THE
CIVIL SERVICE COMMISSION ON
THE 12TH DAY OF JUNE, 2024

Allison Chris Myers
Chairperson
Civil Service Commission

Inquiries
and
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Attachment

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NO. CSV 05208-21

AGENCY DKT. NO. 2021-1815

IN THE MATTER OF RANDY KELLY
DEPARTMENT OF
HEALTH, ANCORA
PSYCHIATRIC HOSPITAL.

William Nash, Esq., for Randy Kelly, appellant (attorneys)

Kevin Sangster, Deputy Attorney General, for Department of Health, Ancora Psychiatric Hospital, respondent (Andrew Bruck, Attorney General of New Jersey, attorney)

Record Closed: February 12, 2024 Decided: May 13, 2024

BEFORE **JOAN M. BURKE**, ALJ:

STATEMENT OF THE CASE

Respondent, Ancora Psychiatric Hospital (Appointing Authority, Ancora), brings this disciplinary action for removal of appellant, Randy Kelly. The Appointing Authority alleges that appellant, a Human Services Technician (HST), physically abused a patient on July 4, 2020, and that removal was the appropriate penalty.

Appellant was charged for this offense with violations of Administrative Order (A.O.) 4:08 B-2.3: Neglect of Duty, loafing, idleness; A.O. 4:08 C-3: Physical or mental abuse of a patient, client, or resident; A.O. 4:08 C-8.2: Falsification; intentional misstatement of material fact in connection with work; A.O. 4:08 D-7.3: Violation of administrative procedure and/or regulation involving safety; and A.O. 4:08 E-1.8: Violation of a rule, regulation or policy. Appellant was also charged with violations of N.J.A.C. 4A:2-2.3(a)(6), conduct unbecoming a public employee; N.J.A.C. 4A:2-2.3(a)(7), neglect of duty; and N.J.A.C. 4A:2-2.3(a)(12), other sufficient cause. (R-1.)

PROCEDURAL HISTORY

On September 25, 2020, the Appointing Authority issued a Preliminary Notice of Disciplinary Action (PNDA) setting forth the charges and specifications made against appellant. (J-1.) The appellant was suspended effective September 26, 2020. Ibid. On September 28, 2020, an amended PNDA was issued. Ibid. The suspension date was amended to September 28, 2020. Ibid. After a departmental hearing on April 22, 2021, the Appointing Authority issued a Final Notice of Disciplinary Action on May 6, 2021, sustaining the charges in the Preliminary Notice and removing appellant from employment, effective September 28, 2020. Ibid. Appellant appealed on May 24, 2021, and the matter was filed at the Office of Administrative Law on June 15, 2021, for hearing as a contested case. The case was initially scheduled to be heard on December 8, 2021, but was adjourned at the request of both parties so that a settlement discussion could be held. On January 31, 2022, a settlement conference was held with the Honorable Susan Scarola, but a resolution was not forthcoming. The matter was rescheduled for April 14, 2022, and May 18, 2022, but was adjourned for further settlement discussions. The matter was heard on November 4, 2022, December 1, 2022, April 19, 2023, August 2, 2023, August 3, 2023, and October 11, 2023, and at the conclusion of the hearing, the record closed. The parties requested to obtain transcripts and submit written closing briefs. The briefs were received on February 1, 2024. On March 18, 2024, an extension was granted in this matter to file the Initial Decision.

FACTUAL DISCUSSION

TESTIMONY:

Michael Voll (Voll) testified on November 4, 2022. He has been employed by the Appointing Authority since 1996. Currently, he is the chief nursing administration officer, a position he has held for approximately three months. In this role, he conducts training and staffing, conducts hiring interviews, and oversees discipline. He is also responsible for undertaking investigations into patient abuse and neglect. Prior to his current position, he was the director of nursing. Voll is familiar with both the appellant and patient T.B. Ancora is a state hospital. It houses severe mental individuals; has an older adult unit with individuals sixty-five years old; houses individuals with developmental disabilities; has a younger population; and houses individuals who are charged with a crime but found not guilty by means of insanity. The Holly Hall, where the incident in this matter occurred, is the forensic unit that houses individuals who have committed serious crimes but are found not guilty by reason of insanity.

The nursing policy and procedure, "Therapeutic Milieu," outlines the policy to "maintain a safe and therapeutic environment of care, focusing upon wellness and recovery." (J-6.) It applies to all nursing staff at all times. An HST is trained in this policy. Under the code of conduct, all employees "are required to act in a manner that promotes and maintains a culture that ensures quality and safety." (J-5.) In addition, the "hospital views all interactions between patients and staff as a powerful force in the psychiatric treatment process." (J-4.) Voll testified that all HSTs are trained in the code of conduct.

Based on what was seen on the tape, the appellant's clenched fist and his pushing of the patient, this behavior could traumatize the patient. The staff's duty is to build a therapeutic relationship. As per Voll, under no circumstance should an employee "push" a patient or an employee. The discipline for a first infraction of "physical or mental abuse of a patient, client, resident or employee" is removal. (J-7.)

On cross-examination, Voll admitted that in the confidential unusual incident report, T.B. is noted to be the "perpetrator of the incident." The charge nurse also reported that T.B. was "taunting P.S. all morning always going his direction so that he could say

something that will lead to his being beaten up." (J-2.) P.S. is another client in Holly Hall D. Nuse Turay further stated:

> patient was very agitated, into my face and even pushed me. I attempted to go back to the nursing station and he followed me and slammed the door while my keys were in the lock. My keys got stuck to the door and all the other keys scattered all over the floor. A staff, Randy Kelly, HS[T], then came to my rescue by helping me picking up the keys and tried to prevent patient from entering the nursing station . . . . If he had been punched in the face he would be bleeding from his nose all over the place . . . . I did not see Mr. Kelly push T.B.
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> [J-11.]

Voll testified that he did not observe the incident. However, on Holly Hall D, there are forensic patients. There are people found not guilty by reason of insanity. The video showed Mr. Turay, a head nurse, being victimized by T.B. Mr. Kelly was visibly seen pushed by T.B. Regardless of what happens, one must return to a calm environment. Voll admitted that it isn't always possible to return to a calm and therapeutic environment. In reviewing the video when Kelly arrived, T.B. was already aggressive and agitated to the charge nurse. In a quickly-moving situation, it can be difficult to follow training in a textbook manner. (1T 108:1–4.) Kelly was not charged with punching a patient, but with pushing a patient. (R-4.) In the patient's written statement, T.B. admitted to pushing the appellant first. Ibid. Voll did not know how long the appellant worked for the Appointing Authority, but he had no issues with the appellant following through on directions. Voll reiterated that on the floor there are murderers, arsonists, and very aggressive and violent patients.

Bao Duong (Duong) works in the IT department. He testified that once an incident is reported, the IT department reviews the incident report and submits a request to the CCTV system to reserve the footage for the date and time of the incident. Duong was not at the scene of the incident and was never on Holly Hall, and he did not observe the incident when it occurred.

Jason Jacobs (Jacobs) testified on December 1, 2022. He has been employed by the Appointing Authority for twenty-four years and for the last ten of those years as a Training Technician III. He is responsible for developing training programs, supervising the training staff, and implementing third-party training. Prior to that, he was a Training Technician II.

Jacobs testified that the reason for training the staff is to create a safe environment for the staff and the patients. Jacobs teaches over 100 programs. Trainings are offered to employees three times weekly. Not all the programs are mandatory for an employee. The mandatory programs include sexual harassment, discrimination, therapeutic options, computer security awareness, and HIPAA. (When individuals attend the training programs, there is a training roster and a signed paper roster. Jacobs reviewed the appellant's training history. (R-9.) The appellant was trained in numerous programs. The main program that he received initial training on was "Therapeutic Options." Ibid. This is a two-day training course. The first day includes training in verbal intervention; crisis intervention; what to do in a crisis situation; how to remain calm; how to reassure a patient; 1:1 intervention, and other intervention techniques. On day two, the training incudes demonstration and return demonstration. The appellant initially received the therapeutic options training days one and two in March 2015 and also in March 2016. As per Jacobs, the training should be taken annually, but it is not a mandate.

The appellant was also trained in the patient service compliance unit. In reviewing the videotape of the incident, Jacobs testified that the patient appears to be the one who initiated the first contact. In the video tape where it was noted that several people were on the ground, Jacobs considered this to be a milieu. He testified that when a patient is escalating, as this patient was, using a cross-hand motion and moving back helps to deescalate the patient. Jacobs testified that pushing a patient is only accepted when there is an imminent threat of severe bodily harm to the patient.

On cross-examination, Jacobs admitted that the last time the appellant had therapeutic options training was in 2017. However, he reiterated that after the initial training it is recommended but not mandated to have the training annually. Jacobs was asked about Department of Health (DOH) Administrative Bulletin 3:18., Policies and

Procedures for reporting and Investigating allegations of Patient Abuse and Professional Misconduct (Policies and Procedures) (P-4). Jacobs testified that the Policies and Procedures usually is updated every few years, with not many substantive changes. The current Policies and Procedures were updated on October 29, 2021, effective September 26, 1997.

The sections on the Policies and Procedures that were updated were the definition of abuse and reflexive contact. It defines abuse as:

> Abuse – Means any act, omission or non-action in which an employee or consultant/contractor engages with patients, that does not have as its legitimate goal the healthful, proper and humane care and treatment of the patient, which causes or may cause physical or emotional harm or injury to the patient, or derives the patient of his/her rights, as defined by law or DOH/DBHS policy. The term abuse for the purposes of AB 3:18 includes verbal and psychological abuse/mistreatment, physical and sexual abuse; exploitation; and neglect. The term reflective contact as defined herein and for the purposes of AB 3:18 shall be excluded from the definition of abuse and is not intended to be deemed abuse in any form.
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> [P-4 at 2.]

And it defines reflexive contact as:

> Reflective contact- shall mean impulsive, minimal, physical contact:
>
> 1. Directed at a patient by a DOH employee, volunteer, intern, or consultant/contractor during an emergent situation aimed at preventing harm, which does not cause injury to the patient;
>
> 2. That may occur in situations where therapeutic and de-escalation techniques have failed and/or would not be appropriate due to immediate safety concerns; and
>
> 3. That includes, but is not limited to, holding a patient away from oneself to maintain distance and /or deflecting the

> patient from making contact with oneself in order to prevent harm.
>
> [P-4 at 4.]

Jacobs testified that pushing a patient is not consistent with restraint or with reflexive contact. Jacobs testified that the overall goal of training is for safety and prevention of injury to the patient or the staff. Jacobs admitted that the appellant's job is hazardous and that he could not guarantee that injury would not occur to the appellant. Jacobs further testified that he currently teaches reflexive contact in his training.

Harold Ingram (Ingram) testified on April 19, 2023. Ingram has worked for Ancora for over thirty years. On July 4, 2020, he was working. His duties that day were to monitor the day room and conduct the census. Ingram, in addressing the incident that occurred that day, testified that T.B. was agitated and attacked the nurse. Mr. Kennedy and Mr. Kelly went to assist. He reviewed the video of the occurrence that could be seen at 11:05 to 11:07 on cameras 38, 39, and 42. Camera 42 was in the hallway. Ingram identified himself on the video as seen behind T.B. in a dark blue shirt and blue pants. Ingram identified the appellant, who was wearing "stone washed jeans and his shirt that is ripped up in the front." (3T 13:13–16.)

On cross-examination, Ingram said he had training in therapeutic options and skills used to control combative patients. In looking at the video, while the incident was occurring, other people came to the floor. Ingram said that was because a code was called. It was seen on the video at 11:09; there was a response to the code with other people showing up to help. Ingram was not sure if there were two codes but knew there was at least one. Ingram testified that he has "know[n]" the patient for a long time and it takes him a while to calm down. According to Ingram, it is typical to attempt verbal redirection for an aggressive patient to calm him down, and if that does not work, you would use physical therapeutic holds that you are trained to do. There is a two-staff hold or a two-step hold. Here, according to Ingram, verbal redirection failed because T.B. pushed the nurse and Randy Kelly. Ingram does not know whether the appellant and the charge nurse were calming the patient down when he saw them first.

Ingram was interviewed a couple times. On August 6, 2020, an interview was done by investigator Dawn Covington. (R-2.) He told the investigator that T.B. got into the nurse's face. T.B. pushed or attacked the charge nurse. T.B., he believed, "lost it," meaning he became super agitated. He testified that T.B. grabbed Kelly and pushed him to the floor using the appellant's shirt. (3T 32:1–5.) Ingram said that both his training and his experience with wrestling and martial arts have helped him in dealing with aggressive patients. Ingram testified that T.B. was combative, out of control. (3T 32:17–18.) Holly Hall D houses people who are dangerous and "Crull" [sic] individuals who go through the litigation process and are found not guilty by reason of insanity. (3T 33:1–3.) There are also detainees who are individuals that are transferred from the county jail to a psych hospital to be evaluated.

Ingram did not see the appellant punch or push T.B. or act violently to T.B. He heard T.B. stating that he would get the appellant fired. (3T 34:17–19.) Ingram testified that he was trained and from his years of experience, he treats the patients as family and with respect, as he was taught by his parents. It is never appropriate to push, punch, or otherwise assault a patient. (3T 41:19–22.) Ingram testified that as shown in the video, he had T.B. in a control hold, with his head on T.B.'s back, which was one of the trainings that he learned so T.B. could not use his elbows or anything to hit Ingram in his face. (3T 43:2–9.) Ingram testified that when you are dealing with 250- to 350-pound men, the training would not be perfect. Ingram testified that T.B. was angry at Nurse Turay. (3T 48:18–19.) According to Ingram, some of the holds you are taught may not work when dealing with violent patients; you just do the best you can. Ingram did not see any blood on T.B. He said that when dealing with the patients, if they hit the floor hard, individuals may think you were too aggressive, but that may not be the situation because individuals who review the tapes have never been on the floor. (3T 52:6–25.)

Edward Tobin (Tobin) has worked at the Department of Health Office of Investigation as the Director of the Office of Investigators for the past six years. The office conducts investigations into client abuse, neglect, or exploitation at the four psychiatric hospitals in New Jersey. Tobin testified that he is the last level of review in an investigation. The Office of Investigation (OI) is assigned when an incident occurs at a hospital. There is communication with his office and the risk management officer at the

hospital. Initially, when there is an incident that deals with abuse, neglect, or exploitation, it is discussed and reviewed by the supervisor in OI and the risk management supervisor at the hospital. If the allegation involves abuse, neglect, or exploitation, it comes to his office, and if it does not, the risk management personnel at the hospital handle it.

The investigators received training by the Department of Human Services (DHS), the DOH, and also by an outside vendor. In May 2019, the investigators were trained by DHS and subsequently by an outside vendor **LRA.** Both investigators involved in this investigation were properly certified. Tobin is familiar with the investigator Dawn Covington, who is now retired. After an investigation is completed, the investigator prepares a report and sends it to her supervisor. The supervisor then reviews the report with the investigator. The supervisor then signs off on the report, and it then comes to his office. Tobin then reviews the signed off report, and if he concurs with the findings, he signs off on it as well.

Tobin is familiar with the incident report in this matter, as he was the last level of review. According to Tobin, once the incident comes to the OI, it is assigned on a rotation basis. The investigator that is up next on the rotation is assigned by the database. The custodian of record is the database. It has an automatic rotation, so the database assigns investigators to an investigation. Here, the investigator supplied a report and made a finding. Tobin's office has no part in discipline; they only submit a report. The completed investigation report was submitted. (R-2.) Tobin said that he approved the completed investigative report, which was signed on August 31, 2020. Ibid. Although it said reviewed on August 31, 2020, according to Tobin, it was actually approved on that date. As part of the investigation, Ms. Covington interviewed several individuals.

On cross-examination, Tobin admitted that he has never been to Holly Hall D, and neither was he familiar with it nor worked there. Tobin was never provided training in therapeutic options. Tobin was never trained in handling a psychiatric emergency. Tobin said there was no supplemental report on this matter. If there was inconsistency, he would alert the supervisor, and he did not recall any significant issue with the reporting in this matter. Tobin testified the abuse that was found was for the pushing of a patient because the investigator did not establish that the patient was punched. The investigator

established that the patient was abused. The record did not establish that the appellant punched T.B.

Tobin testified that he reviewed the report and concurred with the conclusion based on the preponderance of the evidence. Tobin insisted that the patient was pushed, and that was the ultimate finding. Tobin testified that the investigators do not attend training in physical holds or violence containment protocols. Tobin has not reviewed the policy regarding therapeutic option, and it was not part of his review.

Antwaine Streater (Streater) has been employed at Ann Klein Forensics Center for approximately two years as a medical security officer (MSO). Prior to this position, he was a human services aide (HSA) at Ancora. This involves making census checks, monitoring patients, and assisting with the patients' daily needs. On July 4, 2020, the date of the incident, Streater was assigned to a one-to-one patient in Holly Hall D. He recalled that the patient was very upset and irate with the nurse. There was an altercation with a staff member, Mr. Kelly. Streater did not recall being interviewed by the investigator. The record showed that Streater was interviewed by Investigator Covington on July 12, 2020. (R-6.) He recalled receiving training as it relates to coping mechanisms when dealing with difficult patients. There are different mechanisms, such as the use of soft words. He testified that it was never appropriate to push a patient. In a one-to-one situation with a patient, his job was to observe the patient. As such, he is not necessarily fixated on the patient, but he is to watch and observe the patient. For example, if he was to observe a patient for assault, that is what he would observe.

On cross-examination, Streater testified that at the time of this incident, he worked -at Ancora, and his status was not assigned to any building. He was trained in policies. According to the policy, when he is on a 1:1 he must visualize the patient's face at all times. In Streater's written statement, he stated "both Mr. Kelly and T.B pushed each other." (R-6.) Streater stands by his written statement. He, however, did not thoroughly recall the incident or the statement he gave.

Mohammed Turay (Turay) began his testimony on August 2, 2023, and concluded on August 3, 2023. He holds a BSN from the University of Virginia and a BA in Economics

with honors from the University of Sierra Leone. He currently works for Ancora Hospital as a charge nurse. He started in a local pooling with Ancora and then became a permanent employee in or around 2011. He works on Holly Hall D, which he said is a hostile environment. It is tough to work there. The patients tried to get into the nurse's station. Many staff have been injured and are placed on disability.

Turay is familiar with T.B. and recalled the incident on July 4, 2020. Turay was the charge nurse on Holly Hall D that day. As a charge nurse, his duties include maintaining safety. There are two sets of hallways in Holly Hall D where the patients reside. As part of his duty, he keeps the patients from going into the hallway where their dorm or room is not located. According to Turay, on the date of the incident, T.B. was going to the other hallway where he did not belong, and he tried to redirect him. T.B. "was very aggressive, he was very angry; aggressive and agitated." (4T 42:15–16.) T.B. was very upset because Turay was redirecting him. T.B. followed Turay to the nurse's station. Turay's key got stuck in the nurse's station's door as he tried to open it. When the key got stuck, there were other keys attached, and the other keys on the ring fell off and scattered to the floor. (4T 42:19–22.) Turay said he tried to prevent T.B. from getting the keys or getting into the nurse's station. The patients are not allowed into the nurse's station because of the privacy issue under HIPAA. The nurse's station contains all the patients' records. Turay testified that if one of the patients gets into the nurse's station, he could rummage through the medical files of other patients, and that would be a HIPPA violation. At the time of the incident, he was working with a second registered nurse and HSAs.

According to Turay, T.B. came towards him in a forceful manner while he was trying to get into the nurse's station. That is when his key got stuck and other keys fell to the ground. The unit is a sealed unit. Most of the patients are involuntarily committed. It appeared that T.B. was going to attack him, and Mr. Kelly came to help him. Turay testified that he did not see any abuse. (4T 45:16–17.) Turay knew there was a "tussle" but was unable to see what fully occurred because he was more focused on getting the keys that fell to the floor. According to Turay, a patient could get out of the facility with any one of the keys. Because of this, he was more focused on getting all the keys. The nurse's station holds all the patients' information, and if another patient got in, they could

see the information or mess up the file. This has occurred before, and security would be called to get the patient out of the nurse's station.

Turay was trained on abuse protocol. In this incident, he did not report any abuse, as he did not see anything he would characterize as abuse. He did both parts of the therapeutic options training. The therapeutic option did not work on T.B. that day, as he was not listening. On the video presentation, Turay was able to identify the nurse's station on Holly Hall D on camera 38 at 10:58 am. At 11:12 a.m., Magdalena the other nurse, was seen entering the nurse's station. At 11:01–11:07, T.B. could be seen in and out of his room and going to the other hall. Around 11:07–11:26, the appellant arrived at the nurse's station and was trying to help him get his keys and redirect T.B. Turay testified that the appellant told T.B. to let "us do our jobs." Turay testified that Mr. Kelly did not push or punch T.B.

After the incident, T.B. was transferred to Latch Hall D. Turay was also transferred to this location. He recalled having a conversation with T.B. where he said that T.B. told him that the appellant did not push or punch him. Turay said had Kelly punched, pushed, or abused the patient, he would have reported it. (4T 47:24–25; 48:1–2.) If this had occurred, a "doctor would have been notified, the team would have been notified and there would have been an investigation." (4T 48:3–5.) A code was called, but Turay was not the one that called it, as he was part of the incident. A code is called to alert other staff members when there is a patient who is violent or becomes assaultive, and assistance is needed. Other staff members come to the floor and try to settle the situation and ensure safety.

Turay testified that he checked T.B. for injuries, and no injuries were noted, and the patient also denies there were injuries. (4T 51:4–19.) On July 10, 2020, he wrote a report of the incident. Turay signed this report. (J-11.) This was read into the record. Turay stated in his written report that the appellant came to his rescue. According to Turay, the appellant "must have seen him pushing me and trying to get to the nurse's station so he came to prevent me being hurt." (4T 56:16–18.) Turay further wrote that the "patient then pushed both me and Randy Kelly. During the struggle Kelly's t-shirt got torn into pieces." (4T 58:13–15.) Turay, in his written statement, went on to say: "After

the incident patient alleged that Kelly punched him. I did not see Kelly punching him." (4T 58:23–25.)

There was a typed written statement that was dated July 15, 2020, which was unsigned. In this typed written statement, it said that "T.B. pushed us," a reference to him and the appellant. (4T 64:24–25.) Turay did not see the appellant punch T.B. (4T 66:12–15.) Turay was concerned if the patient was hit or punched, he would be bleeding or there would be bruising. T.B. has Vonne Willebrand (VW) syndrome or disease, wherein he bleeds quickly—the factor is less than in a regular human. When he examined him, there was no bruising. In addition, Dr. Kalola also examined T.B., and no bruising was noted. Turay said he had no problem with T.B. and did not notice any problem with T.B. and the appellant in the past. In the last statement in this typed written report, it states "I did not see Mr. Kelly push T.B . . . ." (4T 69:12–13.)

On cross-examination, Turay testified that his current field of specialty is psyche. During his nurse's training, he did a psyche rotation as well as all other rotations. He admitted that he does not diagnose or treat VW disease. He admitted that the clients on the floor he works are mentally and psychologically deficient. It is a rough environment. He was taught not to abuse a patient, and hitting, punching, or pushing would be considered abuse. Turay agreed that he had not seen what was going on, as he was focused on picking up his keys. If Kelly had pushed with intent to hurt, that could be considered abuse. He testified that if someone pushes a patient violently, that is abuse. Turay agreed that it is never appropriate to push or punch a patient. On redirect, Turay testified that Kelly was trapped, and Kelly could have escaped, but he was trying to help Turay. Kelly was preventing T.B. from entering the nurse's station and also protecting Turay, so Kelly could not have escaped.

Magdalena Allen (Allen) received her RN degree from Hostos Community College in 2006. Since then, she has worked at Ancora. When she first began with Ancora, she worked on Cedar B; was transferred to Holly C; and then transferred to Holly D. The patients on Holly Hall D are aggressive, violent, and manipulative. On July 4, 2020, the date of the incident, she was working as the medication nurse. The nurse's station had what they call a "medication window." The patients come to the window at the appropriate

time to receive their medicines. The door to the nurse's station is locked from the outside. Once you come into the nurse's station, the door automatically locks behind you. Allen was working at the time with the charge nurse, Turay, when she heard a commotion. She heard Turay say, "You pushed me. You tried to hurt me." Allen tried to open the door, but it was jammed. She assumed that Turay was backed up to the nurse's station door. Allen peeped out of the medication window to see what was going on. She then called the psychiatrist emergency and called maintenance because she could not get out of the nurse's station. After the commotion ended, she did evaluate T.B. He had no injury, bruising, or bleeding.

According to Nurse Allen, Kelly is a good worker, and he would not hurt anyone. She has worked with him for many years. He tried to deescalate the patients with therapeutic means. Therapeutic options do not always work. While working with Kelly, she did not observe any abuse. On cross-examination, Allen admitted that she could not hear or see everything, as she was in the office. When a patient is acting violent, it is one's duty to deescalate by talking to the patient and calming the patient down; sometimes this can be very difficult. Under no circumstance should you push or punch a patient. If Kelly was to have pushed a patient, that would be considered abuse. On redirect, Allen said as a charge nurse, she had the opportunity to review and observe Kelly's interactions with patients and how he deescalates a situation.

Nurse Allen in the typed, written, unsigned statement says: "No, I did not see Mr. Kelly punch T.B. in the face. That is not him. He would never do that. That was something made up. . . No I don't think Mr. Kelly pushed T.B. I don't think so, but I was not there to see that." (J-8.) Allen admitted that when she sees abuse, she would report it. Allen was familiar with the policy and code of conduct. (See J-4.)

Vincent Malcom (Malcom) works as a senior HST at Ancora. He has worked at Ancora for over thirty-seven years. He has completed some schooling in psychiatry and is a deacon, a minister, and a pastor. He worked in Holly Hall D in his first ten years. (4T 117:5–6.) On the day of the incident, he was working "on a two to one." (4T 117:20.) This involves one patient and two HSTs. He was sitting in the hall, and the other HST was sitting in the room where the patient was resting. (4T 117:19–24.) Malcom said he

heard a commotion. He heard T.B.'s voice threatening the nurse. T.B. was upset about how the team handled a different client. He sat in the hallway closest to the nurse's station. Malcom is familiar with T.B., and when he is upset, Malcom would deescalate T.B. Malcom said that T.B. has a daughter. When T.B. got upset, Malcom would remind him of his daughter. Malcom is multi-talented in that he plays the saxophone, tap dances, and is a personnel trainer. Because of this background, the patients would come to him at times. (4T 120:1–17.)

T.B. made threatening statements to Turay, and one of his co-workers came in to deescalate the situation. Malcom heard Nurse Turay say to T.B., "You are following and threatening me"; T.B. responded by saying, "I should punch you in the head." Malcom said that Kelly stood between Nurse Turay and T.B. Nurse Turay was between the wall and the nurse's station. Usually when this happens, it triggers another staff member to talk to the patient to deescalate. Malcolm could not leave his 2:1 patient. However, T.B. was getting loud. T.B. mentioned, "I am going to prove a point." In reviewing the video at 11:07:23 through 11:07:31, Kelly could be seen holding a chart and redirecting the patient. Kelly tried to deescalate, and T.B. walked away but then came back. When T.B. is angry, he paces.

Malcolm testified that when patients are angry, they tend to want to get even, so the staff intervenes to draw their attention away from the individuals they are focused on. On the video at 11:07:37–38, T.B. made a lunge at Kelly, "grabbed his clothing and ripped them away and both Mr. Kelly and T.B. fell apart." (J-9.) T.B. was following Nurse Turay, who was getting into the nurse's station to get out of T.B.'s way. T.B. was yelling, and the hallway was like an echo chamber. T.B. was pushing; Nurse Turay's keys fell and were sliding in Malcom's direction. Malcom made sure his 2:1 was ok, and then he tried to pick up the keys. This was important to him because if a patient gets one of the keys, he could hurt the staff or swallow the key. They have received training every year on abuse policy. If there is abuse, they would report it to the charge nurse or proper authority. He did not witness abuse in this instance because Kelly used his arms out to keep a safe space.

On cross-examination, he testified that he did not see Kelly punch or push T.B. According to Malcom, the staff is not to abuse patients physically, mentally, or verbally. The policy states that pushing a patient is abuse. On redirect, Malcom admitted that therapeutics at times do not work. Pushing a person for no reason is abuse. You are not allowed to create an unsafe space. If you are pushing to cause harm, that is abuse.

> Physical abuse is a physical act directed at a client, patient or resident of a type that could tend to cause pain, injury, anguish, and/or suffering. Such acts include but are not limited to the client, patient, or resident being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged, and/or struck with a thrown or held object.
>
> [J-7.]

Randy Kelly (Appellant, Kelly) testified that he was hired by the State of New Jersey in 2005. At the time of hire, he worked at the Trenton Psychiatric hospital as a senior building maintenance worker in housekeeping. He was a maintenance worker for three years; then he became involved with direct care as an HSA. In 2007, he received an award for employee of the year. In 2015 based on facilities closing and "bumping" of staff, he ended up at Ancora. His position was the same as an HSA. Prior to his removal, he worked the morning shift in Holly Hall D. The types of consumers or clients on Holly Hall D were involved in assault, individuals who were transitioning from a correctional facility but could not go directly into the public and needed a less restrictive environment. When these individuals are on their medicine, they are fine.

The appellant stated that R-5 was not his written statement that he provided. In reviewing the video taken from camera 38 at 11:06:17 a.m., Kelly testified that Turay was the charge nurse. On the video at 11:06:20 a.m., he identified T.B. as the individual in the red shirt and black shorts. At 11:06:41 a.m., he identified himself in a black shirt and jeans. Kelly was seen holding a clipboard with his census paper. That day he worked the 6:45 am to 3:15 pm shift, and his assignment was to conduct the census. This entails making rounds to ensure all the patients are safe and sound and all the administrative doors are closed. At around 11:07:21 a.m., he heard a commotion and started to pick up his pace and went over to the nurse's station. Arriving as noted on the video at around

11: 07:23. At 11:07:29, there were three people: T.B., the head nurse, and himself. At that time, he started to redirect T.B. by telling him to relax. This is considered a therapeutic option. Initially, it calls for you to talk to the client and try to deescalate the situation, talk him down, or try to reason with him.

Kelly testified that he has been involved in situations like this over 100 times and he used the same training that he did here on July 4, 2020. Talking does not always work. When it does not, the next step is a physical hold. When a person is placed on physical hold, they are then taken to a room where they are physically restrained. This involves placing them in a chair with their arms and legs locked with a Velcro strap.

If a situation occurs when the staff cannot handle the matter, a psychiatrist code is called. The call goes out over the facility's intercom throughout all the building, and anyone who is available is required to show up. Kelly was familiar with T.B. He has intervened and applied therapeutic options with T.B. approximately five times.

At 11:07:30, the head nurse's keys fell off the ring on the floor in front of the door to the nurse's station. He was concerned that if any of the clients got a hold of the keys they would get off the unit. According to Kelly, when he interceded in this matter, he started to talk to T.B. and redirected him. T.B. started to walk away around the 11:07:34 time frame. Kelly then started to pick up the keys. At 11:07:37–39, T.B. came back and pushed Kelly. He said at that time, he put his hand out to do a physical hold. At 11:07:35, he tried to do a physical hold, and T.B., in the scurry, was seen falling back. Kelly reiterated that between 11:07:36–37, he was pushed. Once he was pushed, he went to do a physical hold. (6T 34:1–12.) According to Kelly, when conducting a physical hold, you try hold them "so they can't use their arms or whatever to hit you and you have your head like on their . . . back up by their shoulders so that it is protecting you." (6T 34:15–25.)

Kelly relates the following when viewing the video: Initially, T.B. and the charge nurse were communicating, as seen at 11:07:12 on the video. At 11:07:18 the charge nurse walked away, and T.B. followed him. At 11:07:20, T.B. jumped into the charge nurse's face. The charge nurse then put his head back so he would not be hurt. At

11:07:33, Kelly is seen picking up keys. At 11:07:37, T.B. pushed Kelly. At 11:07:37–38, after Kelly was pushed by T.B., he puts his hands out to do a physical hold. T.B. fell back down. By this time, several people had gotten there. According to Kelly, the patients do not allow you to do a physical hold on them. They will move out of the way and "drop down." (6T 49:15-24.) Kelly testified that between 11:07:38–41 on the video, T.B. was not running away; T.B. was already assaultive. Kelly reiterates that he tried to do a physical hold on T.B., but he fell to the ground. (6T 51:9–25.)

According to Kelly, T.B. is strong and he is not always able to do a physical hold on him. At 11:08:00–14, the staff were trying to put T.B. in a physical hold. It took four staff members to do so. Kelly's clipboard and census paper could be seen on the floor at 11:08:18. Kelly testified that they are not allowed to punch, pinch, push, or kick the clients. Kelly testified that he has been punched in the eye, punched in the forehead, headbutt, spit on, and kicked. During these times, he never retaliated. Placing a client into a physical hold does not constitute physical abuse. In his time working at Ancora, he has done approximately fifty physical restraints. (6T 62:18–21.) Clients have run away or dropped onto the floor to avoid restraints. (6T 63:2–7.) Kelly testified that he exercised judgment with T.B. He had exercised all verbal redirections with T.B. No further verbal redirections could have prevailed, and thus a physical hold was next. T.B. was not hurt here; no one else was hurt. T.B. had no bruising and no bleeding, and he was not at the time able to place T.B. in a restraint.

After the incident, he was not sure what he did or if he walked back to the nurse's station. He was a little shaken up; "it's scary because you never know what's going to happen to you." (6T 75:12–14.) He recalled filling out a written statement, and he signed it and gave it to a supervisor.

On cross-examination, Kelly clarified the difference between an HSA and HST title. He testified that he was an HSA when he first got to the facility, and over time, the title changed to HST. This change occurred sometime in 2014. (6T 83:3–8.) When he went to Ancora, he lost the title and was bumped down to an HSA. (6T 83:9–11.) Kelly has worked with psychologically-impaired individuals since 2005. T.B. was not the first abusive patient he encountered. Kelly testified that he knew T.B. to be an aggressive

person, and he knew T.B.'s diagnosis and treatment plan. On the day of the incident, Kelly had a discussion with T.B. regarding the 13th amendment. (R-5.)

On the video, channel 38 at 11:07:37–38, Kelly denied pushing T.B, but was attempting a physical hold. He insisted that he said to T.B. "relax, let it go," and he "walked away as if he was in agreement." (6T 124:21–24.) Kelly said he never attacked or assaulted T.B.; in fact, he was assaulted. Kelly's instinct was to attempt to put a physical hold on T.B., but he was unable to do so. According to Kelly, Mr. Ingram put T.B. in a physical hold along with others.

Over the fifteen years that Kelly worked at the DOH, he learned that there is a spectrum where individuals go from loud, argumentative, and yelling, and then end in causing actual physical harm to individuals. (6T 139:13–24.) Kelly testified that when T.B. pushed him, he was at the end of the spectrum, where he was physical. Once this occurs, it is difficult or challenging to bring him back to the middle of the spectrum. Thus, with T.B., he had to try to place him in a physical hold.

FINDINGS OF FACT

Because of the conflict between Mr. Voll's and Mr. Tobin's testimony, and that of the appellant, Mr. Turay, Mr. Malcom, and Mr. Ingram, a determination of credibility is required. It is my obligation and responsibility to weigh the credibility of witnesses in order to make factual findings.

Credibility is the value that a fact finder gives to a witness's testimony. The word contemplates an overall assessment of a witness's story in light of its rationality, internal consistency, and manner in which it "hangs together" with other evidence. Carbo v. United States, 314 F.2d 718, 749 (9th Cir. 1963). The term has been defined as testimony that must proceed from the mouth of a credible witness and must be such as common experience, knowledge, and common observation can accept as probable under the circumstances. State v. Taylor, 38 N.J. Super. 6, 24 (App. Div. 1955) (quoting In re Perrone's Estate, 5 N.J. 514, 522 (1950)). In assessing credibility, the interests, motives or bias of a witness are relevant, and a fact finder is expected to base decisions of

credibility on his or her common sense, intuition or experience. Barnes v. United States, 412 U.S. 837 (1973). Credibility does not depend on the number of witnesses and the finder of fact is not bound to believe the testimony of any witness. In re Perrone's Estate, 5 N.J. 514

The record in this matter includes documentary evidence and the testimony of the individuals who prepared the documents or had knowledge of the incidents they described. As a result, after carefully reviewing the videotape, exhibits, and documentary evidence presented numerous times during the hearing, and after having had the opportunity to listen to testimony and observe the demeanor of the witnesses, I **FIND** the following to be the relevant and credible **FACTS** in this matter: On July 4, 2020, T.B. was a patient on Holly Hall D with a history of aggressiveness and VW disease. On that day, appellant was working the 6:45 am. to 3:15 p.m. shift. Immediately prior to the incident with T.B., appellant, wearing a black shirt and jeans, was making his rounds with his clipboard, conducting census. He heard a commotion and went over to see what was happening at the nurse's station. He saw Nurse Turay with his back to the door to the nurse's station. The door to the nurse's station was shut, and he saw keys on the floor. Being concerned that the patients on the floor might get any of the keys, he went to help. At this time, T.B. had backed Nurse Turay up to the nurse's office door. He got between Nurse Turay and T.B. and told T.B. to relax or to "let it go." T.B. at the time seemed to understand and walked away. Kelly started to help Turay pick up the keys from off the floor. Before he completed picking up the keys, T.B. came back, and Kelly stood up to get between T.B. and Nurse Turay. T.B. pushed Kelly, and a tussle occurred between the two men. Kelly testified that he was attempting to conduct a physical hold on T.B. He was seen with his hands up. T.B. was seen falling to the floor. Kelly's shirt was torn, as it appears that T.B. pulled his shirt. The respondent argues that the appellant pushed the patient, T.B.; however, it cannot be determined on viewing the video that the appellant pushed the patient. The view was obstructed by others. There was a milieu, and a code was called by the second nurse who was locked inside the nurse's station and could not get out. Other staff from the facility came to the floor to help.

Several other people got involved, and it took three to four people to restrain T.B. There was no injury sustained by T.B., who reported he was punched. T.B. has VB

disease, which makes him easily bruise or bleed. No bruising or bleeding occurred. Nurse Turay did a full inspection of T.B., and no injury was noted. This was collaborated by Dr. Kalola.

I found the testimony of Mr. Voll credible in explaining the nursing protocol. I found the testimony of Mr. Jacobs credible in that he signed off on the report that was done by investigator Dawn Covington. I also found the testimony of Mr. Tobin credible as to how he trained the employees. Mr. Tobin admitted that in a quickly moving situation, it is not always possible to follow training in a textbook manner. (1T 108:1–6.)

I found the testimony of Nurse Turay to be credible. He testified that he did not see any abuse, and if he did, he would have reported it. Nurse Turay testified that the appellant came to his aid. I found the testimony of Vincent Malcom credible. I specifically found his testimony credible when he testified that T.B. made a lunge at Kelly, "grabbed his clothing and ripped them away and both Mr. Kelly and T.B. fell apart." (J-9.) Malcom also tried to pick up the keys that fell from Nurse Turay because if a patient gets one of those keys, they could hurt the staff or swallow the key. Malcom testified that he did not witness abuse in this instance because Kelly had his arms out to keep a safe space. Mr. Streater testified that he stood by his statement, but did not recall the incident. In his statement, he said both T.B. and the appellant pushed each other.

I found the testimony of Harold Ingram credible. He has worked for Ancora for over thirty years. Ingram did not see the appellant punch or push T.B. or act violently toward T.B. He heard T.B. stating that he would get the appellant fired. Michael Voll and Jacobs discussed training, and so as to the training, they were credible. However, Ingram, Malcom, and Turay were actually part of the incident, and they did not see the appellant push the patient T.B. In addition, they used the training they were given in trying to deescalate the situation. Mr. Turay, Mr. Malcom, and Mr. Ingram all have also approved of the procedures the appellant followed in trying to deescalate patient T.B., and none of them reported abuse. The video is clear that T.B. pushed the appellant and Nurse Turay. Others present said that the appellant did not punch or push T.B. I found the appellant credible when he said that T.B. dropped to the floor as he was trying to put a physical hold onto him.

CONCLUSIONS OF LAW

Appellant's rights and duties are governed by laws, including the Civil Service Act and accompanying regulations. A civil service employee who commits a wrongful act related to his or her employment may be subject to discipline, and that discipline, depending upon the incident complained of, may include a suspension or removal. N.J.S.A. 11A:1-2, 11A:2-6, 11A:2-20; N.J.A.C. 4A:2-2.

The Appointing Authority shoulders the burden of establishing the truth of the allegations by preponderance of the credible evidence. Atkinson v. Parsekian, 37 N.J. 143, 149 (1962). Evidence is said to preponderate "if it establishes the reasonable probability of the fact." Jaeger v. Elizabethtown Consol. Gas Co., 124 N.J.L. 420, 423 (Sup. Ct. 1940) (citation omitted). Stated differently, the evidence must "be such as to lead a reasonably cautious mind to a given conclusion." Bornstein v. Metro. Bottling Co., 26 N.J. 263, 275 (1958); see also Loew v. Union Beach, 56 N.J. Super. 93, 104 (App. Div. 1959).

As to the charge of "Conduct unbecoming a public employee," N.J.A.C. 4A:2-2.3(a)(6), the law is well established. "Conduct unbecoming a public employee" is an elastic phrase that encompasses conduct that adversely affects the morale or efficiency of a governmental unit or that has a tendency to destroy public respect in the delivery of governmental services. Karins v. City of Atl. City, 152 N.J. 532, 554 (1998); see also In re Emmons, 63 N.J. Super. 136, 140 (App. Div. 1960). It is sufficient that the complained-of conduct and its attending circumstances "be such as to offend publicly accepted standards of decency." Karins, 152 N.J. at 555 (quoting In re Zeber, 156 A.2d 821, 825 (1959)). Such misconduct need not necessarily "be predicated upon the violation of any particular rule or regulation, but may be based merely upon the violation of the implicit standard of good behavior which devolves upon one who stands in the public eye as an upholder of that which is morally and legally correct." Hartmann v. Police Dep't of Ridgewood, 258 N.J. Super. 32, 40 (App. Div. 1992) (quoting Asbury Park v. Dep't of Civil Serv., 17 N.J. 419, 429 (1955)).

I **CONCLUDE** that appellant's behavior did not rise to a level of conduct unbecoming a public employee. Appellant tried to protect Nurse Turay and to prevent other individuals on the floor from obtaining keys that could lead to a serious situation. Holly Hall D is the forensic unit that houses individuals who have committed serious crimes but are found not guilty by reason of insanity, murderers, and very aggressive individuals. If they were allowed to get the keys that fell from Nurse Turay, they could let themselves out of the facility or get into the nurse's station and rummage through the personal files of other patients to obtain information. Both Nurses Turay and Allen testified that the appellant would not abuse a patient. Nurse Turay, although focused on picking up the fallen keys, said Kelly did not punch or push T.B. In addition, in a conversation with T.B., Turay was told by T.B. he just wanted to get Kelly in trouble and that Kelly never pushed or punched him. In looking at the video footage, the appellant's behavior does not fit this charge.

Appellant was charged with violating N.J.A.C. 4A:2-2.3(a)(7), neglect of duty. The charge of "neglect of duty" is not defined under the New Jersey Administrative Code, but the charge has been interpreted to mean that an employee has failed to perform and act as required by the description of his or her job title. Neglect of duty can arise from an omission or failure to perform a duty and includes official misconduct or misdoing, as well as negligence. Generally, the term "neglect" connotes a deviation from normal standards of conduct. In In re Kerlin, 151 N.J. Super. 179, 186 (App. Div. 1977), neglect of duty implies nonperformance of some official duty imposed upon a public employee, not merely commission of an imprudent act. Rushin v. Bd. of Child Welfare, 65 N.J. Super. 504, 515 (App. Div. 1961). Appellant did not act carelessly or negligently. I **CONCLUDE** that appellant's behavior does not fit this charge. Respondent has not proven by a preponderance of the evidence that appellant was neglectful of his duty.

Appellant has been charged with violating N.J.A.C. 4A:2-2.3(a)(11), "Other sufficient cause." With regard to the charge of "other sufficient cause," I consider this charge when determining if Ancora Psychiatric Hospital rules and regulations have been violated. With respect to the various charges of violation of the Ancora Psychiatric Hospital rules and regulations, appellant is not guilty of violation of Administrative Order 4:08 B-2.3: neglect of duty, loafing, idleness, or willful failure to devote attention to tasks

which could result in danger to persons or property. On the contrary, the appellant was protecting Nurse Turay from being assaulted by T.B. and preventing not only T.B. but other clients from getting the keys that had fallen from Nurse Turay's key ring. I **CONCLUDE** that appellant's behavior does not fit this charge.

Appellant is further charge with violation of Administrative Order Section 4:08 C-3.1: physical abuse of patient, client, resident or employee; and Section 4:08 C-8.2: falsification; intentional misstatement of material fact in connection with work, employment, application, attendance or in any report. The respondent has not met its burden in presenting evidence by the preponderance of the evidence to support these charges. It is for this reason that I **CONCLUDE** that these charges should be dismissed.

DISPOSITION

I **CONCLUDE** that the Appointing Authority has not sustained its burden of proof as to the charges of violation of a rule, regulation, policy, procedure, or administrative decision, or of mistreatment of a patient. The Appointing Authority has also not sustained its burden of proof as to the charge of conduct unbecoming a public employee, or as to the charge of other sufficient cause. The Appointing Authority has failed to sustain its burden of proof as to the charge of physical or mental abuse of a patient.

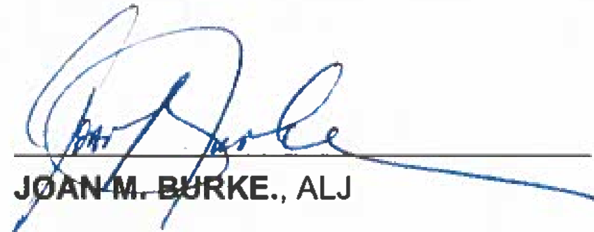
Accordingly, I **ORDER** that the action of the Appointing Authority is **REVERSED**. Appellant's appeal is **GRANTED**.

I **ORDER** that appellant is entitled to back pay, benefits, and seniority pursuant to N.J.A.C. 4A:2-2.10. The appellant is entitled to counsel fees. Pursuant to N.J.A.C. 4A:2-2.12(a), the award of counsel fees is appropriate only where an employee has prevailed on all or substantially all of the primary issues in an appeal of a major disciplinary action. The primary issue in any disciplinary appeal is the merits of the charges, not whether the penalty imposed was appropriate. See Johnny Walcott v. City of Plainfield, 282 N.J. Super. 121, 128 (App. Div. 1995); James L. Smith v. Department of Personnel, No. A-1489-02T2 (App. Div. March 18, 2004); In re Robert Dean (MSB, January 12, 1993). In

the case at hand, the appellant has prevailed on all or substantially all of the primary issues of the appeal.

I hereby **FILE** my initial decision with the **CIVIL SERVICE COMMISSION** for consideration. This recommended decision may be adopted, modified or rejected by the **CIVIL SERVICE COMMISSION**, which by law is authorized to make a final decision in this matter. If the Civil Service Commission does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within thirteen days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **DIRECTOR, DIVISION OF APPEALS AND REGULATORY AFFAIRS, UNIT H, CIVIL SERVICE COMMISSION, 44 South Clinton Avenue, PO Box 312, Trenton, New Jersey 08625-0312**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.



May 13, 2024
DATE

JOAN M. BURKE., ALJ

Date Received at Agency: May 13, 2024

Date Mailed to Parties: May 13, 2024

JMB/sg/jm

APPENDIX

LIST OF WITNESSES

For appellant:

Randy Kelly

Mohammed Turay

Magdalena Allen

Vincent Malcom

For respondent:

Michael Voll

Bao Duong

Jason Jacobs

Harold Ingram

Antwaine Streater

LIST OF EXHIBITS

Joint exhibits:

J-1 Preliminary Notice of Disciplinary Action, September 25, 2020; Amended Preliminary Notice of Disciplinary Action, September 28, 2020; Final Notice of Disciplinary Action, May 6, 2021

J-2 Ancora Psychiatric Hospital Confidential Unusual Incident Report, July 4, 2020

J-3 Daily Sign-In Record, July 4, 2020

J-4 Policy #0500: Ethical Interactions between Patients and Staff

J-5 Ancora Psychiatric Hospital Executive Policy and Procedural Manual, Code of Conduct #0503

J-6 Ancora Psychiatric Hospital Nursing Policy and Procedure, 1.05 Therapeutic Milieu

J-7 Department of Human Services Disciplinary Action Program

J-8 Charge Nurse, Magdalena Allen Written Statement, July 21, 2020

J-9 Vincent Malcom Written Statement, July 20, 2020

J-10 Harold Ingram Written Statement, July 13, 2020

J-11 Charge Nurse Mohamed Turay Written Statement, July 10, 2020

For appellant:

P-1 Comprehensive Medical Monthly Progress Note

P-2 Special Observation Policy

P-3 NOT IN EVIDENCE

P-4 Administrative Bulletin 3:18, October 29, 2021

Closing Summation Brief

For respondent:

R-1 Ancora Psychiatric Hospital Assignment, July 4, 2020

R-2 Department of Health Investigation Report

R-3 DVD—Holly Hall

R-4 Patient's Written Statement, July 14, 2020

R-5 Randy Kelly's Written Statement, July 17, 2020

R-6 Ancora Psychiatric Hospital Antwaine Streater's Employee Statement, July 12, 2020

R-7 NOT IN EVIDENCE

R-8 NOT IN EVIDENCE

R-9 Ancora Psychiatric Hospital Report, Employee Training History

R-10 Prior Disciplines

Closing Summation Brief