STATE OF NEW JERSEY

In the Matter of Mohamed Conteh, Trenton Psychiatric Hospital, Department of Health CSC DKT. NO. 2020-533 OAL DKT. NO. CSV 12603-19	**DECISION OF THE CIVIL SERVICE COMMISSION**

ISSUED: SEPTEMBER 21, 2022

The appeal of Mohamed Conteh, Human Services Technician, Trenton Psychiatric Hospital, Department of Health, removal, effective July 29, 2019, on charges, was heard by Administrative Law Judge Susan G. Olgiati (ALJ), who rendered her initial decision on July 25, 2022. 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 ALJ's initial decision, including a thorough review of the exceptions and reply, and having made an independent evaluation of the record, the Civil Service Commission (Commission), at its meeting of September 21, 2022, accepted and adopted the Findings of Fact and Conclusion as contained in the attached ALJ's initial decision. However, it did not adopt her recommendation to modify the removal to a six-month suspension. Rather, the Commission imposed a four-month suspension.

The Commission makes the following comments. As indicated above, the Commission thoroughly reviewed the exceptions filed by the appointing authority in this matter. In that regard, the Commission finds them unpersuasive and mostly unworthy of comment as the ALJ's findings and conclusions in upholding the charges and the penalty imposed based on her thorough assessment of the record are not arbitrary, capricious or unreasonable. In this regard, upon its *de novo* review of the record, 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, the exceptions filed by the appointing authority are not persuasive in demonstrating that the ALJ's credibility determinations, or her findings and conclusions based on those determinations, were arbitrary, capricious or unreasonable. As such, the Commission has no reason to question those determinations or the findings and conclusions made therefrom.

The Commission further notes that the appellant's argument in reply that the charge of inappropriate physical contact should not be upheld, is similarly unpersuasive. Accordingly, the Commission upholds the ALJ's finding that the appellant was guilty of inappropriate physical contact rather than client abuse as that finding is amply supported in the record. Moreover, the Commission agrees with a penalty short of removal. The ALJ's recommended six-month suspension considers all factors, including the particular facts of the matter as well as the appellant's prior disciplinary history. However, in its *de novo* review of the penalty, the Commission finds that further reduction is warranted. In this regard, given the appellants near 10 years of service with no prior discipline, and the extenuating circumstances presented, the Commission finds that a four-month suspension is appropriate. This penalty will impress upon the appellant that any further infractions may lead to disciplinary action up to and including removal.

Since the removal has been modified, 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 four months after the first date of separation until the date of actual reinstatement. However, he is not entitled to counsel fees. *N.J.A.C.* 4A:2-2.12(a) provides for the award of counsel fees 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 the disciplinary appeal is the merits of the charges. See *Johnny Walcott v. City of Plainfield,* 282 *N.J. Super.* 121,128 (App. Div. 1995): *In the Matter of Robert Dean* (MSB, decided January 12, 1993); *In the Matter of Ralph Cozzino* (MSB, decided September 21, 1989). In the case at hand, although the penalty was modified by the Commission, charges were sustained, and major discipline was imposed. Consequently, as appellant has failed to meet the standard set forth at *N.J.A.C.* 4A:2-2.12, counsel fees must be denied.

This decision resolves the merits of the dispute between the parties concerning the disciplinary charges and the penalty imposed by the appointing authority. However, in light of 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 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 permanent position.

ORDER

The Civil Service Commission finds that the action of the appointing authority in removing the appellant was not justified. The Commission therefore modifies that action to a four-month suspension. The Commission further orders that the appellant be granted back pay, benefits, and seniority from four months after the first date of separation to the actual 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. Pursuant to *N.J.A.C.* 4A:2-2.10, the parties shall make a good faith effort to resolve any dispute as to the amount of back pay. However, under no circumstances should the appellant's reinstatement be delayed pending resolution of any potential back pay dispute.

Counsel fees are denied pursuant to *N.J.A.C.* 4A:2-2.12.

The parties must inform the Commission, in writing, if there is any dispute as to back pay 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 21ST DAY OF SEPTEMBER, 2022

Dolores Gorczyca

Dolores Gorczyca
Presiding Member
Civil Service Commission

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and
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Attachment

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. CSV 12603-19
AGENCY DKT. NO. N/A

IN THE MATTER OF MOHAMED CONTEH,
TRENTON PSYCHIATRIC HOSPITAL,
DEPARTMENT OF HEALTH.

William Nash, Esq., for appellant Mohamed Conteh

Bryce K. Hurst, Esq., for respondents Trenton Psychiatric Hospital and the Department of Health (Matthew J. Platkin, Acting Attorney General, State of New Jersey, attorney)

Record Closed: April 25, 2022 Decided: July 25, 2022

BEFORE **SUSAN L. OLGIATI**, ALJ:

STATEMENT OF THE CASE

Appellant, Mohamed Conteh (appellant or Conteh), appeals the action of Trenton Psychiatric Hospital and the Department of Health (hereinafter collectively referred to as respondents) removing him from his position as a human services technician (HST) at Trenton Psychiatric Hospital (the Hospital) based on disciplinary charges including mental or physical abuse of a patient and conduct unbecoming a public employee arising out of a November 9, 2018, incident with a patient. Appellant denies the charges and argues that

his actions were intended to prevent the patient from self-harm and to protect himself from the patient's attack.

PROCEDURAL HISTORY

On November 16, 2018, appellant was served with a Preliminary Notice of Disciplinary Action (PNDA) suspending him with pay. Thereafter, on or about November 20, 2018, appellant was served with an amended PNDA, suspending him without pay effective that same date. On July 29, 2019, the Hospital issued a Final Notice of Disciplinary Action (FNDA) charging him with the following:

- N.J.A.C. 4A:2-2.3(a)(6): Conduct Unbecoming a State employee;
- N.J.A.C. 4A:2-2.3(a)(12): Other sufficient cause:
  - A.O. 4:08, C3 Physical or mental abuse of a patient, client or resident;
  - A.O. 4:08, D9 Failure to report injury, abuse or accident involving patient, resident or client;
  - A.O. 4:08, E1 Violation of a rule, regulation, policy (specifically P&P 1.901—Patient Abuse & Neglect, 3.025—Patient/Staff Interactions, and 3.501—Code of Conduct: Behaviors that Undermine a Culture of Safety in the Workplace

Based on these charges, appellant was removed from employment effective July 29, 2019.

Appellant filed a timely appeal, and on September 12, 2019, the matter was transmitted to the Office of Administrative Law as a contested case under the Administrative Procedure Act, N.J.S.A. 52:14-1 to -15, and the act establishing the Office of Administrative Law, N.J.S.A. 52:14F-1 to -13, for a hearing under the Uniform Administrative Procedure Rules, N.J.A.C. 1:1-1.1 to -21.6.

This matter was subject to several case conferences, including an initial case conference on October 21, 2019. By the third case conference, held on January 14, 2020, the parties continued to be engaged in the discovery process. Thereafter, this

matter was delayed by the Statewide shutdown in March 2020 due to the COVID-19 pandemic. Discovery was not completed until January 2021. The hearing was held on February 8, 9, 16, and 18, 2021, and March 10, 2021, via Zoom videoconferencing due to the ongoing pandemic. The record remained open, to allow the parties to obtain a transcript of the proceedings and to submit written closing arguments. The hearing transcripts were significantly delayed due to the pandemic, and complete hearing transcripts were not received until February 2022. Upon receipt of the closing arguments, the record closed on April 25, 2022. In accordance with an Order of Extension, the time for issuing this Initial Decision was extended until July 25, 2022.

FACTUAL DISCUSSION AND FINDINGS

Undisputed Facts

Based on my review of the testimony and the documentary evidence in the record, the following **FACTS** are not disputed:

Trenton Psychiatric Hospital is a State-run, inpatient psychiatric hospital. Conteh was employed at the Hospital from 2008 until July 29, 2019, the date of his removal.

T.E. was a patient at the Hospital. She was civilly committed to the Hospital for long-term care. Dr. Mohammad M. Bari[1] is a clinical psychiatrist at the Hospital. He was T.E.'s treating psychiatrist. He monitored T.E.'s medication, including anti-depressants and mood stabilizers.[2] On the morning of November 9, 2018, Dr. Bari signed a psychiatric order placing T.E. on one-to-one monitoring (special observation) for all shifts due to self-injurious behavior.[3] (R-7.) The order directed that T.E. remain within an arm's-length distance and within eyesight. (Ibid.) The behaviors to be observed included increasing irritability, verbalization of a wish to die, and self-injury. (Ibid.)

[1] The transcript incorrectly identifies Dr. Bari's last name as "Barry."
[2] See testimony of Dr. Bari, 2T at 148–50.
[3] The order was signed at 9:27 a.m.

On November 9, 2018, Conteh was assigned to work as T.E.'s one-to-one aide during the 7 a.m. to 3 p.m. shift. During that shift, T.E. requested to go outside and was instructed to wait while nurse Ngozi Nkemka[4] reviewed T.E.'s care plan. In the meantime, T.E. retrieved a plastic knife from the garbage in an attempt to harm herself. Nkemka and Conteh attempted to retrieve the knife from T.E., but she refused and ran into her bedroom. While in the bedroom, T.E. engaged in self-injurious behavior and aggressive behavior towards Conteh and a struggle ensued.

The incident is partially captured on surveillance video.

Appellant and Nurse Nkemka were the only staff in the room with T.E. during the incident.

The initial investigation into the incident conducted by the Department of Health, Office of Investigations, and completed on or about May 3, 2019,[5] concluded that the allegations against Conteh were unsubstantiated. (J-3.) A supplemental investigation conducted by the Office of Investigations dated June 21, 2019, concluded that the allegations had been substantiated. (R-10.)

Nkemka, the supervising nurse, was responsible for assigning roles during the November 9, 2018 incident.

Testimony

The following is a summary of the relevant and material hearing testimony.

For respondents

Veronica Little is a quality assurance specialist with the Department of Health, Office of Investigations. Prior to this, she worked for ten years as a charge nurse at the Hospital.

[4] The transcript incorrectly identifies Ngozi Nkemka as "Negosi Kemcah."
[5] The investigation report appears to be undated, but reflects that Little completed her report on May 2, 2019, and that supervisor Michael Cuffe reviewed the report on May 3, 2019.

Little testified that she conducted the investigation into the allegations of abuse against Conteh. As part of her investigation, among other documents Little reviewed an Unusual Incident Report (UIR) that detailed the nature of the allegations against Conteh. The UIR indicated that Conteh pushed T.E. twice and was the basis for the investigation into potential abuse.

On December 3, 2018, Little reviewed surveillance video of the November 2018 incident. She reviewed the video at the Hospital on its surveillance system. The video showed T.E. and Nurse Nkemka in T.E.'s bedroom. Conteh's hands were visible but the rest of his body was not. The video showed the hands pushing T.E. onto the bed at "least twice." (1T at 32:15–16.) The hands were not stationary, they appeared to be moving forward. (1T at 33:12–17.) Nkemka appeared to be gesturing "stop" and using her hand, as if redirecting Conteh.

Upon completion of her investigation, the charges against Conteh were unsubstantiated and the case was closed. (See Investigation Report, J-3.) At the time, Little's supervisor had not reviewed the surveillance video. A request was made to the Hospital to provide the video to the Office of Investigations, but that was not done.

Once the Hospital provided a copy of the surveillance video to the Office of Investigations, a supplemental report was prepared and the charge of physical abuse against Conteh was substantiated.

On cross-examination, Little acknowledged that both Nkemka and Conteh attempted to use Therapeutic Options to redirect T.E. The verbal part of the Therapeutic Options failed, as T.E. was not responsive to their attempts at redirection.

Michael Cuffe is employed by the Department of Health, Office of Investigations. He is Veronica Little's supervisor. He testified that a supplemental investigation report was prepared because the Hospital did not provide the video evidence to his office until after the case was closed. He read Little's report but did not have the benefit of watching the surveillance video.

Cuffe reviewed the surveillance video in 2019 and wrote "a significant portion" of the supplemental report describing the video of the incident. (See Supplemental Investigation Report, R-10.)

Based on his review of the video, Cuffe found that Conteh "made contact" with T.E. a few times. At approximately 12:45:02, the surveillance video shows "without doubt that Mr. Conteh made contact with the patient." (1T at 96:10–17.)

Cuffe shared his findings with his supervisor, Matthew Cook, and as a result the investigation was reopened. After Cuffe's review of the video, the investigation findings were changed to substantiated.

T.E. has since been discharged from the Hospital. She testified that on the date of the incident she was upset. She requested "coping skills," medication, and to go outside. Her requests were denied, so she took a plastic knife from the garbage and brought it to her room to hurt herself.

She was followed by Nurse Nkemka and Conteh. Nkemka tried to calm her down. Conteh tried to remove the knife from her. She threw the knife down on the ground. She became agitated and tried to charge at Conteh. She did not have the knife when she charged at him. She was not able to leave the room because Conteh was blocking the doorway and kept pushing her back on the bed. She was pushed onto the bed at least three times. She fell on the edge of the bed and injured her back. The pushes were aggressive and hard. As a result of the incident, she sustained injuries in the form of scratches on her neck and back. The scratches on her neck were from Conteh. She had a bruise on her lower back from when he pushed her and she fell on the bed frame.

Nkemka told Conteh to leave her alone and to stop, but he did not comply.

Conteh filed a municipal-court assault complaint against her, and she filed a cross-complaint against him. T.E. acknowledged signing a statement saying, "In no way did [Conteh] assault me or act aggressively towards me. His actions were merely in an effort

to protect himself while helping me as a result of the aggressive manner in which I was acting." She explained that the statement was not accurate and that she signed it because she was told that the charges against her would be dropped. She was concerned that the charges would affect her ability to continue studying nursing. She thought no one would believe her because she was a "psych patient." She apologized to Conteh but did not recall if he apologized to her.

T.E. first saw the video of the incident with the attorney for the respondents as part of her preparation for the hearing in this matter. Watching the video scared her. It increased her anxiety and depression and made her want to harm herself. (2T at 28:2–18.) T.E. testified that she is a sexual-assault survivor. She explained that she was a patient at a local hospital and a staff member took advantage of her while she was on suicide watch.

On cross-examination, T.E. admitted that she attempted to hurt herself with the knife. She did not recall Nkemka or Conteh asking her for the knife, but reiterated that she dropped the knife when she entered the room. She acknowledged that she charged at Conteh, but did not recall breaking his glasses. She explained that she charged at Conteh because she was agitated that she could not hurt herself with the knife. (2T at 49:15–23.)

Philip Rasaw is a Therapeutic Options trainer at the Hospital. He has worked there since approximately 2008. He previously worked for approximately ten years as an HST. Rasaw testified that Therapeutic Options is a crisis-intervention model used to try to deescalate patients. The goal of Therapeutic Options is knowing how to conduct oneself when a patient is in crisis. It is taught to everyone who works in direct care. Therapeutic Options is taught at orientation and employees must recertify every year. Conteh was initially trained in Therapeutic Options on July 10, 2014, and he was retrained on April 18, 2018. The initial training is two days long and the recertification is one day. The recertification concentrates on verbal skills and addresses some physical skills.

Restraints/holds are taught to be used as a last resort. The Hospital's training provides that it is permissible to use a physical hold if a patient hits, or strikes, or one is in imminent danger of assault.

Rasaw is familiar with T.E. He responded to many calls regarding her. She had a history of threatening to swallow plasticware, destroying the unit, and having glass in her pockets.

Rasaw watched the video of the November 2018 incident. In the last couple seconds of the video, he saw hands come out and make contact with T.E., but he did not know where Conteh was in the room. In training, they teach a pivot-and-deflect maneuver, where staff are taught to side-step patient attacks. He explained, however, that when you are on the units there is not a lot of room to do the maneuvers perfectly like in training. Based on his review, he saw that Conteh's actions in the "last couple seconds" of the video were not consistent with training. (2T at 112:17–113:8.) He explained that "at the end I did see his—you know, the hands out that may have inadvertently pushed her, you know, onto the bed." (2T at 112:9–15.)

On cross-examination, Rasaw acknowledged that the records reflected that Conteh received Therapeutic Options training only twice, in 2014 and in 2018. Part of Therapeutic Options includes talking to patients.

Patient bedrooms contain barriers such as wardrobes (closets) that are not present in training. Staff are also taught a body-control restraint to trap the patient in a bear hug. If a patient is too wild, there is a risk in doing this maneuver, as one could lose his balance and cause injury both to the patient and staff. If one is in a tight space, that maneuver should not be used. Conteh did not have a lot of room to create space between himself and T.E. Staff are taught to deflect. Pushing is never taught.

Based on his review of the video, Rasaw did not see abuse, he saw "just bad technique." (2T at 169:19–22.)

Matthew Cook is the chief of investigations for the New Jersey Department of Health. He has held this position since November 2018. Previously he was a quality assurance coordinator in the Office of Investigations from May 2011 until 2018. He testified that he is familiar with the training requirements of direct-care employees.

Cook testified that the investigation into the allegations was initially closed by Michael Cuffe as unsubstantiated. When the Hospital received the investigation report, it questioned the finding, given that there was a video of the incident. Cook's office thereafter received the video. It corroborated the other statements and Conteh's actions were deemed to fit the definition of a physical act that could cause pain, injury, anguish, or suffering—so the allegations were substantiated.

Cook concluded that the video showed that from the last time T.E. was pushed and ran out of the room,-- "an indication of fear." (2T at 206:17–25.) He opined that Conteh's actions towards T.E. violated the policy prohibiting patient abuse.

On cross-examination, Cook concluded that Conteh committed approximately four to five acts of abuse. He acknowledged that these acts were witnessed by Conteh's supervisor, Nurse Nkemka, who was required to report any acts of abuse. He was unaware of any report filed by Nkemka alleging abuse by Conteh.

Ngozi Nkemka is a nurse at the Hospital. She has worked there since 2004. She is currently the supervisor of nursing. On the date of the incident she was on duty and working as the charge nurse.

She testified as to her January 15, 2019, written statement of the incident. (R-4.) T.E. was agitated and became more upset after the plastic knife was removed from her. T.E. punched Conteh. Conteh pushed her away. He pushed her two to three times. T.E. kept charging at him. Nkemka told them to stop and told Conteh to run, but he did not. Nkemka knows T.E. very well. When she starts, she does not stop. T.E. was upset with Conteh after he was able to "snatch" the knife away from her. Nkemka told Conteh to leave the room because she did not want him or T.E. to get hurt. T.E.'s focus was on Conteh; if he left, the incident would stop.

Nkemka also testified to the progress notes she wrote approximately one hour after the incident. (R-6.) It was noisy in the room. T.E. was cursing and screaming. Nkemka was also yelling. She told both T.E. and Conteh to stop. She told Conteh to run away because T.E. was coming at him.

Additionally, she testified to the incident report she prepared on the date of the incident. (J-8.) Both she and Conteh were trying to take the knife from T.E. Conteh was the one who was able to get if from her. T.E. punched Conteh and he pushed her off of him. T.E. tried "two more times to assault him and [he] was able to stop the patient from assaulting him. (3T at 29:17–19.) "Mr. Conteh stopped her from assaulting him by, you know, pushing her away from him." (3T at 29:25–30:1; see also 3T at 44:24–45:1.) "[H]e pushed her to prevent her from attacking him." (3T at 48:14–15.)

After the incident, Nkemka reassigned someone else as the one-on-one for T.E. and she gave Conteh another assignment.

On cross-examination, Nkemka testified that they struggled with T.E. to get the knife from her. She did not throw it on the floor. Removing the knife was the right thing to do. T.E. was trying to cut her wrist with it. Nkemka did not witness abuse by Conteh. She is aware of the policy on reporting of abuse. If she saw abuse, she would have reported it.

Bhanumathi **Bandu** is employed as a physician specialist at the Hospital. She has worked there since 2007. Dr. Bandu testified that she examined T.E. on November 9, 2018, following the incident and prepared a progress note on the same date. She noted that T.E. alleged that she was assaulted by staff that afternoon. Her notes reflect that T.E. was not in distress and that she denied pain. Dr. Bandu reported that T.E. had three red marks on her neck and two superficial scratches on her lower back, and healing scratches on her forearm. She differentiated new injuries sustained by T.E. on the date of the incident from old injuries she had. The "healing injuries" related to old scratches sustained by T.E.

On cross-examination, Dr. Bandu acknowledged that T.E. had been involved in an incident on November 6, 2018, with another patient. During that incident, in which T.E. was listed as the aggressor, she suffered injuries to the left side of her neck. Dr. Bandu explained that those injuries were not the same area where she noted the red marks on T.E.'s neck on November 9, 2018. The new injuries were on the front of T.E.'s neck.

For appellant

Omezie Molokwu is a psychiatric nurse practitioner. He began working at the Hospital in 2017 and remained there for over three years. He was familiar with T.E. She was his daily patient for over a year. She was very sick and unpredictable. She was a danger to herself and others. He also knows Conteh. They worked together often. Conteh was the "most reliable" worker. He "went above" to make sure patients were safe.

Molokwu recalled the November 2018 incident. He was working on the same shift. He recalled learning that T.E. had grabbed a plastic knife from the garbage. She was on one-to-one observation. Suicidal ideations were part of her symptoms. Staff are required to make sure they are within an arm's length of a patient on special observation.

He was familiar with T.E.'s room and was in it often to give out medication. The walkway between the foot of the bed and the footlocker is typically very tight. There is a wardrobe at each bed.

Molokwu reviewed the video of the incident at the hearing. He believed that Conteh was trying to deflect T.E. Based on their training, he would expect Conteh to act as he did, otherwise T.E. could have crashed into one of the wardrobes.

On the date of the incident, Molokwu encountered T.E. in the hallway after she ran out of the room. He attempted to deescalate the situation and calm her. T.E. warned him that she would injure him if he continued, and she kicked him in the knee.

He completed a body-chart report of T.E. following the incident. He did not notice that T.E. had any new injury because of the incident. On the body chart he noted all

injuries he saw, regardless of when they occurred. He made no distinction between old and new injuries. He documented minor abrasions on her neck and head and her low-back area. T.E. denied any pain or distress. There was no swelling or bleeding.

Pursuant to the training received at the Hospital, Molokwu believed that pushing and making physical contact is permitted in limited circumstances, like removing a weapon or for protection of others and self. Under the circumstances, he believed that Conteh made the best decision in deflecting T.E.

Ted Pawalck[6] was employed at the Hospital from 2014 to 2019 as the principal occupational therapist (OT). He is familiar with Conteh, and described him as attentive to his patients, friendly, and compassionate. He knew that T.E. was a patient at the Hospital but he did not work with her.

He attended the municipal-court hearing for the assault charges that Conteh and T.E. filed against each other. He took Conteh to the hearing and acted as a "pseudo" interpreter because Conteh sometimes has problems with his English. At that hearing, Pawalck introduced himself to T.E. as an OT and a friend of Conteh's. T.E. indicated that she wanted to write Conteh a letter to apologize for hurting him. T.E. and Conteh talked at the hearing. They ended their conversation with a hug, and they appeared to play a game like "rock, paper, scissors."

Cecelia Cole is a human services assistant at the Hospital. She has worked there for seven years. She testified that she frequently worked with T.E. Cole had a good relationship with T.E. and often was assigned as a one-to-one.

A few days before the incident, T.E. was involved in a fight with another individual. Cole saw those injuries on November 7, 2018.

On the morning of the incident, Cole saw scratches on T.E.'s neck, they were the same wounds that she previously saw. Later that day, a code was called because T.E. was hitting everyone. T.E. was very angry. She accused Shirley Funches, another staff

[6] The transcript phonetically refers to the witness's last name as "Pollack."

member, of scratching her on the neck. During her interview, Cole informed Veronica Little that the injury on T.E.'s neck was from a fight several days before the incident.

Cole and Conteh were friends. They occasionally ate lunch together. However, she testified that their friendship did not affect her ability to tell the truth.

Mohamed Conteh was hired by the State of New Jersey in November 2008 to work as a human services assistant. Later, he was promoted to an HST. He began working at the Hospital in 2014. He was assigned to work the night shift.

After completing the night shift on November 8, 2018, Conteh was asked to work overtime on the next shift [November 9, 2018]. He was familiar with T.E. and had worked with her before. Conteh was assigned to monitor T.E. as her one-to-one. She had self-injurious behaviors, including pica.[7] She had a history of attempting to kill herself.

On the date of the incident, Conteh performed a contraband check of T.E. to make sure she was not hiding anything. He noticed a wound on her neck. T.E. told Conteh that the marks on her neck were from a fight. Afterwards, they went to the dayroom and played cards for a while. T.E. said that she did not feel well and wanted to see the nurse. They went to the nurse's station to ask about her medication. The doctor was contacted. The doctor advised that it was not yet time for T.E.'s medication. T.E. then asked for her coping skills, like listening to music or permission to go outside, but they were denied.

She then rushed to the trash, retrieved a plastic knife, and ran towards her room. Both Conteh and Nkemka asked T.E. for the knife, but she refused. They followed her to her room.

The room had four beds, with a wardrobe and a hamper at the foot of each bed. The space between the beds and the wardrobes is narrow. The beds are plastic with no edges and they have mattresses on them. The wardrobes are taller than Conteh, who is five feet, two inches, tall, and they are three to four feet wide. The beds and the wardrobes are next to the concrete walls.

[7] A form of eating disorder in which a person eats (swallows) things not usually considered food.

Once inside the room, T.E. attempted to swallow the knife. She was attempting to cut her wrist with the knife. Conteh took the knife from her and put it in inside of his pocket. T.E. then pushed him in the face with both hands and broke his eyeglasses. It happened so quick he could not stop her. She fell on the bed, got up again, and pushed him again, against the wall. She fell back on the bed and pushed Conteh a third time. She was "completely desperate," she kept coming after him, pushing, attacking, cursing, and spitting at him. She was yelling at the top of her lungs, "I'll kill you" "I'll kill you" "I'll kill myself." Everything was out of control and happening quickly. (4T at 76:2–11.)

Conteh pushed T.E. back onto the bed. It was the only safe place there was. He did not have room to move. If he moved, T.E. would have followed him. She would have hit the wall or the wardrobe. Every time T.E. came at him, he told her to "stop" and he put his hands in front of him, but T.E. was kicking, spitting, and yelling. After the knife was removed, the nurse kept trying to talk to her and tried to come in between them so that T.E. would not come after him. T.E. came at him three to four times. He wasn't sure where he made contact with T.E.'s body. He tried to keep her safe. He could not leave the room because it was not safe to leave her. Conteh did not hear the nurse tell him to leave the room.

T.E. rolled off the bed onto the left side and ran out of the room. Prior to this, she was charging at him and not attempting to leave. They followed her because they were concerned she would try to get another object to harm herself. She ran down the hall and sat on the floor. She was blocking the entrance to the doorway. At this point, others responded to the code.

After the incident, Conteh asked to complete workers' compensation papers and to go to the hospital. He went to Human Resources, but they did not take his paperwork. Instead, they asked for his badge and papers because they said he assaulted the patient. He injured his lower back, left ankle, and one of his fingers. He filed an assault charge against T.E. in municipal court. She later filed a charge against him for assault and theft. She said he stole the cord for her headphones. He took the cord as part of the contraband check. She was not allowed to have it. She also accused him of grabbing her by the left

arm and throwing her on a bed and choking her. T.E. gave a statement in municipal court explaining that Conteh did not assault her, but attempted to calm her down and maintain her safety. She was represented by a public defender. His attorney typed the statement from T.E. but the wording came from her. The criminal charges were dismissed.

He was interviewed by Little over the phone; he told her that he pushed T.E. after she attacked him. He did not read the summary of his interview. Conteh denied scratching T.E. He does not have fingernails. Additionally, she was fighting, and there was no way to get a hold on her.

While employed at the Hospital, Conteh never received training to address the situation he encountered with T.E.

On cross-examination, Conteh admitted to pushing T.E., but said that he did so for her safety. He also acknowledged that it was possible that he made contact with her neck or her shoulder. He admitted to moving his hands towards her more than two times. He further acknowledged that when he pushed T.E. she no longer had the knife.

He acknowledged receiving Therapeutic Options training twice during his employment. He was taught to use deflection techniques and to create space between himself and a patient when possible. During the incident, he had no space and nowhere to go.

Credibility

In evaluating evidence, it is necessary for me as the finder of fact to assess the credibility of the witnesses. This requires an overall assessment of the witness's story in light of its rationality or internal consistency and the manner in which it "hangs together" with the other evidence. Carbo v. United States, 314 F. 2d 718, 749 (9th Cir. 1963). "Testimony to be believed must not only proceed from the mouth of a credible witness but must be credible in itself," in that "[i]t must be such as the common experience and observation of mankind can approve as probable in the circumstances." In re Perrone, 5 N.J. 514, 522 (1950).

A trier of fact may reject testimony as "inherently incredible" when "it is inconsistent with other testimony or with common experience" or "overborne" by the testimony of other witnesses. Congleton v. Pura-Tex Stone Corp., 53 N.J. Super. 282, 287 (App. Div. 1958). "The interest, motive, bias, or prejudice of a witness may affect his credibility and justify the [trier of fact], whose province it is to pass upon the credibility of an interested witness, in disbelieving his testimony.'" State v. Salimone, 19 N.J. Super. 600, 608 (App. Div.), certif. denied, 10 N.J. 316 (1952) (citation omitted).

As to the credibility of respondents' witnesses, I accept the testimony of Veronica Little, Michael Cuffe, and Matthew Cook concerning the Department's investigation into the charges against Conteh and the reasons for the differing conclusions of the initial investigation report and the supplemental investigation report as credible. However, the basis for the differing conclusions appears to be a subjective interpretation of the surveillance video. Moreover, the conclusion appears to be focused exclusively on one portion of the video, rather than on the totality of the particular circumstances of this matter.

I also accept the testimony of Dr. Mohammad Bari as reasonable and credible and have incorporated the relevant portions of his testimony into the undisputed facts set forth above.

As to T.E., I do not find her to be a consistent or reliable reporter. She acknowledges that on the date of the incident she attempted to hurt herself with the plastic knife, that she was agitated and charged at Conteh several times, but other key portions of her testimony are in conflict with the credible and competent evidence in the record. Her testimony that she threw the knife on the floor when she entered the bedroom is contradicted by the credible testimony of both Nkemka and Conteh that they struggled with her to remove the knife and that Conteh ultimately removed it from her. Additionally, her testimony that Conteh blocked and prevented her from leaving the bedroom appears inconsistent with the available surveillance video. During the limited times that Conteh is seen on the video, he appears to be located to the right of the doorway. Moreover, T.E. has changed her version of the November 9, 2018, incident several times. In a municipal-

court complaint she charged Conteh with assault and theft. (R-24.) Thereafter, she signed a sworn statement in the municipal-court matter stating that Conteh was attempting to calm her and maintain her safety, and that "in no way did he assault me or act aggressively toward me." At the hearing in this matter, she then testified that the sworn statement was inaccurate, but that she signed it because she believed in doing so, the charges against her would be dismissed. Based on the above, I do not accept her testimony as credible.

As to Philip Rasaw, I accept as credible his testimony regarding Conteh's training record and the Department's training policies and practices. Additionally, I accept his conclusion that Conteh did not engage in abuse, but rather "bad technique," as reasonable and reliable. His testimony in this regard is based on his years of experience as a trainer, his familiarity with the tight layout of T.E.'s room, and the options available to Conteh given the layout, and T.E.'s undisputed self-injurious and assaultive behavior. Further, his conclusion is based on the fact that Conteh and his response to T.E.'s self-injurious and assaultive behaviors are out of the camera's view for a significant portion of the video.

I accept the testimony of Ngozi Nkemka as credible. Her testimony regarding the incident, including that T.E. engaged in self-injurious behavior and assaultive behavior towards Conteh, and that Conteh's actions were intended to protect T.E. and to prevent her attack on him, is supported by other credible and competent evidence in the record, including Nkemka's progress notes from November 9, 2018 (R-6), the incident report of November 9, 2018, in which Nkemka identified T.E. as the aggressor (J-8), and her January 15, 2019, written statement (R-4).

Finally, I accept the testimony of Dr. Bhanumathi Bandu as credible. Her testimony regarding her examination of T.E. several days before the incident and on November 9, 2018, following the incident, as well as her findings of new, albeit superficial, injuries resulting from the November 9, 2018, incident, is reasonable and reliable.

As to the testimony of the appellant's witnesses, I accept Omezie Molokwu's testimony regarding his familiarity with and knowledge of both Conteh and T.E. as sincere

and reasonable. However, as he did not witness the events that occurred within T.E.'s bedroom, and encountered T.E., only after she left the room, his testimony is of limited value in determining whether Conteh engaged in the charges alleged. Additionally, to the extent that Molokwu found that T.E. had no new injuries from the November 9, 2018, incident, his testimony is overborne by the testimony of Dr. Bandu, who examined T.E. both several days before and after the incident and determined that T.E. had new, albeit superficial, injuries from the incident, consisting of three red marks on her neck and two superficial scratches on her lower back.

Similarly, while I accept the character testimony of witnesses Ted Pawalck and Cecelia Cole as sincere, neither witnessed the November 9, 2018, incident, thus their testimony is of limited value in determining whether appellant engaged in the charges alleged. Further, to the extent Cole testified that T.E.'s injuries pre-existed the incident, her testimony is overborne by the testimony of Dr. Bandu—a medical doctor—who examined T.E. both several days before and after the incident and determined that T.E. had new, albeit superficial, injuries from the incident.

Finally, I accept the testimony of appellant as credible. His testimony concerning the November 2018 incident and his actions therein is supported by the credible testimony of Nurse Nkemka, the only other staff member to witness the incident, and her related reports. (R-4; R-6; J-8.) Appellant's testimony that his actions were intended to protect T.E. from self-harm and to protect himself from her attack is reasonable and is consistent with the available video. Further, his testimony that the bedroom was a confined space that prevented him from engaging in other training techniques such as pivot and deflection is supported by the credible testimony of Rasaw, the Department's Therapeutic Options trainer. Finally, appellant's testimony that he received Therapeutic Options training only twice between 2014 and 2018, rather than annual recertification, is supported by the testimony of Rasaw and the Department's training records (R-22).

Additional Findings of Fact

Having had the opportunity to listen to the testimony of the witnesses, and to observe their demeanor, and to assess their credibility, as well as having considered the documentary and video evidence in the record, I additionally **FIND** the following as **FACT**:

The video

The relevant portion from camera seven of the surveillance video shows the following:

At approximately 12:44:21, T.E. enters her bedroom, followed by Nkemka and Conteh. They walk to the right side of the room and are out of the camera's view. Two empty beds are seen in the video. No one and no action are captured within the camera's view for approximately the next thirty seconds.

Beginning at approximately 12:44:51 and continuing through approximately the next ten seconds and ending at 12:45:02, T.E. is seen falling toward the bed. Conteh is not within the camera's view. Nkemka comes into partial view of the camera at the left side of the bed. T.E. gets up and falls back onto the bed. While on the bed she is seen kicking her legs toward the bottom right side. She falls back onto the bed several additional times. T.E.'s falls are consistent with one being pushed.

Each time she falls onto the bed she is seen kicking her legs toward the bottom right side of the bed, getting up, and advancing toward the bottom right side of the bed. As she advances, neither she nor Conteh is fully visible. At approximately 12:45:02, Conteh's hands enter the camera's view. His arms are outstretched with palms forward and he appears to make contact with T.E.'s shoulder area and pushes her onto the bed. Nkemka moves toward the right side of the room and moves her arm out toward Conteh. T.E. gets up from the left side of the bed and runs out of the room. She shuts the door behind her and Conteh and Nkemka run after her.

The incident inside T.E.'s bedroom happened very quickly. The details of the incident are fully discernible only after multiple viewings of the video at both regular and slow speeds.

In addition to the video, I also **FIND** as **FACT** that:

While in the bedroom, T.E. threatened and actually attempted to injure herself with the knife.

Conteh removed the knife from T.E.

Conteh did not block T.E.'s exit from the room. T.E. did not appear to attempt to leave the room before she ran out at approximately 12:45:02.

Conteh received Therapeutic Options training once in 2014 and in 2018. He did not receive annual recertification.

It was loud during the incident.

Nkemka did not seek to charge Conteh with insubordination relating to his actions on the date of the incident. Nkemka did not file any report alleging that Conteh abused T.E. In her November 9, 2018, incident report, Nkemka identified T.E. as the aggressor.

The bedroom contained several beds, wardrobes, and hampers (footlockers) at the foot of each bed. The walkway space within the bedroom was "tight."

Following the incident, T.E. did not express distress or pain and refused treatment. However, superficial injuries consisting of three red marks on her neck and two scratches on her low back were noted by Dr. Bandu.

LEGAL ANALYSIS AND CONCLUSIONS

Appellant's right and duties are governed by the Civil Service Act and accompanying regulations. N.J.S.A. 11A:1-1 to 12-6. A public employee protected by the Civil Service Act may be subject to major discipline for a wide variety of offenses connected to his/her employment. The general causes for such discipline are set forth in N.J.A.C. 4A:2-2.3(a). In an appeal from such discipline, the appointing authority bears the burden of proof to show that the action taken was appropriate. N.J.S.A. 11A:2-21; N.J.A.C. 4A:2-1.4(a). The appointing authority must show by a preponderance of the competent, relevant, and credible evidence that the employee is guilty as charged. Atkinson v. Parsekian, 37 N.J. 143 (1962); In re Polk, 90 N.J. 550 (1982).

Conduct Unbecoming

"Conduct unbecoming a public employee" is an elastic phrase, which 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, 398 Pa. 35, 43, 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)).

Here, the undisputed evidence in the record demonstrates that on the morning of the incident, T.E. had already been placed on one-to-one observation due to her demonstrated self-injurious behavior and aggression to others. Later that day, while Conteh was assigned as her "one-to-one," T.E. took a plastic knife from the garbage and both threatened and attempted to harm herself with the knife. Nkemka and Conteh tried to verbally redirect T.E. but she did not respond to their attempts at redirection. Ultimately, Conteh was able to remove the knife from

T.E. After he did so, T.E. became even more agitated and assaulted Conteh by hitting him in the face and repeatedly charging at him. Nkemka, the then charge nurse and currently the supervisor of nursing, confirmed that Conteh did not abuse T.E. and that his actions were intended to protect T.E. from self-harm and to protect himself from her attack. While the actions taken by Conteh may have been inconsistent with the Department's training policies and procedures, the record demonstrates that he received Therapeutic Options training only twice in four years rather than annual recertification. Moreover, the incident happened very quickly. The entire incident, from the time that T.E. entered the bedroom with knife in hand and threatening and attempting to harm herself until the time that she exited the bedroom, lasted approximately only forty seconds. Thus, appellant had only seconds to react to T.E.'s self-injurious and assaultive behavior. Accordingly, based on the particular circumstances of this case, appellant's actions do not offend the publicly accepted standards of decency, adversely affect the morale or efficiency of a governmental unit, or destroy public respect in the delivery of governmental services.

Accordingly, I **CONCLUDE** that respondents have failed to demonstrate, by a preponderance of the credible evidence, that appellant's actions constitute conduct unbecoming a public employee, in violation of N.J.A.C. 4A:2-2.3(a)(6).

Other Sufficient Cause

N.J.A.C. 4A:2-2.3(a)(12) provides that "[a]n employee may be subject to discipline for . . . [o]ther sufficient cause." Other sufficient cause is an offense for conduct that violates the implicit standards of good behavior that devolves upon one who stands in the public eye as an upholder of that which is morally and legally correct. In re MacDonald, Mercer Cty. Corr. Ctr., 2014 N.J. AGEN LEXIS 236, (May 19, 2014), adopted, 2014 N.J. AGEN LEXIS 1099 (September 3, 2014).

Having concluded that appellant's actions do not constitute conduct unbecoming a State employee, I similarly conclude that they do not violate the implicit standards of good behavior and thus do not constitute other sufficient cause in violation of N.J.A.C. 4A:2-2.3(a)(12).

Here, the specific rule violations that appellant is charged with are:

- A.O. 4:08, C3 Physical or mental abuse of a patient, client or resident;
- A.O. 4:08, D9 Failure to report injury, abuse or accident involving patient, resident or client;
- A.O. 4:08, E1 Violation of a rule, regulation, policy (specifically P&P 1.901—Patient Abuse & Neglect, 3.025—Patient/Staff Interactions, and 3.501—Code of Conduct: Behaviors that Undermine a Culture of Safety in the Workplace.

Physical or mental abuse

Administrative Order 4:08 defines physical abuse as

> 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.
>
> [See AO 4:08, Supplement 3.]

As previously set forth herein, the record demonstrates that appellant's action in pushing T.E. onto the bed was intended to protect her from self-harm and to protect him from T.E.'s assaultive behavior. Appellant's efforts and the efforts of Nurse Nkemka to verbally redirect T.E. were unsuccessful. Even though Conteh was able to remove the plastic knife from T.E., she continued to charge at him. Appellant's credible testimony confirmed that he believed the bed was the only safe place for T.E. to go, and that if he did not push T.E. onto the bed, she might crash into the wardrobe or the concrete wall behind him. The surveillance video confirms that much of the incident occurred outside of the camera's view and that Conteh had only seconds to react to T.E.'s self-injurious and assaultive behavior. Respondents' own witness Philip Rasaw, the Department's Therapeutic Options trainer, concluded that Conteh's action was not abuse, but rather "bad technique." Rasaw further confirmed that the bedroom was a tight space and that certain other training techniques were not possible or were unsafe there. Thus, based on the particular circumstances of this matter, Conteh's action in pushing T.E. onto the bed

should not be considered abuse because it was designed to protect T.E. from self-harm and himself from her assaultive behavior.

Accordingly, I **CONCLUDE** that respondents have failed to demonstrate, by a preponderance of the credible evidence, that appellant's actions constitute other sufficient cause, in violation of N.J.A.C. 4A:2-2.3(a)(12), specifically, physical abuse of a patient in violation of Administrative Order 4:08, C3.

Failure to report injury, abuse or accident involving a patient, resident, or client

As set forth herein, I concluded that appellant did not engage in abuse of T.E. Thus, he should not be charged with failure to report same. Nkemka, the charge nurse who was also involved in the incident, did not report any abuse by Conteh. Rather, in her incident report (J-8), she identified T.E. as the aggressor. The record also demonstrates that Conteh had no reason to believe that T.E. sustained any injury during the incident as he pushed her onto the bed and because he was aware that she had sustained an injury to her neck in a prior incident. The prior injuries sustained by T.E. are confirmed by the testimony and records of Dr. Bandu, as well as other documentary evidence. (See J-39 at DOH 40 and 41; J36; J37)

Accordingly, I **CONCLUDE** that respondents have failed to demonstrate, by a preponderance of the credible evidence, that appellant's actions constitute other sufficient cause, in violation of N.J.A.C. 4A:2-2.3(a)(12), specifically, failure to report injury, abuse or accident involving a patient, resident or client, in violation of Administrative Order 4:08, D9.

Violation of a rule, regulation, policy (specifically, P&P 1.901—Patient Abuse & Neglect, 3.025—Patient/Staff Interactions, and 3.501—Code of Conduct: Behaviors that Undermine a Culture of Safety in the Workplace)

Trenton Psychiatric Hospital Policy and Procedure 1.901, Patient Abuse and Neglect, defines abuse as

> any act, omission or non-action in which an employee 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 a patient, or which deprives a patient of his/her rights, as defined by law or departmental policy.
>
> [Id. at III (Definitions); (J-12).]

Having previously concluded that appellant's actions did not constitute abuse under A.O. 4:08, C3, I similarly **CONCLUDE** that his actions do not constitute abuse under Trenton Psychiatric Hospital Policy and Procedure 1.901. Here, the credible and competent evidence in the record demonstrates that Conteh's actions had the legitimate goal of proper and humane care, specifically, the protection of T.E. from self-harm.

Accordingly, I **CONCLUDE** that respondents have failed to demonstrate, by a preponderance of the credible evidence, that appellant's actions constitute other sufficient cause, in violation of N.J.A.C. 4A:2-2.3(a)(12), specifically, patient abuse and neglect, in violation of Trenton Psychiatric Hospital Policy and Procedure 1.901.

Finally, Policy 3.025, Patient/Staff interactions, and Policy 3.501, Code of Conduct: Behaviors that Undermine a Culture of Safety in the Workplace, were not introduced or admitted into evidence at hearing. Similarly, there was no testimony regarding these policies and they were not addressed in respondents' closing arguments.

Accordingly, I **CONCLUDE** that respondents have failed to demonstrate, by a preponderance of the credible evidence, that appellant's actions constitute other sufficient cause, in violation of N.J.A.C. 4A:2-2.3(a)(12), specifically, Patient/Staff interactions, in violation of Policy 3.025, and Code of Conduct: Behaviors that Undermine a Culture of Safety in the Workplace, in violation of Policy 3.501.

Finally, while appellant is only specifically charged with the above rule, regulation, and policy violations, the Department's Disciplinary Action Program, Administrative Order 4:08, also prohibits inappropriate physical contact or mistreatment of a patient, client, resident, or employee. (A.O. 4:08, C5 (R-19 at TPH 160).) The definition of inappropriate

physical contact or mistreatment is not defined in the Administrative Order but rather is determined on a case-by-case basis.

I have concluded that appellant's actions do not constitute abuse of a patient. However, the competent evidence in the record demonstrates that his action in pushing T.E. onto the bed, although intended to protect her from self-harm and to protect himself from her assaultive behavior, was not consistent with the Department's training or policies. Philip Rasaw acknowledged that appellant's action was "bad technique." He further confirmed that staff are taught to deflect and that pushing is never taught. While recognizing the particular circumstances of this case, including the short timeframe and confined space in which appellant had to react to T.E.'s self-injurious and assaultive behavior, he should have at least attempted to use other training techniques rather than continue to push T.E. back onto the bed in response to her continuing self-injurious and/or assaultive behavior.

For these reasons, I **CONCLUDE** that respondents have demonstrated, by a preponderance of the credible evidence, that appellant's actions constitute other sufficient cause, in violation of N.J.A.C. 4A:2-2.3(a)(12), specifically, inappropriate physical contact or mistreatment of a patient in violation of A.O. 4:08, C5.1.

PENALTY

Having determined that appellant's actions constitute other sufficient cause, in violation of N.J.A.C. 4A:2-2.3(a)(12), specifically, inappropriate physical contact or mistreatment of a patient in violation of A.O. 4:08, C5.1, I must now determine the appropriate penalty to impose.

A civil service employee who commits a wrongful act related to his or her duties may be subject to major discipline. N.J.S.A. 11A:1-2(b), 11A:2-6, 11A:2-20; N.J.A.C. 4A:2-2.2, -2.3(a). This requires a de novo review of appellant's disciplinary action. In determining the appropriateness of a penalty, several factors must be considered, including the nature of the employee's offense, the concept of progressive discipline, and the employee's prior record. George v. N. Princeton Developmental Ctr., 96 N.J.A.R.2d

(CSV) 463. Pursuant to West New York v. Bock, 38 N.J. 500, 523–24 (1962), concepts of progressive discipline involving penalties of increasing severity are used where appropriate. See also In re Parlo, 192 N.J. Super. 247 (App. Div. 1983).

However, "[p]rogressive discipline is not a necessary consideration when reviewing an agency head's choice of penalty when the misconduct is severe, when it is unbecoming to the employee's position or renders the employee unsuitable for continuation in the position . . . ." In re Herrmann, 192 N.J. 19, 33 (2007).

The Department's Disciplinary Action Program provides a penalty for this offense ranging from official written reprimand to removal. (R-19 at TPH 160.) The appellant worked for the Department for approximately ten years, since 2008, without incident. There is no evidence in the record of any disciplinary history prior to the November 2018 incident.

Given appellant's lack of disciplinary history and the particular circumstances of this case, removal is not warranted. However, given the Hospital's duty to protect the vulnerable population that it serves, and the potential harm that appellant's action could have caused, a serious penalty is warranted. Accordingly, I **CONCLUDE** that a 180-day suspension rather than termination is the appropriate penalty.

ORDER

I hereby **ORDER** that the following charges are dismissed: conduct unbecoming a State employee in violation of N.J.A.C. 4A:2-2.3(a)(6), and other sufficient cause in violation of N.J.A.C. 4A:2-2.3(a)(12), consisting of physical or mental abuse of a patient, client or resident in violation of A.O. 4:08, C3; failure to report injury, abuse or accident involving patient, resident or client in violation of A.O. 4:08, D9; and violation of a rule, regulation, policy, in violation of A.O. 4:08, E1 (specifically, P&P 1.901—Patient Abuse & Neglect, 3.025—Patient/Staff Interactions, and 3.501—Code of Conduct: Behaviors that Undermine a Culture of Safety in the Workplace).

I further **ORDER** that the charge of other sufficient cause in violation of N.J.A.C. 4A:2-2.3(a)(12), consisting of inappropriate physical contact or mistreatment of a patient in violation of A.O. 4:08, C5.1, is imposed. I **ORDER** that the penalty of removal is **REVERSED** and is **MODIFIED** to a 180-day suspension. I **ORDER** that appellant be reinstated to his position and that he be issued all applicable back pay and benefits. Finally, I **ORDER** that upon return to employment, appellant undergo all appropriate training regarding patient care and safety, verbal and physical de-escalation techniques, and permissible restraints, holds, and deflection maneuvers, including but not limited to Therapeutic Options.

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.

July 25, 2022
DATE

SUSAN L. OLGIATI, ALJ

Date Received at Agency:

Mailed to Parties:

SLO/sb

APPENDIX

WITNESSES

For Respondent:

Veronica Little
Michael Cuffe
Dr. Mohammad Bari
T.E.
Philip Rasaw
Matthew Cook
Nurse Ngozi Nkemka
Dr. Bhanumathi Bandu

For Appellant:

Omezie Molkwu
Ted Pawalck
Cecilia Cole
Mohamed Conteh

EXHIBITS[8]

Joint Exhibits:

J-1 Final Notice of Disciplinary Action
J-2 Stipulation of Procedural History of Amended Preliminary Notice of Disciplinary Action
J-3 Initial Investigation (unsubstantiated) closed May 3, 2019
J-5 Written statement, Conteh November 9, 2018
J-8 Confidential Assault Incident Report Form (incident report)

[8] Gaps in the exhibit numbers represent pre-marked exhibits that were not admitted into evidence.

J-12 Policy and Procedure 1.901 Patient Abuse and Neglect
J-14 Div. of Mental Services Health Services Admin. Bulletin 3:18
J-17 Policy and Procedure 2.615
J-25 Complaint form (TPH 202 and 204 only)
J-26 Municipal Complaint signed by Conteh
J-31 White board drawing of Phil Rasaw
J-33 Certification of Disposition, Ewing Township Municipal Court (previously petitioner's Exhibit A)
J-34 Suveillance video, November 9, 2018
J-35 Trenton Psychiatric Hospital Policy and Procedure Revised December 12, 2016
J-36 Trenton Psychiatric Hospital Assault incident Report, incident date November 6, 2018 with progress notes.
J-37 DHS Unusual incident report, November 6, 2018
J-38 DHS Unusual incident report, November 8, 2018
J-39 Trenton Psychiatric Hospital Assault Incident Report incident, November 8, 2018 with progress notes.
J-40 PNDA dated November 16, 2018 for Conteh suspending him with pay effective November 9, 2018

For Respondent:

R-4 Written statement of Nkemka dated January 15, 2019 and Cecilia Cole dated November 9, 2018
R-6 Progress notes of nurse Nkemka dated November 9, 2018
R-7 Physician's order by Dr. Mohammad Bari
R-9 Body Chart signed and created by Omezie Molokiou
R-10 Supplemental investigation dated June 21, 2019
R-11 Letter to Conteh dated June 20, 2019
R-19 DOH Disciplinary Action Program
R-20 DHS Administrative Order 4:08
R-21 Therapeutic Options Participant Manual
R22 Training Record, Conteh

R23 Municipal Court Complaint by T.E.

R-24 Signed Statement by T.E.

R-27 Certification of Disposition Municipal Court case against T. E.

R-30 Conteh executed Distribution List of Documents For Full-Time Employees

R-32 Proposed stipulation regarding nurse Nkemka.

For Appellant:

None