STATE OF NEW JERSEY

In the Matter of Sheila Christophe, Department of Health, Trenton Psychiatric Hospital CSC Docket No. 2023-700 OAL Docket No. CSV 09460-22	:	**FINAL ADMINISTRATIVE ACTION OF THE CIVIL SERVICE COMMISSION**

ISSUED: July 13, 2026

The appeal of Sheila Christophe, a Human Services Assistant, Department of Health, Trenton Psychiatric hospital, of her removal, effective August 25, 2022, on charges, was heard by Administrative Law Judge Kimberly M. Wilson (ALJ), who rendered her initial decision on June 4, 2026. No exceptions were filed.

Having considered the record and the ALJ's initial decision, and having made an independent evaluation of the record, the Civil Service Commission (Commission), at its meeting on July 1, 2026, adopted the ALJ's Findings of Facts and Conclusions of Law and her recommendation to uphold the removal

ORDER

The Civil Service Commission finds that the action of the appointing authority in laying off the appellant was justified. The Commission therefore upholds that action and dismisses the appeal of Sheila Christophe.

This is the final administrative determination in this matter. Any further review should be pursued in a judicial forum.

DECISION RENDERED BY THE
CIVIL SERVICE COMMISSION ON
THE 1st DAY OF JULY, 2026

Mary Cruz
Acting Chairperson
Civil Service Commission

Inquiries
and
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Shannon L. Dalton
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Attachment

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. CSV 09460-22
AGENCY DKT. NO. 2023-700

IN THE MATTER OF SHEILA CHRISTOPHE,
TRENTON PSYCHIATRIC HOSPITAL,
DEPARTMENT OF HEALTH.

Quinton N. Robinson, Esq., for appellant Sheila Christophe (Quinton N. Robinson, Esq., Attorney at Law, P.C., attorneys)

Gary W. Baldwin, Deputy Attorney General, for respondent Department of Health, Trenton Psychiatric Hospital (Jennifer Davenport, Attorney General of New Jersey, attorney)

Record Closed: February 25, 2026 Decided: June 4, 2026

BEFORE **KIMBERLEY M. WILSON**, ALJ:

STATEMENT OF THE CASE

Appellant Sheila Christophe, a human services technician (HST) employed by respondent Trenton Psychiatric Hospital (TPH), appeals disciplinary charges brought against her, removing her as an HST for the following charges arising from a May 4, 2021, incident: (i) conduct unbecoming a public employee under N.J.A.C. 4A:2-2.3(a)(6); (ii) neglect of duty under N.J.A.C. 4A:2-2.3(a)(7); and (iii) other sufficient cause under

N.J.A.C. 4A:2-2.3(a)(12), which includes violations of N.J. Department of Human Services (DHS) Administrative Order 4:08 B2-2 (neglect of duty, loafing, idleness or willful failure to devote attention to tasks which could result in danger to persons or property); C8-2 (falsification: intentional misstatement of material fact in connection with work, employment application, attendance or any record, report, investigation or other proceeding); D1-1 (negligence in performing duty resulting in injury to persons or damage to property); D7-1 (violation of administrative procedures and/or regulations involving safety and security); and E1-3 (violation of a rule, regulation, policy, procedure, order or administrative decision).

Should Christophe be removed from her position as an HST? Yes. TPH presented competent credible evidence that Christophe's actions and inactions on May 4, 2021, caused a TPH patient to be assaulted twice and sustain serious, life-threatening injuries. Because Christophe's conduct was egregious and serious, removal is warranted.

PROCEDURAL HISTORY

On or around August 25, 2022, TPH served a Final Notice of Disciplinary Action (FNDA) on Christophe, sustaining disciplinary charges against her and removing her from employment. On or around September 29, 2022, Christophe appealed the disciplinary action, and the matter was transmitted to the Office of Administrative Law (OAL), where it was filed on October 19, 2022, for a hearing as a contested case. N.J.S.A. 52:14B-1 to -15; N.J.S.A. 52:14F-1 to -13.

After attempted settlement proceedings and a series of prehearing conferences on July 14, 2023, November 16, 2023, and December 15, 2023, with Christophe's prior counsel, a prehearing order was entered on January 2, 2024, scheduling hearing dates on February 28, 2024, and March 6, 2024. A final prehearing conference was held on February 16, 2024.

On or around February 23, 2024, Christophe's prior counsel advised that he was no longer representing her, as she terminated his representation, and on the same date, Christophe's current counsel filed a notice of appearance and a request to extend

discovery forty-five days and provide forty-five days to prepare for the hearing. After a status conference on February 26, 2024, I permitted Christophe's counsel to file a motion to reopen discovery on an expedited basis by February 28, 2024. I adjourned the February 28, 2024, and March 6, 2024, hearing dates to allow for motion practice.

By Letter Order dated April 11, 2024, I granted Christophe's motion to reopen discovery and allowed the parties to exchange discovery through May 20, 2024. During a status conference on June 27, 2024, Christophe's counsel raised concerns regarding the discovery received from TPH, and pursuant to a Letter Order dated June 28, 2024, Christophe's counsel was permitted to file a motion to compel discovery by July 15, 2024. Oral argument was held on the motion on September 17, 2024, via Zoom. Pursuant to an Order on Motion dated September 30, 2024, appellant's motion was denied.

During a November 19, 2024, status conference, new hearing dates were scheduled for April 16, 2025, and April 17, 2025. An amended prehearing order was entered on January 24, 2025. Additional status conferences were held on January 23, 2025, and January 27, 2025.

The April 16, 2025, and April 17, 2025, hearing dates were adjourned when counsel was not ready to proceed. Oral argument was heard on April 3, 2025, to address a motion regarding prehearing binders, and a Letter Order was entered on May 30, 2025, regarding that motion. Prehearing conferences were held on July 16, 2025, August 4, 2025, October 9, 2025, and December 2, 2025. Hearing dates were scheduled for December 8, 2025, and December 10, 2025, pursuant to an October 14, 2025, second amended prehearing order.

The hearings were held on December 8, 2025, and December 10, 2025, and the record remained open to allow for post-hearing summation briefs, which I received by February 25, 2026. The record closed that day. Pursuant to Orders of Extension entered on April 7, 2026, and May 1, 2026, the due date for the Initial Decision was extended until June 4, 2026.

FACTUAL DISCUSSION AND FINDINGS

Christophe has worked for TPH as an HST for over twelve years. When she was hired at TPH, Christophe was trained on therapeutic options, a program to help defuse potential incidents with patients, during orientation in 2014 and then recertified in May 2019. (R-5.)

The May 4, 2021, incident giving rise to the disciplinary charges against Christophe was captured by TPH video surveillance footage, which does not include audio. The video surveillance shows the Raycroft West II nurse's station on the bottom right-hand side of the camera view. (R-6, 2744-Z6VQR7 at 0:00:00.) TPH nurses stay in this area during their shift, and patient charts are kept there. The door to the nurse's station is locked and requires a key to open it. Nurses, human service assistants, and HSTs have keys with access to the nurse's station.

The medication room is located behind the nurse's station, which is not visible on the camera view. (Ibid.) The video surveillance shows a hallway running vertically through the frame, with patients' rooms on the right- and left-hand sides of the hallway, and a blue door at the top middle portion of the frame. That door is the entrance and exit to Raycroft West II that connects to Raycroft East II.

At about 0:00:46 in the video surveillance, a patient, later identified as M.H., exits a door on the left-hand side of the camera view. (Ibid.) A TPH employee, later identified as Edith Massaquoi (Massaquoi), is standing in the middle of the hallway near M.H., with a paper bag in her hand. There are two other TPH patients standing in the hallway behind Massaquoi. M.H. walks towards Massaquoi, grabs the garbage bag from her hand, and tears it roughly in half. (Id. at 0:00:47–0:01:00.) Meanwhile, Massaquoi retreats from M.H., unlocks the door to the nurse's station, and enters, remaining there. (Id. at 0:00:47–0:01:02.) M.H. is alone in the hallway, as the other two patients who had been in the hallway either walked away or entered another door off the hallway. At about 0:01:09, M.H. re-enters a door on the left-hand side of the camera view. (Ibid.)

At about 0:01:51, M.H. re-emerges from the door on the left-hand side of the camera view and walks down the hallway towards the nurse's station and out of view. (Id. at 0:01:51–0:02:00.) Two seconds later, M.H. begins throwing garbage into the hallway, and at the same time, a male wearing dark blue scrubs, later identified as Loveday Anyanwu (Anyanwu), attempts to enter the nurse's station. Right as Anyanwu unlocks the nurse's station door, M.H. begins assaulting Anyanwu at the nurse's station door. (Id. at 0:02:09.) The assault continues inside of the nurse's station, where Massaquoi is. (Id. at 0:02:11.) Anyanwu quickly leaves the nurse's station, and Massaquoi and M.H. remain inside. (Id. at 0:02:14.) A charge nurse who was previously inside the nurse's station escaped to the adjacent medication room during the assault.

M.H. wreaks havoc inside the nurse's station, clearing documents and other items off counters and onto the floor, pulling a telephone cord from the wall, and throwing garbage on the floor, with Massaquoi standing nearby and later hiding. (Id. at 0:02:14–0:02:22.) M.H. also assaults Massaquoi, hitting her in the head and face with items in the nurse's station. (R-1 at DOH 067). Massaquoi activates the code alarm signaling an emergency. (Ibid.)

At about 0:02:22, a patient wearing red shorts, identified as H.A., approaches the nurse's station and begins banging on the windows. Other patients begin gathering at the nurse's station, while H.A. is gesturing and pointing at M.H. H.A. begins gesturing towards the blue door at the end of the hallway while other patients gather around the nurse's station. (R-6, 2744-Z6VQR7 at 0:02:35–0:02:46.) One patient wearing camouflage shorts begins hitting the nurse's station window with his fists. (Id. at 0:02:39–0:02:43.)

Christophe appears in the blue door, and at the time, there are seven individuals in the hallway near the nurse's station. (Id. at 0:02:49.) Christophe testified that a code was activated at the time she responded to the nurse's station and that the code alarm, advising all personnel to report to the incident, was not very loud. She later admitted that the code alarm was in fact loud. Christophe was the first TPH staff member to respond to the code alarm.

Meanwhile, H.A. is gesturing at Christophe. (Ibid.) When Christophe begins walking towards the nurse's station, the seven patients standing in the hallway are all looking inside the nurse's station. (Id. at 0:02:57.) As she walks down the hallway, H.A. and the patient wearing camouflage shorts look towards Christophe, pointing towards the nurse's station. (Id. at 0:03:01–0:03:06.)

Christophe testified that the patients were calling her, saying that an incident happened and that Massaquoi was inside the nurse's station. She was planning to go into the nurse's station to see if she could re-direct M.H.

Christophe approaches the nurse's station door and bends down to open the door. (Id. at 0:03:07–0:03:09). Christophe is wearing a black mask covering her mouth as she approaches the nurse's station door. (Ibid.) She does not walk any closer to the nurse's station windows to assess what is happening inside, and Jeffrey Earnshaw, an investigator/quality assurance specialist for the New Jersey Department of Health, Office of Investigations who investigated the May 4, 2021, incident, testified that Christophe had a duty to evaluate the risks of her actions.

H.A. and another patient wearing a blue shirt are standing behind Christophe as she opens the nurse's station door. (Ibid.) These two patients appear to speak to each other, based on mouth movement and gestures. (Id. at 0:03:09–0:03:11.) H.A. is talking while Christophe is opening the door. Christophe unlocks the door, pushes it open, and takes a step back, allowing H.A. to enter the nurse's station first, with three patients entering behind him. (Id. at 0:03:11–0:03:15.)

Earnshaw testified that Christophe could have blocked the door, preventing the patients from entering the nurse's station, or blocked the patient, none of which would have constituted patient abuse. Christophe also should have moved the patients away from the nurse's station door before opening it; however, she took no such action. Christophe agreed that she did not attempt to re-direct the patients as they entered the nurse's station or M.H. before she opened the nurse's station door. She did not attempt to enter the nurse's station or re-direct M.H. while he was inside the nurse's station.

According to Christophe, as she was putting her key into the nurse's station door, she was talking to the patients standing around the door, telling them not to enter the nurse's station. The patients assured her that they would not enter the nurse's station, and she believed that the patients would follow her instruction. Christophe testified that H.A. threatened to kill her if she entered the nurse's station. She said that the patients pushed past her when she opened the door and that she did not have enough time to stop the patients as they entered the nurse's station and that she was the only person on the floor.

I do not accept Christophe's testimony regarding what occurred immediately before she opened the nurse's station door as credible. While she alleges that she told the patients not to enter the nurse's station when she was opening the door, there is no evidence supporting Christophe's claim, as her mouth was covered with a mask. Her allegation that the patients pushed past her is also not supported by the video surveillance footage; Christophe held the door open for the patients to enter the nurse's station. There is no other evidence supporting Christophe's claim that H.A. threatened to kill her before she opened the nurse's station door. Importantly, Christophe's actions are inconsistent with her testimony on what she intended to do once she opened the nurse's station door; she did not attempt to enter the nurse's station, and she did not attempt to re-direct M.H. while he was inside the nurse's station.

While the four patients begin assaulting M.H. inside the nurse's station, punching him while he is standing and stomping him while on the ground, Christophe stands in the hallway, watching. (Id. at 0:03:14–0:03:23.) The patient wearing camouflage shorts holds open the door to the nurse's station and appears to be encouraging Massaquoi to exit. (Ibid.) Christophe walks down the hallway towards to the door to Raycroft East II to get assistance after observing the assault in the nurse's station for about ten seconds. (Ibid.) Christophe testified that she sought assistance because she was not strong enough to stop the patients who were assaulting M.H. At about 0:03:33, Massaquoi exits the nurse's station. (Ibid.) From the time that Christophe opened the door until a lady with a blue shirt appears to exit the medication room and enter the nurse's station, the four patients continue kicking and assaulting M.H., in some instances using objects to effectuate their assault on M.H. (Id. at 0:03:11–0:04:07.)

Massaquoi, Christophe, and another TPH employee reach the blue door to exit Raycroft West II at 0:03:48. After other TPH employees begin walking towards the nurse's station, Christophe begins returning to the nurse's station about a minute after she went to Raycroft East II to seek assistance. (Id. at 0:04:20.) At that time, M.H. is lying prone, face down on the floor of the nurse's station, and his body is shaking. (Ibid.) H.A. is standing near M.H. (Ibid.)

Christophe stops walking down the hallway opposite the nurse's station where TPH patients and staff are gathered. (Id. at 0:04:40.) Christophe walks over to the nurse's station windows and observes what is happening inside for the first time about fifteen seconds later. (Id. at 0:04:55.) Shortly thereafter, H.A. picks up an object that appears to be a cooler and throws it on M.H., who is still lying prone on the floor. (Id. at 0:05:01–0:05:03.) Christophe watches this from the nurse's station windows with other staff and patients; she does not attempt to render any aid or assistance to M.H. (Ibid.)

Christophe speaks with another TPH staff member wearing all blue and then moves away, standing at a corner opposite the nurse's station, at some points with her arm resting on the wall. (Id. at 0:05:06–0:05:15.) Meanwhile, H.A. picks up the cooler and hits M.H., who is still lying on the floor, around his head and upper body nine times. (Id. at 0:05:18–0:05:37.) A TPH employee identified as Junior Appolon (Appolon) enters the nurse's station and stops H.A. from continuing to assault M.H. (Id. at 0:05:29–0:05:41.) At no time does Christophe attempt to intervene or render any aid or assistance to M.H. When H.A. begins attacking Appolon, another patient in a white shirt, identified as M.M., begins attacking Appolon, and Christophe, with other TPH staff, pulls M.M.'s white shirt. (Id. at 0:05:42–0:06:04).

Christophe successfully moves M.M. away from the skirmish between Appolon and H.A. (Id. at 0:06:04–0:06:12.) M.H., however, remains lying prone on the floor of the nurse's station, motionless with no medical response until five minutes later, when a TPH staff member brings a medical cart with equipment to the nurse's station. (Id. at 0:11:58–0:12:06.) During this time, Christophe left and re-entered the scene; at no time did she render any assistance or aid to M.H.

Christophe re-enters the camera view at 0:19:00, and she walks through the hallway past the nurse's station. (Id. at 0:19:00–0:19:22.) Christophe re-enters the camera view at 0:20:44 and walks down the hallway towards the blue exit door. (Id. at 0:20:44–0:21:16.) At no time does she render any assistance or aid to M.H. After this point, Christophe is no longer visible on camera.

M.H. remains prone on the floor of the nurse's station until emergency services arrive with a stretcher. (Id. at 0:26:11.) M.H. was admitted to Capital Health Regional Medical Center (Capital Health) on May 4, 2021, after the incident at TPH. (R-4.) The reasons for M.H.'s hospitalization include a closed traumatic brain injury, acute respiratory failure, and eyebrow laceration. (Ibid.) M.H. was in Capital Health's intensive care unit until June 11, 2021. (Ibid.) On or around July 21, 2021, M.H. was discharged from Capital Health. (Ibid.)

Earnshaw began investigating the May 4, 2021, incident in July 2021. He waited for clearance from the New Jersey State Police, who investigated the incident and brought criminal charges against two of the participants in the incident. Once the criminal charges were resolved, he received clearance to begin the investigation.

Earnshaw began his investigation by reviewing video surveillance of the incident, and he then interviewed staff and TPH patients who were involved. Christophe's representative prepared a written statement regarding the May 4, 2021, incident at her direction, which was part of the interview process. (R-2.) In the statement, Christophe alleged that during the incident, H.A. threatened to kill her if she entered the nurse's station. (Ibid.) She told H.A. not to enter the nurse's station, and he told Christophe that he would not when she put the key in the nurse's station door. (Ibid.) When she opened the door, H.A. pushed past her and began attacking M.H. (Ibid.) According to Christophe, "H.A. told me that he would attack me if I came in to stop him because [he has] killed before." (Ibid.) She then screamed for help. (Ibid.) There is no evidence in the video surveillance footage that Christophe screamed for help after she opened the door to the nurse's station.

According to Christophe, she was never disciplined while working at TPH, which included no suspensions. Christophe's employee disciplinary history consists of the following three events: (i) major discipline from a September 12, 2017, incident where a patient eloped from Raycroft West II that led to a written warning; (ii) major discipline from a May 1, 2017, incident that led to a fifteen-day suspension; and (iii) minor discipline from a February 1, 2018, incident that resulted in an official reprimand. (J-6; R-10).

Based on a review of the evidence admitted into the record, I also **FIND** that the following **FACTS** are not in dispute:

1. TPH's Policy & Procedure number 1.901 addresses patient abuse and neglect. (R-7.) Under the policy, neglect is defined as "the failure of a caregiver (person responsible for the patient's welfare) to provide the needed services and supports to ensure health, safety, and welfare of the patient. These supports and services may or may not be defined in the patient's plan or otherwise required by law or regulation. This includes acts that are intentional, unintentional, or careless, regardless of the incidence of harm. Examples include, but are not limited to, the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care and protection from health, leaving a patient who requires supervision unattended, allowing a patient access to harmful substances, and failing to observe appropriate safety precautions." (Id. at 2 (emphasis added).)

2. TPH Policy & Procedure 2.204.06 titled medical emergencies provides that "[t]imely emergency medical care will be provided to all patients . . . of [TPH]. TPH staff will provide emergency stabilization and care until ambulance and/or life mobile crews are available to assume care and transport the victim to a general hospital as appropriate." (R-8 at 1.)

3. Under the TPH medical emergencies policy, a medical emergency shall be called for life-threatening and non-life-threatening situations, which could include, but are not limited to, a fall resulting in unconsciousness or spontaneous loss of consciousness. (Ibid.) The staff member who first

recognizes the medical emergency shall immediately check the scene for safety and assess the patient before summoning help. (Id. at 2.) HSTs are among the TPH staff who are responsible for taking such action. (Ibid.)

4. Finally, TPH Policy & Procedure 2.605.02 titled psychiatric emergencies provides that as a policy, "it may be anticipated that potentially dangerous behaviors may arise from time to time. It is the policy of [TPH] to maintain a safe treatment environment where such behaviors will be quickly identified and rapidly mitigated. The primary goal in a Psychiatric Emergency is to prevent harm to any individual and to maintain a safe environment." (R-9.)

5. Under the psychiatric emergencies policy, a psychiatric emergency is defined as "any situation where there is an immediate threat of a violence for which de-escalation efforts were ineffective. The danger can be directed towards individuals in treatment, staff, visitors or substantial threat to the environment." (Ibid.)

6. Upon the initiation of a disturbance under the psychiatric emergency policy, when an individual is "escalating in a disturbing manner or threatening manner," the first staff members aware of the crisis and/or situation will use motivational interviewing strategies and de-escalation techniques to de-escalate the individual. (Id. at 2.) If the individual does not respond to those de-escalation techniques, a psychiatric emergency alert may be called. (Ibid.) Staff must act to maintain safety when the individual is an imminent danger to self or others. (Ibid.)

LEGAL ANALYSIS AND CONCLUSIONS OF LAW

A civil service employee's rights and duties are governed by the Civil Service Act (Act) and regulations promulgated pursuant thereto. See N.J.S.A. 11A:1-1 to 11A:12-6; N.J.A.C. 4A:1-1.1 to 4A:10-3.2. The purpose of the Act is to "ensure efficient public service for state, county, and municipal government." In re Johnson, 215 N.J. 366, 375 (2013) (citing Commc'ns Workers of Am. v. N.J. Dep't. of Pers., 154 N.J. 121, 126 (1998)). The Act should be construed liberally towards the attainment of merit appointments and broad tenure protections. See Mastrobattista v. Essex Cnty. Park Comm'n, 46 N.J. 138, 147 (1965). However, "[t]here is no constitutional or statutory right to a government job." State-Operated Sch. Dist. of City of Newark v. Gaines, 309 N.J. Super. 327, 334 (App. Div. 1998).

A civil service employee who commits a wrongful act related to their employment may be subject to discipline, which could include a reprimand, suspension, or removal from employment. See N.J.S.A. 11A:1-2(c); N.J.S.A. 11A:2-20; N.J.A.C. 4A:2-2.2(a); N.J.A.C. 4A:2-2.9. Consistent with public policy and the Act, public entities should not be burdened with an employee who fails to perform their duties satisfactorily or engages in misconduct related to their duties. See N.J.S.A. 11A:1-2(a). Thus, a public entity may impose major discipline upon a civil service employee, including removal from their position. See N.J.S.A. 11A:1-2(c); N.J.A.C. 4A:2-2.2(a).

For appeals concerning major disciplinary action, the appointing authority bears the burden to prove the charges by a preponderance of the competent credible evidence. See N.J.S.A. 11A:2-21; N.J.A.C. 4A:2-1.4(a); 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 Consolidated Gas. Co., 124 N.J.L. 420, 423 (Sup. Ct. 1940). The evidence must "be such as to lead a reasonably cautious mind to the given conclusion." Bornstein v. Metro. Bottling Co., Inc., 26 N.J. 263, 275 (1958). OAL hearings on civil service removal appeals are de novo, both as to guilt and the penalty to be imposed. See Henry v. Rahway State Prison, 81 N.J. 571, 579 (1980); W. New York v. Bock, 38 N.J. 500, 507 n.1, 512 n.3 (1962).

1. Conduct unbecoming a public employee

Christophe is charged with a violation of N.J.A.C. 4A:2-2.3(a)(6), conduct unbecoming a public employee. Conduct unbecoming is an elastic phrase that encompasses "'any conduct which adversely affects the morale or efficiency of [a governmental unit] . . . [or] which has a tendency to destroy public respect for municipal employees and confidence in the operation of municipal services.'" Karins v. Atlantic City, 152 N.J. 532, 554 (1998) (citing In re Emmons, 63 N.J. Super. 136, 140 (App. Div. 1960)). "[I]t is sufficient that the complained of conduct and its attending circumstances be such as to offend publicly accepted standards of decency." Id. at 555 (citing In re Zeber, 156 A.2d 821, 825 (Pa. 1959)).

Such misconduct need not "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 Civ. Serv., 17 N.J. 419, 429 (1955)).

As previously noted, only certain TPH staff had keys to the nurse's station, allowing them access to that area. This fact lends itself to the reasonable inference that TPH patients are not given access to the nurse's station.

Understanding this inference, Christophe made a series of serious mistakes on May 4, 2021, when she responded to the code alarm at the nurse's station. First, she did not assess the totality of the situation before she opened the nurse's station door. Second, she did not attempt to look into the nurse's station or take time to observe the patients standing around the nurse's station door before she opened it. Third, she did not attempt to move patients away before she opened the nurse's station door, and she did not try to re-direct M.H. inside the nurse's station before she opened the nurse's station door. Once she opened the door, she did not try to re-direct the four patients, including H.A., when they entered the nurse's station. Finally, Christophe did not block the nurse's station door, preventing the four patients from entering, or block the patients from

entering. As a result of these failures, M.H. was severely beaten by the four patients and then subsequently by H.A.

While I understand the emergent nature of the May 4, 2021, incident and Christophe's need to respond quickly to the code alarm, it appears that Christophe merely heeded the patients' request to open the nurse's station door. In her role as an HST, Christophe did not make an independent assessment on whether such a response was appropriate. These failures constitute conduct unbecoming a public employee, namely that her behavior and lack of judgment negatively affected the efficiency of TPH and could destroy public confidence in municipal operations. Opening the nurse's station door, allowing patients access to an area where patients are not given access, and allowing those patients to viciously attack another patient offends human decency.

For these reasons, I **CONCLUDE** that TPH has proven this charge against Christophe by a preponderance of the credible evidence.

2. Neglect of duty

Neglect of duty under N.J.A.C. 4A:2-2.3(a)(7) is not defined in the New Jersey Administrative Code. The term "neglect" itself connotes a deviation from normal standards of conduct. In re Kerlin, 151 N.J. Super. 179, 186 (App. Div. 1977). The word "duty" "signifies conformance to the legal standard of reasonable conduct in the light of the apparent risk." Wytupeck v. Cty. of Camden, 25 N.J. 450, 461 (1957). Neglect of duty can arise from omission to perform a required duty as well as from misconduct or misdoing. Cf. State v. Dunphy, 19 N.J. 531, 534 (1955). This disciplinary charge has been interpreted to mean that an employee has neglected to perform and act as required by their job title or was negligent in its discharge. See Avanti v. Dep't of Mil. and Veterans Affs., 97 N.J.A.R.2d (CSV) 564 (May 28, 1996); Ruggiero v. Jackson Twp. Dep't of Law and Safety, 92 N.J.A.R.2d (CSV) 214 (December 11, 1991).

Twice on May 4, 2021, Christophe failed to render any aid or assistance to M.H. during two assaults, the first with the four patients, including H.A., and the second with just H.A. She never entered the nurse's station to check for safety and assess M.H.,

whether before the first assault with the four patients, the second with H.A. or after both incidents. These failures constitute neglect under TPH Policy & Procedure 1.901 and violate TPH Policy & Procedure 2.204.06, which requires TPH staff, including Christophe, to check for safety and assess the patient during a medical emergency. She took no action required under both TPH policies, neglecting to perform and act as required by her job title.

Thus, I **CONCLUDE** that TPH has proven this disciplinary charge by a preponderance of the evidence.

3. Other sufficient cause

Other sufficient cause, as mentioned in N.J.A.C. 4A:2-2.3(a)(12), is other conduct not specifically delineated in the regulation that would violate "the implicit standard 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 Boyd, Cumberland Cnty. Dep't of Corrs., 2019 N.J. CSC LEXIS 621, *121 (July 3, 2019), adopted, Comm'r, id. at **1–2 (Aug. 14, 2019). N.J.A.C. 4A:2-2.3(a)(12) is essentially a catchall provision for why an employee may be subject to major discipline. "An appointing authority may discipline an employee for sufficient cause, including failure to obey laws, rules and regulations of the appointing authority." In re Mumford, 2014 N.J. CSC LEXIS 478, *33 (April 17, 2014), adopted, Comm'r, id. at **1–13 (May 21, 2014).

For her violations of the following offenses under the DHS's Administrative Order 4:08, I **CONCLUDE** that other sufficient cause exists to discipline Christophe.

4. Administrative Order 4:08 B2-2

The DHS's Administrative Order 4:08 B2-2 lists as an offense "neglect of duty, loafing, idleness or willful failure to devote attention to tasks which could result in danger to persons or property." (J-4.) For the reasons stated above on the charge of neglect of duty under N.J.A.C. 4A:2-2.3(a)(7), I **CONCLUDE** that the disciplinary charge of a

violation of Administrative Order 4:08 B2-2 against Christophe has been proven by a preponderance of the evidence.

5. Administrative Order 4:08 C8-2

The DHS's Administrative Order C8-2 includes as a disciplinary offense "[f]alsification: intentional misstatement of material fact in connection with work, employment, application, attendance or in any record, report, investigation or other proceeding." (J-4.) TPH presented no evidence to show that Christophe made an intentional misstatement of material fact. While there are discrepancies between Christophe's statement and the video surveillance, the differences are just that—inconsistencies. There is no evidence in this record that Christophe intentionally falsified material facts here. Therefore, I **CONCLUDE** that TPH has not proven this charge against Christophe by a preponderance of the evidence.

6. Administrative Order 4:08 D1-1

The DHS's Administrative Order 4:08 D1-1 states as an offense "[n]egligence in performing duty resulting in injury to persons or damage to property." (J-4.)

On May 4, 2021, Christophe allowed patients access to the nurse's station, an area to which patients do not have unfettered access. Christophe's repeated failures when responding to the code alarm, such as not assessing the totality of the situation, not attempting to re-direct any of the patients before she opened the nurse's station door, and not blocking any of the patients when they entered the nurse's station, led to M.H. being assaulted twice in the nurse's station, once by the group of four patients and a second time by H.A. The facts as presented show that Christophe violated this provision. I **CONCLUDE** that TPH has proven this disciplinary charge against Christophe.

7. Administrative Order 4:08 D7-1

The DHS's Administrative Order 4:08 D7-1 includes as an offense "[v]iolation of administrative procedures and/or regulations involving safety or security." As previously

noted, on May 4, 2021, Christophe violated TPH Policy & Procedure 1.901 regarding patient abuse and neglect, TPH Policy & Procedure 2.204.06 regarding medical emergencies, and TPH Policy & Procedure 2.605.02 regarding psychiatric emergencies. She failed to render any aid or assistance to M.H. during both assaults in the nurse's station. Instead of preventing H.A. and other patients from entering the nurse's station, Christophe opened the nurse's station door and allowed them to enter, taking no action to re-direct any of the patients, including M.H. and H.A., or prevent either of the assaults. For Christophe's violation of TPH policies, I **CONCLUDE** that TPH has proven this charge by a preponderance of the evidence.

8. Administrative Order 4:08 E1-1

Finally, the DHS's Administrative Order 4:08 E1-1 includes as a disciplinary offense the "[v]iolation of a rule, regulation, policy, procedure, order or administrative decision." (J-4.) As previously noted, Christophe violated Administrative Order 4:08 B2-2, D1-1 and D7-1 on May 4, 2021. As a result, I **CONCLUDE** that TPH has proven this charge against Christophe by a preponderance of the evidence.

PENALTY

Once a determination has been made that an employee violated a statute, rule, or regulation concerning their employment, the concept of progressive discipline guides the determination of a penalty. See In re Carter, 191 N.J. 474, 483–84 (2007). 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). Removal has been upheld where the acts charged, with or without a prior disciplinary history, have warranted imposition of that sanction. See In re Carter, 191 N.J. at 484. Therefore, an employee may be removed from his or her employment, without regard to progressive discipline, if their conduct was egregious. See id. at 484–85; In re Herrmann, 192 N.J. at 33–34.

When determining the appropriate penalty here, Christophe's mitigating factors are the fact that she was the first TPH staff member to respond to the code alarm on May 4, 2021, and the emergent nature of the situation inside the nurse's station, requiring fast and decisive action when M.H. was assaulting Massaquoi.

The aggravating factors, however, include the fact that on May 4, 2021, Christophe allowed patients access to the nurse's station, an area to which they do not have unfettered access. She failed to assess the totality of the circumstances before opening the nurse's station door. Christophe acceded to the patients' desires rather than making an independent decision on the proper course of action. Here, a TPH staff member helped facilitate two life-threatening assaults on a TPH patient. Finally, Christophe rendered no aid or assistance to M.H. during and immediately after those assaults. TPH policies and procedures clearly indicate that Christophe had an obligation to provide aid or assistance to M.H. She did not.

The aggravating factors here outweigh the mitigating factors, in part due to the incident's severity. In addition, Christophe's actions, inactions, and lack of judgment on May 4, 2021, were egregious. Christophe was supposed to care for and protect the patients in a mental health treatment facility, a vulnerable and dependent population. TPH patients are there because they have been found to be a danger to themselves or others. Rather than providing care and protection, a patient ended up in an intensive care unit for six weeks. Christophe has shown that she is unsuitable to remain in her position as an HST, and as a result, progressive discipline will not be imposed here.

For the foregoing reasons, I **CONCLUDE** that removal is the appropriate penalty.

ORDER

I **ORDER** that Christophe shall be removed from her position as an HST at TPH.

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.

June 4, 2026
DATE

KIMBERLEY M. WILSON, ALJ

Date Received at Agency: June 4, 2026

Mailed to Parties: June 4, 2026

KMW/ml
c: Clerk OAL-T

APPENDIX

Witnesses

For appellant:

Philip Rasaw

Sheila Christophe

For Respondents:

Yingzi Deng, M.D.

Jeffrey Earnshaw

Donald Shelton

Natasha Exavier

Exhibits

Joint:

J-1 Preliminary Notice of Disciplinary Action against Christophe dated March 22, 2022

J-2 Final Notice of Disciplinary Action against Christophe dated August 25, 2022

J-3 DHS Administrative Order 2:05 regarding Unusual Incident Reporting and Management System effective October 1, 2024

J-4 DHS Disciplinary Action Program

J-5 Therapeutic Options manual

J-6 Disciplinary history documents regarding Christophe

For Appellant:

A-2 Agreement between State of New Jersey and AFSCME New Jersey Council 63 and its affiliated locals from July 1, 2019 to June 30, 2023

A-5 Photograph

For Respondent:

R-1 DOH Investigation Report dated October 1, 2021

R-2 Written statement from Christophe dated July 12, 2021

R-3 Body chart dated May 4, 2021

R-4 Capital Health Emergency Department discharge instructions for M.H. dated July 21, 2021

R-5 Training record for Christophe

R-6 Video surveillance

R-7 TPH Policy and Procedure Number 1.901, Patient Abuse and Neglect Policy

R-8 TPH Policy and Procedure Number 2.204.06, Medical Emergencies

R-9 TPH Policy and Procedure Number 2.605.02, Psychiatric Emergencies

R-10 Employee Disciplinary History for Christophe