

Health & Hospitals (Bellevue Hospital Ctr.) v. Alexis

OATH Index No. 654/26 (July 1, 2026), *adopted*, CEO Dec. (Aug. 6, 2026), **appended**

Petitioner established that respondent struck a patient. Petitioner did not establish that respondent's absences were excessive. Termination of employment recommended.

**New York City Office of
Administrative Trials and Hearings**
In the Matter of
Health and Hospitals (Bellevue Hospital Center)
Petitioner
-against-
Nick Alexis
Respondent

Report and Recommendation

Julia Davis, *Administrative Law Judge*

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New York City Health and Hospitals/Bellevue (“Bellevue” or “petitioner”) brought this disciplinary proceeding pursuant to section 75 of the Civil Service Law. Petitioner alleges that respondent struck a patient on the side of the face on December 17, 2024, in violation of petitioner’s rules (ALJ Ex. 1). It also alleges that from March 20, 2024, through December 19, 2024, respondent was excessively absent on 17 occasions, seven of which were before or after a scheduled day off (*Id.*). Respondent contends that petitioner did not prove the charges (Tr. 10).

A hearing was conducted by videoconference before me on January 13 and 15, 2026. Petitioner presented documentary evidence, surveillance video, and the testimony of two witnesses: Synaka Slade, Captain of Bellevue Hospital Police; and Dorothy Neal, Bellevue’s Interim Director for Adult Behavioral Health. Respondent presented the testimony of his colleague Peter Simpson and testified on his own behalf. Respondent did not introduce any documentary evidence.

For the following reasons, petitioner established that respondent struck a patient in the face but did not establish that his absences were excessive. I recommend termination of respondent’s employment.

Analysis

Petitioner must prove “its case by a fair preponderance of the credible evidence” *Dep’t of Correction v. Hall*, OATH Index No. 400/08 at 2 (Oct. 18, 2007), *adopted*, Comm’r Dec. (Nov. 5, 2007), *aff’d*, NYC Civ. Serv. Comm’n Item No. CD 08-33-SA (May 30, 2008) (quoting *Dep’t of Correction v. Holston*, OATH Index No. 592/04 at 11 (Sept. 29, 2004)). Preponderance has been defined as “the burden of persuading the triers of fact that the existence of the fact is more probable than its non-existence.” *Prince, Richardson on Evidence* § 3-206 (Lexis 2008); *see also Dep’t of Sanitation v. Figueroa*, OATH Index No. 940/10 at 11 (Apr. 26, 2010), *aff’d*, NYC Civ. Serv. Comm’n Item No. CD 11-47-A (July 12, 2011).

December 17, 2024, Incident (Specification 2)

Petitioner charged respondent with “gross misconduct” prohibited by its rules for striking a patient on the side of the face on December 17, 2024 (ALJ Ex. 1). According to NYC

Health + Hospitals/Bellevue Administrative Policy and Procedure Manual Code HR-8, gross misconduct includes “striking . . . anyone in the hospital or on hospital grounds” (Pet. Ex. 15 at 4-5). Gross misconduct, which “will not be tolerated,” can subject an employee to disciplinary action (*Id.* at 4).

Background

Respondent commenced employment at Bellevue Hospital in April 2019 after having worked for the Transportation Safety Administration at LaGuardia Airport (Pet. Ex. 3; Tr. 109). He works as a behavioral health associate (“BHA”) in 21 North, a hospital unit for patients up to age 17 who are autistic, non-verbal, suicidal, depressive, assaultive, aggressive, schizophrenic, or bipolar (Neal: Tr. 27-28; Resp.: Tr. 113-14). Dorothy Neal was the Director of Nursing for Child and Adolescent Behavioral Health at the time of the incident (Tr. 22). In that role, her responsibilities involved “general oversight” of three in-patient behavioral health units, including the child psychiatric emergency department where respondent worked, “daily supervision on the units,” and staff’s “compliance with the day-to-day responsibilities” (Tr. 23-24). Ms. Neal came to know respondent as a result of time and leave issues and the December 17, 2024, incident with the patient (Tr. 24).

BHAs are “responsible for deescalating situations,” running therapeutic groups, and conducting “environmental checks on the unit” for “contraband or safety issues” (Neal: Tr. 25; Pet. Ex. 2). They serve as “the right hand to the nursing staff . . . [s]o if a patient is agitated or if a patient is displaying behaviors that warrant more of an intervention than they can handle, [BHAs] would escalate that to the nurse” (Neal: Tr. 25). BHAs also are “in charge of supervision to ensure that areas are closely monitored” and are sometimes assigned one-on-one to a patient who may be at risk for falls or self-harm to ensure the patient’s safety (*Id.*). In addition, they assist with activities of daily living, such as supervising showers, meals, and medications, manage movie groups, and coordinate activities (Neal: Tr. 25; Resp.: Tr. 115).

BHAs undergo annual training in de-escalation techniques called Preventing and Managing Crisis Situations (“PMCS”) (Neal: Tr. 26; Resp.: Tr. 116; Simpson: Tr. 160-61; Pet. Ex. 3). The training teaches various interventions, both physical and verbal techniques, to employ when situations escalate. It also teaches teamwork so BHAs know “how to work with a team to

ensure the safety of a patient” (Neal: Tr. 26; Resp.: Tr. 116; Simpson: Tr. 161). As respondent explained, de-escalation techniques include distracting patients and “talking to them not condescending, more like on their level. Like understanding” (Tr. 116, 131). Respondent uses the PMCS training “occasionally . . . throughout the working day,” most often employing de-escalation techniques (Tr. 117). In addition to PMCS training, there is other annual training “that does not involve physical techniques” but “enhance[s] various skills” and reminds BHAs of “their roles and responsibilities when they’re monitoring the hallway, when they’re doing rounds” (Neal: Tr. 26-27).

BHAs are assessed annually on their competency in job-related duties, including “crisis prevention/intervention” (Pet. Ex. 3 at 5-6). According to Ms. Neal, these competencies include identifying threatening behaviors and early signs of agitation, activating the crisis management team as appropriate, demonstrating the use of appropriate physical and self-protective techniques, implementing less restrictive measures through de-escalation and mediation, monitoring patients’ responses, and reporting to nurses and others appropriately (Tr. 31).

The allegation that respondent struck a patient arises from an incident in the hallway of 21 North on December 17, 2024, when respondent attempted to prevent the patient from banging on the window of the nurses’ station, which she was known to do (Neal: Tr. 35-36; Resp.: Tr. 119-20; Simpson: Tr. 163, 177). The patient was upset because she wanted to see a different movie than the one her fellow patients had chosen to show in the day room, where respondent was assigned (Neal: Tr. 35-36; Resp.: Tr. 118-20).¹ When the patient left the day room, respondent followed her into the hallway where the nurses’ station is located (Resp.: Tr. 120, 122).

Video Evidence

The primary evidence concerning the December 17, 2024, incident is a surveillance video of the hallway which did not contain audio (Pet. Ex. 1). The hallway runs from the middle of the bottom of the video, which will be referred to as the near end of the hallway, to a wall at the top of the video, which will be referred to as the far end of the hallway. The nurses’ station

¹ The room was alternately referred to as the day room and activity room (Tr. 18, 34).

is on the right side of the hallway. Patient rooms are on the left side of the hallway. The entry to the day room is on the left side of the far end of the hallway. The patient, respondent, Mr. Simpson, and Nurse Folashade Maiyegun were each identified at trial as the individuals appearing on the video footage (Neal: Tr. 51-54, 61; Resp.: Tr. 121-22; Simpson: Tr. 162-64, 171-73, 177).

The video opens with Peter Simpson, a fellow BHA who was assigned to the hallway post, walking around the near end of the hallway before he disappears from view near the nurses' station (Pet. Ex. 1 at 18:44:01-14; Neal: Tr. 44). A short time thereafter, the patient emerges at the upper left from the day room with a second patient, and they start walking down the hallway (Pet. Ex. 1 at 18:44:48). Almost immediately afterwards, respondent emerges from the day room and follows them (Pet. Ex. 1 at 18:44:57). After the patient has walked about a third of the way down the hall towards the camera, she exits into her room on the left side of the hallway and can no longer be seen (Pet. Ex. 1 at 18:45:01; Resp.: Tr. 132). Respondent walks to the patient's room, waits outside momentarily, and then crosses the hallway towards Mr. Simpson and the second patient, both of whom were near the nurses' station (Pet. Ex. 1 at 18:45:02-11). Mr. Simpson thereafter exits the hallway on the right side just below the nurses' station (Pet. Ex. 1 at 18:45:21).

When the patient reemerges from her room, respondent turns to face her (Pet. Ex. 1 at 18:45:12-17). He takes a couple of steps towards her and leans on the wall on the right side of the hallway, so they are on either side of the hallway facing each other (Pet. Ex. 1 at 18:45:23). The patient remains in the doorway of her room, and they stand against the walls facing each other for about ten seconds when the second patient approaches from the nurses' station and stands next to respondent, temporarily and partially blocking the camera's view of him (Pet. Ex. 1 at 18:45:23-46:10). About 20 seconds later, Mr. Simpson, who had been talking to the second patient earlier, emerges from the nurses' station on the right and walks towards respondent and the patient (Pet. Ex. 1 at 18:46:08-15). At the same time, the second patient walks towards the day room (*Id.*). Mr. Simpson walks away from respondent and the patient, stops with his back against the nurses' station, and appears to be talking to respondent and the patient (Pet.

Ex. 1 at 18:46:15-47:17). Respondent then walks to the far end of the hallway and exits to the right (Pet. Ex. 1 at 18:47:12-22).

While respondent is out of view, Mr. Simpson walks to where respondent had been standing and appears to engage in a conversation with the patient (Pet. Ex. 1 at 18:47:22-35). Respondent reappears, carrying what looks to be a pillow and a sheet, and attempts to hand them to the patient (Pet. Ex. 1 at 18:47:40-50). When she rejects them, he walks away, momentarily stands with his back against the wall on the right side of the hallway, walks to the far end of the hallway, and exits to the right (Pet. Ex. 1 at 18:47:52-48:28). Mr. Simpson walks to and sits on a chair at the near end of the hall, and respondent, who has reemerged at the far end of the hallway, sits on a chair outside the day room (Pet. Ex. 1 at 18:48:27-52).

The patient, who had remained in the doorway of her room, momentarily disappears from view, reemerges, walks across the hallway towards the nurses' station, and starts banging on its window with her left fist (Pet. Ex. 1 at 18:49:12-42). Respondent stands up, walks towards her, and pokes his head into the nurses' station with his arm outstretched and his hand raised perpendicular to his arm in a position commonly understood to mean "stop" (Pet. Ex. 1 at 18:49:42-55). He then moves the patient away from the window by placing his body between hers and the window, and the patient returns to her room, enters it, and respondent waits outside her door (Pet. Ex. 1 at 18:49:58-50:14). When the patient reemerges and walks up and down the hallway, respondent shadows her by walking up and down the hallway with her, remaining between her and the nurses' station (Pet. Ex. 1 at 18:50:23-51:23). After the patient briefly exits the hallway, the walking and shadowing continue, with respondent appearing to speak with her (Pet. Ex. 1 at 18:51:23-52:37).

While respondent shadows the patient and blocks her from approaching the nurses' station, she bumps up against him (Pet. Ex. 1 at 18:52:49-53:14). The walking and shadowing continue, and it appears that the patient elbows respondent and bumps up against him a second time while his back is against the nurses' station (Pet. Ex. 1 at 18:53:04-13). The patient backs away from the nurses' station, walks down the left side of the hallway towards the far end, and then returns to the nurses' station, all while respondent continues to shadow her (Pet. Ex. 1 at 18:53:35-54:05).

The patient again approaches the nurses' station, bumps her body up against respondent's body, and elbows him, while he continues to shadow her and push his body against hers to move her away from the nurses' station (Pet. Ex. 1 at 18:54:06-43). Respondent's back is still against the window when the patient pushes him by placing her left hand on his right arm (Pet. Ex. 1 at 18:54:44-58). She pushes against him a second time by raising her left arm and placing it against his torso (Pet. Ex. 1 at 18:54:59-55:15). She also presses up against respondent and bangs on the window (Pet. Ex. 1 at 18:55:16-21). The patient raises her left hand, seemingly to bang on the window again, but respondent repels it by using his body and left elbow to push her away from both him and the window (Pet. Ex. 1 at 18:55:23-31). During this time, respondent raises his right arm, and although his body blocks the camera from completely recording what he did with his arm, it appears that he strikes the patient's right arm, pushing it down (Pet. Ex. 1 at 18:55:27-29).

Respondent's pushing of the patient's body moves both of them to the left side of the hallway near the entrance to her room, and when they appear to be about a foot apart, she again raises her left arm and open hand (Pet. Ex. 1 at 18:55:30). Although she does not make contact with respondent, he raises his right arm and strikes her in the face in a motion that appears to be a punch, causing her to bring her hands to her face and take several steps back, so her back is against the wall (Pet. Ex. 1 at 18:55:30-34). Respondent takes several steps towards the patient and strikes her face a second time, causing her head to hit the wall (Pet. Ex. 1 at 18:55:34-36). Because respondent's back blocks the camera's view, whether the strike is with an open hand or clenched fist cannot be determined. When respondent hit the patient, Mr. Simpson was sitting on the chair at the near end of the hallway looking down at a phone or other device (Pet. Ex. 1 at 18:52:22-55:43).

The pacing resumes when the patient moves to strike respondent in the head by raising her right arm with her hand open (Pet. Ex. 1 at 18:55:37-42). Because respondent quickly raises his right hand to deflect the strike, it is unclear whether she made contact with his face or head, but she strikes his arm (*Id.*). Mr. Simpson notices what has occurred, approaches, and respondent walks away (Pet. Ex. 1 at 18:55:44-56:57). The patient crosses the hall to the nurses' station and starts banging on the window when Mr. Simpson, who has followed her,

attempts to prevent her from doing so as respondent had – by standing between her and the window when she bangs on it – so she walks down the hallway (Pet. Ex. 1 at 18:55:58-02).

Respondent rejoins the patient and Mr. Simpson and follows them as he resumes walking with the patient and blocking her from the window of the nurses' station (Pet. Ex. 1 at 18:56:02-07). While at the entrance to the nurses' station, respondent makes what appears to be a beckoning motion (Pet. Ex. 1 at 18:56:07). He then resumes interacting with the patient, with Mr. Simpson remaining nearby (Pet. Ex. 1 at 18:56:07-56:27). During this time, respondent appears to be speaking with the patient. Nurse Maiyegun, who had emerged from the nurses' station, and Mr. Simpson remain with the patient and accompany her to her room as respondent returns to the far end of the hallway (Pet. Ex. 1 at 18:56:27-52; Pet. Ex. 6). The patient twice reappears momentarily on the video footage, first when she looks out from her room and again when she crosses the hallway from her room and enters the nurses' station, but she does not interact with respondent either time (Pet. Ex. 1 at 18:57:27-30, 18:57:54-58:05).

Petitioner presented evidence of the existence of other cameras in the North 21 hallway. Captain Slade testified that there "should be" more cameras in the hallway than the single video footage produced and that she "believe[d]" that she pulled and provided to Labor Relations multiple camera angles for the December 17, 2024, incident, including "one more coming from the opposite direction" (Tr. 18-19). Ms. Neal testified that there are multiple cameras in the hallway of 21 North, but that the video footage introduced at trial "was the only angle [she] reviewed" and she did "not remember about other angles" (Tr. 83-84).

Respondent's Testimony and Prior Statements

Respondent testified that he knew the patient because she had been in the Unit for two months (Tr. 118). He had previously spoken with her "to keep her distracted," for example talking "about what she [did] for fun and what she likes as a hobby outside of Bellevue Hospital" (*Id.*). He described his rapport with the patient as "great," explaining that when she had previously banged on the nurses' station, she would calm down when he talked to her, and when she wanted something, she would come to him "more than she would go to any other staff" (*Id.*).

On the date in question, the patient was upset with the movie that her fellow patients had selected to be shown in the day room (Tr. 118-20). Respondent left the day room and followed the patient to talk to her in the hallway because his colleague, Ms. Bowery, “tapped [him] out knowing that [he] had a good rapport with her” (Tr. 120). Respondent described “tapping out” as a staff member choosing another staff member to deal with a patient “they can’t talk to” or with whom they do not have “a good rapport” (Tr. 121). The staff member “usually tap[s] someone out that does have a good rapport with that patient” (*Id.*). Ms. Neal described tapping out similarly, explaining that when a patient is “not responding to an individual staff member, it’s really important for another staff to tap [the first staff member] out because [the goal is] to have a therapeutic interaction with the patient” (Tr. 59). She added that “if someone is having challenges reaching that goal with the patient, then someone should definitely try to intervene and take over” (*Id.*).

After the patient “stormed out [of] the day room,” respondent followed her, and while they were walking down the hallway, she tried to bang on the nurses’ station window (Tr. 133).² Respondent continued trying to engage the patient in conversation and to redirect her from banging on the window, including stepping in front of her to prevent her from banging on the nurses’ station (Tr. 122, 135).

Respondent testified that when he and the patient arrived at the middle of the hallway, still engaged in the conversation where he was attempting “to deescalate the situation or her banging [. . . and] explain the rules of the movie,” she struck him the first time (Tr. 123, 133-34). He “was shocked,” as “normally . . . she never got to that point” because she would “be

² Petitioner argued that the “[m]ost shocking” evidence was “Ms. Neal’s testimony that [respondent] was not even supposed to be in the hallway as there was a staff member already in the hallway who is responsible for monitoring said hallway” (Tr. 192). It also argued that since “the only time that a staff person can be relieved on their assignment is through another nurse,” which did not happen in this case, respondent “shouldn’t have been” in the hallway and the incident “should have never happened” (Tr. 192-93). However, petitioner did not charge respondent with misconduct for leaving the day room and, in contrast, presented evidence that one staff member could “tap” another one out. Accordingly, I did not consider respondent’s leaving the day room in reaching my decision in this case.

mellowed out” after “good communication” (Tr. 123, 131-32, 135-36). The patient struck him a second time, which he described as “the same thing continuously. Like that one blow, then the next blow” with no words being said (Tr. 124). Respondent testified that both strikes occurred after he blocked the patient from the nurses’ station and that he turned around to deflect the third time the patient struck him (Tr. 132-34). Respondent testified that he had his “hands up trying to deflect” after the third strike when Mr. Simpson approached and separated him from the patient (Tr. 123, 134). The patient then “redirected her mood to [Mr.] Simpson” and “started banging on the nurses’ station again” (Tr. 124). When a nurse emerged and started talking to the patient, respondent stepped back (Tr. 125). Respondent has not spoken with either the nurse or Mr. Simpson about the incident (*Id.*).

Respondent asserted that “[t]here was no indication at all” on December 17, 2024, that the patient might strike him (Tr. 117, 123). He explained that he did not de-escalate by taking a step back when the patient first hit him because she had been demonstrating “her normal temperament” beforehand, which “would normally [go] down or phase out” and they would “still be able to talk about it and stuff like that, and she’ll be deescalated with no problem at all” (Tr. 124). Although respondent’s past efforts had calmed the patient down, for example, by asking her if she needed anything and offering her a phone call or snacks, talking to her failed to change her behavior on December 17, 2024, which he realized when she struck him (Tr. 131-32, 135).

Respondent identified when on the video footage the patient first struck him, noting that he had never before been struck by a patient (Tr. 117, 141; Pet. Ex. 1 at 18:55:32). He denied striking the patient, stressing that his “testimony [was] that [he] was trying to deflect” (Tr. 134). He also denied any intent to hit the patient, including denying any intent to hit her in her face (Tr. 126-27). When asked why her body went backwards if he had not struck her, respondent speculated that “maybe [the patient] had flinched” and “guess[ed that] she assumed that [he] was going to hit her” (Tr. 142). He also attributed her body’s movement to him “trying to deflect with [his] hand” and “her force onto my forearm” (Tr. 143). Respondent did not file an incident report because he “believed the incident was minor and manageable at

the time and [he] did not realize [he had] to report that right away” (Tr. 136; Pet. Ex. 4).³ Since December 17, 2024, he has had “[n]o contact at all” with the patient, because he has “ignored her” and has let other staff talk to her when she attempts to talk to him, and because Ms. Neal removed him from patient-facing duties so he could “avoid the patient” (Tr. 125-26).

Respondent conceded that no training he has ever received has taught him that it was acceptable to shove a patient or that it was appropriate to strike a patient (Tr. 131). At the time of the incident, respondent’s most recent PMCS assessments had been in May and June of 2023 (Pet. Ex. 3). He was specifically assessed on “CRISIS PREVENTION/INTERVENTION” on May 1, 2023 (Pet. Ex. 3 at 5).

Respondent’s testimony was consistent with his prior statements to Ms. Neal in interviews on December 23, 2024, and February 18, 2025, both of which were conducted before respondent had viewed the video footage (Pet. Exs. 4, 7; Resp.: Tr. 137). In the first interview, respondent reported that the patient was banging on the window of the nurses’ station and “that he was trying to redirect the patient from banging on the window of the nursing station” when “she hit him in his face” (Pet. Ex. 4). He also reported that his action “was a reflex and [that] he hit her on the top of her shoulder, but not to hit or hurt her” (*Id.*). According to respondent, the patient “then hit him again and he walked away” (*Id.*). In the second interview, respondent explained that he “kept trying to redirect [the patient] away from the window” when “[s]he then swung” at him, and “he blocked her by using his arm to deflect her punch and [he] thought she was going to throw multiple punches at him in that moment” (Tr. 51; Pet. Ex. 7). He also stated that “[h]e was unaware that he hit her in the face and thought he only hit her shoulder” (Pet. Ex. 7).

³ Similar to its position concerning respondent leaving the day room, petitioner argued that although required to report the December 17, 2024, incident to management, respondent failed to do so and claimed that all parties “know why” (Tr. 195). However, petitioner did not present any evidence of such a requirement or charge him with misconduct for failure to do so (ALJ Ex. 1). Therefore, I did not consider respondent’s alleged failure to report the incident in reaching my findings.

Accounts of Employees in the Video Footage: Peter Simpson and Folashade Maiyegun

Respondent presented the testimony of Mr. Simpson, who has worked at Bellevue as a BHA since 2019, has undergone PMCS training concerning aggressive patients, and knows respondent because they both work in 21 North (Tr. 159-61, 165). Mr. Simpson described respondent as “a good team player” who “does his duty correctly and efficiently” and stated that they have “a very good working relationship” (Tr. 160, 165).

According to Mr. Simpson, the “patient was upset” and “went to the nurse booth and was banging on the window,” which was “sometimes” common behavior for her (Tr. 163, 177). He explained that the patient was doing so because she wanted to speak to a nurse, which patients are allowed to do, although “the nurse cannot speak to the patient when they’re angry” so BHAs and “psych techs . . . try to calm [patients] down before they . . . can speak to a nurse or a doctor” (Tr. 177). Respondent was nearer to the patient and had a good rapport with her, so he “was trying to deescalate the situation and redirecting her back to her room,” but she kept “banging, banging, banging on the window” (Tr. 163).⁴ When Mr. Simpson observed that the situation was “getting more like she’s about to attack” respondent, who kept redirecting her even though she kept escalating, Mr. Simpson “tried to” separate everyone, moved respondent away, “redirected [the patient] multiple times back to her room,” and called a nurse to speak with her (Tr. 163-64, 173).

Mr. Simpson testified that he had observed the patient “punch [respondent] a few times” and identified two such times on the video (Tr. 164, 171-73; Pet. Ex. 1 at 18:55:31-36). He denied seeing respondent hit her and described respondent having raised his hands to defend his face and block the attack, even after being shown the portion of the video footage

⁴ Mr. Simpson’s testimony about the incident commenced with him indicating that respondent had worked on December 17, 2024, that he had been shown the video footage one time, and that he appeared on the video footage (Tr. 163). Other than the next question, which asked Mr. Simpson where he specifically appeared on the video, and questions concerning portions of the video shown to him at trial, it is unclear if his testimony about the incident stems from his independent recollection or having previously been shown the video footage (*Id.*).

when respondent struck the patient (Tr. 164, 170-173; Pet. Ex. 1 at 18:55:31-42). Mr. Simpson testified that he wrote a report of the incident with respondent the same day it happened because “[i]t has to be done within 24 hours” (Tr. 168, 177).

Mr. Simpson’s interview with Ms. Neal on February 19, 2025, described the patient “punching” the window of the nurses’ station, respondent “redirecting her and telling her to calm down” and then moving between her and the window to stop her, but “she was punching him and he was blocking the punches” (Pet. Ex. 8). Mr. Simpson’s statement to Ms. Neal did not indicate whether he saw respondent strike the patient. He testified that when he spoke to Ms. Neal after the incident, he “told her exactly what happened.” (Tr. 169). Mr. Simpson insisted that if respondent had struck the patient, he would have said so because they “have to” according to “procedure” and “protocol,” but he also admitted that he would not want to see respondent “get in trouble” (Tr. 165, 169).

Petitioner presented Ms. Neal’s written memorialization of her interview of Nurse Maiyegun, who did not testify at trial (Pet. Ex. 6). On February 18, 2025, Nurse Maiyegun informed Ms. Neal that in December 2024, she exited the nursing station “to assess the situation” because the patient, who “has a history of banging on the nursing station window daily around 6 p.m.,” the general time of the incident on December 17, 2024, was cursing (*Id.*). She attempted to intervene, but respondent “told her to go back inside” and that he ““got it”” (Pet. Ex. 6; Neal: Tr. 44).

Petitioner Established That Respondent Struck the Patient

Petitioner established that respondent struck the patient. The video footage demonstrates that respondent struck the patient twice in the face and that the strikes were unprovoked by any action of the patient’s: they had each been engaged in bumping up against each other prior to the respondent hitting her and she hit him only after he struck her twice (Pet. Ex. 1 at 18:55:30-40). The video footage also establishes that respondent instigated the second strike by taking several steps towards the patient immediately after the first strike and striking her a second time.

I do not credit respondent’s denials that he struck the patient or his explanation that he “was trying to deflect” when he “tried to raise [his] hands up as quick[ly] as possible” (Tr. 134-

35). The video footage demonstrates that respondent continually physically engaged the patient and struck her. It also refutes both his claim that he had “[z]ero contact” with the patient when she was trying to hit him and his denials that he had shoved or hit the patient (Tr. 143-44). Respondent raised his hand before and after he struck the patient in the face – before, when he appears to have hit her arm down and after, when she hit him – but he did not raise his arms to deflect her when he twice hit her in the face (Pet. Ex. 1 at 18:55:28-42). In addition, he affirmatively approached the patient after he first struck her and struck her a second time, contradicting his claim that he was attempting to deflect her actions (Tr. 123-24, 134, 142-44). While the patient pushed and shoved respondent before he struck her, her actions mirrored his and do not excuse or justify respondent’s conduct as petitioner’s rules expressly prohibit an employee from “striking . . . anyone in the hospital” (Pet. Ex. 15 at 4).⁵ *See Fire Dep’t v. Mitra*, OATH Index No. 1628/02 at 12 (Nov. 27, 2002), *adopted*, (Jan. 13, 2003) (self-defense can be a complete justification for an employee participating in a fight “[o]nly when an employee has no reasonable means available to avoid an altercation”).

When, according to Ms. Neal, “someone is agitated and verbal interventions do not work, then [staff members] have to escalate that immediately” by alerting the nurse or the Behavioral Response Team, also referred to as the Crisis Response Team, to avoid injury to the patient or staff (Tr. 36-37). Respondent’s PMCS training informed him of the need to activate the “Crisis Management Team” or report to a nurse as part of CRISIS PREVENTION/INTERVENTION (Neal: Tr. 31-32, 37-38; Pet. Ex. 3 at 5).

Respondent failed to identify the patient’s triggers and early signs of escalation, two aspects of the PMCS’s clinical competency in Crisis Prevention/Intervention training for which he had been evaluated in May 2023 (Pet. Ex. 3 at 5). In the video, the patient exhibits several signs of escalation that Ms. Neal identified: “pacing, . . . hitting, banging, refusing to comply with redirection, [and being] someone who has difficulty talking about what their triggers are, so they act it out in physical ways” (Tr. 32). According to Ms. Neal, a patient can exhibit

⁵ While Ms. Neal denied at trial that the patient struck respondent, her written description of the video confirms that the patient did so “more than once” (Tr. 59; Pet. Ex. 5).

threatening behavior when they want something they cannot have, which respondent acknowledged was the case with the patient (Neal: Tr. 31; Resp.: Tr. 118-20).

Furthermore, respondent stepping towards the patient after the first strike to strike her again reflects a failure to de-escalate. Such failure, especially when he had numerous opportunities to de-escalate, serves as an aggravating factor. As Ms. Neal also noted, when the patient began banging on the nurses' window, respondent's initial response should have been to "try to talk to the patient" and "ask the patient what's going on" and offer his assistance, describing talking to the patient as "the first, most important thing" (Tr. 36). The BHA should tell the patient to "stop banging on the window" and "encourage them to stop" (*Id.*). While respondent did so, he admitted that his attempts to de-escalate the situation by talking to the patient were unsuccessful (Tr. 131). During the length of time respondent interacted with the patient, he had numerous opportunities to step away, especially when it was clear that she was not complying with his direction. In addition, the patient had pushed him several times, so that further physical contact should have been anticipated.

Respondent also did not alert any other staff members and conceded that he did not seek help from a nurse (Tr. 136). In fact, he did the opposite. The video footage of respondent stepping into the nurses' station with his arm and his hand in a position commonly understood to mean "stop" confirms Nurse Maiyegun's account that respondent rejected her attempt to intervene and assist and directed her to return to the nurses' station, saying that he was in control of the situation (Neal: Tr. 44, 58; Pet. Ex. 6; Pet. Ex. 1 at 18:49:55). The video footage also indicates that respondent made what appears to be a beckoning motion at the entrance to the nurses' station only after he had struck the patient (Pet. Ex. 1 at 18:55:30-36, 18:56:07).

I do not credit respondent's contradictory explanations for his failure to employ de-escalation techniques. His expectation that the patient's "normal temperament" would go "down or phase out" is refuted by his testimony that her reaction was "different" because she was calling him different names (Tr. 122, 124). Respondent's assertion that he "was just more shocked than anything" that the patient struck him is self-serving and unsupported by other evidence (Tr. 124). For example, during the interactions between respondent and the patient reflected in the video footage, which lasted over two minutes, respondent had numerous

opportunities to step away, repeatedly approached the patient even when she moved away from him or the nurses' station, and did not walk away from her after he struck her the first time.

The testimony of Mr. Simpson, the only other witness to the interaction between respondent and the patient, presents facts in a light most favorable to respondent, his friend, and is not reliable. *See Dep't of Sanitation v. Menzies*, OATH Index No. 678/98 at 2-3 (Feb. 5, 1998), *adopted*, Comm'r Dec. (Feb. 17, 1998), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 98-101-A (Sept. 9, 1998) (where proof of the charges rests at least in part on the credibility of its witnesses, a determination of witness credibility must consider factors such as: "witness demeanor, consistency of a witness' testimony, supporting or corroborating evidence, witness motivation, bias or prejudice, and the degree to which a witness' testimony comports with common sense and human experience"). Though Mr. Simpson testified that he observed the patient strike respondent more than once, he did intervene. His denial that he saw respondent hit the patient is factually accurate but the reason he did not is clear from the video footage: he was sitting on the chair looking down at a phone or other device (Pet. Ex. 1 at 18:52:22-55:43). When he looked up and rose from his chair, respondent was not raising his hands to defend his face or block the patient, as Mr. Simpson testified (Pet. Ex. 1 at 18:55:43-55; Tr. 164, 173).⁶ In addition, his claim that he and the respondent wrote an incident report on December 17, 2024, is refuted by the lack of any incident report being presented at trial and respondent's testimony that he did not write an incident report.

Finally, respondent contends that the single camera angle produced by petitioner is insufficient to prove that respondent "intentionally or willfully struck a patient nor that he did so in her face" (Tr. 183). Although video footage from cameras on the far end of the hallway might have displayed additional, and in some places unobstructed, views of the incident, respondent can clearly be observed striking the patient in the one video introduced at trial.

For the foregoing reasons, petitioner established by a preponderance of the evidence that respondent struck the patient in the face, which constitutes gross misconduct under

⁶ Mr. Simpson was not asked to identify when that occurred on the video footage.

petitioner's rules. Respondent's explanation of the incident was self-serving, contradicted by the video evidence, and did not comport with common sense.

Specification 2 of the petition is sustained.

Excessive Absences (Specification 1)

Petitioner also alleged that between March 20, 2024, through December 19, 2024, "[r]espondent was excessively absent on approximately seventeen (17) days, seven (7) of which were before or after [his] scheduled day off" and that these unscheduled absences violated its rules (Tr. 189; ALJ Ex. 1). Respondent conceded that he was absent for 17 unidentified days but denied that his absences constituted misconduct (Tr. 179).

Petitioner's rules do not specifically define excessive absenteeism. *Health & Hospitals Corp. (Elmhurst Hospital) v. Oazibullah*, OATH Index No. 1254/25 at 10 (Jan. 26, 2026), *adopted*, CEO Dec. (Feb. 25, 2026) (citing *Health & Hospitals Corp. (Bellevue Hospital Ctr.) v. Lewis*, OATH Index No. 433/15 at 3 (Jan. 26, 2015), *aff'd*, HHC Pers. Rev. Bd. Dec. No. 1579 (July 8, 2015)). This tribunal considers three circumstances establishing misconduct for cases where excessive absence is not defined by agency regulations: (1) absences which are excessive *per se* because the number of them is so extensive; (2) absences which are excessive because of the disruption they cause in the workplace and the adverse impact they have on office efficiency and operations; and (3) absences which are excessive based on circumstances surrounding the missed days of work. *Oazibullah*, OATH 1254/25 at 10 (citing *Health & Hospitals Corp. (Elmhurst Hospital Ctr.) v. Smith*, OATH Index No. 740/22 at 3 (June 30, 2022)).

Petitioner failed to establish that respondent's absences were excessive under any of these three circumstances. First, it failed to establish that respondent's absences were excessive *per se*. The petition did not sufficiently specify the dates respondent was alleged to have been excessively absent. The petition alleged that from March 20, 2024, through December 19, 2024, respondent "was excessively absent on seventeen (17) days, seven (7) of which were before or after [r]espondent's scheduled day off," but it did not identify the 17 dates (ALJ Ex. 1). It referenced but did not contain an "Exhibit C" which the petition indicated "described" both the 17 and seven days. It was not until summation that petitioner's counsel identified the alleged days of unscheduled absences by representing that "[t]he absences are

indicated by the codes in the timesheets” and offering to identify them to the tribunal (Tr. 189; Pet. Ex. 10). The 17 dates were then identified as March 20, 24, May 2, 19, June 29, July 4, 9, 19, August 5, 9, 11, September 16, November 12, 13, 27, December 2, and 12, 2024 (Tr. 189-91). The seven absences that preceded or followed a scheduled day off were identified as March 24, May 2, 19, July 9, 19, August 9, and November 12, 2024 (Tr. 191).

OATH Rule 1-22 requires that a petition must “specifically allege the incident, activity or behavior at issue as well as the *date, time, and place of occurrence*) (emphasis added). 48 RCNY § 1-22 (Lexis 2026). The purpose of administrative pleadings is notice, so a petition is sufficient if it affords notice of the matters to be adjudicated. *Dep’t of Buildings v. Owner, Occupants and Mortgagees of 31 West 11th Street, Apartments 6A and 6B, New York*, OATH Index No. 990/94 at 1-3 (Aug. 26, 1994), *aff’d*, BSA No. 165-94-A, *reprinted in* 80 Bulletin of Bd. of Stds. and Apps. 193 (May 4, 1995), *aff’d sub nom. Hiesiger v. City of New York*, NYLJ, Nov. 6, 1996, at 26, col. 1 (Sup. Ct. N.Y. Co.).

A failure to specify dates in a petition can be cured by evidence at trial. *See Dep’t of Correction v. Knupp*, OATH Index No. 1774/18 at 3-5 (Jan. 4, 2019), *aff’d*, NYC Civ. Serv. Comm’n Case No. 2019-0314 (Aug. 1, 2019) (finding excessive absence proven where witness testimony supplemented unreliable documentary evidence by providing dates of absences that were not specified in the petition). In *Knupp*, the leave request reports introduced into evidence were not all reliable and quantified sick leave usage in hours rather than days. Excessive absence was nevertheless proven because witnesses testified to the dates of respondent’s absences. *Id.* at 3-4.

Here, petitioner’s reliance on timesheets and Ms. Neal’s testimony to prove respondent’s unscheduled absences cured its failure to specify the dates in the petition (Pet. Ex. 10; Tr. 76-78). The timesheets include a legend of codes which indicate whether an employee worked and if not, the reason for the absence (Pet. Ex. 10 at 10, 17, 23). Ms. Neal, whose responsibilities include management of time and leave issues, explained the codes (Tr. 23, 77-78). However, when explaining how the codes signified whether respondent worked or did not work, she identified only three days: March 20, 2024, when respondent had an unscheduled absence, March 21, 2024, when he worked, and March 22, 2024, a day he worked a double

shift (Tr. 76-77). She did not identify the 16 other alleged days of unscheduled absences, any of the seven days alleged to have preceded or followed a scheduled day off, or examples of what she described as respondent's "patterns [of] calling out on day before and day after weekend, scheduled days off and also on weekends" (Tr. 76).

Review of the timesheets establishes 16 of the 17 unscheduled absences despite the limited evidence about the codes. Respondent was completely absent on 13 days and partially absent on 3 days. Respondent was fully absent on March 20, May 2, 19, June 29, August 9, November 12, 13, and December 2, 2024, which was attributed to unscheduled sick leave (Pet. Ex. 10 at 2, 5, 7-8, 11, 18-19); on March 24, and August 5, 2024, which was attributed to unscheduled annual leave (Pet. Ex. 10 at 4, 12); on July 9, and August 11, 2024, which was attributed to unscheduled sick leave from annual (Pet. Ex. 10 at 8, 12); and on July 4, 2024, which was attributed to seven hours of unscheduled sick leave and an hour and a half of unscheduled sick leave from annual (Pet. Ex. 10 at 8).⁷

Respondent was also partially absent for an hour and 20 minutes on July 19, 2024, which was attributed to unscheduled sick leave from annual (Pet. Ex. 10 at 9),⁸ a half-hour of his tour(s) on September 16, 2024, which was attributed to unscheduled annual leave (Pet. Ex. 10 at 14); and a half-hour on December 12, 2024, which was attributed to unexcused lateness (Pet. Ex. 10 at 19-20).

The timesheets did not establish an absence on the remaining day of October 24, 2024. Respondent worked two shifts: the 0800 to 1500 shift, as identified by the code 2948, which indicates overtime, and the 1500 to 2330 shift, as identified as 0000, which indicates actual work time (Pet. Ex. 10 at 15, 17; Neal: Tr. 77).

⁷ I note that the timesheets indicate that respondent's absence on December 19, 2024, the last day of the range noted in the petition, was marked as unscheduled sick from annual (Pet. Ex. 10 at 20; ALJ Ex. 1). Petitioner's counsel initially identified December 19, 2024, as one of the 17 days respondent had an unscheduled absence but then retracted its inclusion (Tr. 189-92). Accordingly, I did not consider it in my analysis.

⁸ The code for the remainder of respondent's shift on July 19, 2024, 7100, was neither identified in the legend nor explained by Ms. Neal (Pet. Ex. 10 at 9; Tr. 76-78).

This tribunal has found the number of a respondent's absences to be excessive *per se* when it far exceeds the threshold for counseling under Operating Procedure 20-10, which is "three (3) unscheduled absences, or two (2) unscheduled absences immediately before or after a holiday or pass day during any six month period" (Pet. Ex. 17 at § IV(A)(2)(b)). *See Smith*, OATH 740/22 at 3-4 ("When the number of unscheduled absences far exceeds the threshold for counseling under Operating Procedure 20-10, they have been found by this tribunal to be excessive *per se*."). However, while the number of respondent's unscheduled absences exceeds the three unscheduled absences that trigger a counseling session, three of the 16 unscheduled absences were for only a limited portion of respondent's tour: one for less than an hour and a half and two for a half hour (Pet. Ex. 15 at B2; Pet. Ex. 10 at 9, 14, 19-20).

Accordingly, the evidence is insufficient to establish that respondent was excessively absent *per se* as a result of the 16 established full or partial days of unscheduled absence over a period of ten months. *Compare Oazibullah*, OATH 1254/25 at 10 (finding being absent for 24 days over seven months with two days before or after a scheduled day off and 11 days over a two-month period excessive); *with Lewis*, OATH 433/15 at 3-4 (finding nine occasions of absences totaling 18 days over a ten-week period not to be excessive). In addition, petitioner failed to establish that the disruption to the workplace or adverse impact on efficiency and operations caused by respondent's absences rendered them excessive. Ms. Neal noted that when respondent failed to report to work, petitioner had "to find someone to replace him," which oftentimes required assigning another employee an overtime shift "or float someone from another area to cover his shift" (Tr. 76). I do not find that her general conclusory statement establishes such a disruption to the workplace or an adverse impact on efficiency and operations to conclude that respondent's absences were excessive. *See Oazibullah*, OATH 1254/25 at 11-12 (witnesses explained that "respondent's absences negatively impacted the hospital's ability to provide optimal patient care and safety, in that respondent's duties could not be performed efficiently and other employees had to be reassigned to perform respondent's duties").

I note that if respondent's absences were found to be excessive, I would not credit his explanation for them. Respondent testified that his absences were "usually" caused by

“chronic hives that . . . could be unpredictable” because “there are times it flares up unexpectedly and make it challenging to adhere to a regular work schedule” (Tr. 113). He explained that he took medication for this condition which causes drowsiness and sleepiness (*Id.*). Respondent discussed his condition and the possibility of applying for FMLA with Ms. Neal but “never got the chance to” apply (*Id.*). He did not provide any corroborating evidence of either his condition or the unidentified medication.

For the foregoing reasons, petitioner did not establish that respondent was excessively absent.

Specification one is dismissed.

Findings and Conclusions

1. Petitioner did not establish that respondent was excessively absent.
2. Petitioner established that respondent committed gross misconduct when he struck a patient.

Recommendation

Having found that petitioner proved its case, I requested respondent’s disciplinary record and received evaluations for the periods of 2021 to 2022, 2022 to 2023, 2023 to 2024, 2024 to 2025, and 2025 to 2026, which I deem ALJ Exhibits 2a, 2b, 2c, 2d, and 2e respectively.⁹ Petitioner’s accompanying email indicates that respondent was appointed on April 1, 2019, has not been promoted or demoted, has no prior formal disciplinary record, and served an unpaid

⁹ Petitioner initially submitted evaluations for the periods of 2023 to 2024 and 2024 to 2025, noting that additional evaluations completed within the five-year term of the request would be “forward[ed] upon receipt, if received” (Email from Edwards to Arenas of Apr. 17, 2026). Approximately ten days later, despite no request for either an extension of the April 17, 2026, deadline or permission to submit information after the deadline had passed, additional evaluations were submitted for the periods of 2021 to 2022, 2022 to 2023, and 2025 to 2026 (Email from Edwards to Arenas of Apr. 28, 2026). Respondent consented to consideration of the additional evaluations to determine the penalty recommendation in this matter (Email from Hill to Davis of May 1, 2026).

pre-trial suspension from March 11, 2025, to April 10, 2025 (Email from Edwards to Arenas of Apr. 17, 2026).

Respondent's 2021 to 2022, 2023 to 2024, and 2024 to 2025 evaluations rated him "Satisfactory" for: 1) effectively utilizing crisis intervention/de-escalation practices and non-physical behavioral management techniques; and 2) observing and identifying potentially harmful client characteristics and environmental variables that may trigger agitated behavior (ALJ Exs. 2a, 2c, 2d). His 2022 to 2023 evaluation rated him "Satisfactory Plus" on these two standards (ALJ Ex. 2b).

Respondent's 2021 to 2022 evaluation described him as "instrumental to the adolescent population on the unit" and noted that "[h]e communicates therapeutically with the patients and ensures that their needs have been met" (ALJ Ex. 2a at 22). Both the 2022 to 2023 and 2023 to 2024 evaluations described him as "a vital asset to the unit" (ALJ Exs. 2b, 2c), the first noting he "is a great team player [who] offers consistent therapeutic support to all the patients" and "works well with the adolescent patient population" (ALJ Ex. 2b at 1), with the second noting that he "engages in appropriate interactions with the patients" (ALJ Ex. 2c at 41). The 2024 to 2025 evaluation described respondent as "promptly attend[ing] to his patients and communicates any patient-related issues to the nurses in a timely manner" (ALJ Ex. 2d at 1). The evaluations also made recommendations for improvement in respondent's performance. The 2021 to 2022, 2022 to 2023, and 2023 to 2024 evaluations each advised respondent to attend trainings in both crisis management and working with the child, adolescent, and autistic inpatient population (ALJ Exs. 2a, 2b, 2c).¹⁰

I recommend a penalty of termination. This tribunal has often found termination to be the appropriate penalty where a hospital worker assaults a patient. *Health & Hospitals Corp. (Metropolitan Hospital Ctr.) v. Babarinde*, OATH Index No. 1360/10 at 2 (Apr. 6, 2010), *modified on penalty*, Exec. Dir. Dec. (June 7, 2010) (citations omitted); *see, e.g., Health & Hospitals Corp. (Bellevue Hospital Ctr.) v. Lee*, OATH Index No. 1645/13 (July 1, 2013), *modified*, Hosp. Dec.

¹⁰ Respondent's 2025 to 2026 evaluation noted that there was a break in respondent's service due to "Leave of Absence Disciplinary" because respondent was "currently out on leave," so there were no assessments of his performance during this time period (ALJ Ex. 2e).

(Sept. 20, 2013) (terminating employment of psychiatric health technician with eight years' experience and no disciplinary history who hit patient in the face after the patient spit at him); *Health & Hospitals Corp. (Woodhull Medical & Mental Health Ctr.) v. Goodman*, OATH Index No. 1632/07 (Dec. 14, 2007). Although it has also sometimes found a penalty less than termination appropriate when the patient was not harmed, I do not find that the lack of proof of physical injury to the patient here justifies a penalty less than termination. *Babarinde*, OATH 1360/10 at 2-3 (citations omitted). Not only did respondent strike the patient in the face at least twice, he had the opportunity to disengage at numerous points during their interaction. Accordingly, I do not find that there was "substantial provocation" that caused a "momentary lapse in judgement" that mitigates a penalty of termination. *Fire Dep't v. Serrano*, OATH Index No. 584/18 at 2, 12 (Mar. 21, 2018), *adopted*, Comm'r Dec. (May 24, 2018) (recommending and imposing 60-day penalty for an emergency medical technician who, after getting spit in the face by a patient who "was partly restrained, emotionally disturbed, and possibly intoxicated," struck the patient twice in the face).

Petitioner's requested penalty of termination is appropriate for the proven gross misconduct. Respondent's striking a patient creates obstacles to petitioner's policy to support "a culture of patient safety" and to BHAs' "whole role and responsibility . . . to ensure safety on the unit" (Pet. Ex. 16 at 1; Neal: Tr. 25-26). Furthering that mission requires that staff interact appropriately with patients, especially those in a psychiatric unit. In addition, as Ms. Neal noted, the impact of the December 17, 2024, incident is twofold. First, "it was a hardship for the emotional trauma for the patient who reported this to her doctor," which Ms. Neal described as "increased trauma that was not present prior to admission" and which caused the patient "to actually be in more treatment with her physicians over her allegation" (Tr. 67-68). Secondly, respondent "had to be removed from duty, and then [the hospital] had to resort to hiring overtime in his place, in his absence," which resulted in "a hardship for staffing" (Tr. 67-68). Finally, not only did respondent fail to take responsibility for his conduct, but his account of the incident is not credible. Although the video footage established that he struck the patient more than once, he maintained his claim that he raised his arm to deflect her from hitting him and denied that he struck her, even after having viewed the video footage.

For the foregoing reasons, I find that termination is appropriate.

Julia Davis
Administrative Law Judge

July 1, 2026

Submitted To:

Eric Wei, MD
Chief Executive Officer

Appearances:

Jade Edwards, Esq.
Attorney for Petitioner

Chelsea Hill, Esq.
Attorney for Respondent

August 6, 2026

Via First Class and Certified Mail

#: [REDACTED]

Nick Alexis
[REDACTED]

Re: *Health + Hospitals (Bellevue Hospital Ctr) v. Alexis*,
OATH Index No. 654/26

Dear Nick Alexis:

As the Chief Executive Officer (CEO) of Health + Hospitals/Bellevue, I have reviewed the recommendation of Judge Julia Davis dated July 1, 2026, regarding your administrative trial, together with the entire record. I have also reviewed your response that was submitted on July 17, 2026.

Based on my review of the aforementioned documents, I accept the findings of fact of Judge Julia Davis.

Given the substantiated charge of gross misconduct that demonstrated that you struck the patient more than once, I agree that the only appropriate penalty is termination. Consequently, I hereby adopt Judge Julia Davis 's recommendation of termination from your position as a Behavioral Health Associate, effective August 6, 2026.

Sincerely,

[REDACTED]

Dr. Eric Wei
Chief Executive Officer
NYC Health + Hospitals/Bellevue

c: Hon. Julia Davis
Joel Viera-Vera – DC37 Council Representative
Chelsea Hill, Esq
Human Resources/Personnel File
Labor Relations