

IN THE MATTER OF ARBITRATION BETWEEN

ABBOTT NORTHWESTERN HOSPITAL,)
ALLIANA HEALTH SYSTEM) FMCS Case No. 111129-51481-3
AND) Daniel Jensen Discharge
INTERNATIONAL UNION OF OPERATING)
ENGINEERS, LOCAL NO. 70)

NAME OF ARBITRATOR: John J. Flagler

DATE AND PLACE OF HEARING: May 5, 2011; Minneapolis, MN

DATE OF RECEIPT OF POST-HEARING BRIEFS: June 6, 2011

APPEARANCES

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THE ISSUE

Did the Company have cause to discharge the Grievant. If not, what is the appropriate remedy?

BACKGROUND

On October 10, 2010, a critical alarm went off at Allina Health System's Abbott Northwestern Hospital (hereinafter "Abbott" or "Hospital"). The alarm indicated that there was something wrong with the Hospital's bone freezer located in a surgery room. The Hospital's Security personnel contacted Daniel Jensen (the "Grievant") and informed him that the alarm had gone off. His job as a Maintenance Engineer was to respond to the alarm and attempt to fix the problem. Upon receiving the call from Security, the Grievant acknowledged the critical alarm with a "10-4," at which point Security silenced the audible alarm. But exactly 24 minutes later, without investigating the cause, attempting to fix it or sharing it with the relief engineer, the Grievant punched out for the day and went home.

The next morning, Surgery personnel discovered the alarm, and another Maintenance Engineer took immediate steps to save the product contained in the bone freezer. It was too late. The contents of the freezer – autologous spine bone parts and skull bone flaps, harvested from and being stored for the Hospital's patients for their future surgeries – were destroyed.

During its subsequent investigation, the Hospital learned that the Grievant, despite having acknowledged the alarm, simply failed to do anything about it. Upon inquiry, the Grievant admitted his error; his excuse was that it "slipped his mind." His undisputed neglect of duty resulted directly in grave damage to the Hospital and its reputation, and more importantly, to the patients it serves.

Ultimately, the implications of the Grievant's error are obvious. The Hospital's expectation that he respond to all critical alarms brought to his attention was compromised. The Grievant's undisputed malfeasance left the Hospital with no choice. On October 25, 2010 the Hospital discharged the Grievant.

FACTUAL BACKGROUND

The material facts are largely undisputed. What follows simply restates what was established of those facts at the hearing.

The Grievant worked as a Maintenance Engineer at the Hospital for five and one-half years. The Maintenance Department provides assistance with such things as building repairs, temperature and lighting requests, minor construction, and is available to respond to urgent alarms related to any facilities maintenance issue affecting safety or patient care. One of the major job responsibilities of a Maintenance Engineer is repair of critical and non-critical equipment systems such as heating and cooling equipment.

Abbott's heating and cooling equipment, like the bone freezer is connected to a computerized alarm system that is altered when the equipment malfunctions. The on-call Maintenance Engineer at any given time is the Hospital's "first responder" when an alarm goes off. In this regard, the on-call Maintenance Engineer is notified by Security that a critical alarm has gone off and it is his responsibility to respond to the alarm, investigate the cause of the

alarm, and begin working on the problem. The bone freezer alarm that sounded on October 10, 2010 was a critical alarm.

The Hospital used the freezer to store human body parts, including autologous spine bone parts and skull flaps that had been harvested from patients during surgery. The Hospital stored the skull flaps in the freezer because they were to be replaced into the patients once the swelling in their brains was reduced to an appropriate level.

Because the freezer temperature climbed to zero degrees, the human body parts had been exposed to unacceptable temperature levels for too long a time period and had to be destroyed consistent with relevant protocols. Thereafter, treating physicians were forced to contact the patients on whose behalf the spine bone parts and skull flaps were being stored, and explain that they would be required to accept prosthetics in order to complete their medical procedures.

The Hospital began its investigation into the bone freezer malfunction immediately. At the outset the Hospital learned that the Grievant had been on duty when the alarm sounded and that he had acknowledged the Security dispatcher's radio call regarding the issue. In turn, therefore, the Hospital placed the Grievant on paid administrative leave pending further investigation.

The Hospital's Senior Human Resources Generalist, Bob Doyle, participated in the investigation. The bone freezer had been functioning without any problems during the months preceding the malfunction.

The Grievant admitted that he received the critical alarm and that he did not follow up on it. His only excuse was that it "skipped his mind." The Grievant concedes that full response to such an alarm is a clearly enunciated job duty and a duty he was expected to carry out with the utmost diligence.

The Hospital's investigation further revealed that there had been no prior instances where a Maintenance Engineer simply failed to follow through to a critical alarm. Hallman, Grote and Doyle all testified that they were unaware of any prior instance where an on-call Maintenance Engineer had acknowledged a critical alarm and did nothing further. Co-worker Willman pointed to an incident involving a roof-mounted air handling unit (referred to during the arbitration as an "S-1 fan"), but then conceded that he had no personal knowledge of whether there had been any action taken. He only knew that the unit had yet to be repaired by the time he came on duty.

On another occasion, the Hospital had discharged another member of the same bargaining unit, who had no prior disciplinary record, for failing to turn on an emergency generator that was served as a back-up power source for the Hospital's equipment over the course of a weekend. Although there were no adverse consequences to the Hospital or its patients as a result of that employee's negligence, the Hospital nonetheless determined that the offense was a serious neglect of duty. The Hospital also discharged other employees for one-time offenses related to stealing products and sexual misconduct, respectively.

After conducting the investigation into the circumstances at issue, the Hospital determine that the Grievant's failure to follow through on the alarm constituted a serious infraction in clear contravention of the rules and expectations and also that his conduct led directly to the destruction of harvested body parts – which not only sullied the Hospital's reputation and created a liability risk, but more importantly, compromised patient safety and care.

POSITION OF THE HOSPITAL

Consistent with the collective bargaining agreement, the parties agreed that the Hospital could discharge an employee "immediately for cause...depending upon the severity of the action for which the discipline is being administered." When assessing whether the discipline imposed is appropriate under the relevant circumstances, arbitrators generally apply the well established "seven tests" of just cause in discharge cases, which are stated as follows: (1) Was the rule under which Grievant was discharged reasonably related to the safe and efficient conduct of the business? (2) Was the rule clearly expressed and effectively promulgated? (3) Did the Company conduct a fair investigation into the facts? (4) Do the facts establish the guilt of Grievant? (5) Does the penalty of discharge fit the proven offense? (6) Has Grievant been afforded even-handed disciplinary treatment? (7) Has the employer either condoned such behavior in the past or otherwise entrapped Grievant into believing such conduct was acceptable? *See In re Cub Foods*, 1991 WL 702015, BMS #91-RA-186 (Flagler, 1991). Application of these tests to the facts at issue demonstrate that the Hospital had more justifiable "cause" to discharge the Grievant. Thus, his grievance should be denied.

Neither the Grievant's misconduct nor the dire result of his neglect of duty is in dispute. The only commensurate discipline under the circumstances is discharge. The facts under each of the "seven tests" of cause demonstrate that the Hospital's decision to discharge the Grievant was proper.

The first factor in a discharge case is whether the rule or duty was reasonable. It is hardly debatable that the Hospital's rule requiring its on-call Maintenance Engineers to respond to alarms signaling the malfunction of critical equipment is relevant and reasonable. Maintenance of the Hospital's critical equipment is essential to ensure that, in large part, patient care and safety is not compromised.

There is no evidence in this case suggesting that the rule or duty at issue is contrary to the safe and efficient conduct of the Hospital. Instead, just the opposite is true.

When a critical alarm sounds and that it is one of the Maintenance Engineer's principal duties to investigate calls on the hospital floor when such alarms go off. The Grievant conceded that when the alarm sounded on October 10, 2010, he had to respond. There is no question that responding to alarms is a rudimentary expectation of any Maintenance Engineer.

The second factor in a discharge case is whether the rule at issue was clearly expressed and effectively promulgated. The effectiveness of the Hospital's rule requiring its Maintenance Engineers to respond to critical equipment alarms is not in question. At least 35% of the

Grievant's major job responsibilities related to responding to equipment alarms and maintaining critical equipment. Approximately six months before the incident at issue, Maintenance staff, including the Grievant, received an e-mail reminding them that issues affecting patient care and patient safety, such as responding to critical alarms, constitute "High Profile Events" that must be responded to with the "utmost diligence."

The process for responding to critical alarms is also documented in the Hospital's Critical Event Notification Process for Maintenance, dated October 8, 2010 (the "Process"). This Process makes clear that when a critical event takes place and an alarm sounds, the on-call Maintenance Engineer is alerted and then begins working on the problem. In short, it is undisputed that the Grievant knew the "rule." Thus, the second test weighs in favor of the Hospital.

There are no material facts in dispute regarding the Grievant's actions which led to his discharge and the Hospital's investigation into the matter was thorough. The investigation of the incident and the Grievant's related misconduct began on October 11, 2010, immediately after management became aware that the bone freezer malfunctioned. After learning that the Grievant was on duty the day before, when the critical alarm sounded, and that he may have failed to adequately respond, the Hospital placed him on paid administrative leave pending further reinvestigation.

Between the date of the incident and October 25, 2010 (Grievant's discharge date), the Hospital's investigation consisted of a review of relevant documents related to the bone freezer, communications with Security and other Hospital personnel, and interviews and meetings with employees knowledgeable of the incident and of Maintenance Department protocols, including the Grievant. When the Hospital interviewed the Grievant, he admitted receiving the alarm while he was on duty and that he failed to respond. The Grievant explained that when he received notice of the alarm from Security he was with a contractor. But instead of responding, he returned to the Maintenance area, put his tools away, and punched out for the day. His only excuse for failing to respond to the alarm was that it simply "slipped his mind."

The investigation further revealed that, as a direct consequence of the Grievant's inaction, the harvested body parts inside the bone freezer were destroyed. These included autologous spine parts and human skull flaps taken from surgical patients. It also learned that the skull flaps were being maintained in the freezer until such time that they could be surgically reattached to the patient when the associated swelling was reduced an appropriate level. Because the temperature in the freezer had risen to an unacceptable level, the human body parts were rendered useless. As a result, the Hospital was forced to communicate this fact to its affected patients, who had to accept prosthetics (instead of their own body parts) to complete their procedures. In short, the severe ramifications of the Grievant's misconduct became painfully obvious during the investigation.

The Hospital also reviewed other incidents of misconduct. There were no other instances of which it was aware wherein an on-call Maintenance Engineer failed to respond to a critical alarm that he or she had acknowledged.

On October 25, 2010, the Hospital again met with the Grievant and confirmed the facts related to his neglect of duty. Given the fact that the Grievant simply ignored one of his core job duties, the fact that he had no excuse for his inattentiveness, and because of the consequences of his actions, the Hospital informed the Grievant that it was terminating his employment, effective immediately.

Did the penalty fit the proven offense? Arbitrators typically apply the rule of proportionality in assessing the sanction selected by management in a given case. The level of discipline permitted by the just cause standard depends on the facts as well as the nature and the consequences of the employee's offense. Discipline must bear some reasonable relationship to the seriousness of the offense.

This factor is easily resolved in the Hospital's favor, as both the nature of the Grievant's misconduct and the consequences of his actions exemplify the seriousness of his offense. One of the Grievant's core duties was to be the "first responder" when notified about an alarm signaling the malfunction of critical equipment and that the Grievant neglected this duty.

There is no dispute that the consequences of the Grievant's actions were dire. Had the Grievant timely responded to the alarm or had he notified the next Maintenance Engineer on duty of the alarm, the body parts maintained in the bone freezer would not have been lost.

Although the Union conceded that the Grievant deserved some level of discipline as a result of his neglect of duty, it argued that discharge was excessive because, in part, the Hospital had knowledge that the bone freezer was not reliable and the alarm system that was connected to the freezer did not have adequate "redundancies." Neither argument is persuasive.

Although the freezer at issue had been in service for a number of years, there was no evidence presented at the hearing suggesting that it had not functioned properly in the months preceding the malfunction. In fact, as detailed on the monthly temperature log, the freezer consistently tested in an acceptable storage range. The employee who was principally tasked with maintaining the surgical freezers, testified that he never had to "turn a wrench" on the bone freezer and he had not been asked to address an issue relative to that same freezer for more than a decade. All three of the Maintenance Engineers who testified stated that possible issues with the freezer, of which the Grievant was admittedly unaware, did not excuse his failure to respond to the subject alarm.

Separately, although Abbott did, in fact, implement a new "Honeywell" alarm system during 2010 for certain pieces of equipment, the bone freezer at issue was not tied to this system because it was already on an alarm system. The Maintenance Engineers were well aware of the notification process and procedure for responding to that alarm – the Grievant just didn't do it.

The Grievant testified that he knew that the bone freezer at issue was not connected to the newer Honeywell alarm system and that, in the past, Security had not attempted to "re-notify" him about an alarm once he acknowledged the initial call (which he did on October 10, 2010). In this regard, the Grievant knew that the alarm at issue did not have the same built-in redundancies as those alarms tied to the Honeywell system. Further, he admitted that, under the

circumstances, he was the next and only “redundancy” after he acknowledged the alarm. The Grievant knew that he was the “redundancy” only magnifies his neglect of duty in this case.

The sixth factor in a discharge case asks whether similarly situated employees have received similar discipline. The Hospital’s witnesses all testified that Grievant’s misconduct was the first of its kind where a Maintenance Engineer simply failed to respond to a critical alarm after acknowledging it. Notwithstanding, the Grievant’s serious neglect of duty is easily analogized to the Hospital’s prior discharge decision involving another bargaining unit member, who failed to turn on a back-up emergency generator. In both cases, the infractions were serious, but the Hospital’s decision to discharge the Grievant is further bolstered by the negative consequences that stemmed from his error.

The Union argues that the Grievant has not received even-handed discipline as evidenced by a prior incident involving the malfunction of a roof-mounted air handling unit in or around April 2010. Although the Hospital acknowledged that this unit malfunctioned during the time period suggested by the Union, this issue is not relevant here or to the discipline afforded the Grievant under the circumstances. During the hearing, co-worker Willman testified about the overheating fan issue in inconclusive terms and contended that because he was the one who ultimately fixed the fan, the Maintenance Engineer on duty before him must not have effectively responded to the initial alarm. But he admitted the Maintenance Engineers on duty before him were actually working on the problem when he reported to work, meaning that they did, in fact, respond to the alarm. And other than his speculation about the efficacy of these team member’s response, there is no evidence in the record suggesting that any Maintenance Engineer was inattentive to his duties in response to the operating fan problem.

Thus, the two incidents are not comparable. The only comparable evidence is that of the employee who was undisputedly discharged for the single act of failing to turn on a generator, thereby compromising patient safety, just as the Grievant did in this case.

The seventh factor in a discharge case is whether the Hospital condoned the Grievant’s behavior or otherwise entrapped him into thinking that his conduct was acceptable. The Union has presented no evidence suggesting that the Hospital knowingly induced in Grievant a belief that the behavior for which he was discharged was in any sense acceptable.

For all the foregoing reasons the Hospital submits that it has fully met and surpassed its burden for showing just cause in this matter.

POSITION OF THE UNION

The Grievant worked as a Maintenance Engineer for the Employer from March of 2005 until his termination on October 25, 2010. At the time of his discharge, the Grievant was the union steward for a bargaining unit of 26 maintenance employees at Abbott Northwestern Hospital.

The Employer completed comprehensive annual performance appraisals for each year of the Grievant's tenure. These appraisals reveal that the Grievant met the Employer's expectations on every one of his job responsibilities, in each year of his employment. The appraisals include commentary about the Grievant's work capabilities and contributions.

During his tenure, the Grievant has never before been disciplined. Before October 10th, he had never failed to respond to an alarm or notice of equipment malfunction. In advance of the discipline at issue here, the Employer offered neither notice or warning, but instead moved to a summary dismissal.

On Saturday, October 10, 2010, the Grievant was scheduled to work alone and did work alone on the 6:00 a.m. to 2:00 p.m. shift. Less than one half hour before his shift was to end, at approximately 1:30 p.m., the Grievant received a single radio notice of a freezer malfunction in the surgery area. At the time of this call he was attending to a contractor who had been called to address a problem with the door to the Hospital's behavioral health ward. Attending to problems with these doors, because of the risk posed by certain psyche ward patients was at the top of the Employer's list of "high profile events" that engineers are to respond to with "utmost diligence." Engineers are expected to partner with contractors, and assist as needed, when attending to high profile maintenance issues.

After receiving the single freezer alert, the Grievant returned to his interaction with the contractor, escorted him out of the building, and simply forgot the call concerning the freezer. The Grievant then clocked out at the usual time and went home. There is no suggestion in the fact record that the Grievant's mistake was intentional or the result of anything other than inadvertence. The Grievant immediately and consistently acknowledged his error. When interviewed on October 23, the Grievant was forthright about his mistake and apologetic.

The Employer fired the Grievant on October 25, 2010. The Employer's corrective action notice cites, as the rationale for summary dismissal, that the Grievant's conduct "put the Hospital at high risk. Because of Dan's actions the content of the freezer had to be tossed."

The freezer had a long history of malfunctioning. Clarence Willman has been 16 years with the Employer as a Maintenance Engineer. He confirmed that the freezer has a long history of problems. Willman has serviced the freezer many times. It had been "banged up" when located in a surgery corridor next to a set of automatic doors. Willman noted that in the late 1990's he had replaced the freezer's compressor and gaskets.

On one occasion, Willman had been called in to work on an emergency basis to repair the freezer. A manager in the surgery area had approved his overtime and had also commanded Willman's maintenance supervisor to give Willman a bottle of scotch for his efforts.

Dan Wietman is the Engineer assigned specifically to attend to surgery equipment and components. Wietman testified that he too had alerted the Employer to the freezer's problems. Three to five years ago it had been taken out of service due to its unreliability, its tendency to lose temperature. Wietman explained that he had spoken with and secured the approval of the Maintenance Manager Hallman to have the freezer rebuilt, but only for the purpose of using it as

a backup. Wietman did not know that the Employer had returned to using the freezer for permanently storing patient tissue.

Wietman testified also that he had spoken to a manager in the Surgery area on three occasions about the problem with the freezer maintaining temperature, while also explaining to her that the freezer was intended and should only be used as a backup while the other reliable freezers were being maintained or repaired.

During the investigation of the Grievant, both Wietman and Willman had reminded Hallman of the freezer's problems and that it should not have been used to store patient tissue. The Employer's Director of Facilities Management Grote acknowledged that in connection with investigation of the Grievant, he had tested that freezer and concluded that it should not have been in service. The Employer then removed it from service and placed it in a warehouse where it now sits. Grote said also that he did not know when the decision to terminate the Grievant had been made.

The Employer has a responsibility to take reasonable steps to minimize risk to the patients. Redundancy in critical alarms better serves patient interests. The Employer's Honeywell system offers that preferable redundancy, unlike the alert sent to the Grievant that originated from the security desk.

Once the alarm is made to the engineer, there is no backup or repetitive alert except on the Honeywell system. Equipment tied into the Employer's Honeywell system is protected by a redundant alarm system. The updated iteration of the Honeywell system sends repetitive alerts to an ever-expanding list of text message recipients until the alarm is responded to.

Willman testified that in 2000 or 2001 he spoke to maintenance manager, Mark Nelson, recommending then that the Employer tie the surgery freezers into the Honeywell redundant alarm system. Even though there was no or little cost associated with this conversion, the Employer neglected to do this until immediately after the Grievant was fired.

The accrediting body for the Hospital, the Joint Commission on Accreditation of Healthcare Organizations, "requires that written procedures shall be developed that specify the action to be taken during the failure of essential equipment..." The Employer identified its Exhibit 2 – the Critical Event Notification Process for Maintenance – as that statement of procedures (along with Exhibit 3). Although dated October 8, 2010, two days before the events that gave rise to the Grievant's termination, the Grievant had never seen and was not aware of that statement of procedures. The first time that the statement of procedures had been distributed to maintenance personnel was in December of 2010, after the Grievant was fired. The Employer asked the bargaining unit engineers then to sign their copy of the procedures to signify that they had received a copy. Willman explained that, on his copy, he noted the discrepancy between the date of the document (October 8, 2010) and the December 2010 date that it was actually distributed for the first time.

The Hospital admitted that the required procedure statement had not been distributed before the Grievant had been fired. Although Employer Exhibit 3 as a component of its

procedure statement offers no specific direction on emergency response, but merely implores “Please use good judgment of who to call and when.”

The Employer has placed at the top of its list of maintenance equipment critical to patient care the fans in its operating rooms. Hallman explained why the proper operation of these fans is critical to patient care. It is a “health/sterility issue,” because the surgery rooms must have proper air exchange. The fans introduce fresh, filtered air during surgical procedures. He noted that the fan alarms, including that for the S-1 fan, are critical alarms because they involve patient care equipment.

Hallman also admitted that there had been problems with the S-1 fan in April of 2010 and that those problems had triggered a “critical event investigation.” Engineer, Clarence Willman, corroborated this. He testified that the S-1 fan had triggered a critical and redundant alarm o which there was no response, by either management or line employees, for thirteen hours. After that time had elapsed, Willman inspected the fan, found a faulty belt and restored its operation. Plainly, nobody before Willman had laid eyes on the errant fan or surely they would have noted first the condition of the belts. Willman learned also from the surgery scheduler and a manager in surgery that multiple patient procedures may have been compromised during the fan’s inoperation. Nonetheless, no discipline issued to any of the multiple recipients of the critical alarm as a result of the Employer’s investigation of this matter.

The Employer’s only attempted rebuttal to the above facts was Hallman’s testimony that he observed three people in the emergency management (EMS) room who may have been looking at computer data which may have been about the S-1 fan problem. He could not confirm, however, who was involved or whether they were in fact looking at the S-1 fan data for this critical alarm event. Hallman did confirm that, as a result of this critical event investigation, there was no discipline issued.

Termination of the Grievant is too severe in view of the substantial mitigating circumstances and the Arbitrator may modify the penalty. An arbitrator has broad authority to modify penalties imposed by employers, even if the contract is silent.

In disciplinary cases generally, therefore, most arbitrators exercise the right to change or modify a penalty if it is found to be improper or too severe, under all the circumstances of the situation. This right is deemed to be inherent in the arbitrator’s power to discipline and in his authority to finally settle and adjust the dispute before him. *The Arbitration Process in the Settlement of Labor Disputes*, 31 J. Am. Jud. Soc’y 54, 58.

Arbitrators have broad discretion to review the reasonableness of the penalty imposed by the Employer in relation to the Employee’s wrongful conduct. The Supreme Court has long established that an arbitrator must “bring his own judgment to bear in order to reach a fair solution of a problem,” which is “especially true when it comes to formulating remedies.” Paperworkers v. Misco, Inc., 484 U.S. 29, 41-42 (1987). The arbitrator must look to see if the grievant is guilty of wrongdoing and if so, whether the cause for discharge is just and equitable and as such, would appeal to reasonable fair-minded persons as warranting discharge. Riley Stoker Corp., 7 LA 764, 767 (Platt, 1947).

The Employer's fault here is overwhelming and grounds for reducing the penalty imposed on the Grievant including neglect of warnings about the faulty freezer. In evaluating penalties, arbitrators may reduce or set aside the penalty when management has "unclean hands" or it is shown that there is "mutual fault." Arbitrators find an employer at fault when management had prior knowledge (S. Frozen Foods, 107 LA 1030 (Giblin, 1996); Ball-Foster Glass Container Co., 106 LA 1209 (Howell, 1996)), when management provided inadequate training to its employees (People Natural Gas, 105 LA 37 (Murphy, 1995)).

The record in this matter is replete with evidence that the Employer had much notice that it was creating risk for its patients by continuing to use a freezer with a known history of maintenance problems for storing patient tissue. At least two maintenance engineers, and the engineer with principal responsibility in the surgery area, had warned the Employer that the freezer at issue was unreliable.

There is much more that clearly establishes the error of the Employer's ways in this freezer fiasco. Wietman reported that more recently than Willman, he had warned the Employer of the freezer's failings. Wietman know that, because of those failings, the freezer had been decommissioned only a few years before the Grievant's firing. It was brought back into service only because Wietman had proposed rebuilding it and for the sole purpose of having a backup. Recalled to rebuilt elements of the Union's case, Hallman did not refute the essential from both Willman and Wietman about the known inadequacy of the freezer, that despite those inadequacies, the Employer had resumed using the freezer for storing patient tissue before it failed, yet again, in October of 2010.

In connection with its investigation concerning the Grievant, the Employer tested the freezer and found it lacking. Grote confirmed this, while Hallman also confirmed that Willman and Weitman had reminded him during the same investigation that they had long found the freezer finicky. It took the Grievant's loss of his job to convince the Hospital to place the freezer where it belonged along ago: in a warehouse, empty, and unplugged.

Arbitrators have often mitigated employer-imposed penalty where the employer's fault consists of failing to take reasonable steps to add redundancy to safety measures. For instance, the Arbitrator in Union Carbide Corp., 110 LA 667, 673 (Caraway, 1998), held that, due to fault attributable to the Employer, discharge of the grievant was too severe. There, the grievant was operating a dock crane when a block fell from the crane's cable nearly hitting other employees. The arbitrator found that employees had made earlier requests for the employer to install a safety device which would have prevented the problem. Because the employer ignored these requests, the Arbitrator held that this fault on the Company's part was grounds for reducing the Grievant's discipline. Similar cases abound where arbitrators ordered reinstatement of the grievant due to the employer's contributing error.

In the present case, the Employer offered no explanation for failing to earlier tie the surgery freezers to its Honeywell Alarm system. The Honeywell system provides redundant, repetitive alarms that continue until the equipment is attended to. Clarence Willman had suggested tying the freezers into the Honeywell system nearly a decade before the Grievant was

fired. The Hospital had the capability to make this adjustment long ago at no cost, but simply neglected to take this simple step. Due to this neglect on the Employer's part, the Grievant received only a single alert on October 10, 2010. When that alert slipped his mind, there was no redundant reminder. His mistake was plainly compounded by the Employer's. This is particularly remarkable where the Employer acknowledged here, through the testimony of both Hallman and Grote, its responsibility to take reasonable steps to minimize patient risk. After the Grievant was fired, Willman said that it took little time and no cost to add the freezers to the Honeywell system as he had suggested a decade earlier.

It is a well-settled arbitral principle that Employer's have an obligation to clearly communicate and disseminate policy for which they expect compliance.

In the case at hand, the Employer failed to communicate either clear policy expectation or clear depiction of penalty that would ensue for violation. To aggravate matters, this particular Employer is governed by accreditation requirements which mandate the dissemination of clear policy concerning the action to be taken upon the failure of essential equipment. Although the Employer produced at hearing a writing of this sort and dated October 8, 2010, the unrefuted evidence revealed that the policy had never been disseminated to the bargaining unit until December of 2010, two months after the Grievant was fired. For his part, the Grievant made clear that, although he understood well his obligation to respond to all problem alerts, he had never seen the Employer's "Critical Event Notification Process for Maintenance" policy which depicts whom to call, when, and under what circumstances. When confronted with this, Hallman confirmed this failure of dissemination, while offering that employees were instead expected to rely on "common sense." This unwritten and unpublished common sense expectation cannot be reconciled with Employer obligation under arbitral law.

The Employer also argues that the absence of clear policy is immaterial where here the Grievant simply lost track of the call he received on October 10. This argument is not based on fact, but only on speculation. And if we are to engage in speculation, isn't as likely that had the Employer clearly communicated and consistently communicated its expectation about how maintenance workers were to respond to equipment failure calls, while also making clear that the penalty for failure would be severe, that the call the Grievant received would not have slipped his mind. Stated another way, isn't it appropriate for the Arbitrator to take arbitral notice that workers are less likely to forget that for which the penalty for forgetting is severe?

Less than six months after firing the Grievant, the Employer conducted another "critical event" investigation involving the failure of the S-1 fan which supplies clean, filtered air to operating rooms in the surgery area. There is no dispute here that the fan failed, that the Employer investigated its failure and then failed to discipline anybody. Nor did the Employer refute Willman's testimony that he studied the fan failure data from that event which revealed that operating rooms were without clean filtered air circulation for thirteen hours, that multiple patient procedures conducted during that period were compromised, that multiple persons, including managers, had received and failed to respond to the S-1 fan alarm.

In an effort to explain this apparent and dramatic inconsistency in the application of discipline, the Employer offered only that Hallman's account suggests that there was response to

S-1 alarm, albeit feeble. Because Hallman could not identify the purported responders or even that they were attending to the S-1 unit, there is little in the way of fact foundation upon which to build such an argument. Not to mention that the failure in response to a fan alarm – an alarm that was active for more than twelve hours involving operating room fans that are critical to patient care – to check the fan’s belts, may fall considerably shy of feeble and, thus, constitute a distinction without a difference.

The juxtaposition here between mode of discipline and work history is stark. Without warning, the Employer fired an employee who hasn’t a single work blemish. Into his sixth year of employment, the Grievant hadn’t been coached, counseled, warned or otherwise disciplined for any infraction of any sort. In formal performance appraisals, the Employer hasn’t noted a single instance where the Grievant failed to meet expectations. And from the narrative commentary on the appraisals the Employer found the Grievant to be honest, hardworking, respectful, and helpful. Surely in the litany of mitigating factors that this case offers for reducing the penalty, this should not go unnoticed.

The irony of this case is palpable. Here an employer fires a good employee for a single moment of inadvertence. Yet, had the Employer not failed to heed multiple warnings the freezer’s unreliability, that it should be used only for backup purposes and that patient care would be best served by tying surgery freezers to the redundant alarm system, the Grievant’s mistake would have passed without consequence.

Had the Hospital disposed of the freezer when first warned of its propensity to fail, there would have been no security desk alert on October 10. Had the Hospital used the freezer only for its intended purpose, occasional backup rather than ongoing storage of patient tissue, there would have been no patient consequence had the Grievant not responded on October 10. Or, had the Hospital understood the significance of applying its repetitive alarm system to surgery freezers when first warned nearly ten years ago, rather than after firing the Grievant, the Grievant’s fleeting moment of forgetfulness – perhaps attributable to distraction would have passed also without consequence to him or to patients.

In the end, the Employer here acted intentionally, made conscious decisions at critical intervals not to heed important warning. The Grievant’s mistake was entirely unintentional. The Employer here had much time and many opportunities to take reasonable steps any one of which would have led to a different outcome on October 10. The Grievant had merely a single instant to react. In this light, the Grievant isn’t without fault, but his fault plainly pales relative to that of the Employer. For this reason and the others addressed above the Union seeks affirmation of the grievance, reinstatement of the Grievant with backpay and restoration of all lost contractual privilege and benefit, subject only to discipline suitable to the infraction.

DISCUSSION AND OPINION

The Employer presents a substantial prima facia case, using the oft-cited seven steps of just cause analysis.¹ The Union offers arguable challenges based on three of these tests’

¹ Koven, A.M. and S. Smith, Just Cause: The Seven Steps, BNA, Washington, DC (1992).

disparate treatment, excessive punishment relative to mitigating factors, and lack of warning as to the penalty for violation of the applicable work rule.

In regard to the defense of disparate treatment the Union cites the April 2010 failure of the S-1 air exchange fan which provides clean, filtered air to operating rooms in the surgery department. There remains no dispute over the facts that:

- The fan was out of commission for about thirteen hours.
- There were some nine surgical procedures performed while the fan was not functioning.
- Redundant alarms were sounded to alert on-duty maintenance personnel to the break down of the fan.
- Maintenance Engineer Willman testified that immediately upon reporting for work he was directed to repair the S-1 fan which by the time had been out of commission for thirteen hours.
- He discovered upon arrival at the job site that the drive belts were off the fan.
- He refitted the fan belts and completed the repairs in about 25 minutes.
- The Hospital could not identify the on-duty maintenance personnel who supposedly responded to the alarm.
- The Hospital attributed the lack of timely repairs, however, to inefficient workmanship.
- No one was disciplined for this failure of effective follow-up on the fan breakdown alarm.

Analysis and Findings: It should be obvious that the risk to patient safety and health resulting from the performance of nine surgical procedures in operating rooms lacking required fresh air circulation and temperature control was potentially greater in the S-1 fan failure incident than in the loss of cooling in the freezer unit for which the Grievant was terminated. It is undisputed that proper operation of such fan is listed as a priority health/security issue critical to patient care because air exchange involving exhausting of “used air” and bringing in fresh filtered air is mandated as a means of controlling infection.

The Hospital insists that maintenance engineering employees did, in fact, respond to and followed up on the redundant alarms from the breakdown of the S-1 fan in April 2010. No alarm logs, no repair performed reports, no direct testimony from any maintenance or other employee on what repairs, if any, had been performed or attempted were submitted by the Hospital, however. The only defense offered by the Employer to the charge of disparate treatment lodged by the Union based of the S-1 fan breakdown incident consists of the vague speculation that the failure to promptly restore the non-operational fan to service must have resulted from inefficient workmanship.

This speculation misses the test of logical deduction by a wide margin. The uncontroverted testimony of Maintenance Engineer Clarence Willman reveals that the failure of the S-1 fan resulted from the power transmission belts having been thrown from the flywheel that turns the fan blades. During the testimony on what specific mechanical breakdowns could possibly have caused the air exchange system to fail, I disclosed that I had been identified through placement tests in the Marine Corps as possessing high mechanical aptitude. I

demonstrated this aptitude by initially serving as a tank mechanic and once virtually built a car from junk yard parts costing \$175 during poverty years in graduate school.

I speak from special competence, therefore, in concluding that no person holding the position of maintenance engineer could conceivably have looked at the S-1 fan with its belts off the flywheel and failed to recognize the obvious cause of the breakdown. I'll describe the sequence of steps any mechanic with the ability to change batteries in a flashlight would follow to restore the S-1 fan to service:

1. Remove the wall section that screens the fan system from accidental damage to hallway traffic.
2. Perform a visual examination of the S-1 fan (which would have immediately shown that the fan belts were off the fly wheel).
3. Manually turn the fly wheel to determine whether a fouled or broken bushing had caused the shaft attached to the fan blades had "frozen."
4. Apply lubricant to both fly wheel shaft and the drive shaft of the electric drive motor.
5. Manually turn the drive shaft to determine whether the backings are undamaged.
6. Power up the drive motor to determine by sound if it seems to be working properly.
7. Loosen tension control on the fly wheel to create enough "play" to reattach fan belts.
8. Attach fan belts – set proper tension on belts to accomplish smooth transfer of power from drive engine to fly wheel.
9. Power up system and check by sight and sound that the air exchange works as required.
10. Log in a repair report on tasks performed and results accomplished.
11. File report with appropriate record keeping source.

These repair steps are so elemental that they have probably been performed by any young person who has ever thrown and replaced the sprocket chain on a bicycle. Logic dictates, therefore, that no employee holding the job of maintenance engineer had followed through on the S-1 fan breakdown in April 2010 until the examination of the mechanism by Maintenance Engineer Willman who promptly restored air exchange to service in less than a half hour.

Based on the foregoing findings of fact, the conclusion must follow that:

1. The Hospital failed to conduct a competent investigation into the S-1 fan failure of April 2010. This failure is illustrated by:
 - Lack of records to identify those who were responsible for the thirteen hour lapse in the air exchange system repair.
 - Lack of any repair log – an essential of equipment maintenance following any mechanical malfunction.
2. Absence of any disciplinary action against any employee on duty at the time who ignored basic steps to identify cause of air exchange mechanism and to follow through with indicated repairs.
 - In fact, if the thirteen hour repair delay resulted from poor workmanship, as the Hospital asserts, the maintenance engineers who could not reattach the fan belts

should be discharged for a level of gross incompetence which could place other critical mechanical systems at substantial risk.

- The payroll records and duty rosters from the two preceding shifts before Willman restored service to the air exchange fan certainly are retrievable items. From these documents plus follow-up interviews it surely was possible for the Employer to determine the names of those maintenance engineers responsible for failing to make the simple repairs needed to restore service over the thirteen hours of the S-1 fan shutdown. It would perplex the credulity of the most gullible to conclude that, despite knowing the time and place of the system shutdown, the Hospital could not have identified the personnel responsible for the thirteen hour delay in making the elemental repair to the S-1 fan mechanism.

The unavoidable conclusion to these findings is that the Employer afforded disparate treatment to the Grievant as compared to those employees guilty of an egregious failure to properly follow through on the redundant alarms sounded in the April 2010 breakdown of the air exchange system in the surgery department. This disparate treatment included the following violations of his contractual rights to procedural just cause:

- The Employer conducted a more rigorous and thorough investigation into the Grievant's neglect of duty than it did into identifying those responsible for the equally, if not more serious, dereliction of duty in the shutdown of its air exchange system in surgery.
- The Hospital's speculation that the thirteen hour shutdown of the S-1 fan mechanism resulted from poor workmanship, if true, warrants discharge of those so lacking in job skills as posing a continuing health/security risk as compared to the Grievant's one time in five years offense.
- The dispositive due process violation of the equal treatment standard, of course, arises from the discharge of the Grievant as compared to no disciplinary action whatsoever against those responsible for the at least equally intolerable risk involved in the unwillingness or inability to effect prompt repairs to the air exchange system in the April 2010 incident.

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The Union's second line of defense opts for a lesser penalty than discharge based on the assertion of Employer negligence as a contributing factor to the consequences of the freezer loss of power. In this regard, the Union contends that the Hospital (1) knew of the freezer's past record of unreliability and ignored advice from its own maintenance staff to use it only as backup, and (2) ignored advice from its staff to bring the freezer on line with its Honeywell redundant alarm system.

Turning to the first prong of the Union's contributory cause argument, it must be noted that law and logic draws a distinction between the initiating cause (or proximate cause), and remote or mediate cause. In practical terms the proximate cause refers to that act or omission without which there would not have been the result at issue, while the remote cause concerns acts or omissions which would have had no independent effect if it not were for the prime or initiating cause.

This distinction often drawn in negligence cases applies in the instant matter to fix responsibility – in the sense of obligation or duty – for the ultimate result of ruined body parts. In this regard, it cannot be denied that the Grievant had a clear duty to fully respond to the freezer alarm by following through to either promptly repair the unit or to arrange for timely removal of the perishable material to a safe repository. He did neither.

By contrast, the Union has not shown that the Hospital had any obligation to guarantee preservation of the autologous materials other than to keep in place a procedure to either provide for prompt repair of a malfunctioning freezer or, in the alternative, the transfer of the perishable parts to safe keeping. The Hospital met its responsibility for guaranteeing one or other of these protective outcomes by putting the alarm system in place and assigning a qualified employee, the Grievant, to carry through on the procedures required to safely secure the necessary outcome.

Analysis now turns to the argument that “but for” the Hospital’s disregard of advice to replace the freezer or to put the freezer alarm on the Honeywell, the loss of the perishables would not have occurred. This proposition ignores the reality that once the Hospital had an entirely satisfactory system installed, one which had never failed in the past, any improvements to the existing set up was purely discretionary. To establish that the Hospital somehow abused its discretionary authority by not improving a time system, the Union would need to show that, among all the monetary demands on the Hospital’s resources, its administrators made a careless or reckless decision not to have moved improvement of its alarm system higher on its list of priorities. No such showing has been made in this matter. In particular, we cannot speculate about what possible tradeoffs the Hospital may have made in deploying its resources among the many competing claims on its resources.

Based on the foregoing findings the Union’s contributory negligence defense is hereby rejected.

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The Union contends further that the Employer violated a basic principle of industrial just cause by failing to give the Grievant clear and certain notice of the discharge penalty for violation of his duty to effectively respond to all problem alerts. The Hospital’s position on this item is that clear warning is included in Exhibit 2 “Critical Event Notification Process,” but more recently by the e-mail, issued some six months before the subject incident, that responding to critical alarms constitute “High Profile Events” which must be responded to with “utmost diligence.”

Analysis and Findings: Was the Grievant timely and clearly on notice that the dereliction of duty he committed would result in his discharge? Examination of the communications issued by the Employer to maintenance engineers whose duties included a full and effective response to a trouble alarm nowhere mentions the penalty of discharge. Indeed, these mention no penalties whatsoever. The notices speak of the need for due diligence and comment on “critical importance” of efficient response but never warn of personal consequence for failure of due diligence in carrying out their response obligations promptly and thoroughly.

Arbitrators sometimes test the effectiveness of warnings for rule violations by simply asking a disciplined employee if he/she was surprised at the penalty imposed. In a large number of instances the answer is “Yes, I had no idea that I was breaking any rule,” or “Yes, I knew it was inappropriate but I never thought this mistake would cost me my job” and similar sentiments. The lesson here is that if the rule is clearly stated, effectively promulgated and sets forth the penalty for its violation, no disciplined employee can be able to truthfully say they did not know the rule and the consequence for its violation. In short, no grievant should be able to express surprise when told they are suspended or discharged for violating a particular work rule.

In the present matter, the Grievant cannot claim that he was unaware of the job requirement that he was responsible for addressing the freezer breakdown alarm. Inspection of the documents presented by the Hospital to support its claim to proper and clear notice, however, shows them to fall far short of meeting this test of procedural just cause. This test of clear notice is surprisingly simple, it merely requires written notification, effectively promulgated that says “If you do X, or fail to do Y, you will be subject to discharge.”

It would be unlikely that the Grievant would have let the freezer alarm “slip my mind,” if he knew such a misstep would put his well paid job on the line, particularly in the currently depressed job market.

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Finally, the Employer argues that the discharge was commensurate with the gravity of the offense. In particular, the Hospital emphasizes the liability risk consequent to the loss of the harvested body parts and the burden on medical personnel to inform patients that, instead of their own natural materials, they would require artificial replacement of skull parts and vertebrae.

The Union concedes that the Grievant’s offense resulted in substantial burden on the Employer and that an appropriately heavy penalty should be issued. Against these admissions, however, the Union pleads for a lesser penalty than discharge on the grounds of several mitigating factors, including:

- Five plus years of not only unblemished but of superior performance and reliability as demonstrated by his performance evaluations and work record.
- His one time slip of memory was obviously related to the time expired between his “10-4” acknowledgement of the alarm and his distraction in monitoring a contractor’s repair of the security mechanism on the “psych ward” closure. His duties required that he give first priority to ensuring that the contractor complete his task and leave the tightly secured area of his assignment.

DECISION

As commonly happens in arbitration hearings, the parties examine and cross examine witness skillfully, present carefully selected exhibits and subsequently submit well argued briefs. The content of all this evidence and argument in most instances, centers on the main issue in contest when disciplinary and discharge cases are the subject. It rarely happens, no matter how exhaustive the presentations, that either party spends any appreciable time or effort to the critical question of remedy.

In the instant case, the parties stand at polar extremes – the Hospital offering absolutely nothing as to remedy, except to call for upholding the discharge decision, which obviates remedy by definition. The Union implies that some penalty less than discharge would be called for but then proceeds to call for a complete make whole remedy. This leaves the Arbitrator between the scylla of the Hospital’s “no remedy” and the Charybdis of the Union’s “complete remedy.”

The parties ought not be surprised that given absolutely no guidance in the record, I choose not to attempt to navigate these perilous waters unaided. Accordingly, the most appealing option is to call upon the parties to present evidence and argument on their respective versions of the appropriate remedy to be granted to the Grievant upon reinstatement. If the parties so choose, I will schedule an executive session for the sole purpose of hearing such evidence and argument the parties wish to have considered in the crafting of the remedy. In the alternative, if jointly chosen, the parties can present their positions in this regard in writing.

I will contact the advocates in a conference call shortly after issuance of the Decision and Award on the merits. If any disagreement remains over convening an executive session on closing the record in writing, it can be resolved in the conference call.

DECISION

1. In light of the foregoing findings which include substantial due process flaws such as:
 - Disparate treatment
 - Inadequate forewarning of the consequences for failing to effectively respond to the freezer alarm.
 - Failure to factor long and meritorious service into the discharge decision including absence of any prior disciplinary action as well as other considerations such as the high priority security duties, he shall be promptly reinstated to duty upon meeting the following conditions.

2. The excuse that the freezer alarm “simply slipped my mind” raises a troubling question suggesting the possibility of some neurogenic memory impairment. To avoid the risk of imposing such an industrial risk on the Hospital, the Grievant is directed to schedule a fitness for duty certification regarding whether his recent memory function falls within the “normal” or acceptable range for men of his age.

3. To avoid any dispute over competency or bias, the attorneys shall jointly select the neurologist from a list of local specialists in memory disorders to conduct the examination and notify the parties of the medical findings. The medical opinion will not be reviewable.
4. Restoration of the Grievant's insurance coverage may not apply to the neurological opinion, in which case the Employer shall compensate the neurologist as part of the make whole remedy.

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This Decision ought not close without some indication of my expectation for the ultimate award on backpay. The list of reasons for reinstatement are listed above. The reasons for an appropriately heavy penalty are now set forth. There can be no dispute over the fact that the Grievant's offense placed the Hospital at substantial risk of civil suit. Even if the Grievant were to be held as acting ultra vires, rather than as an agent for the Hospital, the rightfully prized reputation of the name Abbott Northwestern of Alliana Health System would suffer.

At a minimum, the burden of embarrassment placed on the Hospital's spokesperson who had the unhappy task of notifying patients and their doctors of the destruction of their harvested body parts required the highest level of skill and tact. Further, it should be noted that when the Grievant apparently treated the alarm with so little urgency that it just slipped his mind, he ignored the possibility that even more calamitous damage could have resulted from his offense.

Taking the gravity of his offense into consideration therefore, I must advise the Grievant that the ultimate penalty will fully reflect the consequence to the Employer. In like vein, the many procedural errors committed by the Hospital in handling this and the S-1 fan incident will result in appropriate proportionality in crafting the ultimate award.

June 29, 2011
Date

John J. Flagler, Arbitrator