Shianne Scott

PeaceHealth Southwest Medical Center, 2024 BL 204328, 2024 BNA LA 30

BEFORE SHIANNE SCOTT, ARBITRATOR

IN THE MATTER OF THE ARBITRATION BETWEEN

OREGON FEDERATION OF NURSES AND HEALTH PROFESSIONALS, AFT LOCAL 5017, TECH UNIT, on behalf of A__ (Grievant),

Union

and

PEACEHEALTH SOUTHWEST MEDICAL CENTER,

Employer

ARBITRATION OPINION AND AWARD

Date Issued: May 6, 2024

May 6, 2024

BNA Headnotes

LABOR ARBITRATION

SUMMARY

[1] Discharge – Safety Rules Violation – Warning ►118.659 ►118.303

Arbitrator Shianne Scott ruled that PeaceHealth Southwest Medical Center had just cause to discharge a radiologic technologist who erroneously overexposed a patient to radiation by taking X-rays exams of them immediately after they had been X-rayed by another technologist. Although he admitted his mistake, the grievant—who had already received a written warning two months prior for X-raying 10 patients while possessing an expired state health license—failed to inform his supervisor of the mistake, attempted to cover it up by ordering deletion of the second set of X-rays less than 15 minutes after discovering the mistake, blamed the patient when he was confronted with the error, and harbored no remorse during the course of the investigation. Arbitrator Scott found that comparator evidence showed that the medical center viewed radiation overexposure to be a grave matter, and there wasn't evidence that internal record systems showing that the patient had already been examined were malfunctioning at the time the grievant conducted the second X-ray exam.

APPEARANCES:

On behalf of the Union:

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INTRODUCTION

This Arbitration Opinion and Award (this Award) arises pursuant to the Collective Bargaining Agreement (the CBA) between the Oregon Federation of Nurses and Health Professionals, Local 5017 (the Union), on behalf of A__ (Mr. A__, or the Grievant), and PeaceHealth Southwest Medical Center (the Employer, or PeaceHealth) (collectively, the Parties), under which Shianne Scott was appointed to serve as Arbitrator (the Arbitrator), and under which this Award shall be final and binding amongst these Parties.

THE HEARING

An in-person two (2)-day hearing was held at PeaceHealth in Vancouver, Washington, on January 18, 2024 (Day 1) and March 13, 2024 (Day 2) (collectively, the Hearing). On Day 1, despite the ice and snow that affected the hearing location, both Parties timely arrived and had the full opportunity to examine and cross-examine witnesses, introduce exhibits, make timely objections, and make opening arguments concerning all of the issues in dispute. Eric C. Stuart (Mr. Stuart) represented the Employer at the Hearing and filed the Employer's Post-Hearing Brief. Jordan Barbeau (Ms. Barbeau) represented the Union and the Grievant on Day 1; she also served as the official custodian of record (the Custodian of Record) on Day 1.

Prior to the Hearing on Day 2, the Parties agreed that Shane Youtz (Mr. Youtz) would serve as the Custodian of the Record for Day 2. Mr. Youtz also represented the Union and the Grievant on Day 2 and filed the Union's Post-Hearing Brief. Again, as with Day 1, both Parties had the full opportunity to examine and cross-examine witnesses, make timely objections, and introduce exhibits.

THE PARTIES' STIPULATIONS

At the Hearing, the Parties stipulated:

- The Arbitrator may make an audio recording of Day 1 for her own personal use.
- Employer Exhibits 1 through 14, and 16 and 17, are admitted.
- Union Exhibits 1 through 10 are admitted.
- The Employer has the burden of proof and the burden of production.
- This matter is properly before the Arbitrator and there are no issues as to whether this matter is arbitrable.
- A grievance was not filed over the Grievant's discipline for failing to maintain his license.
- The Parties will submit their Post-Hearing Briefs to the Arbitrator on or before April 3, 2024.
- The Parties will submit their Post-Hearing Briefs to the Arbitrator in both Word and PDF format.
- The Parties will exchange their briefs amongst themselves.
- The Arbitrator shall have thirty (30) days from receipt of the Post-Hearing Briefs to issue the Award.
- Based on statutory**[*2]** requirements in Washington, if the Arbitrator awards a remedy, the Parties agree that any unemployment the Grievant receives will be offset as a mitigating factor.

THE RECORD

A court reporter's transcript of the Hearing was not provided; however, as set forth above, the Parties stipulated that the Arbitrator could make an audio recording of Day 1 for her own personal use. The Employer provided an audio and video recording of Day 2. Unfortunately, the audio/video recording did not include the last portion of Day 2, which included a small portion of the Employer's rebuttal case.

THE WITNESSES

The following witnesses testified under oath at the Hearing:

For the Employer:

1. Maria Leal, Diagnostics Imaging Supervisor
2. Jason White, Diagnostics Imaging Manager
3. Amy Wood, Labor Relations Partner

For the Union:

1. Shawna Lee Ross, Tech Bargaining Chair and Union Stewart/Ultrasound Technician

2. A__, Grievant

THE EXHIBITS

The following exhibits were admitted at the Hearing:

1. Joint Exhibits.

Exhibit Number	Description
J-1	Collective Bargaining Agreement, in effect November 5, 2019 through June 30, 2023
J-2	Grievance dated September 22, 2022 and the Employer's written responses
J-3	Termination Notice dated September 21, 2022
J-4	Corrective Action Notice dated June 15, 2022 — Step 3 Final Written Warning
J-5	Corrective Action Notice dated March 17, 2020 — Step 2 Written Warning

2. Employer Exhibits

Exhibit Number	Description
E-1	PeaceHealth Code of Conduct
E-2	A__ Resume 2017
E-3	X-ray Images by DRM
E-4	X-ray Images by SO MEH
E-6	Image Removal Request Form by SO dated August

Exhibit Number	Description
	15, 2022
E-7	E-mail re: Epic Access Control
E-8	E-mail re PACS foot marked wrong
E-9	Radiation Safety Program
E-10	PeaceHealth Health Record for Legal and Business Purposes Policy
E-11	E-mail re Safe2Share Caregiver Injury Report
E-12	E-mail between A__ and Film Library
E-13	ARRT Standards of Ethics
E-14	Grievant's Written Statement
E-15	Screenshots from PeaceHealth's Safe2Share Website as of 1/24/2024
E-16	E-mail from Maria Leal to Diagnostic Imaging Department re Image Delete Request — Reminder
E-17	Additional Diagnostic Imaging Image Removal Form submitted by Grievant on August 15, 2022
E-18	Corrective Action Notices submitted as Comparator Evidence

3. Union Exhibits.

Exhibit Number	Description
U-1	A__ Past Performance Evaluations
U-2	Request to Remove Prior Corrective Action
U-3	E-mails re Prior Technical and Access Issues
U-4	E-mails re Changes to Image Deletion Process
U-5	Image Removal Forms April 2021 — September 2022
U-6	A__ "My Learning" Report
U-7	Radiology Team Meeting Agendas Jan. 2021-July 2022
U-8	PeaceHealth Safe2Share Electronic Reporting Policy
U-9	PeaceHealth Record for Legal and Business Purposes Policy (duplicate of E-10)
U-10	PeaceHealth Radiation Safety Program (duplicate of E-9)

POST-HEARING MATTERS

As noted above, the Parties stipulated during the Hearing that Post-Hearing Briefs would be submitted on or before April**[*3]** 3, 2024. However, on March 26, 2024, the Employer's counsel notified the Arbitrator that the Parties mutually agreed to extend the date to April 12, 2024. On April 12, 2024, both Parties timely submitted their Post-Hearing Brief to the Arbitrator in PDF and Word format as requested. The record was then closed. This Award is timely issued.

THE ISSUES TO BE DECIDED

The Employer asserts that the issues to be decided are:

> Whether A__ was discharged for just cause [sic], if not, what shall be the remedy?[1]

Conversely, the Union asserts that the Parties stipulated that the issues to be decided are:

> Does reasonable cause exist for the discharge of A__? If not, what is the appropriate remedy?[2]

According to the undersigned's audio recording, the Union proposed that an issue to be decided on Day 1 is whether the Grievant was discharged for "just cause." The Employer stipulated to that issue. I note that Mr. Youtz was not present on Day 1; this likely explains the very small discrepancy between the Parties' statement of the issues. Based only on the audio recording and her copious notes from Day 1, the Arbitrator adopts the Employer's statement of the issues to be decided.

RELEVANT AGREEMENT PROVISIONS

The Employer and the Union are Parties to a Collective Bargaining Agreement (the CBA), in effect, from November 5, 2019, to June 30, 2023, which contains the following relevant articles:

ARTICLE 6

EMPLOYER RIGHTS

> The union recognizes the Employer's right to operate and manage its business and facilities. Except where limited by a specific provision of this Agreement, all rights are subject to the Employer's exclusive control. These rights include but are not limited to the following: to determine the number of employees to be employed in each operation, shift, or department; to establish, change, modify, interpret or abolish the Employer's policies and procedures; to increase or diminish, change, improve or discontinue operations, programs and jobs, in whole or in part; to increase or diminish, change, improve or discontinue personnel, in whole or in part; to hire, promote, and transfer employees; to suspend, discharge, demote and discipline employees for just cause;
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> ***

ARTICLE 8

DISCIPLINE AND DISCHARGE

> **8.1 Discipline and Discharge:**
>
> **8.1.1** No employee shall be disciplined or discharged without just cause.
>
> **8.1.2** The Employer agrees that progressive discipline should apply to those cases where the employee's conduct or performance does not warrant a more severe level of discipline, including immediate discharge.
>
> ***

8.1.7 The Employer will provide an affected employee with a copy of any written disciplinary notice. The employee shall sign the notice only to acknowledge receipt, and the employee's signature shall not constitute agreement with the disciplinary action or an admission of guilt.

8.2 Progressive Discipline. Written disciplinary notices will not be considered after two (2) years if there have**[*4]** been no further disciplinary occurrences during that two-year period, with the following exceptions: (1) violation of the Employer's non-discrimination policies, including sexual harassment; (2) conduct threatening or endangering patient safety; (3) coworker abuse issues or; (4) theft or falsifying records, or (5) unlawful breach of confidentiality or other privacy. Such disciplinary notices shall remain in effect for a maximum of three (3) years for purposes of progressive discipline.

8.3 Removal from File. Upon request of an employee, written disciplinary notices will be removed from the personnel file on the applicable timeline.

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ARTICLE 9

GRIEVANCE PROCEDURE

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9.3.4 Step 4. If the grievance is not resolved at Step 3, the Union may no later than 14 days after receiving the Employer's Step 3 response, notify the Employer of the Union's intent to submit the matter to arbitration. By mutual agreement, the parties may request the services of a mediator by submitting the dispute to the Federal Mediation and Conciliation Service prior selecting an arbitrator. If the parties do not pursue mediation or the dispute is no [sic] resolved in mediation, the parties will within 14 days of the conclusion of mediation or notification to proceed to arbitration, seek to select a disinterested party to serve as an arbitrator. If the Employer and the Union are unable to agree upon an arbitrator, then the arbitrator will be selected by process of elimination from a panel of five arbitrators furnished by the Federal Mediation and Conciliation Service. The arbitrator will render a decision as promptly as possible after the date of case presentation. The decision of the arbitrator will be final and binding on the Employer, the Union, and the employee(s).

9.4 The Arbitrator. The arbitrator will have no authority to change, modify, subtract from or add to the provisions of this Agreement. Instead, the arbitrator will have authority only to apply and interpret the provisions of this Agreement in reaching a decision. The arbitrator's fee and expenses will be borne equally by the parties. All other expenses, including attorney's fees, will be borne by the party incurring those expenses.

OTHER RELEVANT PROVISIONS

The following Employer's rules and policies, the Washington Administrative Codes (the WACs), and the American Registry of Radiologic Technologists (the AART) Standards of Ethics are also relevant to this Award:

A. The Employer's Rules and Policies.

1. PeaceHealth's Code of Conduct. The PeaceHealth Code of Conduct (the Code of Conduct), effective on April 29, 2022, is applicable to all PeaceHealth Vancouver employees. The Code of Conduct provides, in relevant part:

> PeaceHealth is called to create a safe, ethical workplace built upon a commitment to integrity and honesty amongst our caregivers, providers, patients, and community partners. In support of our commitment,**[*5]** PeaceHealth requires every caregiver to follow our policies and procedures. They represent expectations about our conduct and encourage us to do the right thing. They protect Peace Health and our patients, and you-our caregivers-and demonstrate our commitment to the highest ethical standards and to each other.
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> ***
>
> **Caregiver Responsibilities.**
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> Compliance begins with you. All caregivers have a vital role in shaping our culture at PeaceHealth and are responsible to:
>
> ▪ Comply with the requirements and related policies that impact your daily work
>
> ***
>
> ▪ Communicate in an honest, ethical and forthright manner
>
> ▪ Adhere to the ethical and professional standards of any license or certification you hold
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> ***
>
> **Enforcing Disciplinary Standards**
>
> At PeaceHealth, violating our Code of Conduct represents a breach of trust-the trust that our patients and communities place in us, and the trust we place in each other to make decisions that honor our shared Values.
>
> Caregivers are expected and required to comply with PeaceHealth's Code of Conduct. Violations will be investigated on a case-by-case basis, which may result in disciplinary action, up to and including termination.
>
> ***

Safe2Share

Safe2Share is PeaceHealth's systemwide, patient health reporting solution. Safe2Share provides a system for caregivers to report patient, caregiver or visitor safety concerns, events or injuries.

There are two ways to make a Safe2Share report:

■ Crossroads > *Report Incident* and click on *Patient/Visitor/Caregiver/Variance*, or;

■ From the Learning Home Dashboard in CareConnect. Log into Safe2Share using your 3x3 and password OR anonymously to submit a report. If you have any questions or need assistance with the Safe2Share tool, contact our Service Desk at **Ext. 6464**, or **1-800-452-1425**.

Safe2Share helps us* to *provide* 100% *Perfect Care, Zero Harm-every time, every touch-to the patients we are called* to *serve.[3]

2. PeaceHealth's Radiation Safety Program. PeaceHealth's Radiation Safety Program, effective on June 10, 2021, applies to the Diagnostic Imaging Department at PeaceHealth Vancouver. It provides, in relevant part:

SCOPE

Applies to all PeaceHealth Southwest Medical Center (SWMC) departments that have potential exposure to radioactive materials or radiation producing devices.

PURPOSE

To identify the program and practices implemented to ensure safe use of radioactive materials.

DEFINITIONS

• **ALARA:** As low as is reasonably achievable.

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POLICY

PeaceHealth Southwest Medical Center (SWMC) is required to use, as a condition of its Radioactive Materials License to use, to the extent practicable, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are as low as is reasonably achievable (ALARA).

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3. Staff notes and reports deviations from accepted radiation practices.

3. PeaceHealth Health Record for Legal and Business[*6] Purposes. The Employer's Health Record for Legal and Business Purposes Policy, in effect October 21, 2020, provides, in relevant part:

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> The legal health record is the record that is released upon verification of valid and acceptable request. The legal health record does not affect the discoverability of other information held by the organization.

4. The Safe2Share Electronic Reporting Policy. The Employer's Safe2Share Electronic Reporting Policy, effective on July 2, 2022 (the Safe2Share Policy), applies to all employees at PeaceHealth. It provides, in relevant part:

> **PURPOSE**
>
> The purpose of this policy is to establish requirements for the use of Safe2Share reporting, as an important Patient Safety, Risk Management Programs that work to improve the health services to prevent patient harm.
>
> ***
>
> **POLICY**
>
> It is the policy of PeaceHealth that caregivers and credentialed providers complete a Safe2Share report under the following circumstances:
>
> • Upon any occurrence or event that involves a) an unsafe condition, b) an unanticipated outcome with respect to a patient care, c) a potential or actual unexpected or adverse outcome, or posing a risk to health care operations or the organization.
>
> ***
>
> • An occurrence concerning medical staff or caregiver behavior that may, or does, adversely impact patient care.
>
> ***
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> • The purpose of Safe2Share is to report, document, and respond to Serious Safety Events, Close Calls, incidents, and other occurrences. Safe2Share is intended to help prevent harm by capturing potential or actual issues that could lead to caregiver or patient injury, analyze the information, and mitigate to help prevent the risk of re-occurrence. Variance reporting provides for documentation of variations in processes or practices.
>
> • The purpose of Safe2Share Feedback reporting is to report, document, and respond to patient complaints and grievances.
>
> ***

DEFINITIONS

• **Caregiver:** An employee of PeaceHealth, including credentialed providers.

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• **Harm:** Physical or psychological injury or damage, excluding injury or damage directly due to the Patient's illness or underlying condition.

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• **Variance:** An event, occurrence, incident, or any unanticipated condition, circumstance, or outcome that is not consistent with the routine processes or care of a patient and/or routine operation of the facility. A "variance" may be a potential or actual serious adverse preventable event or occurrence that involves a patient, visitor, caregiver, volunteer, student, or credentialed provider.

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2. Safe2Share Confidentiality

a. Safe2Share files are confidential and privileged, and are protected from discovery for the purposes of litigation under law.

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3. Safe2Share Workflow

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c. Safe2Share files are routed on a "need to know" basis and may not be distributed beyond the immediately-involved departments, medical staff office or administrators.

4. Required Reporting and Actions

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2. No retaliatory or disciplinary action is taken against any individual(s)**[*7]** who completes and submits a factual event report in good faith unless mandated by law or after a thorough and objective investigation verifies unprofessional conduct or practices as described below[.]

B. The WACs. The WACs, at Section 246-221-090 provide, in pertinent part:

Each licensee or registrant shall monitor occupational exposure from sources of radiation at levels sufficient to demonstrate compliance with the occupational dose limits of WAC 246-221-010 , 246-221-030 , 246-221-050 and 246-221-055 .

(1) Each licensee or registrant shall monitor occupational exposure to radiation from licensed (or registered) and unlicensed (or unregistered) radiation sources under the control of the licensee or registrant and shall supply and shall require the use of individual monitoring devices by:

(a) Each adult likely to receive, in one year from sources external to the body, a dose in excess of 10 percent of the applicable limits specified in WAC 246-221-010 (1).

C. The AART Standards of Ethics. Lastly, the AART Standards of Ethics, revised on September 1, 2021, provide:

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Failure to Report Error

22. Failing to immediately report to the Certificate Holder's or Candidate's supervisor information concerning an error made in connection with imaging, treating, or caring for a patient. For purposes of this rule, errors include any departure from the standard of care that reasonably may be considered potentially harmful, unethical, or improper (commission). Errors also include behavior that is negligent or should not have occurred in connection with a patient's care, but did not (omission). The duty to report under this rule exists whether or not the patient suffered any injury.

FINDINGS OF FACT

After a thorough review and careful consideration of the testimony and documentary evidence presented by the Parties, I make the following Findings of Fact.

The Parties

PeaceHealth Southwest Medical Center (the Employer, or PeaceHealth), provides healthcare services to the community in and around Vancouver, Washington. The Oregon Federation of Nurses & Health Professionals, AFT Local 5017 (the Union) is the exclusive bargaining representative for all bargaining unit members covered by the CBA; this includes radiologic technologists.[4]
A__ (Mr. A__, or the Grievant) was employed by the Employer in the Diagnostic Imaging Department (the Department) as a licensed Radiologic Technologist, from September 18, 2017, through his discharge date, September 21, 2022. This Award concerns the Union's grievance over Mr. A__'s discharge for an incident that occurred while Mr. A__ was on duty on August 15, 2022 (the Final Incident). As of the Final Incident, Mr. A__ worked on the night shift, from 7:00 P.M. to 7:30 A.M., three (3) days a week, and reported to Diagnostic Imaging Supervisor Maria Leal. Ms. Leal reports to Jason White, the Diagnostic Imaging Manager. Mr. White began working for the Employer in May 2022,**[*8]** approximately four (4) months before Mr. A__'s termination. Both Ms. Leal and Mr. White appear to be imminently qualified for their jobs.

The Grievant's Education, Employment Background, Job Duties and Licensing Requirements

Mr. A__ holds a four (4)-year degree in Psychology and a two (2)-year degree in Radiological Technology. Mr. A__'s resume, submitted to the Employer during the interview process, states:

Committed to providing quality and safe imaging for patients by obtaining diagnostic images the first time while applying the lowest radiation dose possible.

Mr. A__ testified that his primary job duties at PeaceHealth were to perform X-rays on patients in accordance with a physician's order, "to the best of my ability," and that he was also required to do his "best" to ensure patient safety. Mr. A__ further testified that he was required to follow procedures to stay in compliance with cleanliness and safety protocols within the Department. I believed Mr. A__'s testimony in that regard.
Mr. A__ was licensed to X-ray patients through the AART, and through the Washington Department of Health. Mr. A__ knew and understood that he must keep his license current in order to safely X-ray patients; Mr. A__ further knew and understood that he is responsible for adhering to the AART's Standard of Ethics and the Washington State licensing requirements. Those requirements include, but are not limited to, "reporting an error made in connection with imaging, treating, or caring for a patient." During his testimony, Mr. A__ acknowledged that he was required under the AART to report to his supervisor "any information concerning an error made in connection with imaging, treating, or caring for a patient." Based on the overall record, Mr. A__ was also imminently qualified for his job at PeaceHealth.

The Grievant's Training History

Upon hire, the Employer provided extensive training to Mr. A__, as evidenced by Mr. A__'s "My Learning Report." The trainings applicable to this Award include, among other things, the Code of Conduct, the Radiation Safety Policy, and the Safe2Share Policy.
Mr. A__ received training on the Code of Conduct in every year of his employment, from 2017 through 2022. The Code of Conduct specifies:

> Safe2Share is PeaceHealth's systemwide, patient health reporting solution. Safe2Share provides a system for caregivers to report patient, caregiver or visitor safety concerns, events or injuries.
>
> There are two ways to make a Safe2Share report:
>
> ■ Crossroads > *Report Incident* and click on *Patient/Visitor/Caregiver/Variance*, or;
>
> ■ From the Learning Home Dashboard in CareConnect. Log into Safe2Share using your 3x3 and password OR anonymously to submit a report. If you have any questions or need assistance with the Safe2Share tool, contact our Service Desk at **Ext. 6464**, or **1-800-452-1425**.
>
> ***Safe2Share helps us* to *provide* 100% *Perfect Care, Zero Harm-every time, every touch-to the patients we are called* to *serve***.[5]

Mr. A__ also received a considerable**[*9]** amount of training on the Radiation Safety Policy. The Radiation Safety Policy provides that employees should only expose a patient to radiation in an amount that constitutes "ALARA," which stands for "As Low As Reasonably Achievable." Ms. Leal credibility testified that the reason for the ALARA principle is: "Basically, any radiation that one obtains is a lifetime dose, so that stays with the patient." The Radiation Safety Policy requires employees to "report deviations from accepted radiation practices." An overexposure of radiation is considered a "deviation" from radiation practices. Union Stewart Shawna Lee Ross, an Ultrasound Technician, credibly testified that she, also, is trained on the ALARA principle.

Mr. A__ received video trainings on the Safe2Share Policy at least twice; first on February 5, 2019, and second; on September 7, 2020. While there is no direct evidence of the content of those videos, Mr. A__ most likely received a copy of the Safe2Share Policy during those trainings. The most recent version of the Safe2Share Policy was in effect on July 2, 2022, about a month and a half before the Final Incident. More likely than not, Mr. A__ received a copy of the most recent Safe2Share Policy, or at least had access to the Safe2Share Policy. The Safe2Share Policy specifies that a Safe2Share report should be made when:

> • An occurrence concerning medical staff or caregiver behavior that may, or does, adversely impact patient care.

The Safe2Share Policy also provides:

> No retaliatory or disciplinary action is taken against any individual(s) who completes and submits a factual event report in good faith unless mandated by law...

At the Hearing, Mr. White credibly testified that a Safe2Share report can be made on the Safe2Share website on the Employer's "Intranet" (the Intranet). Mr. White also testified that the Intranet can be accessed by any employee at workstations throughout PeaceHealth, and specifically, if a radiologist technologist needed to report anything, the technologist could click the button that says "Diagnostic Imaging Radiation" at the top right corner of the Safe2Share website, which would send the report directly to the Department. Mr. A__ utilized the Safe2Share website to report a potential workplace injury on March 21, 2021, about sixteen (16) months before the Final Incident.

Based on the overall record, Mr. A__ knew and understood he must provide "quality and safe imaging for patients by obtaining diagnostic images the first time while applying the lowest radiation dose possible." As more fully addressed below, Mr. A__ knew and understood that he should report an "error" when an error occurs, especially when the error concerns any potential harm to a patient. A "report" could include, but is not limited to, a Safe2Share Report,**[*10]** or an e-mail report to Mr. A__'s supervisor, manager, or the Chain of Command, as credibly testified to by Mr. White. As of the Final Incident, in addition to Ms. Leal and Mr. White, the Chain of Command included, but was not limited, to Todd Russell, the Department's former Director, and Gary Foster, the Chief Executive Officer of PeaceHealth.

The Grievant's Work Performance

Mr. A__'s performance reviews are part of the record. On his most recent performance review, for the period July 1, 2020, through June 30, 2021, Ms. Leal noted that, as a night shift technologist, Mr. A__ "can be counted on for maintaining a good working relationship with ED staff."[6] Ms. Leal assessed Mr. A__'s overall performance as "in alignment with patient safety and clinical excellence." Ms. Leal also noted: "I appreciate that [Mr. A__] is open to giving and receiving feedback for improvement." Again, as

more fully addressed below, Mr. A__ was good about communicating with Ms. Leal and others, both within his Department, and in the Chain of Command whenever he believed patient care could be affected. Nothing in the record suggests that Mr. A__ exhibited poor work performance prior to the Final Incident.

The Grievant's Disciplinary History

1. The March 17, 2020, Step 3, Written Warning

On March 17, 2020, the Employer issued a Step 3 Written Warning to Mr. A__ for "inaccurate attestation of time." The Union filed a grievance over the Step 3 Written Warning. At the grievance meeting, someone on behalf of the Union stated: "This was simply an error." The undersigned has no reason to disbelieve the Union's position that this was "simply an error," particularly because the Employer ultimately agreed to reduce Mr. A__'s discipline to a Step 2 Written Warning. The reduced Step 2 Written Warning, issued on July 22, 2020, states that the warning is for "[f]ailure to keep accurate timecard records."

On August 14, 2022, Mr. A__ requested that the July 22, 2020, Step 2 Written Warning be removed from his personnel file pursuant to the CBA at Article 8, Section 8.2. The Employer denied Mr. A__'s request, stating that the discipline could not be removed "per your falsification of records." The Step 2 Written Warning should have been removed in accordance with the CBA, as there is no *evidence* that Mr. A__ received discipline for "falsification of records."

2. The June 15, 2022, Step 3 Final Written Warning

On June 15, 2022, the Employer issued a Step 3 Written Warning to Mr. A__ for failing to renew his Washington Department of Health License prior to the expiration date, and for X-raying ten (10) patients without a license. At the Hearing, Mr. White credibly testified that a lapse in license "is a serious offense in and of itself." Amy Wood, Labor Relations Partner, also credibly testified that when she was advising the Employer on the level of discipline to issue to Mr. A__**[*11]** concerning the Final Incident, "the important piece" was that Mr. A__ was at a Step 3 Final Written Warning when the Final Incident occurred.

The Union did not file a grievance over the Step 3 Written Warning. As credibly testified to by Ms. Ross, if discipline is not grieved, "it is the grievant's decision." Further, if a discipline is not grieved, Ms. Ross acknowledged that "the discipline stands." Nothing in the record suggests that any testimony by Ms. Ross was inaccurate.

The X-Ray Image Removal Process

X-ray images are considered "diagnostic." Ms. Leal credibly testified that "diagnostic" images means that the radiologist technologist has properly performed the X-ray image(s) per the physician's order. Following the radiologist technologist's submission of X-ray image(s) in the Employer's computer system, the physician reviews the X-ray(s) and provides a report to the patient that addresses the unique images displayed in the X-ray(s). For this reason, X-ray images are part of a patient's legal medical record unless the X-ray image is deleted from the Employer's system.

As a licensed radiologic technologist, Mr. A__ had authority to determine whether an X-ray image should be deleted from the Employer's server because the image was "not diagnostic." For example, it would be

proper to delete an X-ray image if it is mistakenly taken at the wrong angle and therefore not diagnostic. As of the Final Incident, the film library had authority to carry out a radiologic technologist's request to delete an image; however, the library did not determine whether it is proper to do so; that decision was left to Mr. A__ and the other licensed radiologic technologists.

As credibly testified to by Ms. Leal, once an image is deleted, it is placed in an out-PACS[7] server to be queued for deletion. In essence, as credibly testified to by Mr. White, "the garbage is not off the curb yet; it's not picked up yet; but it is sitting there waiting to be deleted." Typically, deleted images stay on the out-PACS server for approximately thirteen (13) months before they are permanently deleted.

Initially, the Employer merely required Mr. A__ and other radiological technologists to create an online ticket in order to have an X-ray image deleted. However, on or about January 4, 2021, the Employer changed its policy "due to a Caregiver complaint about deleting images that are part of the patient medical record." The complaint was submitted to the legal department; for this reason, the Employer took the complaint very seriously and changed its policy.

From and after January 4, 2021, the Employer required radiological technologists to complete a "Diagnostic Imaging Image Removal Form" (Image Removal Form) and submit the form to the film library before an X-ray could be deleted. In December 2020, shortly before implementing the new policy, Ms. Leal reminded radiological technologists that they needed to "state the reason**[*12]** for the request" on the Image Removal Form because the library would not be able to delete the requested image(s) "without being provided a reason." Ms. Leal credibly testified that Mr. A__ expressed displeasure with the new image removal process.

On January 27, 2021, Diane White, PACS/RIS Analyst, provided further instructions on how to complete the Image Removal Form. Ms. Leal sent a follow-up e-mail to the Department on February 4, 2021 with step-by-step instructions on how to complete the Image Deletion Form. Ms. Leal sent an e-mail to Mr. A__ the next day, February 5, 2021, "with further information" on how to complete an Image Delete Form. The Employer also covered the new Image Removal Form process in Radiology Staff Meetings on January 22, 2021, July 15, 2021, and May 24, 2022. During the January 22, 2021 staff meeting, the Employer specified:

> Reminder- please make sure to provide as much detail as necessary regarding your request. Example: "Wrong image" - the question being "why is the image wrong?"

On April 18, 2022, Ms. Leal sent another e-mail to everyone in the Department, reminding that an Image Removal Form must be completed "to maintain compliance with the tracking of any removal of images from a patient's study." As set forth below, Mr. A__ complained about the Image Delete Form process around the same time that Ms. Leal sent her April 18, 2022, e-mail.

The Employer randomly audits Image Removal Forms. Based on the overall record, there is no rule as to when, or how often, those forms are audited. As credibly testified to by Mr. White, the Employer's expectation is that radiological technologists should report "any concern" about patient care, including an X-ray error, to the Department's supervisor, either by sending an e-mail, or by filing a Safe2Share report. At the Hearing and on its Post-Hearing Brief, the Union disputed that Mr. A__ knew or should have known that he should have sent a Safe2Share report following the Final Incident.[8] I will address that issue in detail below.

Mr. A__'s E-mail Communications with the Department

Based on the overall record, prior to the Final Incident, Mr. A__ complied with the Employer's expectation to report "any concern" about patient care or about an X-ray error to his supervisor and others in the Chain of Command. For example, on March 23, 2021, Mr. A__ e-mailed Ms. Leal concerning a wrong order label placed on a patient's foot.

On April 5, 2022, Mr. A__ e-mailed everyone in the Department, including Ms. Leal, Mr. Russell, and copied Mr. Foster. The subject of the e-mail is "Ridiculous Deletion Protocol." Mr. A__ complained that one of the workstations in the Emergency Department was not working and that the film library had not deleted an X-ray as requested. Mr. A__ indicated that he should have the ability to delete an X-ray if he makes a mistake. The film library advised Mr. A__ that it could not locate**[*13]** the Image Delete Form, so the library had no way of knowing "what images need to be removed." In pertinent part, Mr. A__'s April 5, 2022, e-mail states:

> As professionals we do our best due diligence to be sure that our exams are ended correctly, accurately and without error. However, *we are humans, not machines, we occasionally make errors and need to correct them* (emphasis added).

I agree with Mr. A__'s statement that "we are humans, not machines."

In response to Mr. A__'s April 5, 2022, e-mail, Mr. Russell explained in detail the reason why the Image Deletion Form process was put in place. Mr. Russell also informed Mr. A__ that, while he understood Mr. A__'s frustration, Mr. A__ should have completed an Image Removal Form per the "implemented process."

There are other examples of Mr. A__'s ability to communicate with his superiors, such as where Mr. A__ complains repeatedly about the Employer's computer systems not working properly. Mr. A__ also provided credible testimony about his frustrations about the computer systems. I could certainly understand Mr. A__'s frustration. That said, I did not find Mr. A__'s testimony about his frustrations and problems with the Employer's computer systems to be relevant to the Final Incident, because Ms. Leal confirmed there were *no problems* with the computer systems at issue during the Final Incident.

As a final example, on June 27, 2022, Mr. A__ e-mailed the entire Department, Ms. Leal, Mr. White, Mr. Russell and Mr. Foster, to report that an X-ray examination mistakenly ended early and he had no ability to fix the mistake. Mr. A__ stated: "Mistakes happen [sic] we are humans not robots." Again, I agree with Mr. A__ that, "mistakes happen." I also agree with Mr. White's credible testimony that mistakes happen, but the Employer needs to know about the mistakes to correct them.

The Final Incident

On Monday, August 15, 2022, Mr. A__ reported to work as scheduled. A student intern, Melisa[9] Hua, was "shadowing" Mr. A__ on that date. Mr. A__ first checked in with the Lead on duty, Heather Stein, to find out what X-ray exams needed to be performed. Ms. Stein asked Mr. A__ to complete some "portable exams," which required Mr. A__ to go to patients' rooms to perform X-ray exams. Mr. A__ testified at the Hearing and during the investigation that he was "rushing" throughout his shift on August 15, 2022, because of the amount of patients that needed X-rays that night. I do not doubt that testimony.

Ms. Stein was not in the Department when Mr. A__ returned from performing the portable exams. More likely than not, Ms. Stein was not present because she normally left work at 7:30 P.M., thirty (30)

minutes after Mr. A__'s night shift started. Upon his return, Mr. A__ separated out the printed X-ray orders into three (3) stacks: portables, triage in the Employment Department, and patients already admitted in the Emergency Department. Mr. A__'s coworker, Danielle Muller, took the portable orders; Mr. A__ took the triage orders.

One of the triage**[*14]** orders included a patient with the initials "M.C" (the Patient). Ms. Hua informed Mr. A__ that she could not locate the Patient on the patient worklist. Mr. A__ opened EPIC (one of the Employer's patient records systems) to view the Patient's charting file, and noted that the Patient's file for the current X-ray order had not been opened in EPIC.

At the Hearing, the Employer established through its "audit trail" (the Audit Trail) that Mr. A__ could not see an open file for the Patient in EPIC because Ms. Muller completed the order in EPIC without first opening a patient file. Ms. Leal credibly testified that, while Ms. Muller's failure to open the file in EPIC was not "good work flow," Ms. Muller's actions were "not something the Employer would issue corrective action for." Ms. Leal also credibly testified that EPIC and PACS are "basically interchangeable."

The Employer's Audit Trial shows that Ms. Stein made an X-ray appointment for the Patient at 7:06 P.M. The Audit Trial also establishes that Ms. Muller's X-ray images were available to view in the PACS system at 7:54 P.M., and in fact, the X-ray images were admitted. Ms. Muller's initials, "DRM," were time-stamped at 7:54:53 P.M.

At the Hearing and during the investigative interview, Mr. A__ testified that in addition to looking at EPIC, he also looked in PACS to ensure the patient had not already been imaged. Unfortunately, though I really wanted to believe Mr. A__, I did not believe that testimony, as the Employer's records establish that Mr. A__ did not check the PACS system before imaging the Patient, and, as addressed below, Ms. Hua reported that she did not see Mr. A__ check the system before X-raying the patient. In any event, Mr. A__ correctly performed two (2) X-ray images of the Patient in accordance with the doctor's order. The record shows that both Mr. A__'s initials, "SO" and Ms. Hua's initials, "MEH," were on the X-ray images, time-stamped at 8:10:13 P.M. Mr. A__ did not close out the exam in EPIC until 8:48 P.M., twenty (20) minutes after Mr. A__ submitted an Image Delete Form to have the X-rays deleted.

After imaging the Patient, Mr. A__ demonstrated to Ms. Hua how to manually enter the X-ray images into the system. The record is unclear which system (PACS or EPIC) Mr. A__ was showing Ms. Hua. What is clear is that after Mr. A__ completed the exam, Mr. A__ told his coworker, Michael "Todd" Rightmire (Mr. Rightmire), that he was not sure why he could not find the Patient in the system. Trying to be helpful, Mr. Rightmire reviewed the PACS system and informed Mr. A__ that the Patient had already been imaged by Ms. Muller. At that point, Mr. A__ realized he overexposed the patient to radiation. Put simply, the overexposure did not meet the ALARA standard. Mr. A__'s face turned red and he began "cursing." It is unclear from the record what words Mr. A__ used when he was "cursing," but I find that evidence to be credible.

Upon realizing his error, Mr. A__ told Ms. Muller "not**[*15]** to touch the exam." At the Hearing, Mr. A__ admitted that he was "100% responsible" for the Patient's X-rays, and that being "busy" is not an excuse for radiation overexposure. Mr. A__ also acknowledged under oath that the "overexposure" of the Patient was "unfortunate."

The Employer's records establish that at 8:25 P.M., Mr. A__ submitted an Image Delete Form to request that the X-ray images of the Patient be deleted. In the section of the Image Delete Form that asked for the "Reason for image adjudgment form," Mr. A__ wrote: "Image needs to be deleted." This did not conform with the Employer's expectation that Mr. A__ should provide "as much detail as necessary." Mr. A__ acknowledged at the Hearing that the Image Delete Form "was poor work on my part." An

employee in the library completed the deletion process at 8:30 P.M., before Mr. A__ closed out the exam at 8:48 P.M.

Mr. A__ did not report the Final Incident to Ms. Leal or anyone else within the Department. Mr. A__ did not report the Final Incident to the Chain of Command. Mr. A__ did not submit a Safe2Share report. Mr. A__ testified that he believed he complied with the Employer's expectations to report an error, because Ms. Leal's name was on the Image Delete Form. I did not believe that testimony, especially given the fact that the Employer only randomly reviews Image Delete Forms. Mr. A__ never admitted, either at the Hearing, or during the investigation, that he knew, or should have known, he should have reported the Final Incident, either via an e-mail, or via a Safe2Share Report.

On the same date (August 15, 2022), Mr. A__ submitted a second Image Delete Form. This time, Mr. A__ described the reason for the image adjustment: "Image needs to be deleted, not diagnostic." It is unclear from the record whether that second Image Delete Form was submitted before, or after, the Image Delete Form he sent concerning the Patient. In any event, more likely than not, Mr. A__ did not receive any discipline because of the second Image Delete Form, because it specified that the X-ray should be deleted because it was "not diagnostic."

Ms. Hua Reports the Final Incident to Ms. Leal

On Friday, August 19, 2022, Ms. Hua reported the Final Incident to Ms. Leal. Ms. Leal credibly testified that she would not have known anything about the Final Incident if Ms. Hua had not reported the Final Incident. Ms. Leal further credibly testified that when Ms. Hua made the report, Ms. Hua's concerns were multiple; they included the fact that Mr. A__ had been working "quickly;" that she did not see Mr. A__ "check to see if the X-ray had already occurred;" that Mr. A__ cursed and his face turned red once he discovered he had overexposed radiation to the Patient; that Ms. Hua's initials were on the X-rays, and that she (Ms. Hua) was concerned that she would be "in trouble" because her initials were**[*16]** on the X-rays. Ms. Hua's report that she did not see Mr. A__ "check to see if the X-ray had already occurred" is buttressed by the Employer's documentation showing that Mr. A__ did not check PACS before imaging the Patient.

Unfortunately, Ms. Hua no longer worked for PeaceHealth as of the Hearing and the Employer did not have the means or capacity to call Ms. Hua as a witness. While the rules of evidence (State or Federal) are more relaxed in an arbitration, the burden of proof remains the same *as if* the hearing is held before a judge in State or Federal court. In that regard, the Arbitrator generally relies on the Federal Rules of Evidence (FRE) as a guideline, and for consistency reasons. While Ms. Leal's testimony concerning Ms. Hua's report could be considered hearsay, more likely than not, Ms. Leal's testimony concerning Ms. Hua's report is an exception to the hearsay rule under the FRE at either Section 803(4)(b) or Section 804(a) and (b)(3).

Ms. Leal's Investigation

Ms. Leal credibly testified that she was "shocked" to hear about the Final Incident, and that, one of the first things she did was check her e-mail to determine if Mr. A__ had reported the Final Incident. Ms. Leal also checked to see if Mr. A__ filed a Safe2Share report concerning the Final Incident. Ms. Leal ultimately located the Image Delete Form on the out-PACS server. Ms. Leal also obtained the Audit Report, which established that Mr. A__ subjected the Patient to "overexposure" of radiation on the Final Incident. Ms. Leal credibly testified that her main concerns following her investigation were that the Patient had been "overexposed" to radiation and in particular, Mr. A__ failed to report the same. Her other concern was

that the Image Delete Form did not provide enough information to determine why the images had been deleted, and that, without specific information that established the images were not "diagnostic," the X-ray images should have been maintained in the patient's medical record for the doctor to review. Ms. Leal's testimony in that regard was credible and believable.
As part of the investigation process, the Employer held a meeting with Mr. A__ to hear his side of the story. The record is unclear as to which date the meeting occurred. What is clear is that Mr. A__ voluntarily provided a written statement concerning the Final Incident; the relevant part states:

> *At no point did the patient make mention of having been previously xrayed* (emphasis added).

The Termination Notice

On September 21, 2022, the Employer discharged Mr. A__. The termination notice states, in pertinent part:

> **Termination Reason:**
>
> Recent incident requires Corrective Action due to patient safety concern and Caregiver's failure to follow policy and procedure.
>
> Performance History: Date(s) of previous related corrective action(s). Attach narrative or supporting documents as needed.
>
> 2/16/20- Step 2 Issued for inaccurate attestation of time
>
> 5/2/22- Step 3 Issued for failing to renew his**[*17]** Washington Department of Health License, prior to expiration date and allowing license to lapse; worked and imaged patients without an active license
>
> Summary of Final Incident:
>
> 8/15/22- A__ imaged a patient in errorand rather than reporting this radiation overexposure incident of a patient to his supervisor, and via the Safe2Share Reporting system, he requested, via the Film Library, for the patient's medical images to be removed. This removal of medical documentation from the patient's health record also caused a delay in the patient images being sent for a Radiologist dictation and caused a patient safety concern. A__ failed to report the incident, according to the *Safe2Share Electronic Reporting Policy*, which establishes the requirements for the use of Safe2Share reporting as an important Patient Safety, Risk Management Program that works to improve the health services to prevent patient harm.
>
> This act also violates the *Health Record for Legal and Business Purposes Policy*, which identifies a health record as composed of documentation of healthcare services provided to an individual in any aspect of healthcare delivery and is a formal legal business record of Peace Health ("legal health record") and is to be protected under the security of the electronic health record.[10]

Mr. White testified that he took Mr. A__'s Step 2 Written Warning into consideration when the Employer determined that Mr. A__ should be discharged. Mr. White also credibly testified that the Employer understands that "mistakes" can be made, especially when an employee is in a rush, but that the Employer needs to know about the mistakes so that the mistakes can be corrected. Lastly, Mr. White credibly testified that he did not see any "remorse" from Mr. A__ during the investigatory meeting, and that he took that into consideration when determining the final level of discipline.

The Comparator Evidence

At the Hearing, the Employer presented comparator evidence; summarized as follows:

Date of Alleged Incident	Date of Alleged Incident	Caregiver Initials	Description of Incident	Department	Level of Discipline Imposed	Previous Discipline
10/12/2020	10/19/2020	DM	Caregiver allegedly failed to check patient identifiers, prior to imaging, exposing wrong patient to unnecessary radiation exposure	Diagnostic Imaging	Step 3 Final Written Warning	None
2/8/2021	3/25/2021	ER	Caregiver allegedly did not validate patient's order prior to imaging, causing unnecessary radiation exposure to the wrong body part	Diagnostic Imaging	Step 3 Final Written Warning	None
7/27/2023	8/9/2023	CO	Caregiver allegedly failed to provide care	Hospice House	Termination	None

Date of Alleged Incident	Date of Alleged Incident	Caregiver Initials	Description of Incident	Department	Level of Discipline Imposed	Previous Discipline
			consistent with the Caregiver Behavior Standards			

The Grievance

On September 22, 2022, Union Stewart Jerry Chidester timely filed a grievance (the Grievance) on Mr. A__'s behalf. In relevant part, the Grievance alleges that the Employer "unjustly" terminated Mr. A__ in violation of Article 8. The remedy requested is:

> Immediately**[*18]** reinstate Mr. A__ to the position of Radiological Technologist on the night shift with the same work schedule. [sic] Compensate Mr. A__ with back pay from the date of termination to the date of reinstatement. Make Mr. A__ whole.

The Employer denied the Grievance at Step 1, Step 2 and Step 3. Having been unable to mutually resolve the Grievance, the Union referred the Grievance to arbitration. This Award is timely issued.

DECISION

The Just Cause Standard

In labor arbitrations, the "just cause" standard is the standard for determining whether a particular disciplinary action was justified."[11] This particular CBA does not provide a definition of "just cause," but it can be reasonably implied that the Parties intended to apply the generally accepted meaning of "just cause," which has evolved in labor-management jurisprudence to mean that "just cause" is a broad and elastic concept, involving a balance of interests and notions of fundamental fairness.[12] Described in very general terms, the just cause standard is one of reasonableness:

> [W]hether a reasonable (person) taking into account all relevant circumstances would find sufficient justification in the conduct of the employee to warrant discharge (or discipline).[13]

Put simply, the determining factor in the just cause analysis is what is *reasonable*, given *all* of the circumstances of the particular case.[14]

What is the Employer's Quantum of Proof ?

The Parties stipulated that the Employer has both the burden of proof and the burden of production in this case. The Parties did not stipulate, however, whether the burden of proof is a preponderance of the evidence or clear and convincing evidence. As stated by the Elkouris:

> In discharge cases, depending on the nature of the violation charged, arbitrators may require proof by a "preponderance of the evidence," or even clear and convincing where the violation is in the nature of a criminal offense or otherwise seriously impugns the employee's character.[15]

Here, I apply the clear and convincing standard, defined as:

> the evidence is highly and substantially more likely to be true than untrue. In other words, the fact finder must be convinced that the contention is highly probable.[16]

Credibility Findings

This Award is based on evidence which at times was in direct conflict. In particular, the Union strenuously asserted at the Hearing and in its Post-Hearing Brief that Mr. A__ was not aware he should file a Safe2Share report concerning the Final Incident.[17] Conversely, the Employer alleges that Mr. A__ knew or should have known to file a report via Safe2Share; or, in the alternative, Mr. A__ knew/should have known to at least notify the Employer *by e-mail*, rather than provide notification via the Image Removal Form for the Patient, a form that is randomly audited.

Upfront, writing this Award was difficult because Mr. A__ appears to be highly intelligent, well-educated, and well-spoken, and I believed *most* of his testimony. In fact, on Day**[*19]** 1, I was totally convinced that the penalty imposed was too harsh for Mr. A__'s infraction. After all, Mr. A__ made a mistake, and we *all* make mistakes. Nevertheless, based on the Arbitrator's review of the overall evidence, I find that the Employer's testimony and evidence is more credible than the Union's testimony and evidence concerning the Grievant's knowledge and understanding of the Employer's Safe2Share Policy, and whether he knew or should have known to make a Safe2Share report. Moreover, even assuming, *arguendo*, Mr. A__ did not know he should have made a report via Safe2Share, based on Mr. White's testimony that the Employer expected Mr. A__ to *either* file a Safe2Share report or e-mail management concerning the overexposure, as well as Mr. A__'s testimony that he knew he was required under the AART to report to his supervisor "any information concerning an error made in connection with imaging, treating, or caring for a patient," at a bare *minimum*, Mr. A__ knew or should have known he should have reported the overexposure of the Patient to his supervisor via e-mail. I make these findings for the following reasons.

First, as set forth above, Mr. A__ was trained on the Safe2Share Policy, which is spelled out in *both* the Code of Conduct, and in the Safe2Share Policy. Second, Mr. A__ knew how to make a report on the Safe2Share website, because he did so on March 21, 2021. Third, the overall record is replete with instances where Mr. A__ complied with the Employer's expectation to report an "error" or anything else that could impact patient care. This includes, but is not limited to, evidence that establishes that Mr. A__ reported potential patient care issues to *the entire Department*, his supervisor, his manager, and other management through the Chain of Command, including the CEO, on the various dates listed above. This is why it is strange and bizarre that Mr. A__ did not report his error concerning the overexposure of radiation on the Patient following the Final Incident. If Mr. A__ had at least sent an e-mail to Ms. Leal or anyone else in the Department about the "overexposure" and admitted to his mistake, he likely wouldn't have been fired. I say this because Mr. White credibly testified that "mistakes happen," but that the Employer needs to know about the mistakes to correct them (or words to that effect).

Moreover, on Day 1, Mr. White demonstrated how to use the Safe2Share website to file a report that would have gone *directly* to the Department, for the *Department's* eyes only.[18] Additionally, the Safe2Share Policy provides that there will be "no retaliatory or disciplinary action" taken against an employee for simply reporting an incident that could involve a problem with patient care. This troubled me, because if Mr. A__ had just sent an e-mail or filed a report through Safe2Share, again, he probably would not have been discharged.

At the end of Day 1, the Arbitrator asked the Employer to make screenshots of the Safe2Share website as a**[*20]** demonstrative exhibit for admission on Day 2 (the Screenshots). On Day 2, per the Arbitrator's request, the Employer brought copies of the Screenshots. The Employer proposed to admit Screenshots of the first page of the Safe2Share website, and of what a Safe2Share report form would look like as Employer's Exhibit 15. The Screenshots are dated January 23, 2024. The Union objected to the relevance of the Employer's proposed Exhibit 15 based on Ms. Ross's testimony that the button that says "Diagnostic Imaging Radiation" was not on the Safe2Share website as of the date of the Final Incident. In contrast, Mr. White consistently testified on *both* days of the Hearing, that the "Diagnostic Imaging Radiation" button was on the Safe2Share website when he first began working for the Employer in/about May 2022. More likely than not, Mr. White's testimony concerning whether the Diagnostic Imaging Radiation button was on the website as of the Final Incident is credible, particularly since he had only been employed at PeaceHealth for about four (4) months as of the Final Incident and it was his *job* to know what is required of radiological technologists.

That said, not only was Mr. White's testimony credible, I also find Ms. Ross's testimony to be *completely credible* and believable because she admitted *under oath* that while she believed the "Diagnostic Imaging Radiation" button was not on the website as of the Final Incident, she could not "recall" for sure, because August 15, 2022 "was a long time ago" (or words to that effect). I find Ms. Ross's testimony to be completely honest and credible, especially since she fiercely defended Mr. A__ during the Hearing, and she clearly wanted to help the Union prove Mr. A__'s case. I also believed Ms. Ross because she really had *nothing* to gain by lying.

Mr. A__ also testified that the "Diagnostic Imaging Radiation" button was not on the Safe2Share website as of the Final Incident. While again, I find Mr. A__ to be an incredibly intelligent, well-educated, and well-spoken person, unlike Ms. Ross, Mr. A__ had *every* reason to be untruthful. Thus, unfortunately, in this instance, Mr. A__'s testimony can be presumed *not credible*, especially since that testimony is contradicted by a credible witnesses who ultimately had nothing at stake in the outcome. Put simply:

> [A]n accused employee is presumed to have an incentive for not telling the truth and that when his testimony is contradicted by one who has nothing to gain or lose, the latter is to be believed.[19]

As one arbitrator has also noted, a grievant has an incentive to misstate the facts:

> Certainly [sic] an employee charged with misconduct leading to severe discipline or discharge has an interest in avoiding the responsibility and the blame and there is a recognized tendency on the part of such individual to misstate facts and circumstances.[20]

Lastly, based on the overall record, Mr. A__**[*21]** knew that the Employer only randomly audits the Image Removal forms. For this reason, more likely than not, Mr. A__'s request to remove the Patient's X-rays on the night of the Final Incident and his failure to report his mistake was *deliberate*. It is also

important to note that Mr. A__ knew he was on a final written warning for X-raying patients without a license. He likely feared that if he reported the overexposure, he may be terminated. The fact that he got caught after Ms. Hua reported the Final Incident was likely something he was hoping would not happen. The bottom line is, more likely than not, Mr. A__ knew and understood that he should report *anything* that was deviant from any requirements, rules, policies, WACs, or the ethical rules under the AART, either by e-mail, or through a Safe2Share report. And, it is truly unfortunate that he did not do that. If he had, the outcome of this Award would have been very different, because I agree with both Mr. White and Mr. A__ that mistakes happen. As more fully addressed below, my problem is not that Mr. A__ made a mistake; my problem is that Mr. A__ did not report the mistake, had no remorse for making the mistake, attempted to cover-up his mistake by ordering that the X-rays—X-rays which were *diagnostic* and part of the Patient's medical record—should be deleted, then, when confronted with his mistake, *he blamed the Patient*.

Did the Employer Establish Uniformity of Discipline in this Matter?

Yes. Concerning the comparator evidence presented by the Employer, the Union asserts:

> It seems evident, given all the testimony, that x-ray images are often redundant, requiring overexposure on a frequent basis. It also seems evident that the Employer understands the fact that many x-ray images are necessarily discarded — and yet has never terminated anyone for double exposure even in truly reckless situations.[21]

This is an excellent legal argument, but unfortunately, I cannot agree with the Union's well-written argument based on this record. While it is true that the comparator evidence establishes that no employee has been discharged for radiation overexposure in the past, there are at least two (2) factors that distinguish this case from those other disciplinary cases.

Before I address those factors, first, I agree with the Union that it was not reasonable to consider Mr. A__'s Step 2 Written Warning when considering the proper penalty, because that discipline should have been removed from Mr. A__'s personnel file as of the date of the Final Incident. That said, even disregarding the Step 2 Written Warning, the first factor is that Mr. A__ received a Step 3 Written Warning on June 15, 2022, a mere *two (2) months* before the Final Incident. Furthermore, the Step 3 Written Warning was not grieved, and for good reason, because Mr. A__'s failure to renew his license and then X-raying patients without a license is a serious infraction, one that implies major liability ramifications**[*22]** to the Employer, which the Employer rightfully did not ignore. And, unlike Mr. A__, *none* of the other comparators had *any* previous disciplinary history in their record, and certainly not for a serious infraction such as X-raying patients *without a license*.

The second factor is that, based on the comparator evidence, the Employer consistently finds overexposure of radiation to a patient to be a serious matter. This is because, in at least two (2) other instances, the employees were issued a Step 3 Written Warning, even though neither of those employees had *any* previous disciplinary history. This evidence establishes that the Employer's termination of Mr. A__ under the circumstances was consistent with other discipline issued for radiation overexposure.

Did the Employer Establish Just Cause to Terminate Mr. A__?

Regrettably, yes. In that regard, the Union asserts:

> Mr. A__ should not be terminated in this instance. At most he should have been put on notice that he should file a "Safe2share" report in instances of double exposure. He did not get that opportunity; instead, he was immediately terminated based upon an investigation that ignored mistakes made by others and a record keeping system made confusing by at least two unreliable software systems.[22]

I compliment the Union's counsel on this meritorious argument and agree that Mr. A__ had trouble working with the Employer's software systems in the past, as he complained early and often about that. Having said that, ultimately, this decision rests on the *facts* and the overall *evidence*, and not on the Union's meritorious legal argument.

Here, I am mindful that Mr. A__, for all intents and purposes, was simply trying to do his job on the Final Incident. I am also mindful that Mr. A__ was "rushed" and "busy," and can respect that. Even Mr. White recognized that "mistakes happen" when we are rushed and busy. And, while I have no doubt that Mr. A__ was frustrated about the computer software systems in the past, there simply is no concrete *evidence* that EPIC and PACS were not working properly during the Final Incident. Rather, based on Ms. Hua's report to Ms. Leal, and the Audit Report, more likely than not, Mr. A__ simply did not check PACS before he began the exam. If he had, Mr. A__ would have seen that the Patient's X-rays were taken by Ms. Muller a minimum of sixteen (16) minutes *before* he began the exam. Again, understanding that Mr. A__ was incredibly busy, it is understandable that he made a mistake. The problem was once Mr. A__ realized his mistake and understood that he was responsible for overexposing the Patient above the ALARA limit, he immediately (within fifteen (15) minutes) submitted an Imaging Removal Form to have the X-rays deleted *knowing* that the Employer would not likely see the Imaging Removal Form, because it only randomly audits those forms. To exacerbate matters further, Mr. A__ did not explain the reason why the X-rays should have been deleted; a fact that Mr. A__ acknowledged**[*23]** at the Hearing was "poor work on my part." That said, Mr. A__ had no remorse during the investigation, and still does not. Rather, Mr. A__ testified *under oath* that his error during the Final Incident was "unfortunate," but he never said that what he did was *wrong*. The most important fact is that, ultimately, rather than taking full responsibility for his error, Mr. A__ actually placed the blame on the *Patient*; did not report his error as he had done so many times before (establishing that Mr. A__ certainly knew how to do so), and then tried to cover-up his mistake by having the X-rays deleted. If Ms. Hua had not reported the Final Incident to Mss. Leal, the Employer probably would not have even *known* what Mr. A__ did, which he was probably hoping would happen.

The bottom line is because Mr. A__ did not recognize or take responsibility for his actions, because he knew or should have known to report his error to the Employer, and because he had recently received a Step 3 Written Warning for X-raying patients without a license, I am convinced that the Grievance should be denied, as it would be irresponsible for the undersigned to return Mr. A__ to work under these circumstances. Put simply, as another arbitrator stated:

> Due to...blasé attitude towards the health and safety of her fellow employees it would be irresponsible to place her back on a shop floor where employees must rely on each other to maintain an adequate level of safety.[23]

In sum, *both* of the Union's counsel offered well-reasoned arguments at the Hearing and in the Union's Post-Hearing Brief as to why the Grievance should be sustained and Mr. A__ reinstated with back pay.

Ms. Ross, too, was an *excellent* advocate for Mr. A__, and if I were a Union member I would be happy to have her advocate for me. Having said that, regretfully, no amount of great advocating helps Mr. A__ in this instance.

CONCLUSION

This was a difficult decision. That said, unfortunately, the Grievance is denied. Put simply, based on Mr. A__'s lack of remorse, his deliberate actions in having the X-rays deleted within fifteen (15) minutes after the X-rays were taken, his failure to report his conduct—an action that he *knew* or should have known must be done—and, taking into consideration that Mr. A__ had just received discipline for a very serious offense just two (2) months before the Final Incident, I have no choice but to find that the Employer established by clear and convincing evidence that it had just cause to terminate Mr. A__.
If Mr. A__ had complied with his ethical requirements to report to his supervisor "any information concerning an error made in connection with imaging, treating, or caring for a patient;" the outcome would probably be different; if Mr. A__ demonstrated remorse for his actions, the outcome would probably be different; if Mr. A__ acknowledged he was wrong and made a mistake, the outcome would probably be different; if Mr. A__ did not deliberately**[*24]** have the diagnostic X-rays deleted without first reporting his error via either Safe2Share or a simple e-mail to the Employer; again, the outcome would probably be different; if, when confronted with his conduct, Mr. A__ did not blame the Patient for his actions, the outcome would probably be different. Unfortunately, Mr. A__ did none of those things.

THE AWARD

The Grievance is denied. The Arbitrator's fee and expenses shall be borne equally by the Parties, as provided in Article 9 at Section 9.4.

DATED this 6th day of May, 2024.

Shianne Scott, Arbitrator

Portland, Oregon

fn 1 Employer's Post-Hearing Brief at page 1.

fn 2 Union's Post-Hearing Brief at page 3.

fn 3 All emphases in the original.

fn 4 See the CBA at Article 1 and Appendix A.

fn 5 All emphases in the original.

fn 6 The acronym "ED" refers to the Employment Department.

fn

7 "PACS" is an acronym that stands for Picture Archiving Communication System.

fn

8 *See, e.g.*, Union's Post-Hearing Brief at page 6.

fn

9 Ms. Leal credibly testified that Ms. Hua's first name has only one (1) "s."

fn

10 Emphases in original; reference to the policy numbers omitted.

fn

11 Mittenthal, Richard and Vaughn, M. David, *Just Cause: An Evolving Concept*, Arbitration 2006, at page 32.

fn

12 *See*, *Clearwater Paper Corp.*, 132 LA 465 (2013).

fn

13 *2017 WL 1536542* (AAA), 9, citing *RCA Communications, Inc.*, *29 LA 567, 571* (1961). *See* also *Riley Stoker Corp.*, *7 LA 764, 767* (1947).

fn

14 *State of Alaska*, *114 LA 1305* (Gaba, 2000).

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15 Elkouri & Elkouri, *How Arbitration Works*, Chapter 8, Section 8.9.E. page 44 (8th ed., 2020).

fn

16 *Colorado v. New Mexico*, 467 U.S. 310 (1984).

fn

17 *See* Union's Post-Hearing Brief at page 6.

fn

18 See the Safe2Share Policy at 3.c.

fn

19 *Lincoln Electric System*, *125 LA 1185* (2008); citing to, United Parcel Service, 66-2 ARB & 8703 (1966) quoting Stessin, *Employee Discipline* 44 (1960).

fn

20 *Lincoln Electric System*, *125 LA 1185* (2008); citing to *Consumer Plastics Corp.*, *83 LA 870, 875* (1984), quoting *Brooks Foundry Inc.*, *75 LA 642, 643* (1980).

fn

21 Union's Post-Hearing Brief at page 25.

fn

22 Employer's Post-Hearing Brief at page 8.

fn

23 *Mission Foods*, *118 LA 1608* (Gaba, 2003).