

**IN THE MATTER OF ARBITRATION BETWEEN**

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<b>MINNESOTA NURSES ASSOCIATION,</b>	)	
	)	<b>ARBITRATION</b>
<b>Union,</b>	)	<b>AWARD</b>
	)	
<b>and</b>	)	
	)	<b>THERESA PETERSON</b>
	)	<b>DISCHARGE GRIEVANCE</b>
<b>METHODIST HOSPITAL,</b>	)	
	)	
<b>Employer.</b>	)	<b>FMCS CASE NO. 080226-53889-3</b>
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Arbitrator: Stephen F. Befort

Hearing Dates: July 29-30 and August 18, 2008

Post-hearing briefs received: October 2, 2008

Date of decision: October 30, 2008

**APPEARANCES**

For the Union: Phillip I. Finkelstein

For the Employer: James M. Dawson

**INTRODUCTION**

The Minnesota Nurses Association (Union) is the exclusive representative of a unit of registered nurses employed at Methodist Hospital (Employer). The Union brings this grievance claiming that the Employer violated the parties' collective bargaining agreement by discharging Theresa Peterson without cause. The grievance proceeded to an arbitration hearing at which the parties were afforded the opportunity to present evidence through the testimony of witnesses and the introduction of exhibits. The parties

waived the contract's requirement of a three-member hearing panel and agreed that this matter may be heard and decided by a single neutral arbitrator.

### **ISSUES**

1. Did the Employer deny the grievant her Weingarten rights? If so, what is the appropriate remedy?
2. Did the Employer have just cause to discharge the grievant? If not, what is the appropriate remedy?

### **RELEVANT CONTRACT LANGUAGE**

#### **Article 17. Discipline and Termination of Employment**

No nurse shall be disciplined except for just cause. Except in cases where immediate termination is appropriate, the Hospital will utilize a system of progressive discipline. A nurse's participation in the Economic and General Welfare Program of eligibility for longevity benefits will not constitute just cause for discharge or other discrimination.

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A nurse participating in an investigatory meeting that reasonably could lead to disciplinary action shall be advised in advance of such meeting of its purpose. The nurse shall have the right to request and be granted Minnesota Nurses Association representation during such meeting. At any meeting where discipline is to be issued, the Hospital will advise the nurse of the right to have Minnesota Nurses Association representation at such meeting.

### **FACTUAL BACKGROUND**

The Employer is an acute care hospital located in St. Louis Park, Minnesota. The Employer has employed the grievant, Theresa Peterson, as a registered nurse since 1998. She had not been subject to discipline prior to her discharge, and her performance evaluations generally have been positive. At the time of her discharge, Ms. Peterson was assigned to the Critical Care Float Pool, and more specifically to a subgroup of critical care nurses known as the "Flying Squad." The Employer assigns members of the Flying

Squad to provide patient care anywhere within the hospital as needs dictate. Sue Henderson serves as the manager of the float pool group.

Ms. Peterson is an active member of the Minnesota Nurses Association. At the time of her termination, she served as one of the Tri-Chairs of the RN bargaining unit at Methodist Hospital.

The Employer admitted patient “X” to 3 North/South on January 6, 2008. Patient X was a 93 year old woman suffering from renal failure and sepsis infection. She was having difficulty passing urine and was severely bloated. Although patient X was in serious condition, her treating physician, Dr. Karen Enockson, was treating her aggressively in an attempt to return her to health. Dr. Enockson charted that patient X’s “prognosis [was] poor, if no improvement in urine output/blood pressure [by later on January 7], likely will proceed with comfort care.”

On January 7, 2008, Ms. Peterson was assigned to work on 3 North/South Unit, which is a cardiac care unit. Ms. Peterson’s assigned shift that day was a twelve-hour shift beginning at 7:00 a.m. She subsequently agreed to extend her shift until 11:30 p.m.

The staffing matrix on 3 North/South is for a nurse to provide care for three patients unless one or more is acutely ill, in which case the ratio is adjusted to one nurse for two patients. Since Ms. Peterson was assigned to care for patient X, she was responsible for only two patients on January 7.

On the morning of January 7, Dr. Enockson decided to address patient X’s fluid retention by an aggressive administration of Lasix, which is a diuretic. At 8:40 a.m., Dr. Enockson directed that patient X receive 40 milligrams of Lasix. At 10:16, Dr. Enockson issued two additional orders. First, she directed that patient X receive another 80

milligrams of Lasix. Ms. Peterson administered this dose at approximately 10:37 a.m. In addition, Dr. Enockson ordered that 500 milligrams of Lasix be administered as a drip over a 24-hour period.

According to patient X's electronic medical record, Ms. Peterson started the 500 milligram drip at 11:45 a.m. She attached the Lasix bag to a pump and programmed the pump to infuse the Lasix at a uniform rate over the desired 24-hour period. When Ms. Peterson returned to Patient X's room at 12:15 p.m., she observed that the 500 milligram bag was empty, meaning that the entire amount of Lasix had infused in less than 30 minutes. The parties do not dispute that the infusion of such a high dosage of Lasix over a short period of time is a serious medication error that potentially could lead to dire health consequences including death.

In accordance with Hospital policy, a nurse is expected to take the following steps in the event of a medication error: 1) immediately inform the treating physician; 2) inform the charge nurse; 3) quality track the incident on the Employer's computer intranet; and 4) chart the occurrence of the error on the patient's medical record. It is undisputed that Ms. Peterson failed to take three of those steps. She did not respond to the medication error by contacting Dr. Enockson, by quality tracking the incident, or by charting the occurrence in patient X's medical records. Ms. Peterson, however, testified that she did report the error to 3 N/S charge nurse Leslie Larson at about 3:30 p.m. on January 7. Larson testified that Ms. Peterson never made such a report.

In terms of medical records, the grievant made two entries on patient X's chart that have been called into question. First, she charted that between noon and 1:00 p.m. on January 7 she began a "Lasix gtt 20." This notation denotes a drip infusion of Lasix at

the rate of 20 milligrams per hour. Second, at 10:22 p.m. of the same day, Ms. Peterson noted on patient X's chart that "patient had total of 640 mg IV Lasix throughout the day."

At 11:30 p.m. on January 7, nurse Robyn Hanscomb relieved Ms. Peterson in caring for patient X on 3 N/S. During the shift change report, Peterson told Hanscomb that the Lasix administered to patient X went in "a little too fast." According to Peterson's testimony at the arbitration hearing, she also informed Hanscomb that she had forgotten to call the doctor about the medication error. Hanscomb, in her testimony, denied that Peterson ever made the latter statement. Hanscomb further testified that it was not until the early morning hours of January 8 that she discovered that the Lasix drip order was still active. Realizing that the Lasix must have infused way too fast, Hanscomb testified that she asked the charge nurse on duty if she was aware of any medication error involving patient X and that the charge nurse responded in the negative.

Susan Rock, another Flying Squad RN, relieved Ms. Hanscomb at 7:00 a.m. on January 8. During their shift change report, Rock asked Hanscomb if Dr. Enockson was aware of the medication issue. Hanscomb responded that she was unsure of that fact. Both nurses then quality tracked the medication error on the intranet system.

Ms. Rock also called Dr. Enockson and advised her of the possible medication error. Dr. Enockson visited patient X that morning and determined that the patient's condition was continuing to deteriorate and that further medical intervention was not warranted. Patient X died later that day. A subsequent investigation determined that the medication error was not the cause of death.

Lisa Shaw, Nurse Manager of the 3 North/South Unit, learned of the possible medication error from Hanscomb and Rock shortly after the January 8 morning shift

change. Ms. Shaw, in turn, sent an e-mail message to Sue Henderson, the Float Pool Manager, notifying her of the incident and the quality track reports. Henderson was not on duty that day and did not see the e-mail message until the morning of January 9.

Later on the morning of January 9, Roxanna Gapstur, Senior Director of Nursing, asked Ms. Henderson to bring Ms. Peterson to a meeting in the office of Human Resources Director Mark Nordby. While in transit, Peterson asked Henderson if she needed Union representation for this meeting. Henderson replied that she did not think so. At the meeting, Gapstur informed Peterson that she was being placed on paid administrative leave pending an investigation into the incident. The Employer representatives did not ask any questions of Ms. Peterson during this meeting.

Ms. Gapstur coordinated an investigation over the next several days. She interviewed a number of employees and reviewed pertinent medical records. Meanwhile, Mr. Nordby contacted Union Business Agent Scott Kleckner and scheduled a meeting with Ms. Peterson for January 14.

On January 14, Mr. Kleckner and Union Tri-Chair Lori Christian accompanied Ms. Peterson to the meeting. Mr. Nordby indicated that only one Union representative would be permitted to attend the meeting along with the grievant. The Union representatives objected, stating that multiple representatives had been permitted in the past and that Peterson desired both to attend. After Nordby renewed his objection, the Union group caucused and decided that Ms. Christian would serve as the sole Union representative for the meeting.

The Employer representatives posed a number of questions to Ms. Peterson during this meeting. According to Ms. Christian, the Employer representatives attacked

Ms. Peterson on a personal basis during this meeting, using a shaming and belittling manner of interaction. Gapstur and Nordby, in contrast, described the tone of the meeting as serious and uncomfortable, but certainly not demeaning. Mr. Nordby concluded the meeting by advising Ms. Peterson that she had until the next day to resign or face termination. The Employer terminated Ms. Peterson effective January 24, 2008. (The Employer also issued Ms. Hanscomb a verbal warning for failing to report her knowledge of the medical error to Dr. Enockson.)

Following the termination, a number of Union members raised questions about the Employer's actions and the two remaining Union co-chairs sent an explanatory e-mail to a group of Union stewards at their home addresses. A print version of the e-mail was posted on some Hospital bulletin boards, and Ms. Gapstur sent a letter to all of the stewards correcting what she viewed as inaccurate information. Business Agent Kleckner then sent out a responsive communication urging that the matter not be tried in public. Ms. Gapstur followed with a second letter again addressing what she described as "inaccurate and incomplete" information.

The Union submitted two additional pieces of evidence. First, the Union elicited testimony suggesting that Ms. Rock was circulating a petition or otherwise spearheading some type of campaign to obtain Ms. Peterson's removal from the Flying Squad for perceived performance problems. A number of Employer witnesses testified that they never saw such a petition and that they were unaware of such a campaign.

Second, Mr. Kleckner testified to eleven prior situations in which nurses at the Hospital had engaged in some sort of inappropriate conduct. In each instance, the Employer responded with progressive discipline steps rather than immediate discharge.

The Employer submitted responsive testimony to the effect that none of these other incidents involved an affirmative attempt to conceal a serious medication error.

## **POSITIONS OF THE PARTIES**

### **Employer**

The Employer first argues that it did not violate Ms. Peterson's Weingarten rights, either by failing to afford representational rights at the non-investigative January 9 meeting, or by limiting Ms. Peterson to one Union representative at the January 14 meeting. The Employer then contends that it had just cause to discharge the grievant. The Employer maintains that Ms. Peterson violated Hospital policy by failing to report the occurrence of a serious medication error. More significantly, the Employer claims that Ms. Peterson took affirmative steps to cover up the medication mistake. In terms of the appropriate sanction, the Employer points out that Ms. Peterson's efforts at concealment constituted serious acts of misconduct and deprived patient X of appropriate medical treatment. The Employer denies that the termination of Ms. Peterson constitutes disparate treatment, alleging that none of the comparator situations cited by the Union involved a nurse who consciously attempted to hide the occurrence of a serious error in medication.

### **Union**

The Union initially argues that the Employer failed to afford Ms. Peterson her Weingarten representation rights at both the January 9 and January 14 meetings. Turning to the merits of the disciplinary action, the Union asserts that the Employer did not have just cause to support its discharge decision. While the Union acknowledges that Ms. Peterson made a serious medication error while caring for patient X, it claims that she

informed both charge nurse Larson and relief nurse Hanscomb of this error. These reports, the Union maintains, demonstrate that Ms. Peterson was not trying to conceal the occurrence of the medication error. In any event, the Union argues that the Employer's termination decision is too severe of a sanction given Ms. Peterson's good work record and the fact that some of her fellow nurses were plotting to obtain her removal from the Flying Squad roster. The Union further contends that termination amounts to disparate treatment as compared to the lesser, progressive discipline that the Employer used to address other nurse incidents, including that of Ms. Hanscomb's failure to report the medication error to Dr. Enockson.

## **DISCUSSION AND OPINION**

### **Weingarten Rights**

The Union claims that the Employer violated Ms. Peterson's right to Union representation at both the January 9 and January 14 meetings with Hospital management. On January 9, Ms. Peterson asked Ms. Henderson in transit to a meeting at which she was placed on paid administrative leave if she needed Union representation for this meeting. Henderson replied that she did not think so. On January 14, the Employer summoned Ms. Peterson to an investigatory meeting. Although Ms. Peterson desired to have two Union representatives attend this meeting, Mr. Nordby indicated that only one representative would be permitted to attend. As a result, Ms. Christian served as the sole Union representative at this meeting.

In NLRB v. Weingarten, 420 U.S. 251 (1975), the Supreme Court ruled that an employee in a unionized setting has the right to have a union representative present at an investigatory meeting that reasonably could lead to discipline. In the instant case,

however, the Employer did not abridge Ms. Peterson's Weingarten rights with respect to either meeting. First of all, the January 9 meeting was not investigatory in nature; the sole purpose of this meeting was to inform Ms. Peterson that she was being placed on paid administrative leave. Since the Employer representatives did not ask any questions of Ms. Peterson, her Weingarten rights were not violated by the absence of a Union representative. Secondly, the Employer did not deny Union representation at the January 14 meeting, but simply limited the number of representatives permitted to attend. While it may have been better form for the Employer to implement this restriction in a less highly charged disciplinary event, the case law is clear that an employer may limit the number of representatives present so long as the grievant is afforded the right to the presence of at least one Union representative. *See Barnard College*, 340 NLRB 934 (2003). The Employer, accordingly, did not deny Ms. Peterson her Weingarten rights in the context of this case.

### **Just Cause**

In accordance with the terms of the parties' collective bargaining agreement, the Employer bears the burden of establishing that it had just cause to support its disciplinary decision. This inquiry typically involves two distinct steps. The first step concerns whether the Employer has submitted sufficient proof that the employee actually engaged in the alleged misconduct or other behavior warranting discipline. If that proof is established, the remaining question is whether the level of discipline imposed is appropriate in light of all of the relevant circumstances. *See Elkouri & Elkouri, HOW ARBITRATION WORKS* 948 (6<sup>th</sup> ed. 2003). Each of these issues is discussed below.

### **The Alleged Misconduct**

The Employer alleges that Ms. Peterson engaged in three separate, but related, acts of misconduct. They are: 1) making a substantial error in administering medication to a patient; 2) failing to report the medication error in conformance with Hospital policy; and 3) taking affirmative steps to conceal the occurrence of the medication error.

### **Medication Error**

The parties do not dispute the fact that Ms. Peterson made a serious error in administering medication to patient X. On January 7, 2008, Dr. Enockson instructed Ms. Peterson to administer 500 milligrams of Lasix by means of a drip solution over a 24-hour period. Ms. Peterson, however, mis-programmed the pump such that the Lasix infused in 30 minutes or less. Both parties agree that this was a serious medication error that could have resulted in dire health consequences.

A number of Employer witnesses testified that the Employer has never discharged an employee solely for making a medication error. The Employer acknowledges this practice and describes it as a means of encouraging employees to promptly disclose such errors so that their deleterious effects may be minimized. In light of this policy, the actual fact that Ms. Peterson made a medication error is not itself a basis for discipline in this matter.

### **Failure to Report Error**

The Employer has promulgated and communicated a policy specifying the steps a nurse is expected to take in the event of a medication error. These steps include the following: 1) immediately inform the treating physician; 2) inform the charge nurse; 3) quality track the incident on the Employer's computer intranet; and 4) chart the

occurrence of the error on the patient's medical record. Ms. Peterson testified that she was aware of this policy.

It is undisputed that Ms. Peterson failed to report the medication error to Dr. Enockson. In addition, the record establishes that Ms. Peterson did not quality track the incident or chart it in patient X's medical records. These are clear and significant violations of the Employer's policy.

At the arbitration hearing, Ms. Peterson testified that she reported the medication error to 3 North/South unit charge nurse Leslie Larson at about 3:30 p.m. on January 7. Such a report, if true, would constitute at least partial compliance with the Employer's reporting policy. This testimony, however, is not credible for two reasons. First, both Ms. Gapstur and Mr. Nordby testified that Ms. Peterson never made this claim at the January 14 disciplinary meeting. It is difficult to believe that Ms. Peterson would omit to mention such important exonerating evidence at this meeting. Second, Ms. Larson testified unequivocally at the arbitration hearing that Ms. Peterson never made such a report on January 7. Thus, the record supports a finding that Ms. Peterson failed to comply with the Employer's medication error reporting policy in all respects.

#### **Affirmative Concealment of the Error**

The most serious allegation of misconduct asserted by the Employer is the claim that Ms. Peterson took affirmative steps to conceal the occurrence of the medication error. The Employer cites to a number of evidentiary sources in support of this claim.

First, the Employer points out that Ms. Peterson did not take the obvious step of informing Dr. Enockson of the error. Although Ms. Peterson testified that she did not make a conscious decision not to inform Dr. Enockson, the record shows that Ms.

Peterson sent two text messages to Dr. Enockson between 1:00 and 2:00 p.m. on July 7 and did not mention the medication error in either message. Given the gravity of the error and the proximity in time to the text messages, it is difficult to interpret this lack of notice as resulting from mere inadvertence.

Second, Ms. Peterson did not inform either charge nurse Kathryn Trelfa (working 7:00 a.m. to 3:30 shift) or Nurse Manager Lisa Shaw (working full day shift) of the medication error. What is particularly significant about this silence is that both nurses interacted with Ms. Peterson in providing care for patient X following the occurrence of the medication error. Here again, it is difficult to believe that Ms. Peterson would not recall the serious medication error while working side-by-side with these nurse supervisors in the presence of patient X.

Ms. Peterson's charting provides a third evidentiary basis for the Employer's claim of a cover-up. It is undisputed that patient X's medical record for January 7 makes no reference to the medication error. But, two other features of that day's medical chart raise additional concerns. Ms. Peterson recorded on patient X's chart at 10:22 p.m. that "patient had total of 640 mg IV Lasix throughout the day." This notation implies that patient X received a steady infusion of Lasix over a lengthy period of time. This rings a discordant note, however, since patient X received no Lasix at all after 12:15 p.m. The Employer claims that the obvious import of the "throughout the day" notation was to mask the 500 milligram dump between 11:45 a.m. and 12:15 p.m. Further, Ms. Peterson also charted that between noon and 1:00 p.m. on January 7 she began a "Lasix gtt 20" for patient X. This notation reports a drip infusion of Lasix at the rate of 20 milligrams per hour. That is the approximate rate that would have occurred if the 500 mg of Lasix

would have infused over a 24-hour period of time. But, as we know, that is not what came to pass. Why would Ms. Peterson claim a “Lasix gtt 20” flow after the 500 mg of Lasix already had been infused? An attempt at concealment is the most obvious answer. At least that is the belief to which Dr. Enockson and Director of Nursing Gapstur testified.

As a rebuttal to this line of argument, the Union maintains that Ms. Peterson informed Ms. Hanscomb of the medication error upon the shift change that occurred at 11:30 p.m. on January 7. The Union contends that Ms. Peterson would not have informed Ms. Hanscomb of the error if she was engaged in a concerted attempt to conceal the incident.

According to Ms. Peterson’s testimony at the arbitration hearing, she told Hanscomb that the Lasix administered to patient X went in “a little too fast.” Peterson’s testimony claimed that she also informed Hanscomb that she had forgotten to call the doctor about the medication error. Hanscomb, in her testimony, denied that Peterson ever made the latter statement and stated that she assumed that Peterson had informed the doctor as required by Hospital policy. Here again, Ms. Peterson made no reference to this alleged second comment during the January 14 investigative meeting.

Under the circumstances, Ms. Peterson’s “a little too fast” comment falls considerably short of providing a meaningful disclosure of either the serious medication error or her failure to report the incident. Indeed, the comment appears intended to mask the gravity of the situation to someone who likely would notice that something was amiss.

Viewing the totality of the circumstances, the Employer has carried its burden of establishing that Ms. Peterson took affirmative steps to conceal the medication error that took place on January 7. She did not inform the treating physician or nurse supervisors of the error in spite of being in regular contact. Most significantly, her notations on patient X's medical record appear inexplicable except as a means to cover-up the medication error incident.

### **The Appropriate Remedy**

The Employer asserts that the extremely serious nature of Ms. Peterson's misconduct warrants the ultimate penalty of discharge. As discussed above, Ms. Peterson not only failed to report the occurrence of a serious medication error in accordance with Hospital policy, but she took steps to conceal both the error and the lack of reporting. By engaging in such conduct, the Employer argues, Ms. Peterson exceeded the scope of her practice as a registered nurse and effectively precluded the Employer from providing appropriate medical treatment to patient X. As a number of Employer witnesses testified, this fundamental failure of professional responsibility makes it difficult, if not impossible, to further entrust Ms. Peterson with patient care responsibilities.

The Union raises two lines of argument in urging the appropriateness of a lesser penalty. These arguments are discussed in the following two sections.

### **Mitigating Circumstances**

The Union initially maintains that mitigating circumstances warrant a reduction in the penalty issued to Ms. Peterson. Here, the Union points to two purported ameliorating factors. First, the Union asserts that Ms. Peterson had a good and lengthy work record. She has worked for ten years with the Employer and has no previous record of discipline.

In addition, she received generally positive performance evaluations throughout this employment period.

As a second factor, the Union contends that Ms. Peterson may have been reluctant to disclose the medication error given the circumstances in which some co-workers were mounting a campaign to obtain her removal from the Flying Squad unit. In particular, the Union claims that Ms. Rock was orchestrating a petition drive in support of such an endeavor. While the record contains scant evidence that such a petition ever existed, it does establish that some fellow nurses were concerned with Ms. Peterson's performance on the elite Flying Squad team.

It is true that a good work record and/or extenuating circumstances may warrant progressive discipline short of discharge in many contexts. Had Ms. Peterson's misconduct been of a minor nature, for example, it is doubtful that a discharge sanction would be supported by just cause. But, it is well-recognized that an immediate discharge may be proper for very serious acts of misconduct such as "theft, physical attacks, willful and serious safety breaches, [and] gross insubordination" without prior resort to progressive discipline. *The Common Law of the Workplace: The Views of the Arbitrators* (Theodore St. Antoine, ed., 2nd ed. 2005), § 6.7. Ms. Peterson's actions in this matter are akin to such serious acts of misconduct. By attempting to conceal a serious medication error, Ms. Peterson placed a patient's life in jeopardy. It is difficult to conceive of a more fundamental misstep in a nurse's professional conduct than what occurred in this case.

## **Disparate Treatment**

The Union additionally argues that the Employer engaged in disparate treatment by discharging Ms. Peterson. The Union references three evidentiary sources for this assertion.

First, the Union draws a comparison to the discipline that the Employer issued to Robyn Hanscomb. As noted above, Ms. Peterson informed Ms. Hanscomb at the time of the shift change on the evening of January 7 that the Lasix had been administered “a little too fast” to patient X. Nonetheless, Ms. Hanscomb did not report the error to Dr. Enockson or quality track the incident. The Employer issued only a verbal warning to Ms. Hanscomb for these omissions. The Union contends that the far heavier discharge sanction imposed on Ms. Peterson for similar conduct constitutes inequitable disparate treatment.

Second, the Union introduced documentation concerning eleven other situations in which the Employer sanctioned nurses for inappropriate behavior. The behavior at issue in these cases involved a wide range of misconduct such as failure to follow medication orders and protocols, theft of medication, inaccurate charting, and administering medication to the wrong person. In each of these cases, the Employer responded with progressive discipline short of discharge. The Union maintains that the Employer’s leap to an immediate discharge in the instant matter represents disparate treatment by comparison with these earlier cases.

Third, the Union also finds evidence of disparate treatment in the two letters that Ms. Gapstur sent to Union stewards following Ms. Peterson’s discharge. In these letters, Ms. Gapstur took issue with what she termed “inaccurate and incomplete” information

contained in two prior Union communications. Mr. Kleckner testified that he had never before observed an employer interfere with local bargaining unit leadership in this manner. The Union argues that this interference is evidence that the Employer singled out Ms. Peterson for disproportionate treatment because of her involvement as a Union Tri-Chair.

I do not find this evidence to be persuasive. None of the comparator situations urged by the Union involve a substantially similar instance of misconduct undertaken to conceal the occurrence of a serious medication error.

Taking these arguments in order, Ms. Hanscomb's conduct on January 7 hardly was comparable to that of Ms. Peterson. Ms. Peterson told Ms. Hanscomb that the Lasix infused "a little too fast." This communication did not inform Ms. Hanscomb that a major medication error had occurred or that Ms. Peterson had failed to report the medication error. More significantly, there is no evidence that Ms. Hanscomb took any action to conceal wrongdoing. Ms. Hanscomb made an erroneous assumption that Ms. Peterson had acted in accordance with Hospital policy, but that is the extent of her culpability.

Similarly, none of the eleven prior disciplinary incidents involved anything comparable to Ms. Peterson's misconduct. None of the individuals subject to lesser discipline were charged with attempting to cover-up a serious medication error. The fact that the Employer generally responds to employee missteps by progressive discipline does not mean it is without authority to impose more significant discipline in response to more significant misconduct.

Finally, Ms. Gapstur's two post-discharge letters are insufficient to support the Union's claim that Ms. Peterson was terminated for her involvement in Union activities. Ms. Gapstur's letters purport to correct inaccurate information contained in earlier Union correspondence, but do not indicate any anti-union sentiment in doing so. In addition, the letters were issued after the alleged discriminatory event - the termination - already had taken place. In the absence of some other evidence of anti-union animus, a supervisor's informational response to Union communications, even if unprecedented, falls far short of establishing the existence of disparate treatment under these circumstances.

### **Conclusion**

This is not an easy case. Ms. Peterson has amassed a good record as a nurse at Methodist Hospital, and she has exhibited remorse concerning her conduct on January 7, 2008. Nonetheless, the Employer has carried its burden of establishing that its discharge decision was supported by just cause. The failure to report a serious medication error coupled with an affirmative effort at concealment represents a fundamental failure of professional responsibility. While an Employer should be expected to assist employees in correcting behavior in many instances, it need not tolerate a performance flaw that goes to the very essence of the duties expected of a safety-sensitive employee.

**AWARD**

The grievance is denied.

Dated: October 30, 2008

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Stephen F. Befort  
Arbitrator