IN THE MATTER OF AN ARBITRATION
PURSUANT TO A COLLECTIVE AGREEMENT

BETWEEN:

MICHAEL GARRON HOSPITAL

"the Employer"

-and-

ONTARIO NURSES' ASSOCIATION

"the Association"

AWARD

Sole Arbitrator:	**Christopher White**	
For the Employer:	**Allan Wells**	**Osler, Hoskin & Harcourt LLP**
	Jacob Yacoumidis	**Manager, Labour and Employee Relations**
	Nicholas Bigaignon	**Senior Labour & Employee Relations Specialist**
	Karen Kerry	**Manager, Complex Continuing Care**
For the Association:	**Anna Bowness**	**Legal Counsel**
	Yohannes Cheru	**Bargaining Unit President**
	Janice Baker	**Incoming Grievance Co-chair**
Hearing Date:	**June 3, 2022**	

INTRODUCTION

1. I was appointed as sole arbitrator of a grievance dated May 29, 2019 and filed by the Association on behalf of its member, the Grievor, in connection with the termination of her employment by letter dated May 23, 2019.

2. I met with the parties initially on October 8, 2021 at which time the parties attempted to resolve the issues in dispute through mediation. Unfortunately, those efforts were not successful and the parties then engaged in case management. The parties elected to utilize a mediation-arbitration procedure on the next day of hearing and, in accordance with their agreement, I issued a Procedural Order that included the process to be used, as follows:

MEDIATION-ARBITRATION PROCEDURE

5. It is the parties' shared desire to have an efficient, effective and fair process for the resolution and/or adjudication of the grievance. Accordingly, the following procedure shall be utilized:

i) I am empowered to act with the powers of a mediator/arbitrator pursuant to section 50 of the Labour Relations Act, 1995 to deal with the balance of this proceeding, subject to any variation as set out below.

ii) On the next scheduled day of hearing, I will meet with the parties separately in mediation. During that day I would hear from the parties respecting the facts that they wish to advance respecting the issues in dispute. As part of the process, I will ensure that I let each party know those facts advanced by the other side that I consider material to my determination of the grievance should a settlement not be achieved in order that both sides have an opportunity to address those directly.

iii) In the event that an arbitrated decision is necessary I reserve the right to direct the parties to call any witness to give evidence respecting specific subject matter that I consider necessary to my determination of the case. Examination of the witness(es) by both parties will be limited to that specific subject matter. Given the pre-hearing procedure set out above, it is entirely possible that I will not require any witnesses to be called. It is my expectation that counsel for each party will provide me with any submissions during the course of my meetings with the parties on the understanding that any argument should be concise and focused. To be clear, I would consider facts and submissions provided during the mediation phase as constituting evidence and argument in the arbitration phase.

iv) The goal of the process is to allow the hearing on the issues before me to be completed at the conclusion of the day scheduled for mediation/arbitration. While section 50 of the LRA contemplates "succinct reasons" within five (5) days of the conclusion of the hearing, I appreciate that more detailed reasons may be merited in this case and those would be provided on the parties' understanding and agreement that some additional time for writing may be required on my part.

v) It should be understood that this process must be flexible and fair to both parties such that it may be that some additional hearing time is required notwithstanding our best efforts to be timely and efficient.

6. Should a party wish to rely on caselaw in the event that an arbitrated decision is required, all such cases should be provided to opposing counsel no later than one (1) week prior to the hearing date. I would direct that the relevant sections of any case to which a party wishes to refer be highlighted in advance.

7. Finally, as a condition of the parties' agreement that the above-noted process be used, it has been agreed that any decision rendered by me will be anonymized. For

greater certainty, I would confirm that this Procedural Order will not be made public and may not be distributed by either party or any participant in the process to any third party without prior anonymization of the Grievor.

3. Prior to the next scheduled date, I was provided with each parties' document book together with the caselaw on which they intended to rely if an arbitration phase was required. I met with the parties on June 3, 2022 as scheduled and there were brief attempts to settle the Grievance without success. Meeting with the parties separately, I was then provided with the evidence on which they intended to rely and I gave each side an opportunity to know and respond to what had been presented by the other. At the conclusion of these exchanges, each party provided me with their submissions respecting the evidence and the law and, again, each side was provided with an opportunity to know and respond to the other's arguments.

4. In accordance with the agreed process, this Award provides the parties with my decision together with "succinct reasons" as contemplated by section 50 of the *Labour Relations Act, 1995*.

THE EVIDENCE

5. The Grievor was a part-time Registered Nurse whose employment with the Employer commenced on June 12, 2018. She was terminated by letter dated May 23, 2019 and, therefore, had just less than one (1) year of service at the time of her dismissal. The Employer's letter of termination stated:

> *Four recent incidents of concern regarding your conduct during your shifts on April 13th, 14th and 19th were brought to the Hospital's attention and an investigation into these matters was subsequently initiated.*
>
> *The first incident involves your administration of the narcotic Hydromorphone on three occasions during your shift on April 13, 2019. Specifically, you failed to scan the Hydromorphone prior to administering it to the patient and you allowed for unduly long lapses between the time you signed out the Hydromorphone on the narcotics sheet and the time you recorded administering it in the patient's PowerChart MAR record. You also failed to administer the Hydromorphone in accordance with doctor's orders by administering it approximately every four hours instead of every eight hours. Further, on April 14th, after being asked about the timing of your administrations by two colleagues, you falsified the patient's PowerChart MAR record to create the impression that you had administered the Hydromorphone in accordance with doctor's orders when, in fact, you had not.*

The second incident involves your failure to attend to a patient alarm for approximately five minutes on April 19, 2019. The alarm signaled that the patient was not receiving adequate oxygen.

The third incident involves your failure to appropriately prepare a dose of insulin for a patient April 19, 2019. Specifically, you were to prepare 55 units of insulin in two separate 50-unit syringes. Instead, you prepared one syringe with an unmeasured amount above the 50-unit mark that, in your assessment, was roughly equivalent to 55 units.

The fourth incident involves your failure to appropriately change the settings on a patient's vent April 19, 2019. Despite subsequently acknowledging to a coworker that you were unsure how to do so, you attempted to change the setting, albeit incorrectly, instead of seeking appropriate assistance.

When asked about these incidents during the formal investigation meeting on May 10, 2019, in the presence of Human Resources and your union representative, you confirmed the occurrence of these incidents but failed to acknowledge any misconduct or demonstrate any remorse for your actions.

…, your actions placed your patients' safety at risk and demonstrated poor judgment and application of basic nursing principles, as well as breaches of the Hospital's Medical Administration Policy, the Documentation Entries: Identification and Notation policy, the Error Management – Electronic Record policy and the Hospital's Code of Conduct. Your actions are also inconsistent with the College of Nurses of Ontario's Practice Standards and Eight Rights of Medication Administration policy. Furthermore, your lack of remorse and awareness of your misconduct is concerning and places into question your ability to ensure this behaviour is never repeated. As a result, the trust and confidence necessary for a continued employment relationship has been irreparably damaged.

6. I was provided with the Employer's documentation in support of the allegations together with the notes from its investigation of the events in question.

7. The Grievor provided a detailed response to the allegations at the hearing. With respect to the second allegation involving a patient alarm, she advised that she did not hear the alarm from the patient's room (signalling a potential problem with the patient's ventilator) while at the nursing station and did not notice the flashing light as she was working on an administrative task that demanded her complete attention. The Association noted that the hospital is a busy environment and there are many types of alarms vying for staff attention making it understandable that the alarm in question might not be noticed. The Employer questioned this, noting that the nurse who did respond to the alarm had, in fact, been working with an isolation patient in a room that was farther away than the Grievor's location.

8. With respect to the third allegation involving preparation of insulin, the Grievor stated that in her prior workplace, larger syringes were available that could accommodate 100 units. In this case, her thinking was that using one 50-unit syringe with a bit of extra insulin estimated by the Grievor would be better for the patient as it would only necessitate one needle injection rather than two. Upon her colleague advising that the preparation of two syringes was required, the Grievor complied and that was how the insulin was administered. In response, the Employer stated that the Grievor's proposed course of action only ended when the colleague advised that she would not provide the confirming signature necessary when insulin is administered. At that point, it is agreed that the Grievor did not proceed to administer the 55 units with one syringe.

9. With respect to the fourth allegation, it was the Grievor's evidence that the unit was very busy at the time in question and she exercised her clinical judgment to adjust the patient's vent to the best of her ability knowing that she would need to check with her colleague as she was not entirely sure about the process. She did check with the colleague as soon as possible and was advised about the correct procedure. It is not disputed that the colleague was required to readjust the patient's vent from the settings used by the Grievor. The Employer's position was that there is no evidence that this was an urgent situation and that the Grievor should have checked on the proper process with her colleague prior to attempting to resolve the situation without the requisite knowledge.

10. The first allegation against the Grievor listed in the termination letter of May 23, 2019 is by far the most serious. The Grievor provided a number of statements respecting the incident involving her administration of hydromorphone to a patient. It is not disputed that the patient in question had a standing order from his physician that permitted the administration of hydromorphone every eight (8) hours, should it be needed. The Grievor stated that on the day in question it was the patient's birthday and that his family made requests that his medication be adjusted so that he might be more comfortable/alert at that time. She further said that she phoned the doctor on call for instruction and was advised that she could administer hydromorphone as often as every four (4) hours. It was asserted that another employee ("Ms. P.") was present while this call was made. The Grievor stated that she was unable to change the standing order in the system on her own and that the on-call physician was apparently unable to do this remotely. Nevertheless, it was the Grievor's evidence that she did have permission to proceed on the basis of the verbal direction that she had received.

11. The Grievor did administer hydromorphone to the patient at intervals shorter than eight hours and documented this in the Medical Administration Record (MAR). The following day a

colleague raised this with her and, while the nature of those discussions are somewhat in question, it is not disputed that the Grievor later went into the MAR and changed the times at which she said she administered the hydromorphone to the patient. The changes to the times at which she documented providing the medication were significant and are measured in hours, rather than minutes. At the hearing the Grievor confirmed that the revised version of the MAR reflects the actual times at which she administered the hydromorphone. In response to a question as to why the first set of times had been entered in the record, the Grievor indicated that reconciliations to these records do take place occasionally as some inaccuracy can occur in the extremely busy work environment that exists in a public hospital.

12. The Employer had a number of concerns about the Grievor's evidence as it was relayed to them. First, they challenged the suggestion that the Grievor had called a physician to change the patient's standing order for hydromorphone. They pointed to the Grievor's statement in the investigation interview it conducted on May 9, 2019 which reads:

> *7) Did you call the Physician to change the order of Hydromorphone from every 8 hours to every 4?*
>
> *[Answer] No, because at the point the patient had already settled.*

When this was raised with the Grievor, it was submitted that the interview in question took place after a double shift, that she was preoccupied with a situation involving one of her children and that she was confused while answering this question as she thought that it was possibly referencing a situation that involved a different patient on a later date.

13. That response, in turn, was provided to the Employer who then referred to a statement written by the Grievor and provided to it on or about May 18, 2019 when there could be no suggestion that the Grievor was confused or operating under any pressure caused by fatigue or external pressures. In that statement, the Grievor detailed her dealings with the patient, his family and the administration of hydromorphone but does not reference calling a physician to change the standing order. Finally, the Employer's response was put to the Association and Grievor who replied that the Grievor's statement was intended to detail her dealings with the patient's family and not the specifics of the Grievor's administration of hydromorphone on the date in question.

14. The Employer's second significant concern was the Grievor's revision to the MAR in this case. They reviewed the supporting documentation in some detail to demonstrate that the changes were significant and that they only occurred after the Grievor was advised of the issue

by her colleagues. Again, the Grievor's response was that revisions to records are required from time to time in a busy hospital setting.

15. Finally, it was the Grievor's evidence that the co-workers who had raised concerns respecting her performance to the Employer were part of a group that viewed her as an outsider and were, therefore, "out to get her" in some respects. The Grievor identified some issues she had experienced in the workplace with a Personal Support Worker (PSW) who worked in the unit and who had behaved in a confrontational manner towards her. It was suggested that this PSW had influenced other employees, including those involved in the incidents in question, to act against her interests. In response the Employer noted that the employee identified was a PSW while the Grievor was an RN and, therefore, not in a subordinate position. More important, the Employer submitted that there was no evidence that any of the individuals who had interacted with the Grievor in the incidents on which the Employer's decision to terminate was grounded, had been shown to act improperly in any way. Particularly with respect to the first allegation, the Employer took the position that its decision was supported by the documents created by the Grievor's own hand as well as her own statements during the course of the investigation.

THE CASELAW

16. Each party provided me with authorities that have been carefully reviewed. These are:

<u>Employer's Authorities</u>

i) *Thunder Bay Regional Health Scientces Centre and ONA (Rahinaho), Re*, 2012 CarswellOnt 11392, 112 C.L.A.S. 281, 224, L.A.C. (4th) 191 (Marcotte)

ii) *Ontario Nurses' Association v. Humber Regional Hospital*, 2000 CanLII 10598 (ON LRB) (McDowell)

iii) *Royal Victoria Hospital v. O.N.A.*, 2011 CarswellOnt 8742 (Luborsky)

<u>Association's Authorities</u>

iv) *Royal Victoria Regional Health Centre v. Ontario Nurses' Association*, 2013 CanLII 49406 (ON LA) (Craven)

v) *Capital Health Authority v. U.N.A., Local 33*, 2010 CarswellAlta 2828, A.G.A.A. No. 67, 104 C.L.A.S. 157, 201 L.A.C. (4th) 394 (Lucas)

EMPLOYER SUBMISSIONS

17. The Employer submitted that it had proven, on a balance of probabilities, each of the incidents considered in its decision to terminate the Grievor's employment for just cause. It was the Employer's position that when these issues were raised with the Grievor during its investigation, she had not disputed the allegations in any material fashion but neither had she acknowledged any misconduct or demonstrated any remorse. To the extent that the Grievor version of events may now be different, the Employer characterized these as untruthfulness on her part and submits that her evidence should be disregarded as not being credible. With respect to any suggestion by the Grievor that those co-workers who raised issues about her performance were somehow acting with improper motives, the Employer asserts there is no evidence beyond the Grievor's bare assertion that this is so. In any event, the Employer states that even if it were accepted that the Grievor's co-workers did not like her, that does not negate the evidence respecting her performance which is clear, cogent and convincing.

18. It was submitted by the Employer that the Grievor is a short-service, part-time employee who is working in the healthcare sector which requires a high standard of performance, diligence and trustworthiness. In this regard, the Employer directed me to the Practice Standards governing "Medication" and "Documentation" as issued by the College of Nurses of Ontario ("the CNO"). As stated by the Employer, when these Patient Standards are not observed, patient lives may literally be at stake. The Employer argued that the Grievor's actions disclosed a failure to meet the standards of professional competence required of a registered nurse and, together with her response to the allegations, had fatally undermined the trust that was essential to a viable employment relationship. For these reasons, it was the Employer's position that the Grievance must be dismissed.

ASSOCIATION SUBMISSIONS

19. The Association provided a complete and detailed submission in support of the Grievor. It was noted that, of the four (4) incidents listed in the letter of termination, two involved issues that the Association characterized as "minor". These were the third allegation involving the preparation of an insulin syringe and the fourth allegation involving the adjustment of a patient vent. In both cases, it was emphasized that there was no harm to the patient, that there was no suggestion that the Grievor had sought to conceal her actions and, to the contrary, the Grievor sought guidance from her co-worker respecting the correct procedures to be followed. Rather than treating these events as requiring a disciplinary response, the Employer should have considered these as learning opportunities to be utilized in educating the Grievor. At most, it was submitted they should have attracted a non-disciplinary counselling.

20. With respect to the second allegation involving the Grievor's non-response to an alarm from a patient's ventilator, it was submitted that the Grievor's evidence that she was not aware of the alarm should be accepted. Even if it were found that the Grievor should have been aware of the alarm and responded, the Association submitted that this, too, would be a circumstance where the Employer should have treated the matter as a learning opportunity for the Grievor. Finally, it were determined that the Grievor was actually aware of the alarm and did not respond appropriately, the Association submitted that this was an incident that should attract relatively minor discipline. Again, it was emphasized that there is no evidence of any harm occasioned to the patient in question.

21. Turning to what both parties acknowledge as the most serious allegation involving the Grievor's management of a patient's hydromorphone medication, the Association accepted the possibility that documentation errors occurred but disputed the allegation of medication errors. I was urged to accept the Grievor's evidence that she received a verbal approval to change the patient's standing order respecting hydromorphone. Accordingly, it was submitted that the Employer had not proven that the Grievor had committed a medication error. In the circumstances, any documentation error should similarly be treated as a learning opportunity for the Grievor and a disciplinary response, should one be required, would be at the least severe end of the scale.

22. The Association also argued that the Employer's investigation was flawed. It was submitted that the Employer had only interviewed those co-workers who had negative statements to make about the Grievor and her work performance. The Association stated that two other employees present on the date of the first incident were not interviewed. One of those was Ms. P., who the Grievor had stated was present during her phone call with the on-call physician alleged to have given her verbal approval to change the standing order for administration of hydromorphone. I was advised that there was a second employee on the shift in question, Ms. J., who was also not interviewed. While the Association could not confirm that Ms. J. had any information that would be relevant to the Employer's decision-making, it was submitted that a proper investigation would have seen her interviewed.

23. Finally, in the event that it was determined that the Grievor had misconducted herself such that discipline was appropriate, the Association submitted that there were mitigating factors that should be taken into consideration. I was advised that the Grievor was a single mother with three children, the youngest of whom was a son, aged 13. It was further submitted that termination is properly understood to be a devastating life event, potentially damaging to an employee's career path, self-esteem and financial security. On the latter point,

I did ask whether the Grievor had been able to mitigate her losses and was advised that she had been able to do so to some extent.

24. I relayed the substance of the Association's submissions to the Employer who were content to rely on their initial submission, noting only that the Grievor, as a registered nurse, had significant employment opportunities available to her in the period between the date of termination and this hearing.

DECISION

25. In accordance with the process agreed by the parties, I am providing succinct reasons for this decision. That said, the parties and the Grievor may be assured that I have carefully considered the evidence, both documentary and *viva voce*, the authorities provided and the submissions of legal counsel. I would also note for the record, that the Grievor provided extensive evidence during the hearing and that I endeavoured to ensure that she understood the allegations made by the Employer and, more particularly, the matters that would be of greatest emphasis in any decision so that she might address these directly.

26. In dismissing the Grievance, I have focused primarily on the first incident on April 13, 2019 in which it was alleged that the Grievor made multiple errors in her administration of hydromorphone to a patient and subsequently changed her documentation to conceal her actions. I find on a balance of probabilities that the Grievor did misconduct herself as alleged by the Employer. It was the Grievor's evidence that she had contacted an on-call doctor who gave her verbal approval to change the patient's standing order that limited the administration of hydromorphone to him once every eight hours. Simply put, that evidence is not credible. The Grievor cannot identify the doctor in question and made no notation in any of the medical documentation to that effect. In the investigation meeting of May 9, 2019, when asked a very clear question about whether she called the physician to change the order, the Grievor responded in the negative and, indeed, provided a reason why she had not done so.

27. During the hearing, the Association advised that the Grievor was tired and under stress during the meeting of May 9 and stated that her answer reflected confusion as to whether the question related to the events of April 13 or those on a later date. A review of the interview notes in their entirety undermines this explanation, as the subject matter for the entire interview to that point and for an extensive period thereafter were focused entirely on the Grievor's administration of hydromorphone to the patient in question on April 13. It is clear that the Grievor had recollection of those events throughout the inteview and was answering the questions posed to her in a direct and clear manner. To suggest that she was confused and

did not understand that the question as to whether she phoned the physician for direction in the middle of this portion of the interview simply defies credibility. Further, a statement that she wrote herself and provided to the Employer at a later date about the incident makes no mention of receiving any instruction from a physician to change the standing order. The Association argued that the purpose of the statement was to deal with other aspects of the events in question (primarily the fact that the patient's family had asked that he be able to sit up during his birthday celebration), but it is hard to understand why the Grievor would not state that she had a physician's instruction to change the standing order if that, in fact was the case. At this juncture, the Grievor was certainly aware of the Employer's concerns.

28. The Association submitted that the Employer's investigation was flawed as it did not interview Ms. P. who was said to have been present when the Grievor allegedly made the call to the physician. I would note that there was no evidence that the Employer was advised of this alleged call, let alone Ms. P.'s purported presence during it, prior to making its decision to terminate the Grievor's employment. While it was suggested that the Association may have raised the Grievor's position that she called the physician at a later date, that was not a suggestion that was accepted by the Employer at the hearing. In any event, I do not consider that to be an issue that requires resolution for the purposes of this case. Even if were determined that the investigation was somehow flawed in this regard, it was open to the Association to call Ms. P. as a witness to corroborate the Grievor's evidence. It did not do so.

29. Similarly, to the extent that it was asserted that the Employer should have interviewed another co-worker, Ms. J., on the basis that she was present in the workplace on the day in question, I cannot find that this constituted a failure on the part of the Employer. Simply put, it is incumbent on all parties in an investigation to identify any witnesses or documents that may be relevant to the findings of fact being undertaken. But where the investigating party does not believe, or ought not reasonably to believe, that a particular individual may have relevant information, they cannot be faulted for failing to interview such person. I note that at the conclusion of the Grievor's interview she was asked if there was anything relevant to the issue that she wished to share. No mention of Ms. P. (or Ms. J.) was made by either the Grievor or the Association representative present at the interview.

30. Accordingly, I find on a balance of probabilities that the Grievor did not obtain direction from a physician to change the standing order for the patient's hydromorphone medication that required a period of eight hours between doses. The Grievor initially documented that she gave the patient hydromorphone after intervals of 5 hours + 25 minutes and 4 hours + 4 minutes. She subsequently changed the documentation to reflect administration of the hydromorphone after 6 hours + 20 minutes and 7 hours + 40 minutes. Under either scenario,

the Grievor administered the hydromorphone in a manner that did not comply with the standing order. It may well be that the Grievor was trying to accommodate the request of the patient's family but that does not a constitute a valid reason for this decision. Her actions constitute serious breaches of the Employer's policies as well as the CNO's Practice Standard on Medication.

31. During the hearing the Grievor stated that her revisions to the documentation she completed respecting the timing of her administration of the hydromorphone were to correct her original errors. Even assuming this to be the case, the Grievor was unable to explain in any clear and logical fashion how her initial entries were so significantly flawed. The Grievor was not correcting errors measured in minutes that might be understandable in the context of a busy workplace with many matters competing for her attention. In this case, the errors were measured in hours. The explanation offered is neither credible nor supported by any corroborating evidence. Rather, I consider it more likely that the Grievor, in fact, administered the hydromorphone at the times she initially indicated in the records and subsequently revised the documentation to lengthen out the period between doses after the problems with her actions were drawn to her attention by co-workers. That is also consistent with the times at which the Grievor signed out the hydromorphone. Further, in each case, the Grievor recorded herself signing out the hydromorphone from the locked medication drawer after the times at which she documented administering the drug in her later revisions to the MAR. In the result, I find that the Grievor's actions constitute serious breaches of the Employer's policies and the CNO's Practice Standard on Documentation.

32. I consider that these breaches by the Grievor, in and of themselves, are misconduct that merit the disciplinary response of discharge imposed by the Employer. Notwithstanding that determination, there are the three other incidents identified in the termination letter together with the other issue associated with the administration of hydromorphone (i.e. the delay between the Grievor's signing out the hydromorphone and her initial charting of its administration in the MAR). With respect to the third incident involving the overfilling of the 50-unit syringe for insulin and the fourth incident involving her improper setting of a patient's vent, it must be acknowledged that no harm was occasioned by the patients. At the same time, the Grievor's actions represented risk of harm to the patients in question and must be viewed as serious errors. Aside and apart from any issues with her clinical judgment, the Employer had valid concern that the Grievor's actions represented an "Act first, seek clarification second" mentality that exacerbated risk in this health care setting. In the case of the preparation of an insulin syringe, the Grievor actually carried out the preparation and clearly would have carried out the treatment but for her colleague's unwillingness to sign off on the procedure. In the

case of the vent adjustment, again, the Grievor carried out the procedure (improperly) and then sought guidance.

33. The Grievor's actions in this regard are problematic. While they may not have merited serious discipline if considered individually, they are properly factors in any review of the Employer's decision to discharge the Grievor. Similarly, the Grievor's failure to attend the patient whose ventilator alarm was signalling a problem is problematic. The Grievor's explanation that she did not hear the alarm is possible but, on a balance of probabilities, I must conclude that she did not respond because she wished to first complete the administrative task with which she was involved. I consider the fact that she was closer to the patient's room from which the alarm was operating than the colleague who eventually responded, as evidence that supports this conclusion.

34. I have also considered the evidence related to the Association's position that the Grievor was a victim of co-workers who were improperly acting against her interest. I heard no evidence to corroborate such a contention. And, as noted by the Employer, even if it were the case that the co-workers who were interviewed in connection with these matters did not like the Grievor, the Grievor does not deny the occurrence of the incidents but, rather, is concerned that the co-workers elected to disclose or discuss them. Further, in connection with the most serious issue involving the Grievor's medication and documentation errors, the evidence that is critical to my determination rests in the documentation and not with the co-worker statements.

35. In the result, I conclude that the Grievor engaged in culpable misconduct and I consider termination of employment to be a reasonable level of discipline. In such an event, the Association urged me to consider the Grievor's personal circumstances and the extremely serious consequences termination represents for any employee. As noted above, it appears that the Grievor has been able, to a greater or lesser extent, to mitigate her losses. I further note that the parties agreed to anonymize the Award which should go some distance to assuaging any concerns about negative impact on the Grievor's career. I have also considered her short-term status as a part-time employee and, most important, my finding that she was not truthful, both in her assertion that she contacted the on-call physician and in her revisions to the MAR. Accordingly, I do not consider there is any basis on which to exercise my discretion to vary the discipline and the Grievance is hereby dismissed.

DATED this 6th day of June, 2022.

Christopher White