### Denenberg #3

IN THE MATTER OF ARBITRATION BETWEEN:

Employer

AND

Union

#### **ISSUE**

Was the discipline and discharge of the Employee for just cause and, if not, what then shall be the remedy?

#### **REMEDY SOUGHT**

Reinstatement to his former position.

#### BACKGROUND

The dispute between the union and the employer was not resolved during the grievance procedure, and it ultimately came before this system board. A hearing was held on May 5, 1993, during which the parties were afforded an opportunity to present evidence and argument.

Witnesses were sworn. Post-hearing briefs were filed.

The 1989-1994 Mechanics' Agreement includes the following provisions:

ARTICLE X SENIORITY

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F. An employee covered by this Agreement shall lose his seniority status and his name shall be removed from the seniority list under the following conditions:

\* \* \*

2. He is discharged for cause.

# ARTICLE XVII DISCIPLINARY ACTION

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B. No employee shall be discharged without a prompt, fair and impartial investigative hearing at which he may be represented and assisted by Union Representatives. An employee will also be entitled to investigative review hearing if he so requests upon being advised of a disciplinary suspension. The hearing will be held before any suspension is served. Prior to the actual hearing the Union and employee will be given copies of any previous disciplinary action letters which are to be considered and the Union will be advised in writing of the precise charges against the employee. The Union and employee will have at least forty-eight (48) hours advance notification of the hearing should they so desire. Nothing herein shall be construed as preventing the Employer from holding an employee out of service pending such investigation.

# ARTICLE XXI GENERAL AND MISCELLANEOUS

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D. When any new equipment is put into service by the Employer, employees covered by this Agreement will be given an opportunity to become familiar with such new equipment, without change of classification or rate of pay; provided, however, that the Employer may fix a reasonable time within which such employees must become familiar with such new equipment. Training received which is contiguous with, or during an employee's regular work shift, will be paid at an employee's regular classification rate on a straight time basis . . . [Joint Exhibit 1]

The Employer Maintenance Manual - Handling provides in part:

### Towing- General

6. The man on the tractor will have primary responsibility for the overall towing operation. The man in the cockpit will be responsible for brake application, when requested. When signal men or guide men are used, they will be responsible for their respective assigned areas...

A. The Flight Operations Manual states "The Captain's command of the aircraft begins with the signal to start the aircraft's engines or the start of the push-back procedure, whichever comes first." Since the Captain may receive tower instructions which deviate front the planned push-out, the tractor operator must be in communication with the cockpit at all times in order to receive these instructions. [Employer Exhibit 17]

This matter involves three levels of discipline, culminating in a Level 5 discharge, imposed on the Employee when he was an A&P mechanic at the Employer's facility at Airport 1. At each level, he was accused of violating Employer rule of conduct No. 38: "Failure to do job assignment, careless workmanship, or unacceptable job performance." The rule provides for penalties ranging from "Level 1 to discharge" [Employer Exhibit 1].

According to the Employer, the Employee's disciplinary history includes the following infractions:

Date	Level	Infraction
09/28/91	4	Damaging two aircraft during pushback.
01/29/92	4	Improper sheetmetal repair to aircraft.
02/24/92	5	Damage to aircraft with scissor lift.

#### The Push-Back Incident

On November 15, 1991, the following notice was issued to the Employee:

On 9/28/91 you pushed Aircraft 1 off Terminal "B" and tailed it behind Aircraft 2 parked on Gate 62. The left wing of Aircraft 1 struck the right wing of Aircraft 2 causing damage to the 02 HF antenna of Aircraft 2, requiring replacement. Aircraft 1 required sheetmetal repair to the left wing leading edge puncturing an 8" x 2" area. Both flights were delayed approx. 2 hrs each and caused unnecessary inconvenience to our passengers. Due to your inability to properly assess sufficient wing tip clearances, I am assessing you a Level IV Discipline. Please be advised that any further discipline that you are assessed for any reason will result in a Level V Discharge.

[Employer Exhibit 5]

The Employee submitted a written statement on the night of the accident, explaining his part in it:

Arriving on my shift 15:20 my assignment was to push Aircraft 1 with Person 1. Person 2 was lead mechanic at Terminal "B" Person 3 & Person 4 were the taxi crew.

Aircraft 1 was subsequently hooked up for push back by Person 1 & me on Gate 63. In the interim Aircraft 2 arrived at Terminal "B," was parked & being checked by Person 5 & Person 6, While Person 1 & myself were oiling #2 engine on Aircraft 2 now parked on Gate 62; the Aircraft 1 representative said, "We're ready to move, now." We left Aircraft 2, & were unable to finish oiling. Person 7 was notified of this problem.

Pushing back Aircraft 1 Person 4 told me his exit was Romeo Fox. The adjacent gate to our left was empty but had carts on Gate 64. On Gate 65 another aircraft was just being parked.

I elected to turn clockwise towards Gate 62 where Aircraft 2 was parked, since Aircraft 1's fuselage was in close proximity to the stationary jet way.

Aircraft 1 was pushed from the gate without incident; However to clear Aircraft 2 I had to push wane of the Port Authority's centerline so much so that Aircraft 1's right wheel Boggie was over the double line, almost on the berm. While straightening Aircraft 1 for the Romeo Fox exit Person 1 signaled me to stop. It is at this time I was aware that we had struck Aircraft 2's right VHF antenna, damaging it & puncturing Aircraft 1's left wing tip, approximately 6" to 12" inboard of its left wing tip.

I told the cockpit crew what had happened & backed Aircraft 1 away from Aircraft 2, again straightened the aircraft & brought it to the Romeo Fox intersection where it was subsequently dispatched.

The only other contributing factors to this incident was that the sun was in the west in back of Person 1, and the distraction in paying attention to the max nose wheel deflection angle. Both Aircraft 2 & our remaining aircraft were dispatched without incident at the same exit terminal 'B's' Romeo Fox.

[Employer Exhibit 18]

The union concedes that the damage described by the Employer occurred but argues that it was not due to the Employee's carelessness or negligence. It makes the following assertions:

The Employee was following the instructions of the captain of Aircraft 1, who was in the cockpit of the plane being pushed back. He instructed the Employee to try another mute, since the original exit was blocked by the Tower. Conditions at the job site further hampered the Employee. The Employer gate in question is among the most congested at the airport. The sole guideman was a wing walker on the terminal side who used non-standard signals and was

difficult to see because of the western sun. After the accident two wing walkers became standard. Finally, a yellow guideline painted on the tarmac was inaccurate, making correct aircraft positioning more difficult; after the accident the line was painted out by the Port Authority. In view of all the contributory factors—environmental and human, it would be unfair to punish the Employee. Furthermore, no aircraft maintenance supervisors or lead mechanic was present at these gates, In sum, the Employee, along with others, was the victim of a flawed system.

The written statement indicated that he elected to push back from Gate 63 in a clockwise direction, around the terminal rotunda. A problem arose as the plane the Employee was maneuvering swung wide, "well left of the Port Authority's centerline," from the Employee's vantage point, to avoid Aircraft 2. The right wheel went onto the non-reinforced apron. It was in straightening out the aircraft to avoid the apron (and banging over an active taxiway, as described below) that the Employee struck Aircraft 2.

Upon close examination, few genuinely exculpatory details emerge from this account; the conditions cited by the union are, if not optimal, the prevailing conditions in that gate area. Failing to cope with conditions that were known to the Employee does not in itself insulate him from blame, Although there were casual references to the area in union testimony as an "accident waiting to happen," no concrete evidence was introduced to show that mishaps actually occurred there more frequently than at other gates. As the Employer cogently pointed out, none of the union witnesses apart from the Employee testified to having accidents themselves at Terminal B, despite the concerns they expressed.

The maintenance manual [Employer Exhibit 17] makes clear that the tractor operator bears "primary responsibility" for the towing operation. Absent direct orders from an Employer maintenance supervisor, the tractor operator is the person on the ground who is in charge—

subject only to the commands, if any, relayed from the control tower by the pilot in the cockpit. The wing walker is a subsidiary figure who assists with hand signals. If the Employee was unable to understand the hand signals—as suggested in the testimony of Person 3, one of the Employer mechanics in the cockpit—the prudent course would be to stop and insist that the guideman use standard signals. Similarly, glare from sunlight could not be an unusual occurrence; if it seriously hampered the Employee, the proper step, given what was at stake, would have been to stop pushing until good visual communication with the guidernan could be established. The tractor operator must always be in a position to recognize that the guideman has spotted a hazard.

The Employee said he was concerned about being on the apron, and he was supported by the testimony of Person 8, the local union president, who is a lead mechanic. The apron surface, according to Person 8, was precarious:

If you ever pushed a 747...following that yellow line and went to the left of it, the wing tip and gear would be placed on a soft shoulder which is paved but not reinforced. Your wing tip would hang over into an active taxiway which is on the other side of the grass.

Nevertheless, Person 8, who was not a witness to the incident, acknowledged on cross examination that even at other terminals mechanics must use their judgment and experience to determine safe aircraft movement.

The union contends that a yellow line was blacked out by the Port Authority because it was the cause of the accident. Illustrating the defects of that line, Person 8 testified that "when moving an aircraft off [Gate] 63 towards your right, if there is a 747 against [Gate] 62, at some point you would hit that aircraft if you stayed on the guideline," The Employer, however, maintained that the line was intended not to guide push-backs with a wing walker but primarily to assist inbound

planes, which have no wing walkers. Whatever the proper use of the line may have been, the fact remains that the Employee never claimed to have relied on the line: he determined for himself, with the aid of the wing walker, the aircraft's path. Indeed, he said that he was distracted by watching the "max nose wheel deflection angle;" he did not say he had been misled by the line. Unfortunately some of the Employee's testimony was unreliable. Some of it contradicted his written statement or was cryptic in regard to such critical details as the layout of the terminal area or the positions of the aircraft. While it is true that the incident happened 20 months before the hearing, his inability to describe events clearly is puzzling, especially since the union had provided diagrams of Terminal B, a banjo terminal, showing the numbered gates. The Employee also had the opportunity to consult his own written statement as well as the testimony of the previous Employer and union witnesses.

Person 3 did provide a coherent account of the incident from his vantage point, stressing the difficulties with which the Employee had to contend. Even from the cockpit, the witness said, it looked as though the wing would clear the other plane. The Employer points out that Person 3 previously had refrained from offering a detailed version of the event; he did not appear at the Employee's Level 4 IRH and third-level appeal hearings. When Supervisor Person 9 spoke to Person 3 just after the incident, the Employer asserts, he remembered less about the incident than he did in his testimony before the board. The Employer argues that eyewitness details materializing for the first time at the board hearing are inherently suspect and that prior silence casts doubt on credibility.

Person 3 responded that he had not been more forthcoming because he failed to appreciate the significance of the incident until the Employee was discharged; Person 9 had led him to believe

that the Employer did not take the incident seriously. Nevertheless, the Employer undoubtedly has identified a troubling aspect of the Person 3 testimony.

Also calling into question the significance of the account are serious contradictions with the Employee's version of the incident. Person 3 described Romeo Fox, the normal alleyway, as blocked by the tower, which controls it: taking that route would result in a half hour delay. A "Captain Brian" of Aircraft 1 therefore elected to try Romeo Echo, Person 3 recalled, despite the objection of the Employer personnel in the cockpit. According to Person 3, the Employee, too, was perturbed and used "industrial language" to express his displeasure at the choice of Romeo Echo. The Employee's written statement, however, maintained that he was told by Person 4, one of those in the cockpit with Person 3, that the alleyway to be taken was Romeo Fox. During his direct testimony, the Employee maintained that Romeo Fox was "the more difficult route." He said:

We were going backwards to Romeo Fox. We were deviating from the centerline to give us clearance to go to Romeo Fox, which was a harder departure area.

A machinist who regards Romeo Fox as the harder departure area would be unlikely to use "industrial language" at the prospect of going to Romeo Echo, as Person 3 recalls the Employee doing. Moreover, although Person 3 said "Captain Brian" selected the alleyway, the Employee's written account implies that a Aircraft 1 representative merely told the ground crew, "We're ready to move now," without specifying the direction of the push-back. This conflict undercuts the union's theory that the Employee should be excused because he was following an order issued by the plane's captain.

comment to me was that they were doing their job as they were supposed to and didn't have control of the airplane."

<sup>&</sup>lt;sup>1</sup> Person 9 testified: "Based on Person 3's testimony, if I gave the impression that there. would be no further action, I probably did make that statement to Person 3 and Person 4, the other taxi member, as I remember it, because their

It is exceedingly difficult to discover mitigating circumstances when crucial aspects of accounts offered by union witnesses cannot be reconciled, The bulk of the Employee's own evidence would indicate that he began the push-back by tailing Aircraft 1 towards Romeo Echo so that he could then, in his own words on cross examination, "swing very wide enough to exit out of Romeo Fox." It was this turning maneuver, which the Employee himself devised, that brought Aircraft 1 close--too close, as it proved—to the Employer plane. Since the Employee was exercising his own discretion, the Employer was justified in holding him primarily responsible when the maneuver went awry.

#### The Sheetmetal Repair (Level 4)

The second Level 4, which was assessed on February 26, 1992, cited the following details:

On 1/29/92, you accomplished a sheetmetal repair on a Sales & Service Contract Company 1 B727 right leading edge flap. Approximately 2 days after this I received a call from a local Company 1 Maintenance Representative, The Company 1 Rep expressed his dissatisfaction with the repair and asked if it could be re-evaluated. Upon investigation it was revealed that the entire job needed to be done over again, due to the fact that it was an improper repair. It was evident that the B727 SRM (Structural Repair Manual) was not adhered to at all. When questioned about this incident and asked if the repair was done per the SRM. You replied, "No." It was necessary for the repair to be done over again. This involved 2 mechanics and 1 foreman for approximately 7 hr. with new material and use of equipment. Furthermore, you need to understand that the repair you attempted to accomplish on this aircraft was unacceptable. We can all be very thankful that the inferior repair did not fail in flight and result in further damage or incidence, which could have jeopardized the safety of passengers and crew on board. At this time I am giving you a Level IV Discipline. I am further advising you that any future discipline will result in a Level V Discharge, [Employer Exhibit 6]

In his testimony, Aircraft Maintenance Foreman Person 10 identified photographs submitted by the Employer as "the repair [the Employee] accomplished on the aircraft" [Employer Exhibits 7 A & B].

He evaluated the repair in the following terms:

Upon investigation it has too many things wrong with it. We couldn't find anything right with it. It was an incorrect repair. It didn't follow the maintenance manual or the Structural Repair Manual. The decision was made to remove it from the aircraft as soon as possible. [T]his area was a very critical area on the aircraft, a leading edge, a flight control surface. There were specific instructions on how this repair was to be accomplished. We found none of them evident. There were basic mechanical flaws, basic knowledge that you're taught in school . . . I asked the Employee if ... the repair was dons per the SRM [Structural Repair Manual]. He said no. I asked him why. He said that the repair was the correct repair.

Person 10 also testified that in his opinion the Employee would have lost his license had the FAA discovered work of such poor quality. The union challenged that opinion but did not dispute Person 10's conclusion that the work was inadequate. The essence of Person 10's testimony therefore stands without rebuttal in the record. It is sufficient to establish that the Employee was responsible for a repair that betrayed elementary errors of craftsmanship, threatened flight safety, offended the airline that paid for it, and entailed costly reworking. Yet even at the board hearing, the Employee offered no explanation for his shoddy workmanship. Given the potentially tragic consequences of a faulty wing surface, the Employer was justifiably concerned by the Employee's apparent indifference. Under these circumstances, it is impossible to discover any mitigating factor. Thus, the Employer had good reason to discipline the Employee for careless workmanship in this instance.

#### **The Scissor Stand**

On March 31, 1992, the Employee was given notice of a proposed Level 5:

On 2/24/92, I was the on-coming shift foreman and had just started my shift when at 2300. I was told by yourself that you needed to fill out an accident report; I asked why, and you stated that you had put a "crease" in a DC10 fairing. Upon investigation into this incident I, indeed, found a 2" x 1" "L"-shaped puncture in the body fuselage fairing just

forward of the center cargo pit door, on the right side of A/C 03630. I asked you what you were doing and how it happened. You explained that you thought the control switch on the driver's Panel was in the up/down position but in fact it was in the drive position, then thinking you were going to lower the scissor lift you drove the maintenance lift into the side of the fuselage while inspecting the fasteners on the door hinge area. After reviewing your personnel file, I find that that is not the first time you have damaged a piece of equipment or aircraft. As a matter of fact there are countless incidents documented and undocumented of your failure to be totally conscious and aware of your surroundings.

We have hid numerous conversations about this type of unacceptable performance, yet the incidents continue. I have tried to "reach you" in every way I know. You have become a safety risk to yourself and everyone around you. Before there is any further damage, or injury to yourself or your fellow employees, I feel I have but no other alternative but to propose you be assessed a Level V Discharge, (Employer Exhibit 9]

The Employee maintains that the accident was not his fault; it was caused by the inadequacy of the equipment. He was operating a rented scissor stand, with which he was relatively unfamiliar, in a poorly lit gate area. The stand was vastly inferior to similar equipment owned by Employer, he said. It lacked lights and other safety features, and its instruction placard was defaced by hydraulic oil. Shortly after the accident the equipment was removed.

The scissor stand struck the aircraft, according to the Employee, because he could not ascertain whether the toggle switch was in the up-down or the forward-aft mode of operation. The Employee had never received formal training in the operation of the stand, although another mechanic had shown him how to use it. After this accident, a joint safety committee recognized the lack of "a ground equipment training program especially with the leased equipment" and assigned a local union safety committeeman to implement a formal training program [Union Exhibit 6). The union also maintains that the delay-38 days—between holding the Employee out of service and the conducting of the IRH is unfair and excessive under the terms of the contract,

especially since the previous Level 4 had not yet not been subject to the grievance appeals process.

For the Employee to prevail, he would need to show that the accident should be attributed to unfavorable working conditions, including defective equipment. His task is complicated, however, by the fact that, rented or not, the scissor stand had been in general use under presumably similar conditions by employees, including the Employee himself, for about 17 months. During that period, there had been no incident. He said that another machinist had shown him how to use the equipment, a form of training that is normally considered acceptable. In addition, Employer safety officials had evaluated the equipment in question before the accident and pronounced it safe.<sup>2</sup> An Employer witness pointed out that portable lights can be used by mechanics if greater illumination is required. It is difficult to believe, furthermore, that the Employee depended on reading the placard each time he chose between drive mode (horizontal movement) and up-down mode (vertical movement). Even after a short period of routine use, the proper toggle switch settings for such basic motions should have been second nature to him and required no prompting.

The third-step decision concluded that

A logical and reasonable explanation for the accident is that the Employee placed the unit in drive in order to position it to the aircraft, completed his assigned job and attempted to lower the unit, forgetting it was still in the drive mode (Employer Exhibit 2].

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<sup>&</sup>lt;sup>2</sup> The only limitation placed on its use pertained to maximum height, which was not a factor here.

Nothing in the record impugns that conclusion. It remains more plausible to attribute the accident to the Employee's lapse of awareness than to defects in the equipment. The assignment of blame to him thus was proper.

DISCUSSION

Before the incidents in question here, the Employee's record, as reflected in Employer documents, was as follows:

Date	Level	Infraction
04/06/90	3	Rule 32: Failure to maintain acceptable level of dependency.
05/20/90	-	Walked off job due to disagreement with ramp supervisor. Foreman not advised. Counseled by Foreman.
12/26/90	-	Tow bar damaged in push back. Described in Employer records as a counseling or letter in file.
08/22/91	3	Rule 38 (reinstated Level 3): Damage to the fender of a ground power unit while dispatching an Aircraft at Gate 62 of Terminal B.
08/03/91	-	Taxi qualification removed due to failure to observe ground marshal signals resulting in nearby hitting mechanic with #1 engine while taxiing. Poor attitude during counseling.

The Employee's performance with regard to safety clearly had been a matter of concern to the Employer even before the discipline under review here. The series of incidents that began in September, 1991, prolonged a pattern of safety-related problems.

The union has argued that the Employee has been punished too harshly for accidents that occurred in the context of less-than-ideal working conditions and contributory errors committed

by others. Only the Employee was disciplined in the push-back incident, although he was interfacing with a cockpit crew, commanded by a captain, as well as other members of the Employer maintenance crew, including a radio man who relayed instructions to the Employee. Yet detailed examination of the incidents at issue demonstrates that the Employee failed to exercise good judgment, due care and respect for basic procedures, despite being a seasoned mechanic.<sup>3</sup>

In the push-back incident, the Employee became "distracted" and did not ensure proper clearance for the wing tip. In the scissor lift incident, he punctured a plane by improper operation of a common piece of equipment. In the repair incident, he inexplicably bungled what should have been a routine metal-working task. Each instance resulted in significant loss to the Employer, and in each the damage is more reasonably ascribable to the Employee's failings than to the working conditions. Accidents due to poor conditions typically occur randomly, affecting employees more or less equally. But there was no evidence in the record that others had a similar pattern of mishaps.

The essence of an A&P mechanic's responsibilities surely must be meticulous attention to the details and standards of his craft, as well as the exercise of care and caution, even under the pressures created by flight schedules and working conditions. Cutting corners and losing one's concentration are potentially lethal traits for an employee in such a safety-sensitive position. Unfortunately, the portrait of the Employee which emerges from the evidence is that of a mechanic with precisely those propensities.

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<sup>&</sup>lt;sup>3</sup> The Employee was hired as an A&P mechanic on March 10, 1986. He testified to his extensive experience pre-hire background: an A&P mechanic since 1981, similar experience on military aircraft for 17 years, qualifications as a private pilot, flight engineer and propulsion technician and maintenance scheduler.

The Employee's admirable qualifications and wealth of experience working with aircraft' contrast sharply with his display of unsafe or unsound work practices during the period leading to the discharge. Although a slip or two by a novice might be understandable, persistent substandard performance by a seasoned mechanic is less explicable and less tolerable. The cause of the Employee's poor safety record and indifferent attitude remains obscure. The record yields no basis even for speculating about a possible underlying personal circumstance that might be corrected. Tangible grounds for expecting an improvement are thus lacking.

The union has cited two system board cases in support of its argument for reinstatement. Case No. 78446/78448 - PITMM [Francis J. Robertson, Chairman, January 24, 1974] involved a push-back accident in which a DC-10, a jetway and an attack transducer were damaged. The tractor driver was assessed a suspension of five days and his guideman two days. The tractor operator had been responsible for a previous accident, caused by "failing to make sure that a piece of equipment was clear of an airplane." The Employer maintained that the prior accident justified additional time off<sup>4</sup>. In upholding his suspension, the board concluded:

We think the evidence by a fair preponderance indicates that the driver did not exercise reasonable care in the handling of this pullback operation. The evidence does not establish that there was any fault in the steering which would in any way have contributed to this accident. The attempt to excuse the driver's performance on that ground leaves room for doubt that he realized that the tractor wheels would have been turned to the right after the first stop. His explanation of why he did not start the move by going straight back in essence disregarding the guideman, signal for a straight pushback is not persuasive. If he felt the straight pushback move was hazardous with the equipment in place the logical thing to do would be to have the equipment moved. On the whole, we cannot quarrel with the conclusions reached by [the Employer] concerning the driver, It follows that his grievance must be denied.

In the case of the guideman, it is apparent that [the Employer] found no fault in him giving the initial signal for a straight pushback and that the Employer is relying on the view that he should have been more alert to the position that the tractor operator had

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<sup>&</sup>lt;sup>4</sup> This case occurred prior to the introduction of the non-punitive system, which means that the earlier Employees served time off instead of receiving levels.

placed himself in after the first stop. This is a debatable matter. It is clear from the testimony that the tractor operator straightened the tractor wheels out after the stop and then had pushed straight back, the jetway would have been cleared. It is questionable as to whether or not in the exercise of reasonable caution the guideman should have been held to expect that the driver would not straighten the wheels so as to accomplish the straight pushback. It must be borne in mind that after giving the signal to resume the straight pushback the guideman (as he testified) did have some responsibility for protecting the rear of the aircraft. In the absence of definitive Employer regulations or instructions concerning a guideman's duties in this situation, we have reservations about the propriety of holding the guideman at fault.

The union cites this case as proof that the Employee's actions (in the worst case scenario) merit no more than a suspension. But a more salient point is that the board clearly assumed the tractor operator had primary responsibility in a push-back, as the Employer maintenance manual [Employer Exhibit 17] emphasizes, even when working with a crew. The board absolved the guideman by overturning his suspension. The moral is that blame for an accident cannot be displaced onto others without sufficient reason, which is lacking here. In addition, in his testimony, as opposed to his written statement, the Employee did not claim that crew actions--in the form of irregular signals--contributed to the accident; he merely indicated that "the wing looked like it cleared but Person 1 told me to stop."

The other award also signifies that in determining a penalty, according to the principle of progressive discipline, the Employer may properly take into account a prior accident. There is no question that Employee advanced through the system progressively, one level at a time, as successive accidents and instances of poor performance accumulated. In fact, he had been given extra consideration: he was offered counseling, letters and a repeat of Levels 3 and 4 before discharge was imposed.<sup>5</sup>

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<sup>&</sup>lt;sup>5</sup> One prior Level 3 was for poor dependability, a serious but unrelated infraction.

In the second case cited by the union, No. 76248 ORD [Laurence E. Scibel, Chairman, October 17, 1973], the system board reinstated a Ramp Serviceman (who had approximately five years of seniority) on a last-chance basis with no back pay, in spite of the "many disciplinary layoffs for the many accidents he had" [Union Brief, p. 7]. Indeed, in that case, the union argued<sup>6</sup>

that the Employee is a "very intense and high strung young man who throws body and soul into his job performance thereby sometimes getting himself into hot water" and that while "these tendencies and his defensive attitude when approached by the co-workers or supervisors, does not enhance his popularity or ability to co. exist", nevertheless the Employee has "demonstrated to the Employer that the shook of being discharged has caused [him] to learn his lesson end he would be a conscientious and safe employee if given one last chance".

The board's decision to reinstate the Employee, despite his "record of careless and unsafe operation of Employer equipment," flowed from the following analysis of the facts:

[I]n each cue the errors which he committed appear to be momentary ones, and there is no evidence of deliberate action on his part; that is not to say, however, that these violations were not serious or that the Employer is under any kind of obligation to suffer them interminably. That is to say, however, they must be considered in the light of the fact that the Employee is a young man and in view of what appears to be an improved record between February 1972 and January 1973.

The board gave consideration to the fact that the ramp serviceman was a young man whose record had been improving in the year prior to discharge, and it reckoned that the accidents were caused by "momentary" lapses rather than "deliberate action," By contrast, the Employee is far from inexperienced, and his record had certainly been not improving in the year prior to discharge. The defective Company 1 repair can hardly be deemed other than deliberate. A last chance has already been extended, in the form of a second Level 4.

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<sup>&</sup>lt;sup>6</sup> At the Employee's Level 5 IRH, as reflected in the IRH decision, the Employee union adopted a similar argument: "The Employee is very intense, high strung and throws himself into job" [Employer Exhibit 10].

Nothing in the record, moreover, suggests that the Employee has been shocked into recognizing his shortcomings. When confronted by his supervisor about the Company 1 repair, the Employee insisted that his approach was superior to that prescribed by the official manual. He has evidently not changed that opinion, judging by his silence on the subject at the arbitration hearing. On those subjects that he did address, the Employee often undermined the testimony of the other witnesses brought forward on his behalf by the union, which made a vigorous attempt to present the Employee's history in the most favorable light.

The union poignantly articulated the grim consequences of discharge from employment, especially in hard economic times. The union noted that the Employee has already lost the opportunity to earn in excess of \$50,000 in wages since his termination. Yet, despite one's personal sympathies for the employee, there are no substantial grounds for overturning the Employer's assessment of him as an unacceptable risk, Sadly for the Employee, a remarkable accumulation of untoward events made the employer lose confidence in his ability to work in a safe manner, The measured application of progressive discipline had no effect. As the board in the cited case observed, the Employer is not bound to suffer interminably. In this instance, the Employee has been unable to show why the Employer should be made to suffer any longer an employee who has repeatedly jeopardized safety.

#### CONCLUSION

For the reasons discussed above, and after considering all arguments and the entire record, the impartial chairman finds that each of the disciplinary levels under review here was issued for just cause. Accordingly, the grievances of the Employee must be denied.

International Association of Machinists and

# **DECISION**

The undersigned chairman of the System Board of Adjustment, having been designated in accordance with the collective bargaining agreement entered into by the above-named parties, and having duly heard the proofs and allegations of the parties, awards as follows:

The two Level 4s and the discharge of Employee were for just cause. Accordingly, his grievances are denied.