IN THE MATTER OF
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,
RSA 2000, c H-7

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF EDONG TAH

DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF MEDICAL LABORATORY TECHNOLOGISTS OF ALBERTA

March 18, 2024

I. INTRODUCTION

1. The Hearing Tribunal of the College of Medical Laboratory Technologists of Alberta ("College") held a hearing into the conduct of Edong Tah on October 26, 2023, and April 29-30, 2024. The Hearing Tribunal received written submissions from the parties and met to deliberate on August 14, 2024.

2. The members of the Hearing Tribunal were:

   Ms. Aischaa Hammond, MLT, Chairperson
   Ms. Danielle Marchand, MLT
   Ms. Naz Mellick, public member
   Mr. Vince Paniak, public member

3. Appearances:

   Mr. Taylor Maxston, legal counsel for the Complaints Director
   Ms. Maggie Fulford, Complaints Director

   Mr. Edong Tah

   Mr. Gregory Sim, independent legal counsel for the Hearing Tribunal

II. PRELIMINARY MATTERS

Application to Proceed in Mr. Tah's Absence

4. As Mr. Tah was not present at the College by 9:30am on October 26, 2023, the Complaints Director made an application to proceed in the absence of Mr. Tah pursuant to section 79(6) of the *Health Professions Act*, RSA 2000, c. H-7 ("HPA").

5. The Complaints Director called Ms. Avaleen Petryk, Hearings Director, to testify about the College's attempts to serve notice of the hearing on Mr. Tah.

6. Ms. Petryk testified that on August 9, 2023, she sent a letter to Mr. Tah enclosing a Notice of Hearing, Notice to Attend, and Notice to Produce for the October 26, 2023, hearing date. This was marked as Exhibit 1. Ms. Petryk sent the letter by registered mail to Mr. Tah's mailing address on file with the College. Ms. Petryk next identified the Canada Post Registered Mail tracking record which indicates that her August 9, 2023, letter was available to be picked up at the post office but was not claimed by September 6, 2023, when it was returned to the College. The Canada Post record was Exhibit 2.

7. On August 9, 2023, Ms. Petryk also emailed a copy of the letter enclosing the Notice of Hearing, Notice to Attend, and Notice to Produce to Mr. Tah using the email address on file with the College. A copy of Ms. Petryk's email enclosing the Notices was marked as Exhibit 3. Mr. Tah responded to Ms. Petryk's email the following day, August 10, 2023. He sent three emails to Ms. Petryk that day. Copies of the emails were marked as Exhibit 4.

8. On September 12, 2023, Ms. Petryk sent another letter to Mr. Tah by registered mail to his mailing address on file with the College enclosing an Amended Notice of Hearing, Notice to Attend, and Notice to Produce regarding the October 26, 2023, hearing date. This was marked as Exhibit 5. The Canada Post registered mail record again confirmed that the September 12, 2023, letter was available to be picked up at the post office until October 18, 2023, when it was unclaimed and returned to the College. The Canada post record was marked as Exhibit 6.

9. Ms. Petryk also emailed a copy of her September 12, 2023, letter to Mr. Tah using his email address on file with the College on September 13, 2023. A copy of the September 13, 2023, email attaching the Amended Notice of Hearing was marked as Exhibit 7. Mr. Tah replied to Ms. Petryk's email the same day, September 13, 2023. A copy of Mr. Tah's email reply was marked as Exhibit 8.

10. Ms. Petryk identified an email exchange between Mr. Maxston and Mr. Tah dated September 20, 2023, that was marked as Exhibit 10. Mr. Maxston asked Mr. Tah to confirm whether he would be attending the hearing on October 26, 2023. Mr. Tah replied to ask "Does it make a difference. Is that how law is practiced?"

11. Ms. Petryk then identified an email chain between Mr. Tah and Mr. Maxston on October 22, 2023. Mr. Tah wrote that he would be unable to attend the hearing in person and requested to attend virtually, by phone. Mr. Maxston responded the following day, October 23, 2023, that he was asking the College's Hearings Director to forward a link to Mr. Tah to attend the hearing virtually. The emails were marked as Exhibit 12 and Ms. Petryk testified that she did send a link to Mr. Tah to attend the hearing virtually.

12. Mr. Maxston then made submissions in support of the application to proceed in Mr. Tah's absence. He submitted that Mr. Tah was given appropriate notice of the hearing, but he had not called in or accessed the virtual hearing link by 10:00am. The Hearing Tribunal then deliberated on the application.

13. During the Hearing Tribunal's deliberations, we were advised that Mr. Tah had called in. He advised that he had thought the hearing was starting at 12:30pm. The Hearing Tribunal reconvened the hearing and advised that we had been prepared to proceed in Mr. Tah's absence. The hearing then proceeded with Mr. Tah attending virtually.

Objection to Jurisdiction

14. Mr. Tah objected that the complainant was another regulated member of the College rather than a member of the public. He suggested that the complaint was therefore invalid.

15. Mr. Maxston responded that the prerequisites for jurisdiction were demonstrated in the Complaints Director's application to proceed with the hearing. He submitted that the objection should be overruled, and the hearing should proceed.

16. The Hearing Tribunal met to consider Mr. Tah's objection. The HPA does not preclude complaints from one regulated member of the profession about another. The Tribunal has jurisdiction to consider the charges in the Amended Notice of Hearing. Mr. Tah's objection was overruled and the Hearing Tribunal proceeded with the hearing.

Application to Close the Hearing

17. In advance of [redacted] testimony, Mr. Maxston applied to close the hearing for a portion of her testimony during which she would speak to a lab test result that identifies a specific patient. Mr. Maxston indicated he was applying pursuant to section 78(1)(a)(iii) of the HPA, which permits the Hearing Tribunal to close part of the hearing to the public because not disclosing a person's confidential health information outweighs the desirability of having the hearing open to the public. Mr. Tah had no issue with this so the Hearing Tribunal directed that a portion of [redacted] evidence be heard in private.

18. There were no objections to the composition of the Hearing Tribunal. There were no other preliminary matters.

III. CHARGES

19. The Amended Notice of Hearing listed the following charges of unprofessional conduct against Mr. Tah:

    1. On or about November 20 and 21, 2021, and while you worked for Alberta Precision Laboratories at the [redacted] you acted unprofessionally regarding co-worker B by:
        a. Yelling at co-worker B repeatedly; and/or
        b. Yelling at co-worker B for approximately two hours in a locked room at the [redacted] lab department.

    2. While you worked for Alberta Precision Laboratories and practiced at the [redacted] you failed to meet the minimum standards for the practice of medical laboratory technology by one or more of the following:
        a. Failing to access employer Standard Operating Procedures when appropriate;

b. Failing to follow Standard Operating Procedures;
c. Failing to complete laboratory tests in a timely manner;
d. Failing to provide accurate test results;
e. Failing to check when Quality Control had been done;
f. Failing to prioritize urgent testing;
g. Failing to provide urgent test results in a timely manner;
h. Failing to re-run critical values to confirm test results;
i. Failing to properly warn patients prior to inserting needles when collecting specimens;
j. Failing to follow proper infection prevention and control requirements, including failure to avoid cross-contamination;
k. Failing to provide emergency urgent ECGs in a timely manner;
l. Failing to multitask appropriately;
m. Failing to refrigerate perishable stock in a timely manner or at all;
n. Failing to perform collection of specimens from patients in a timely manner;
o. Failing to perform electrocardiograms in a timely manner; and/or
p. Failing to properly identify patients.

IV. EVIDENCE

20. The following exhibits were entered into evidence during the hearing on October 26, 2023:

Exhibit 1: Notice of Hearing, Notice to Produce and Notice to Attend, August 9, 2023
Exhibit 2: Canada Post Tracking Page
Exhibit 3: Email chain regarding Notice of Hearing
Exhibit 4: Emails acknowledging Notice of Hearing
Exhibit 5: Amended Notice of Hearing, Notice to Produce and Notice to Attend, September 12, 2023
Exhibit 6: Canada Post Tracking Page
Exhibit 7: Email chain regarding Amended Notice of Hearing
Exhibit 8: Emails acknowledging Amended Notice of Hearing
Exhibit 9: Email exchange with Mr. Tah August 17, 2023
Exhibit 10: Email exchange with Mr. Tah August 9, 2023
Exhibit 11: Email exchange with Mr. Tah October 5, 2023
Exhibit 12: Email exchange with Mr. Tah October 5, 2023
Exhibit 13: Duplicate of Exhibit 5
Exhibit 14: Investigation Report
Exhibit 15: Email from Mr. Maxston to Mr. Tah, October 5, 2023.

21. The following witnesses testified on October 26, 2023:

Maggie Fulford, Complaints Director

Maggie Fulford, Complaints Director

22. Ms. Fulford has served as Complaints Director for the College for 5 years. She received the complaint about Mr. Tah and engaged an investigator to conduct an investigation. The investigator completed an investigation report that she reviewed and referred this matter to the hearing. Mr. Tah acknowledged that he had received a copy of the investigation report and it was marked as Exhibit 14.

Adjournment

23. Mr. Maxston then sought to adjourn the balance of the hearing due to the delay caused by Mr. Tah's late arrival. The Complaints Director was concerned she would not get through the testimony of the next two witnesses, [redacted] and [redacted] before end of day and there would be no substantive prejudice to Mr. Tah to adjourn. Mr. Tah opposed the adjournment as the Complaints Director had sufficient time to prepare her case and he had been required to take the day off work.

24. The Hearing Tribunal considered the adjournment request and decided to grant it. The Complaints Director was seeking to adjourn so that the substantive testimony of [redacted] and [redacted] could be heard in one block. This would allow Mr. Tah to have a fulsome opportunity to cross-examine on the same day. The Tribunal also preferred to hear the evidence this way.

Hearing Continuation: April 29, 2024

25. The hearing resumed on April 29, 2024. Mr. Tah attended virtually and requested a further adjournment. Mr. Tah said that he was attending from Cameroon where he had travelled for stress leave. He said it was very hot and he had no lights in his house in Cameroon. He suggested the hearing should be adjourned until he returns to Canada within the next three months or so. Mr. Tah suggested that the alleged unprofessional conduct occurred in Canada so the hearing should wait until he was in Canada.

26. On behalf of the Complaints Director Mr. Maxston opposed the further adjournment request. Over two years had passed since the conduct in the complaint and the April 29, 2024, hearing date was set with Mr. Tah's input. It would be unfair to the complainant and inconsistent with the College's mandate to further delay the hearing.

27. The Hearing Tribunal met to consider Mr. Tah's request for a further adjournment and decided to deny it. The Tribunal has an obligation to address hearings in a timely manner and the hearing had already been adjourned for six months. There was no evidence that Mr. Tah was unable to return to Canada for the hearing. Mr. Tah's internet connection was working well and a further adjournment would increase the risks of fading memories and evidence.

28. The following witnesses testified during the hearing on April 29-30, 2024:

[redacted]

29. [redacted] submitted the complaint about Mr. Tah to the College. [redacted] identified her complaint and the attached email to her employer dated November 22, 2021, reporting her concerns with Mr. Tah as part of the Investigation Report entered as Exhibit 14.

30. [redacted] is not a member of the College, but she has been a regulated member of another College, the Alberta College of Combined Laboratory and X-Ray Technologists since 2013 and holds the CXLT professional designation. [redacted] had been working with Mr. Tah at Alberta Precision Laboratories ("APL") in the [redacted] while he was in training for the position with APL. [redacted] was employed as a CLXT 1. In cross-examination she explained that she works in all areas of the lab. She had not previously had a training day with Mr. Tah, but on November 20-21, 2021, her role included training and supervising Mr. Tah to complete the majority of the APL training binder before he would be permitted to work independently. [redacted] and [redacted] were MLT 1's and their duties also included training and supervising Mr. Tah.

31. [redacted] and [redacted] reported to [redacted] and [redacted] both of whom were in supervisory positions known as MLT 2's. [redacted] and [redacted] reported to [redacted]

32. [redacted] testified that APL maintained a large number of very specific protocols, known as "Standard Operating Procedures," for CXLTs and MLTs to follow when at work. She explained that every test performed in the lab has a Standard Operating Procedure and following the Standard Operating Procedures is important because it ensures that APL's lab results can be compared to results generated by other laboratories. The Standard Operating Procedures were documented and stored on shelves above the lab bench where employees worked. They were readily accessible to Mr. Tah.

33. [redacted] then described her experiences working with Mr. Tah with reference to her complaint. She testified that while supervising Mr. Tah over the weekend of November 20-21, 2021, she told him that she would be observing him performing the laboratory tests, so that she could sign off his training binder, because his training was coming to an end soon and he would be expected to perform lab tests on his own without constant supervision.

34. [redacted] said that Mr. Tah did not know how to perform lab procedures on his own. He was trying to report lab test results without accounting for interferences, deviations and deficiencies for which he should have consulted the Standard Operating Procedures. He would not refer to the Standard Operating Procedures on his own, unless [redacted] insisted that he do so. [redacted] testified that Mr. Tah became frustrated while working and yelled at her approximately 10 times to "just tell me what to do!"

35. [redacted] then described a number of specific incidents with Mr. Tah's conduct on the weekend of November 20-21, 2021. She said that she had to tell Mr. Tah how the slide stainer works and how to clean it, but he should have been proficient at it by this time. Cleaning the stainer is the subject of a Standard Operating Procedure but Mr. Tah was not performing the task according to the Standard. [redacted] said that proper cleaning is important so as not to disrupt the sensors that trigger the stain to come out and control the amount of stain that is dispensed. If the stains are not properly dispensed, then the technologist can misidentify cells in a sample. They would not appear to be the expected colour that the technologists use to identify them.

36. [redacted] then described that when performing a differential cell count, the machine had "starred", meaning that the count would need to be verified with a manual cell count. She checked Mr. Tah's manual count against the machine's count and her own manual count found them to be significantly different. Mr. Tah had also counted 1 immature cell, but when [redacted] asked him what to do when an immature cell is observed, he was unable to answer that a 200-cell count should be performed. Mr. Tah argued with [redacted] saying, "there is only one" immature cell and "it's not a big deal." He refused to accept that the Standard Operating Procedure required a 200 cell count until she pulled out the Procedure and showed him.

37. [redacted] then described that when performing a cell count, there are two parts. The first step is to count the cells. The second is to assess the cell morphology. Mr. Tah began preparing slides to assess the cell morphology without checking to see whether that patient had already had this procedure done within the past 30 days. Making slides is a lengthy process and the Standard Operating Procedure calls for the technologist to first check to see if slides have been made recently before making them again. Mr. Tah was performing the procedure out of order, contrary to the Standard Operating Procedure and making slides unnecessarily.

38. [redacted] then described that when performing a beta-hydroxy butyrate test, Mr. Tah wrote the patient's information on the worksheet in the binder before running the test, instead of applying the computer-generated label. This increases the risk of recording inaccurate information and is contrary to the Standard Operating Procedures. Mr. Tah also failed to check when the instrument's quality control had last been verified, and she had to prompt him to confirm that is had been done. Quality control verification is important for this assay and is a requirement to ensure accuracy and performance of the instrument.

39. [redacted] described an incident while reporting a chemistry sample for Urea, CRP and Creatinine. She noticed a slight hemolysis in the sample. This is an interference substance that can affect test results; in this case the Urea was affected. When hemolysis occurs, it requires the results to be reported with a comment that the test result could be increased or decreased due to hemolysis. [redacted] said that Mr. Tah was unable to answer when she asked him about the proper procedure. He was unable to locate the correct Standard Operating Procedure and he did not want to include the standard comment. He argued with her and wanted to write his own comment instead. He had wanted to write "marked hemolysis" which would have been inconsistent with the Standard Operating Procedure.

40. [redacted] then described that when a transfusion medicine sample was going to be delivered to the lab to be tested, she asked Mr. Tah if he had been signed off to do it. He said that he had, but when she looked at his training binder, he had only been signed off to perform type and screen testing. He was not approved to cross match if the physician ordered blood. [redacted] said that Mr. Tah argued with her, became very frustrated, and yelled at her to "just tell me what to do."

41. [redacted] then described performing an electrocardiogram ("ECG") with Mr. Tah on a 90-year-old patient in the emergency department. [redacted] explained that the ECG machine has three indicators for the quality and reliability of the tracing. A green indicator is acceptable. A yellow indicator is a warning, and a red indicator means the tracing is of poor quality. An ECG tracing can be reported despite a yellow indicator, but only after all of the trouble shooting procedures have been tried and after consulting with the physician. In this instance the patient was hooked up to the ECG machine and the machine indicated yellow. Mr. Tah wanted to accept the test result and move on, so [redacted] had to insist that they troubleshoot. The Standard Operating Procedure requires multiple steps to try to obtain an acceptable result. [redacted] said the patient had been sitting at a 30-degree incline and she had to prompt Mr. Tah to lay the patient flatter, but also to warn the patient before he adjusted the bed.

42. [redacted] then described how she and Mr. Tah were tasked with a complete blood count, chemistry test panel and lactate for a patient. The Standard Operating Procedure is to remove the tourniquet when collecting a lactate sample, but the lab aide was having trouble collecting the sample, so [redacted] suggested using the tourniquet and making a note that they had deviated from the Standard Operating Procedure. When preparing for the collection Mr. Tah grabbed two tourniquets and said that it was his practice for difficult collections. [redacted] questioned him and explained that the Standard Operating Procedure was not to use any tourniquets, let alone two, but he insisted that he knew how to do difficult collections. [redacted] refused to allow him to use two tourniquets and threw out the extra one. She said that during the collection Mr. Tah omitted to warn the patient before inserting the needle and once the needle was in, he

let go of the butterfly, which flipped around and the patient screamed “no more! Get it out!”.

43. [redacted] then described that Mr. Tah had not been prioritizing the high priority Stat samples over the less urgent routine samples. ER called for urgent results but instead of performing the urgent ER slide, Mr. Tah intended to do a routine in-patient slide first and he had to be corrected. He also left a reagent on the ACL analyzer longer than necessary and was taking the reagent off the instrument instead of performing the urgent slide. This delayed performing the ER slide and delayed getting the test results to the Emergency department unnecessarily. [redacted] said that she had to open the procedure manual, show Mr. Tah the correct pages and prove to him that she was not lying about doing things the correct way.

44. [redacted] then described an incident in the microbiology department, which is a room within the main lab that is separated by a locked door. [redacted] was working with Mr. Tah when samples were delivered to the lab to test for C-diff. [redacted] said he had to do the test, so that she could sign him off in the training binder. Mr. Tah did not want to perform the new test; he wanted to perform quality control duties instead. He had been instructed to do quality control in the afternoon, if time permitted. Mr. Tah argued and refused to perform the tests. [redacted] insisted and Mr. Tah eventually relented but he became frustrated and began yelling that [redacted] had sabotaged him, that she was trying to intimidate him and that she was treating him like he was stupid. [redacted] said Mr. Tah was yelling for approximately 20-25 minutes, but the whole incident was more like an hour.

45. [redacted] was not satisfied with the outcome of the workplace investigation of her complaint. She did work with Mr. Tah after the November 20-21, 2021, weekend, but never alone. She refused to work alone with him again. She later learned that Mr. Tah had not been successful in completing his probationary period.

46. In response to questions from the Hearing Tribunal, [redacted] confirmed that she was individual “B” in allegation 1. The lab’s main door was locked, but the door from the main lab into the microbiology department was also locked. Staff would have to go through two key coded doors to get to the room where Mr. Tah had been yelling at [redacted] [redacted] also confirmed that after she made her workplace complaint there was a meeting with human resources, [redacted] [redacted] and an HSAA representative, and a further meeting with [redacted] and Mr. Tah. [redacted] was unable to recall whether Mr. Tah had apologized or if he had just suggested moving forward to work together.

[redacted]

47. Mr. Maxston next called Ms. [redacted] has been a regulated member of the College since 2013. She was employed with APL as a Clinical Supervisor while Mr. Tah worked there and she was aware of the complaint about his conduct. [redacted] duties included overseeing the operational needs of nine laboratories, but she was based in an office and she was not regularly onsite at any of the labs.

48. [redacted] testified that Mr. Tah was in-training for his position with APL. He received three to four weeks of training in each lab department, but in cross-examination she said that the amount of training in each area depends on the employee. He would work with another lab technologist reviewing Standard Operating Procedures, performing tests as indicated, performing manual differential cell counts, and performing maintenance as needed.

49. [redacted] testified that the Standard Operating Procedures were step-by-step procedures for specific tests in the lab. They are important to follow so that tests can be completed properly and with accurate results. The Standard Operating Procedures are all available to staff as they work in the lab. [redacted] said that at the time, in 2021, there were binders of all of the required Standard Operating Procedures in every department of the lab. The procedures were also accessible electronically.

50. [redacted] confirmed that Mr. Tah's supervisors during his training included two onsite MLT 2's, [redacted] and [redacted] His trainers were responsible to check off the skills in the MLT training checklists as Mr. Tah learned them. [redacted] and [redacted] reported to [redacted] about Mr. Tah's progress, as did other APL employees, including [redacted] and [redacted] was an MLT 1 working for APL at the [redacted] and was involved in Mr. Tah's training. [redacted] was also an MLT 1 in the same position as [redacted]

51. [redacted] reviewed a November 1, 2021, email from [redacted] in which [redacted] set out several concerns about Mr. Tah's work. [redacted] email described her concerns with Mr. Tah's ability to multitask and prioritize. She referred to Mr. Tah focusing too much on routine tasks, like daily maintenance, and not readily "switching gears" to take care of patient samples, including "STAT" or urgent samples. [redacted] referred to a "consistent lack of urgency" on the part of Mr. Tah on every bench that she had trained him on.

52. [redacted] email described that Mr. Tah did not recognize that critical test results need to be re-tested to confirm them. He also could not tell where the patient was located in order to call in the critical test results. These are Standard Operating Procedures. [redacted] recounted an incident in which she observed Mr. Tah wanting to call results to the Emergency Department when the records showed that the patient was actually at the [redacted] Medical Clinic. [redacted] explained that she had previously trained Mr. Tah on how to tell where a patient is located in order to call in critical test results. Calling the ordering physician with critical test results is part of the Standard Operating Procedure during regular operating hours.

53. [redacted] email then stated that Mr. Tah did not consult the Standard Operating Procedures when he doesn't know what to do unless he is told to do so. He prefers to look at his own notebook. [redacted] testified that relying on a notebook is a problem because the Standard Operating Procedures change. It is important for Mr. Tah to be referring to the most updated versions rather to notes that he made himself during his training.

54. In cross-examination [redacted] was asked if she had brought [redacted] November 1, 2021, email to Mr. Tah. [redacted] explained that she had met with Mr. Tah on February 5, 2021, to discuss the concerns with his practice and professionalism. She said she advised him that he was at risk of not passing probation.

55. [redacted] also described emails from [redacted] on February 12 and 14, 2022. [redacted] emails explained that she worked with Mr. Tah on February 9, 2022. Mr. Tah started earlier and was already at work when [redacted] arrived. When she arrived, she asked Mr. Tah what she could take over for him. Mr. Tah pointed to some samples in the collections window that he said he hadn't gotten to. [redacted] found a body fluid cell count sample that had clotted. The sample had been ordered at 1757 hours and received the in lab at 1938 hours. [redacted] could not say whether the sample had clotted before arriving at the lab, but she said nothing had been done with it until 2330 hours when she documented that the test could not be performed due to clotting. [redacted] email said the sample should not have been left sitting in the collections window "for hours".

56. [redacted] email then described that she noticed a critical glucose test result for an outpatient waiting in the chemistry batch. Mr. Tah had already repeated the test to verify the critical result, but he hadn't recorded the results and notified the patient's physician. [redacted] tried to phone the physician and couldn't reach them, so she notified the pathologist on call. When she told Mr. Tah about this he said he had also been unable to reach the physician. [redacted] asked Mr. Tah why he hadn't notified the pathologist, but he wasn't aware that he had to do this. The test was run and repeated by 22:28 hours, but the critical glucose result was not phoned to the pathologist until 23:30 hours by [redacted] Mr. Tah didn't notify anyone about the critical result for at least one hour.

57. [redacted] email also described noticing some boxes of stock left unpacked, including one that said "refrigerate immediately". The box containing tricontrols and calibration verification kits along with a cold gel pack had reached room temperature and could have been ruined.

58. [redacted] testified about a report of concerns with Mr. Tah from [redacted] that was also dated November 1, 2021. [redacted] email reported that Mr. Tah lacked a sense of urgency or an idea of how to prioritize his workload and "STAT" tests. He gave an example of Mr. Tah failing to multitask and failing to prioritize "STAT" cardiac collections

over reporting a non-urgent test result. Another example was while training Mr. Tah, they had three collections to do: a cough, an ECG, and a timed collection. [redacted] email said that Mr. Tah did not understand how to prioritize an ECG and a timed collection over the cough. A third example was when the Emergency Department called for an urgent ECG for a declining patient. [redacted] email said that Tah refused to go and said he wanted to finish maintenance on the lab equipment first. [redacted] testified that "STAT" or urgent collections should be done within 15 minutes of the physician's order, according to provincial standards.

59. [redacted] email also stated that Mr. Tah took excessive periods of time to do basic collections of samples and ECGs. It took Mr. Tah 20-25 minutes to do an ECG, even after doing "dozens" of them. [redacted] testified that provincial standards required ECGs to be completed within 15 minutes.

60. [redacted] email reported that Mr. Tah would refuse to open a Standard Operating Procedure for anything and instead referred only to his notebook, which contained errors. He refused to follow APL procedures and refused to listen even when [redacted] explained them. As an example, [redacted] said that Mr. Tah removed the lid from a vial to draw blood to test for blood gases instead of inserting a needle through the lid, even after [redacted] told him "no". [redacted] said Mr. Tah did not understand or seem to care when he explained that this could invalidate the results. [redacted] confirmed that the Standard Operating Procedures for anaerobic collections provide that air should not be introduced into the vial when testing for blood gases.

61. [redacted] email described "major issues" with Mr. Tah's practice of universal precautions and infection control. He described Mr. Tah failing to properly doff his personal protective equipment (PPE), touching a door lock keypad with contaminated gloves, and wiping his forehead while in an isolation room. He observed Mr. Tah use the dirty computer with his bare hands, even after dealing with a positive COVID patient sample. [redacted] also described observing Mr. Tah handle known COVID and C.diff positive samples, remove his PPE, and then handle the dirty samples with his bare hands. [redacted] said that he had counselled Mr. Tah many times about universal precautions and infection control but Mr. Tah did not listen. [redacted] testified that Mr. Tah's conduct failed to follow AHS standards and risked making himself and others sick.

62. [redacted] email described Mr. Tah acting unprofessionally and displaying "attitude" with nurses, patients, and at times yelling when calling the Emergency Department or acute care. He also described Mr. Tah failing to identify patients consistently. Instead of asking patients to spell their names and provide their date of birth, Mr. Tah would read out names and ask if the names were right. This increased the possibility of error. [redacted] confirmed it was contrary to the Standard Operating Procedures.

63. [redacted] email explained that when performing quality control tasks, he observed Mr. Tah fail to follow the necessary procedures, even after being told how to do it properly.

64. [redacted] then described a further email from [redacted] dated February 7, 2022, with additional concerns about Mr. Tah. [redacted] email described working a very busy shift with Mr. Tah on January 20, 2022. [redacted] said that despite receiving a large number of STAT samples, Mr. Tah did not prioritize the samples or demonstrate an understanding of the urgency of the lab's workload. He refused to help [redacted] and the other staff to manage the workload, including by refusing to perform a "STAT STAT" ECG at the request of the Emergency Department. Mr. Tah instead prioritized his own break time over the needs of patients and the lab.

65. [redacted] email then described an incident on February 2, 2022. [redacted] was working alone with Mr. Tah as the lab was short-staffed when a "STAT" request to type and crossmatch blood came in. [redacted] said he had been assisting the nurse to order the blood so he knew the patient was O Negative and he also knew the lab had one unit of O Negative blood available. [redacted] left Mr. Tah to do the tests and went on break. When he returned [redacted] said that Mr. Tah had failed to result urgent tests and he had dispensed O Positive blood for the patient instead of O Negative blood. Mr. Tah did not understand that this could only be done in emergency situations and that it required consulting the pathologist. [redacted] said he had to open the Standard Operating Procedure to show Mr. Tah and then urgently inform his supervisor. [redacted] testified that giving the patient the wrong blood type was contrary to the Standard Operating Procedures because it could limit his ability to receive blood transfusions in the future. Mr. Tah should have consulted the pathologist before proceeding.

66. [redacted] email also described how at about 10:30am, Mr. Tah had been tasked with preparing intravenous immunoglobulin ("IVIg") for a patient who was being put under anesthesia. Mr. Tah took approximately one hour to perform the task. [redacted] said that the day surgery nurse came looking for the product after about 20 minutes, but Mr. Tah had not even started to prepare it. [redacted] said that at 11:25am Mr. Tah told him the IVIg was tagged and in the fridge. [redacted] said that timing is very important in IVIg processing. [redacted] testified that preparing IVIg should normally take 10-15 minutes at most.

67. [redacted] described a further email from [redacted] dated March 4, 2022. [redacted] email described another incident of concern on March 1, 2022. [redacted] e-mail described observing that Mr. Tah reported a mono test in hematology using the wrong type of sample tube (Mint green top tube). [redacted] testified that Mr. Tah's use of the wrong type of tube created a risk of an incorrect result. The Standard Operating Procedures specify the type of sample tube, but Mr. Tah was not reading them.

68. [redacted] testified that Mr. Tah did not successfully complete his probationary period as an MLT 1 at APL and his employment was terminated as a result. Mr. Tah cross-examined [redacted] but there were a number of questions to which [redacted] could only say that she was reading from [redacted] and [redacted] email messages.

69. The Complaints Director then closed her case.

Edong Tah

70. Mr. Tah did not testify or call any witnesses of his own, but he provided an email message dated May 29, 2024, with several attachments, including a 13-page typed statement. Mr. Tah was responding to an email from the Hearings Director which stated that he could provide his testimony in-person, virtually, by phone, or by documentation. The Hearing Tribunal accepted this material as Mr. Tah's evidence but noted that Mr. Tah did not make himself available to be cross-examined or to answer questions from the Tribunal about his evidence.

71. Mr. Tah attributed the evidence from [redacted] to [redacted] anger with [redacted] who assigned her to train Mr. Tah. He said [redacted] wanted to "destroy" him. He attributed [redacted] statements about him to her misplaced anger with [redacted] He suggested that [redacted] had animosity towards him due to his complaint about [redacted] to [redacted]

72. Mr. Tah acknowledged that he had issued the wrong type of blood for a patient without consulting the pathologist, but he said the patient was fine and the pathologist had even told him so. Mr. Tah said this one mistake was blown out of proportion because of the "previous flimsy lies".

73. Mr. Tah provided copies of his probationary employee reviews from [redacted] in High Level, Alberta where he said he had none of the same problems as in [redacted] He also provided a 1-year anniversary certificate of employment with APL that he received May 16, 2023.

74. Mr. Tah's written statement described that he began working as an MLT 1 at APL in the [redacted] and stated that he completed his training and had begun working independently. He said his training in hematology went smoothly and that he received positive feedback, except from [redacted] who "did mention some stuff about slide reading." Mr. Tah said that he was unaware of [redacted] November 1, 2021, email setting out concerns until at least early 2022. He said that if there was anything verifiable in [redacted] email it would have been brought up with him sooner. Mr. Tah said this meant that [redacted] had fabricated his concerns due to his own insecurities.

75. Mr. Tah said that after hematology, he moved on to transfusion medicine and had no issues whatsoever. He said that he used a "jotter" notebook to facilitate his work, but it wasn't in place of the Standard Operating Procedures. Mr. Tah said that [redacted] was again looking for "something beyond his scope so he can have something negative to say."

76. Mr. Tah said he next worked in collection, packaging and shipping, urinalysis, and centrifugation. He said he only worked 10 hours in this area because of his previous experience. Mr. Tah said the lab assistants were so impressed with his work, especially in collections, that "it was like talk of the Lab." Mr. Tah said that [redacted] did not like the praise Mr. Tah was receiving and accused him of showing off. Mr. Tah said he also did two weeks in chemistry and special chemistry, which he passed with no issues.

77. Mr. Tah said it was at this point that [redacted] yelled at him that he wasn't listening and that he should leave and do online reading. Mr. Tah said [redacted] also reported him to [redacted]

78. Mr. Tah then recounted that in early November he worked three consecutive night shifts with [redacted] and provided constructive feedback to him on his work. Mr. Tah described how he was able to perform a collection that [redacted] couldn't. Mr. Tah also described how he proposed multi-tasking to save time on busy shifts, but [redacted] refused. Mr. Tah disputed that he had wanted to perform maintenance tasks at 1am or that his quality control work was deficient. He said that if his quality control work was deficient it would have been flagged in the system. Mr. Tah acknowledged when collecting an anaerobic blood sample that a bit of draw blood from the tubing was attached to the needle but "no air went into the anaerobic bottle" because the pressure in the bottle was small and he caught it quickly. Mr. Tah said [redacted] saw this as an opportunity and refused to sign his training sheet for blood culturing. [redacted] subsequently intervened and signed his training sheet.

79. Mr. Tah disputed that he did anything wrong by wiping his brow with his "elbow shoulder arm" when he would sweat in a hot room during a collection. He said it was "not like I touch my face with my fingers while wearing gloves." He also said there were no issues with his urgency and referred to his turnaround time, which he said was good.

80. Mr. Tah suggested that [redacted] had influenced [redacted] to be critical of him. This led to [redacted] noticing a critical glucose result on the computer for a known diabetic patient and resulting it without consulting Mr. Tah, who had run the sample. Mr. Tah said that a normal technologist would have asked him about it first. He said he had tried to call the physician twice, but no one picked up.

81. Mr. Tah then discussed [redacted] complaint to APL on November 22, 2021. Mr. Tah said APL found [redacted] complaint to be unfounded. He then described the APL

investigation which he believed related to an incident involving a Clinical Safety Coordinator who was fitting him for a mask.

82. Mr. Tah acknowledged dispensing O positive blood for an O negative patient, but he said this was a common practice for emergencies where the patient is male and there is a shortage of O negative blood. He said the pathologist even told him it was ok, as immune responses occur in less than 20% of cases, but that he should call her first. Mr. Tah said that [redacted] only heard about this after the fact and added it to her complaint that was deemed unfounded.

83. Mr. Tah's statement then described issues with his employer-sponsored accommodations in [redacted] and how his employment with APL was terminated on March 10, 2022. He stated that he experienced systemic racism at APL in [redacted] and characterized the staff who complained about him as "evil racist intended individuals".

84. Mr. Tah then described a December 25, 2021, night shift while he was still working for APL in [redacted] He said he was called to do a 15 lead ECG. A registered nurse had already done a 12 lead ECG, but she didn't know how to do the 15 lead. Mr. Tah said that the nurse left for about 5 minutes before coming back asking about the report. Mr. Tah said that the nurse complained to [redacted] about how long it had taken him to do the 15 lead ECG. Mr. Tah also described that he received inadequate training on testing cerebrospinal fluid, and that [redacted] reporting him for not following a tube numbering system that [redacted] had created.

V. SUBMISSIONS

Complaints Director's Submissions

85. The Complaints Director's submissions explained that the discipline process that Mr. Tah underwent with APL is separate and independent from the College's discipline process under the HPA. Mr. Tah engaged in unprofessional conduct pursuant to section 1(1)(pp)(i) and (ii) of the HPA, in that he displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services; and contravened the HPA, the College's Code of Ethics and Standards of Practice.

86. The Complaints Director reviewed the evidence of [redacted] and acknowledged Mr. Tah's evidence, including his "[redacted] Probationary Employee Review" dated June, September, and November 2022. These documents indicated that Mr. Tah had satisfactory knowledge of his position, good communication with patients and the team, and no quality issues or issues using the required procedures.

87. The Complaints Director submitted that the weight of the evidence shows that Mr. Tah did not meet the College's Standards of Practice and Code of Ethics. She submitted that [redacted] evidence should be accepted because she worked in the laboratory and

directly observed the events that she described. Further, [redacted] evidence was substantiated by the emails from [redacted] and [redacted] The Complaints Director attached an appendix cross-referencing the evidence from the hearing with specific provisions of the Standards of Practice and Code of Ethics.

Mr. Tah's Submissions

88. Mr. Tah did not provide submissions separate from his May 29, 2024, email with attachments as described above. The Hearing Tribunal considered this material as Mr. Tah's submissions, as well as his evidence.

VI. DECISION

89. The Hearing Tribunal has found the following allegations proven: 1(a), 2(a), 2(b), 2(c), 2(f), 2(g), 2(j), 2(l).

90. The Hearing Tribunal has found the following allegations not proven: 1(b), 2(d), 2(e), 2(h), 2(i), 2(k), 2(m), 2(n), 2(o), 2(p).

VII. DECISION WITH REASONS

Allegation 1(a)

91. Allegation 1(a) alleged that on or about November 20 and 21, 2021, and while he worked for APL at the [redacted] Mr. Tah acted unprofessionally regarding co-worker B by yelling at co-worker B repeatedly.

92. [redacted] testified that during the weekend of November 20-21, 2021, Mr. Tah yelled at her for approximately 20-25 minutes in the lab's microbiology department, which is separated from the main lab by a locked door. [redacted] said that Mr. Tah argued with her about the work she asked him to do. He became frustrated and began yelling that [redacted] had sabotaged him, that she was trying to intimidate him, and that she was treating him like he was stupid. [redacted] testimony was consistent with her November 22, 2021, email to her employer about Mr. Tah's conduct that weekend.

93. [redacted] was cross-examined by Mr. Tah. [redacted] was somewhat defensive, and she argued with Mr. Tah at times, but Mr. Tah had been quite argumentative during [redacted] direct testimony. He had frequently interrupted Mr. Maxston's questions of [redacted] argued with her testimony, accused her of lying and attempted to interrupt with his own assertions of fact. The Hearing Tribunal did not find that Mr. Tah's cross-examination undermined [redacted] evidence that he had yelled at her. [redacted] also responded to questions from the Hearing Tribunal and maintained her evidence.

94. Mr. Tah did not testify, but he submitted an undated written statement that the Hearing Tribunal accepted as evidence. Mr. Tah's statement did not deny that he yelled at [redacted] over November 20 and 21, 2021. He instead referred to [redacted] yelling at him in the transfusion medicine department and suggested that he left the lab "at once". Mr. Tah did not make himself available to be cross-examined by the Complaints Director or to answer questions from the Hearing Tribunal about his evidence.

95. The Hearing Tribunal considered the evidence and felt that it showed a busy, stressful workplace, but Mr. Tah's conduct exceeded what might reasonably be expected to be tolerated. The Hearing Tribunal preferred [redacted] testimony over Mr. Tah's for the reasons set out above and finds that Mr. Tah did yell aggressively at [redacted] in the microbiology department behind a locked door for 20-25 minutes. His behaviour represented a lapse in judgment and breached the College's Code of Ethics.

96. Principle 2(g) of the College's Code of Ethics states that regulated members of the College display integrity and respect in all their professional interactions. Principle 2(i) states that a regulated member adheres to professionalism in all forms of communication. Principle 3(a) states that a regulated member maintains a level of personal conduct that upholds the integrity of the profession and the trust of the public. By yelling aggressively at his co-worker, Mr. Tah did not show the level of integrity and respect that the profession and the public expect. Mr. Tah's conduct amounted to unprofessional conduct for a regulated member of the College.

Allegation 1(b)

97. Allegation 1(b) alleged that Mr. Tah yelled at co-worker B for approximately two hours in a locked room. [redacted] evidence was that Mr. Tah yelled at her in a part of the lab separated by a locked door, but not for "approximately two hours". The Hearing Tribunal found that allegation 1(b) was not proven on the evidence.

Allegation 2(a)

98. Allegation 2(a) alleged that while working for APL at the [redacted] Mr. Tah failed to meet the minimum standards for the practice of medical laboratory technology by failing to access employer Standard Operating Procedures when appropriate.

99. [redacted] and [redacted] both testified that APL maintained Standard Operating Procedure manuals for MLTs and CXLTs to access while at work. These were documented and stored in hard copies where they would be readily accessible to Mr. Tah, as well as electronically. Following the Standard Operating Procedures is important so that the lab's results can be compared to results from other labs.

100. [redacted] testified that Mr. Tah did not know how to perform lab procedures on his own without accounting for interferences, deviations, and deficiencies, but he would not refer to the Standard Operating Procedures unless she insisted that he do so. She said he would instead become frustrated and yell "just tell me what to do!" [redacted] described Mr. Tah improperly performing a number of tasks, but failing to consult the Standard Operating Procedures over the November 20-21, 2021 weekend, including when cleaning the slide stainer, performing a manual differential cell count, preparing slides to assess cell morphology, failing to use a computer-generated patient identification label for a beta-hydroxy butyrate test, reporting the results of test with a hemolysis, trouble-shooting an ECG, and using a tourniquet to collect a lactate sample.

101. Mr. Tah did not dispute the importance of the Standard Operating Procedures or dispute that he had omitted to access and consult them in the circumstances [redacted] described. He said that he used a "jotter" notebook to facilitate his work, but he said it wasn't in place of the Standard Operating Procedures. Mr. Tah did not include any parts of his "jotter" or refer to any of the Standard Operating Procedures with his evidence.

102. The Hearing Tribunal accepted [redacted] evidence that Mr. Tah failed to access the Standard Operating Procedures on a number of occasions when he was not performing a task correctly and when it would be appropriate to consult them. Mr. Tah's conduct represented a lapse of judgment. Standard Operating Procedures are important to ensure the lab results are accurate and comparable to other test results. Standard Operating Procedures also change from time to time. It is important for MLTs to refer to them regularly to ensure their practices are consistent with the Standard Operating Procedures and up to date.

103. The College's Standard of Practice 3.3(v) requires an MLT to exhibit knowledge of and apply to their professional practice, the principles of quality management to safeguard client care, including adherence to employer processes, policies and procedures. Mr. Tah breached this standard. His failures to access Standard Operating Procedures in the circumstances that [redacted] described were serious and unprofessional because the lab's Standard Operating Procedures exist to ensure lab tests results are accurate, reliable, and comparable from one lab to another. The Hearing Tribunal considered that this finding, which relates to accessing the Standard Operating Procedures, is very similar to the finding in allegation 2(b) relating to following those Procedures. The Tribunal decided to treat them as one finding of unprofessional conduct.

Allegation 2(b)

104. Allegation 2(b) alleged that while he worked for APL at the [redacted] Mr. Tah failed to follow Standard Operating Procedures. [redacted] set out a number of examples in which she testified that Mr. Tah failed to follow the Standard Operating Procedures for lab tests as described in allegation 2(a), above. Mr. Tah did not assert that he had consistently followed the Standard Operating Procedures. The Hearing Tribunal

found that Mr. Tah's conduct represented a lapse of skill and judgment and that breached the College's Standard of Practice 3.3(v). His conduct was serious and unprofessional because the lab's Standard Operating Procedures exist to ensure lab tests results are accurate, reliable, and comparable from one lab to another. The Hearing Tribunal considered that this finding is very similar to the finding in allegation 2(a) and the Tribunal decided to treat them as one finding of unprofessional conduct.

Allegation 2(c)

105. Allegation 2(c) alleged that while working for APL in [redacted] Mr. Tah failed to complete laboratory tests in a timely manner. [redacted] testified that Mr. Tah wasted time in the lab and delayed the reporting of test results to the Emergency Department unnecessarily. He omitted to prioritize higher acuity samples over less urgent samples. This led to telephone calls to the lab seeking overdue test results. [redacted] said that she had to open the procedure manual and show Mr. Tah the correct pages to prove to him the correct way to do things.

106. During his cross-examination, Mr. Tah did not undermine [redacted] evidence that he wasted time in the lab and delayed tests and the reporting of test results unnecessarily. The Hearing Tribunal accepted [redacted] evidence and finds that Mr. Tah did fail to complete laboratory tests in a timely manner.

107. This was a lapse of skill and judgment and contravened the College's Standards of Practice. Standard 1.3(vi) states that the MLT must assume personal responsibility for their professional decisions and the impact of those decisions on the quality of their practice. This includes taking appropriate action in responding to and mitigating situations which jeopardize the care of clients or brings harm to the profession. Standard 3.2(iv) states that the MLT must exhibit leadership within the profession and within the broader healthcare provider community, through demonstrating initiative and effective time management. Standard 3.3 states that the MLT must exhibit knowledge of and apply to their professional practice, the principles of quality management to safeguard client care.

108. Mr. Tah was in training with APL at the [redacted] but he was not new to the profession. He was an experienced MLT having previously worked in Newfoundland and Labrador. Mr. Tah ought to have appreciated the need to prioritize samples for testing based on patient acuity and demonstrated that he understood that need and managed his time effectively. His failure to do so contrary to the Standards of Practice was unprofessional conduct. The Hearing Tribunal considered that this finding of failing to complete lab tests in a timely manner is very similar to the finding of failing to prioritize urgent testing in allegation 2(f) and the Tribunal decided to treat them as one finding of unprofessional conduct.

Allegation 2(d)

109. Allegation 2(d) alleged that while working for APL at the [redacted] Mr. Tah failed to provide accurate test results. There was insufficient evidence of Mr. Tah reporting inaccurate test results to find this allegation proven. The Hearing Tribunal considered the evidence of [redacted] and [redacted] observations, but neither [redacted] nor [redacted] testified at the hearing and neither of them could be cross-examined or questioned by the Hearing Tribunal.

Allegation 2(e)

110. Allegation 2(e) alleged that while working for APL at the [redacted] Mr. Tah failed to check when quality control had been done. The Hearing Tribunal found this allegation not proven. [redacted] testified to one incident in which Mr. Tah omitted to check when quality control had last been done. The Tribunal considered that even if Mr. Tah had forgotten to check when the quality control had last been done on this one occasion, his conduct did not amount to unprofessional conduct. The type of lab apparatus Mr. Tah was using is highly accurate so the risk of an inaccurate result from an outdated quality control check was very low. Further, Mr. Tah's conduct was an isolated error that could reasonably be made by any MLT.

Allegation 2(f)

111. Allegation 2(f) alleged that while working for APL at the [redacted] Mr. Tah failed to prioritize urgent testing. [redacted] testified that Mr. Tah had not been prioritizing the higher acuity samples for testing over the less urgent samples, leading to calls to the lab for delinquent test results.

112. [redacted] complaint explained that Mr. Tah had run a complete blood count test for a patient from the emergency department who also required a cell morphology assessment. [redacted] testified that emergency department patients generally require lab results urgently, so these tests are given priority over routine tests.

113. [redacted] testified that Mr. Tah had run the complete blood count and was attending to other tasks when the emergency department called asking for the test results. Mr. Tah told the emergency department he would send them the results soon, but when he went into the computer system to release the test results, he failed to realize that the complete blood count results would not be reported to the emergency department until he had made and analyzed the cell morphology slide. Mr. Tah attempted to load the slide stainer in a manner that would take longer than necessary. [redacted] had to correct him and reload the slide stainer herself. Then, when the slide was ready to be analyzed, Mr. Tah went to analyze a slide for an in-patient first, before analyzing the slide for the higher acuity emergency patient. [redacted] said that she had to tell Mr. Tah to prioritize the slide for the emergency patient and pointed out that they had already called asking for the test results.

114. For his part, Mr. Tah testified that he had good turnaround times for lab tests and results, but he did not respond to the incident [redacted] described or point to any specific examples of turnaround times.

115. The College's standard of practice 1.3(vi) requires that MLTs take appropriate action in responding to and mitigating situations that jeopardize the care of clients or bring harm to the profession. Standard 2.4(iii) requires that MLTs adhere to technical trouble shooting processes to recognize, initiate corrective action, and document problems in the post-analytic phase, including the reporting of timely results.

116. Mr. Tah's conduct as described by [redacted] delayed the reporting of test results for longer than necessary and contravened these standards of practice and represented a lapse of skill and judgment. The Hearing Tribunal finds that Mr. Tah's conduct rose to the level of unprofessional conduct. In this case, Mr. Tah was performing a test for a patient in the emergency department for whom the department had already called looking for the test results. Mr. Tah's failure to appropriately prioritize and complete the test for the emergency department demonstrated a lack of corrective action and risked jeopardizing the patient's care. The Hearing Tribunal considered that this finding is very similar to the finding in allegation 2(c) and the Tribunal decided to treat them as one finding of unprofessional conduct.

Allegation 2(g)

117. Allegation 2(g) alleged that while working for APL at the [redacted] Mr. Tah failed to provide urgent test results in a timely manner.

118. [redacted] testified and described a February 12, 2022, email from [redacted] in which [redacted] wrote that upon arriving for work on February 9, 2022, she noticed that Mr. Tah had run a blood glucose test. The test showed a critical glucose level of 32 mmol/L for an outpatient, but the test result was still waiting to be reported. [redacted] email said that Mr. Tah had already repeated the test to verify the result, but he hadn't notified the patient's physician or the pathologist on call.

119. [redacted] identified the glucose test result report as page 26 of exhibit 14. The test result report corroborated [redacted] email. The report showed that the sample was initially tested at 22:13 hours and that the test was repeated at 22:28 hours. In both instances the patient's glucose level was measured at 32 mmol/L. This is critically high and the patient was at serious risk of harm. Upon repeating the test and obtaining the same critical result, Mr. Tah should have taken steps to notify the patient's physician urgently, or if the patient's physician could not be reached, Mr. Tah should have contacted the on-call pathologist as specified by the Standard Operating Procedures.

120. Mr. Tah responded to this allegation that the patient was a known diabetic and that he had called the patient's physician twice about the result, but no one had picked up the phone. Mr. Tah did not address why he hadn't called the on-call pathologist when he couldn't reach the patient's physician. Mr. Tah also suggested that [redacted] should have consulted with him before reporting the critical glucose result herself.

121. The Hearing Tribunal did not accept that [redacted] should have consulted Mr. Tah before trying to reach the patient's physician and then the on-call pathologist. Mr. Tah had run and re-run the test to verify the result. The test results both confirmed a critically high blood glucose level. This is a serious medical condition. If Mr. Tah had been unable to reach the patient's physician, he should have followed the Standard Operating Procedure and called the pathologist to raise a concern about the patient's safety. It shouldn't have been necessary to wait for [redacted] to come into the lab and notice that the critical test result had not been reported to anyone.

122. The College's Standard of Practice 1.3(vi) requires that MLTs take appropriate action in responding to and mitigating situations which jeopardize the care of clients or bring harm to the profession. Standard 2.4(iii) requires that MLTs adhere to technical troubleshooting processes to recognize, initiate corrective action, and document errors or problems in the post-analytic phase – including the communication of critical and priority results. Mr. Tah's failure to make sure the critical glucose result had been properly reported jeopardized the patient's care and safety. He failed to initiate corrective action to ensure the timely communication of the critical test results. These breaches of the Standards of Practice and Mr. Tah's lapse of skill and judgment were serious and amounted to unprofessional conduct.

Allegation 2(h)

123. Allegation 2(h) alleged that while working for APL at the [redacted] Mr. Tah failed to re-run critical values to confirm test results. This allegation was not proven. There was insufficient evidence that Mr. Tah had failed to re-run critical test results to verify them.

Allegation 2(i)

124. Allegation 2(i) alleged that while working for APL at the [redacted] Mr. Tah failed to properly warn patients prior to inserting needles when collecting specimens. Warning a patient before inserting a needle to collect a specimen is generally advisable, but the College's Standards of Practice do not mandate a specific warning. There was insufficient evidence of unprofessional conduct to find this allegation proven.

Allegation 2(j)

125. Allegation 2(j) alleged that while working for APL at the [redacted] Mr. Tah failed to follow proper infection prevention and control requirements, including failure to avoid cross-contamination.

126. [redacted] testified about an email from [redacted] in which he described "major issues" with Mr. Tah's universal precautions and infection control. [redacted] described Mr. Tah failing to properly doff his PPE, touching a door lock keypad with contaminated gloves after visiting an isolation patient, and wiping his forehead while in an isolation room. He said he observed Mr. Tah use the dirty computer with his bare hands, even after dealing with a positive COVID patient sample. [redacted] also described observing Mr. Tah handle known COVID and C.diff positive samples, remove his PPE, and then handle the dirty samples with his bare hands. [redacted] said that he had counselled Mr. Tah many times about universal precautions and infection control but Mr. Tah did not listen. [redacted] testified that this conduct by Mr. Tah did not comply with AHS standards and risked making himself and others sick.

127. Mr. Tah did not respond to most of [redacted] concerns about his universal precaution and infection control practices. Mr. Tah disputed that he did anything wrong by wiping his brow with his "elbow shoulder arm" when he would sweat in a hot room during a collection. He said it was "not like I touch my face with my fingers while wearing gloves." Based on Mr. Tah's acknowledgment that he had wiped his brow of sweat with his elbow, shoulder, or arm in an isolation patient's room and [redacted] testimony that his was contrary to AHS standards and increased the risk of infection, the Hearing Tribunal found this allegation proven. The Tribunal accepts that Mr. Tah wiping his face with his sleeve is a problem. Mr. Tah could have used a paper towel to wipe his brow and properly disposed of it in the patient's room rather than using the sleeve of his personal protective equipment.

128. Mr. Tah's conduct was a lapse of skill and judgment. The College's Standard of Practice 2.5(ii) and (x) also state that MLTs must promote and adhere to safe work practices that minimize risks to themselves and their clients. This includes adhering to employer policies and procedures for infection prevention and control and for the use of personal protective equipment and other safety equipment. Mr. Tah breached these obligations which exist for his safety but also for the safety of patients and other healthcare workers. This conduct rises to the level of unprofessional conduct.

Allegation 2(k)

129. Allegation 2(k) alleged that while working for APL at the [redacted] Mr. Tah failed to provide emergency ECGs in a timely manner. The Hearing Tribunal considered the evidence for this allegation but found that the corroborated evidence was insufficient to prove that Mr. Tah failed to perform emergency ECGs in a timely manner. Allegation 2(k) was not proven.

Allegation 2(l)

130. Allegation 2(l) alleged that while working for APL at the [redacted] Mr. Tah failed to multitask appropriately.

131. [redacted] testified that while working with Mr. Tah she asked him to test samples that had come to the lab for C.diff. Mr. Tah had not yet demonstrated that he was competent to perform this test on his own. Mr. Tah had also been instructed to perform some quality control tasks in transfusion medicine that day, time permitting. [redacted] said that she asked Mr. Tah to do the C.diff tests first, because there was an outbreak in long-term care and she had told the nurse that they would complete the tests before the end of their shift. [redacted] said that she explained to Mr. Tah that it was more important to complete the tests than it was to do quality control tasks and that they had enough time to do both if they would get started. [redacted] said that Mr. Tah argued with her and he eventually descended into yelling.

132. Mr. Tah did not offer a different account of this incident. During his cross-examination of [redacted] Mr. Tah asked whether the C.diff tests and the quality control tasks could have been done within a similar timeframe. [redacted] confirmed that they could, but the quality control tasks were really evening responsibilities that did not need to be done during the day. She said that Mr. Tah was arguing and stalling. She said that he was not working on the task at hand at any point during the weekend.

133. The Hearing Tribunal was satisfied that Mr. Tah failed to multitask appropriately by performing the C.diff tests as directed by [redacted] and performing quality control tasks when possible, as time permitted. This represented a lapse of judgment.

134. The College's Standard of Practice 3.1(iv) requires that MLTs communicate and collaborate effectively to ensure quality service delivery, including anticipating, contributing, responding, and working effectively in a changing environment. Principle 2(a) of the Code of Ethics requires that MLTs assume personal responsibility for their professional decisions and the impact of those decisions on the quality of their practice. Mr. Tah's conduct contravened these requirements. He did not act collaboratively or work effectively when he argued with [redacted] about the prioritization of C.diff testing over routine quality control tasks. Mr. Tah's actions disregarded the impact of his prioritization on the patient and the quality of his practice. These contraventions were significant and amount to unprofessional conduct.

Allegation 2(m)

135. Allegation 2(m) alleged that while working for APL at the [redacted] Mr. Tah failed to refrigerate perishable stock in a timely manner or at all. The Hearing Tribunal found the evidence to be insufficient to prove this allegation. Perishable lab stock is generally packaged in such a way that it does not necessarily need to be unpacked and refrigerated immediately. In this case the evidence was that the stock was

packaged with a gel pack that would have kept it cold for some time. The evidence did not establish that Mr. Tah was exclusively responsible for refrigerating the perishable stock or the amount of time that the stock went unrefrigerated.

Allegation 2(n)

136. Allegation 2(n) alleged that while working for APL at the [redacted] Mr. Tah failed to perform collection of specimens from patients in a timely manner. There is no specific duration of time that collecting a sample should take without falling below expected standards or constituting unprofessional conduct. Every patient and collection is different. With experience, some MLTs may become faster or more efficient at collections than others, but this does not mean the other MLTs are engaged in unprofessional conduct. There was also a lack of evidence about which samples from which patients took too long to be collected. The Hearing Tribunal found this allegation not proven.

Allegation 2(o)

137. Allegation 2(o) alleged that while working for APL at the [redacted] Mr. Tah failed to perform ECGs in a timely manner. The Hearing Tribunal found this allegation not proven for the same reasons as in allegation 2(k).

Allegation 2(p)

138. Allegation 2(p) alleged that while working for APL at the [redacted] Mr. Tah failed to properly identify patients. The Hearing Tribunal found this allegation not proven due to insufficient evidence. [redacted] did not testify. Mr. Tah was unable to cross-examine [redacted] about the patients to whom he was referring in his email.

VIII. ORDERS

139. The Hearing Tribunal will receive submissions on sanctions and costs in light of its findings of unprofessional conduct. To date, the Complaints Director has made limited submissions in writing. The Hearing Tribunal directs that this decision be circulated and that the parties make written submissions on sanctions and costs orders. Either party may request an oral hearing on sanctions and costs orders, in which case the Tribunal will decide whether to hold a further oral hearing.

Signed on behalf of the Hearing Tribunal by the Chair:

Ms. Aischaa Hammond, MLT

Dated March 18th, 2025