IN THE MATTER OF AN ARBITRATION CONCERNING THE GRIEVANCE OF KEN MAIR ("GRIEVOR")

BETWEEN:

UNITED STEELWORKERS OF AMERICA, LOCAL 5890
("Union")

- and -

IPSCO SASKATCHEWAN INC.
("Employer")

ARBITRATOR:

Gary G.W. Semenchuck, Q.C.

ARBITRATION HEARING DATES:

September 27 and 28, 2007

COUNSEL AND REPRESENTATIVES:

Larry B. LeBlanc, Q.C. for the Employer

Mike Park, District 3 Staff Representative for the Union and the Grievor

DATE OF AWARD: October 18, 2007

ARBITRATION AWARD

INTRODUCTION AND PRELIMINARY MATTERS

This Arbitration relates to a grievance by Ken Mair ("Grievor") against IPSCO Saskatchewan Inc. ("Employer") relating to an incident on November 2, 2006 resulting in a one day suspension.

The parties agreed that I was properly constituted as the Arbitrator to determine this grievance and there were no preliminary objections or issues.

FACTS

There is no dispute about the facts relating to the incident on November 2, 2006. The Incident Investigation Report (Exhibit 9) described the incident facts as follows:

> "Ken had just finished doing a F/M work roll change and was going back to put the roll change bail in its stand. He had just gone past the back drum scraper to position the bail when the 25 ton hook went through the limit switch, broke cable and came crashing down. It fell approx. 3-4 feet from employee walkway and approx. 10 feet from nearest employee (Brock Gigian)."

I will refer to other facts from the evidence throughout this Award.

This incident occurred at approximately 9:00 p.m. on November 2, 2006 during the twelve hour nightshift from 7:00 p.m. to 7:00 a.m. An investigation was commenced immediately after the incident by a team consisting of Brent Stockbrugger, Cliff Selinger, Dave Evans, Ken Mair and Roger Juarez. The Grievor provided a handwritten statement of his version of events on November 2, 2006 and an Incident Investigation Report Form was completed by Brent Stockbrugger in his own handwriting.

On November 9, 2006, the Employer delivered a Notice of Disciplinary Action (Exhibit 3) to the Grievor suspending the Grievor for one day for "undue care and attention" describing the reason in the following terms:

> "Operator inadvertently had the auxiliary hook in 1st notch up during a roll change. The hook went through the limit switch, snapping the cable thus allowing the hook block to fall to the ground. The hook block missed a coworker by approximately 10' and is a recordable OH&S incident."

On November 18, 2006, the Grievor filed a grievance (Exhibit 4) stating:

> "Ken feels the discipline is unfair. The limit switch on the crane failed (as according to inspection by electrician) and therefore failed to prevent this incident. The incident was not entirely Ken's fault but equipment failure!"

The Grievor requested that the discipline be reduced to a written warning. The Employer denied the grievance at steps 1, 2 and 3 and proceeded to this Arbitration. In its denial at the 3rd stage (Exhibit 5), the Employer stated:

> "Mr. Mair was operating a crane on November 2, 2006 and took his auxiliary hook through the limit switch snapping the cable causing the hook block to fall to the ground. It is true that the limit switch failed, but the controller did not fail. The controller was left in an operating position causing the auxiliary hoist to operate without the awareness of the operator. This is clearly a significant operator error that posses (sic) a critical safety concern. In our view the fact that the limit switch failed is not a factor in considering an appropriate response to this incident. The limit switch is a safety device designed to offer protection in situations where a hook is run past the safe stopping zone and up into the drum. The limit switch failed at some point during the shift but because the limit switch is not meant to be a stopping device relied upon in normal operating situations the operator is still liable for the consequences of his error. However, we did consider a number of factors that mitigated in favor (sic) of Mr. Mair getting lesser discipline. We considered Mr. Mair's operating performance, his disciplinary record and his candor (sic) during the incident investigation, all of which served to reduce the discipline. It was determined that the appropriate level of discipline for these specific circumstances is a 1-day suspension. The Union has suggested the discipline is too harsh and that he should have received a written warning. Under the circumstances, we believe a 1-day suspension is fair and appropriate. This grievance is denied."

In his written statement dated November 2, 2006, the Grievor stated:

> "At approximately 9:00pm. I was opperating (sic) the 60 ton mill crane going to do a roll change. I lifted the 25 ton hook I stopped it about 18 inches down from the limit weight the hook always travels up when you stop it. The hook lifted the limit switch weight about 3 to 4 inches so I dropped the hook until it was about 2 inches under the weight.
>
> I proceeded to do the roll change. I mentioned on the radio that the 60 ton hook was pretty slow the roll change went normal. when I picked up the old rolls to put them on the buggy I was over the buggy and I checked each notch to see if they were all working.
>
> I unhooked from the rolls and the bail turned to the right position to put it in the stand so I moved the crane over to the stand and as I was about to trolley out towards the stand the 25 ton hook dropped to the ground. I immediately checked my controls and they were all in the neutral position. I then informed Dennis Top of what happened on the radio he told me to stay in the crane and not to move the crane untill (sic) photographs were taken etc."

Brent Stockbrugger testified that he was working as a supervisor at the time of the incident. He heard a loud bang and, from his position in the pulpit in the rolling mill, he looked to his left and saw a block and hook settling on the ground. He said it hit and bounced. He immediately went down onto the floor of the rolling mill and told the Grievor to remain in the crane and not to move or do anything. Mr. Stockbrugger called maintenance and electricians and, after they completed their safety checks, the Grievor was instructed to move the overhead crane to the boarding station. Mr. Stockbrugger testified that he met the Grievor at the bottom of the stairs by the boarding station and that the Grievor was "very shaken up". Mr. Stockbrugger also testified that the Grievor was very forthcoming about his actions that night. The Grievor told Mr. Stockbrugger that he was sure he left the control in neutral for the 25 ton hook and that when he checked immediately after the incident, the control was in neutral. Upon further questioning from Mr. Stockbrugger, the Grievor said there could have been a chance the controller was in the up position but he didn't know how it got there.

Mr. Stockbrugger admitted that the limit switch on the 25 ton hook did fail and he testified that, if the limit switch is operating, the load should stop. He also testified that the limit switch is an emergency stopping device to prevent the load from

travelling too high so it can't damage the drum or the cables. In cross-examination, Mr. Stockbrugger admitted that he could not say whether the Grievor did or didn't put the lever in the first notch. Mr. Stockbrugger admitted that he did not know what the Grievor did.

Mr. Todd Tribe, area manager of the rolling mill, testified that the investigation came to no conclusion as to when or how the controller for the 25 ton hook got engaged. He stated that it had to have been inadvertently engaged because the hook can't move unless it is engaged. Mr. Tribe stated that the Grievor was candid and very truthful and the Grievor didn't know what had happened. Mr. Tribe also confirmed that the limit switch failed on the 25 ton hook. In cross-examination, Mr. Tribe stated that he was aware of two incidents in which the limit switch failed and the hook fell, this one and one other. He also admitted that the limit switch is a safety device which should stop the hook going into that limit switch. If the limit switch had not failed and the Grievor had taken it out of the limit, Mr. Tribe testified that he probably would not have known about the incident.

The Grievor testified that he has been employed at IPSCO for almost 20 years and he has been a crane operator for 15 years. He is a certified crane operator on the overhead cranes in the Steel Division at IPSCO. On November 2, 2006, he had commenced his shift at 7:00 p.m. and had gone through his inspection procedure for the overhead crane including testing the 25 ton limit switch. Prior to 9:00 p.m., the Grievor had been using the 25 ton hook when Fred Singer, a supervisor, called for a roll change. The Grievor proceeded to move the crane into position for the roll change which involved stopping his work with the 25 ton hook and hoisting that 25 ton hook up and hoisting the 60 ton hook down while travelling into position. The Grievor stated that when he stopped the upper movement of the 25 ton hook it continued upwards for about one foot as it always does. On this night the Grievor stated that the 25 ton hook had lifted the weight a few inches and he put it down 2 or 3 inches to be below the weight. He had completed the roll change with the 60 ton hook and was trolleying out when he saw the 25 ton hook going down out of the corner of his eye and hitting the floor. He automatically put the controls in neutral but he doesn't actually remember doing that. He did look at the controls and saw that they were all in neutral. He testified that he does not dispute that the controller for the 25 ton hook had to be in the up position but he doesn't

know how it got there. In cross-examination he admitted that operators should be aware of the position of their hoist control levers.

ARGUMENT

Mr. LeBlanc argued on behalf of the Employer that the Grievor was not in proper control of the crane and the 1-day suspension was reasonable discipline for carelessness.

Mr. Park argued that the Grievor inadvertently set in place circumstances in which the hook went into the limit switch area and if the limit switch had worked we would not be dealing with any discipline. Mr. Park argued that this was a minor careless act which ought not to attract discipline but the grievance had requested that the penalty be reduced to a written warning and that was as far as I could go.

ANALYSIS AND DECISION

At the Union's request, and with the cooperation of the Employer, I did visit the rolling mill at IPSCO and climb into the overhead crane which had been operated by the Grievor. I have also reviewed the evidence, including the Exhibits, and the authorities submitted by the Employer and the Union.

In a discipline case, the employer must prove on a balance of probabilities that the employee has been guilty of some misconduct deserving a disciplinary response. In this Arbitration, however, the grievance raises only the issue of the penalty by requesting that the penalty be reduced to a written warning. As a result, I will not comment on the proof of misconduct and I will deal only with the penalty imposed by the Employer. In that regard, the question to be answered is whether the 1-day suspension is excessive discipline in all of the circumstances. If the 1-day suspension is excessive what should the discipline measure be?

I agree with the principle that an Arbitrator should not interfere with a penalty imposed by the employer unless that penalty is clearly unreasonable. The

principle was stated by Arbitrator Devine in *Re District of West Vancouver and Amalgamated Transit Union Local 134*[1]:

> "… [a]n arbitrator ought not to substitute his or her notion of the appropriate penalty unless the penalty selected by the Employer is clearly unreasonable having regard to all of the circumstances of the case."

Arbitrator Outhouse stated the principle in these terms in *Re Volvo Canada Ltd. and Canadian Automobile Workers, Local 720*[2]:

> "The point is that the imposition of disciplinary sanctions is an inexact science. Provided that the penalty imposed by the employer does not offend the arbitrators' sense of justice and equity, it should not be tampered with merely for tampering's sake. (See: *Amalgamated Transit Union, Local 508 v. Metropolitan Transit Com'n of Halifax, Etc.* (June 20, 1983), unreported, at p. 15)
>
> Putting the matter in a somewhat different way, the question that arbitrators should ask themselves when considering penalty substitution, is whether the penalty imposed by the employer is within the range of reason having regard to all the circumstances of the case. Arbitrators should not interfere with a penalty merely because, had they been the employer, they would have handled the matter somewhat differently. (*Re Volvo Canada Ltd. and U.A.W., Loc. 720*, (1984) 16 L.A.C. (3d) 153 at p. 159)."

I also firmly believe that safety is paramount in any workplace and particularly in an industrial workplace which has many activities which are potentially dangerous.

However, the circumstances of this grievance are such that I am driven to the conclusion that the 1-day suspension was clearly unreasonable. The Employer never came to any conclusion about how the lever control for the 25 ton crane ended up in the up position. The Employer assumed that the lever control had to be in the up position

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1. *Re District of West Vancouver and Amalgamated Transit Union Local 134* (1998), 70 L.A.C. (4th) 233 (Devine) at p. 240.
2. *Re Volvo Canada Ltd. and Canadian Automobile Workers, Local 720* (1990), 12 L.A.C. (4th) 129 (Outhouse) at p. 136.

because the 25 ton hook would not move upwards in any other way. The Employer described the incident in the following terms at page 5 of the typed Incident Investigation Report (Exhibit 9):

> "Failure believed to be caused by operator mistakenly leaving the hoist in 1st notch upwards combined with a faulty limit switch. Limit switch had failed electrically due to a faulty contact switch." (emphasis added)

The Employer also considered it to be an inadvertent error. The Employer also emphasized that the limit switch was a safety device for emergency purposes and was not to be used by an operator to stop the hook. In my view, the purpose of the limit switch was to prevent this type of incident. Somehow, on November 2, 2006, the 25 ton hook was moving upwards when it should have been stopped. That was clearly an emergency situation which should have been prevented by the limit switch. However, the limit switch failed and, as a consequence, the cable snapped and the 25 ton hook and block fell 45-50 feet to the floor. Fortunately, no injuries occurred.

CSTEC Craning Course Manual, Module 8, Overhead Crane, Specifications and Usage (Exhibit 13) describes the limit switch in this fashion:

> "Limit Switch
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> Hoist limit switches are used on all hoists to prevent the hoist from raising too high and breaking the wire ropes. A limit switch is for emergency use only; not to be used during normal operation. Limit switches are not fail safe an (sic) cannot be depended on. The more a limit switch is used, the less reliable it will be."

Module 9, General Inspection Requirements To Ensure Safe Crane Operations, contains the following statement:

> **"Hoist Safety Limit Stops**
>
> AVOID using the limit stop as a means to stop the hoist motion regularly. It is a safety device for the protection of yourself and fellow workmen and should be reserved for emergency use only."

The evidence does not indicate that the Grievor used the limit stop to stop the hoist motion regularly or at all. On November 2, 2006, the 25 ton hook was going upwards without the Grievor being aware of that action. That was clearly an emergency situation and the purpose of the limit switch was to prevent the hoist from raising too high and breaking the wire ropes. Mr. Forrester, in cross-examination, testified that the Employer has been investigating other devices and is taking steps to put rotary limits on the cranes and such rotary limit has been put on this particular crane. The Employer is to be commended for that action because safety devices need to function and operate properly in emergency situations.

The Employer also emphasized that the more a limit switch is used, the less reliable it will be, which is information provided in the Training Manual for crane operators. In my view, however, the Employer should have a policy relating to the use of limit switches and some standard for a regular review of them because those limit switches are tested at the commencement of every shift, which means twice in a 24 hour period. That testing alone would amount to using the limit switch 60 times a month and that raises in my mind a question about when the reliability of the safety switch might come into question…is it 6 months or one year or longer?

All of the authorities cited by the Employer involved a deliberate action on the part of the Grievor. Even the authorities which related to a single incident involved a deliberate, rather than an inadvertent, act by the Grievor. For example, in the Stromberg Award relating to Saskatchewan Union of Nurses and Midale Union Hospital, the Board found that the Nurse did not check the patient's identification band prior to administering medication which was intended for a different patient. In the Award by Arbitrator Rose in *Re ITT Automotive Inc. and Canadian Autoworkers, Local 199*[3], the grievor denied any knowledge about the incident when confronted by the employer. The grievor subsequently admitted responsibility for putting a gouge in the grinding wheel because he got angry after getting sparks in his eye all day. In the case before me, there is no evidence of any deliberate act and there was no denial or attempt to hide the incident. In my view, this incident is entirely unique and different from a deliberate course of action or ignoring safety procedures. In this grievance, there is no evidence of any discipline history relating to the Grievor and the Grievor was completely honest and forthcoming in

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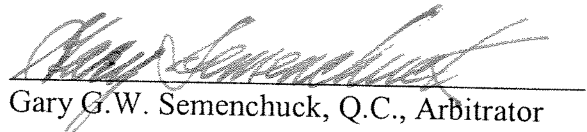
[3] *Re ITT Automotive Inc. and Canadian Autoworkers, Local 199* (1995), 51 L.A.C. (4th) 308 (Rose).

his statement on the night of the incident and in his evidence. Under these circumstances, I consider the 1-day suspension to be unjust and inequitable.

Under all the circumstances, I find that the 1-day suspension was not reasonable and a written warning should be substituted as the appropriate penalty. Accordingly, the 1-day suspension is set aside and the Grievor is to be compensated for his lost wages. I will reserve my jurisdiction to deal with any issues over the implementation of this Award.

DATED at the City of Regina, in the Province of Saskatchewan, this 18th day of October, 2007.



Gary G.W. Semenchuck, Q.C., Arbitrator

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