IN THE MATTER OF AN ARBITRATION

BETWEEN:

UNITED STEEL WORKERS, LOCAL 5890
(CHUCK STICE ARBITRATION)

UNION

AND:

EVRAZ REGINA STEEL (A DIVISION OF EVRAZ
INC. NA CANADA)

EMPLOYER/EVRAZ

AWARD

Sole Arbitrator:	Kenneth A. Stevenson, Q.C.
Appearing for the Union:	Leslie McNabb, Staff Representative, USW
Appearing for the Employer:	Mathias Link, Counsel Troy Lalonde, Senior Manager, Human Resources
Hearing:	August 17, 18, 19, and 29, 2016 Regina, Saskatchewan
Date of Award:	September 16, 2016

AWARD

I. BACKGROUND

1. On April 2, 2016 at approximately 1700 hours Chuck Stice (the "Grievor") was operating a locomotive moving twelve railcars loaded with scrap from the weigh scale in the Employer's Regina Yard. The cars were to be pulled along the scale track past the F1 switch and then pushed back through the F1 switch onto the F1 unloading track. The locomotive and twelve cars did not stop after the F1 switch, rather they continued down the line past Pasqua Street until the locomotive struck twelve empty CP railcars parked on the storage track causing seven of the cars to derail. The resulting damage to the cars and track has been estimated at $600,000. The Grievor says that notwithstanding his continued efforts to stop/slow the locomotive, it continued to pick up speed on the downslope leading to the point of the collision.

2. The Employer conducted an investigation into the collision and concluded that the collision and derailment were *"...due to Locomotive Operator negligence"*. On April 15, 2016 the Grievor's employment was terminated. On the same day the Union filed a grievance alleging unjust and unreasonable termination.

3. The parties agree that I have been properly appointed as arbitrator and that I have jurisdiction to hear and determine all of the issues raised by the grievance.

II. EVIDENCE

4. The Grievor has worked for the Employer since August 1997 in both steel and pipe operations. For approximately ten years he has worked in the Yard in various positions including: Lime Blower, Switchman, Mobile Crane Operator, and Locomotive Operator since 2011.

5. Shortly before 5:00 p.m. on Saturday, April 2, 2016 the Grievor and his switchman, Danon W. (the crew), received instructions from Kevin Hicks, Area Manager Yard Operations, to move railcars loaded with scrap from the F2 loading track to the scale to have the cars

weighed and then move them through the F1 switch onto the F1 track. The Grievor operated locomotive No. 11 as it hooked up to twelve loaded scrap cars on F2 track and pulled them onto the Evraz main track. The switchman aligned switches appropriately to allow the Grievor to push the cars down the main track onto the scale track for weighing.

6. The crew completed the weighing operation by starting with the lead car behind the locomotive. Because of the weight of five of the cars, it was necessary that they be split-weighed. The weigh tickets show the weights of seven cars: one at 92 tonne and five between 106 tonne and 122 tonne with one car at 150 tonne. The five splits weighed from 168 tonne to 190 tonne. The total weight of the twelve cars was approximately 1800 tonnes. Each railcar was either 52 or 65 feet in length. The total length of the train, including the locomotive and twelve cars would be approximately 230 meters. The scrap cars do not move from the Evraz tracks and they are not subject to the typical weight restrictions for railcars in the range between 120 to 130 tonnes.

7. After weighing the final car, the switchman radioed the Grievor the okay to move: *"forward, take it away"*. At this point the locomotive would be approximately seventy meters from the F1 switch. In order to pull all of the cars past the F1 switch, the cars would have to be pulled approximately 300 meters. The Grievor accelerated the locomotive to get the load moving.

8. The locomotive's GPS recording provides significant information about the locomotive's movements. The locomotive accelerated variously to 2, 3 and 4 kmph to spot the railcars at the scale and engaged its independent brake to bring the cars to a stop. The start/stop movements took between 20 and 40 seconds. At the end of the weighing the locomotive would be starting and stopping where the locomotive would be more than 200 meters past the scale with approximately 90% of the weight on a downhill grade. The GPS shows that in weighing the final car, over a period of 40 seconds, the train accelerated to 4 kmph and then came to a stop.

9. When pulling the cars from the scale the locomotive reached a speed of 9 kmph at the F1 switch approximately 70 meters after the pull commenced. From the start of the pull to reaching

F1, 23/24 seconds lapsed. At Pasqua Street the locomotive was travelling at approximately 17 kmph and continued at this speed for approximately 400 meters. The locomotive then slowly accelerated until approximately four and one-half minutes after the F1 switch it achieved a speed of 27 kmph before it struck the parked railcars. The GPS shows some speed flicker variance of 1 kmph after the locomotive was past the F1 switch. The GPS shows a time lapse from the start at the scale to collision of approximately 4 minutes 40 seconds.

10. Danon has worked for Evraz since January 2012 and been a switchman since October 2013. On April 2 he was the switchman during the Grievor's operation of the locomotive. After completion of the weighing of the twelve cars he told the Grievor *"forward, take it away"*. He completed some paperwork at the scale; he then drove to the F1 switch where he counted down the cars until they were clear of the switch: *"five cars, three cars, two , one, half, 15, 10, 5, bring it back when you stop"*. Moments later he thought he would have to go and watch the Pasqua Street crossing. The Grievor radioed the switchman *"I'm not stopping"*; he repeated these words in response to the switchman's inquiry as to whether he was *"... slowing down at all"*. Danon did not hear anything over the radio about the brakes. He was worried about the Grievor so he drove down the line to help.

11. On April 12, Danon wrote a third statement at the request of management following his phone discussions with the Grievor. He said that there were three brakes on the cars at F2 and that it *"took a lot to get out"*. When weighing the cars he removed the handbrakes from No. 2 and 3 cars; as always, and as trained, he left the brake on the bottom (last) car to stop the cars from running away. He says that as trained, he always takes the extra brakes off; he does this many times a shift without telling the locomotive operator. On April 2 in doing this he did not need to ask the locomotive operator for 3 point protection. There was one brake on, this was normal and it happens all the time going through the Yard. His opinion is that the brake at the bottom is a "must"; others not so.

12. Although he is not a locomotive operator, Danon is of the opinion that the operator should be able to tell by pulling whether or not the brakes are on other cars. His experience is that the locomotive operators go past the switch at least once every day, sometimes by a few car

lengths. He agrees that communication between the operator and switchman is key. The locomotive operator is ultimately responsible for controlling movement and there should never be any assumptions. They have pulled more than twelve cars; maybe up to fourteen or fifteen cars, from scrap. Mostly they pull four to six cars.

13. Mr. Brent Orb completed an investigation and prepared a report for the Saskatchewan Ministry of Highways and Infrastructure, Planning and Policy – Rail Services "(MHI Report"). The report summarized the accident, identified contributing factors that led to the accident, outlined corrective action taken and recommendation for further corrective action. Mr. Orb reports that the Grievor stated that he *"started testing the brakes when the locomotive was next to the F1 switch"* when the GPS showed the train traveling approximately 10 kmph.

14. Paul Grona, Lead Hand, Millwright and Heavy Duty and Automotive Technician was called out to the accident scene to check the brakes on the locomotive. He found the independent brake partially applied with air pressure still holding at 15 psi. He found all brake shoes at 50%. At that time he did not see any indication of the wheels *"flat spotted"*. The next day on examination at the locomotive shop he found a small flat spot; at some point the wheel had stopped turning. He could not speak to the recency of the flat spots or how they occurred. He says one would hear a flat spot *"pounding on the rail; pretty good bang; physically feel it"*. He started the locomotive and built up to 40 psi on the brake cylinder pressure and 120 psi on main pressure. These indicated that the operation was okay. When the locomotive was held under full throttle when it was loaded up in forward and reverse with the brake applied, it held. The evidence of Roger Assailly and Brent Orb is that this would show that the brakes could stop the locomotive, but does not tell if it could stop what the locomotive was pulling.

15. Mr. Roger Assailly had a long career as a locomotive engineer until his semi-retirement in 1999 when he continued working as an inspector and providing training. He has done locomotive safety inspections and audits since 2007. Under his contract with MHI, on April 13, 2016 he performed a safety audit of locomotive No. 11. He determined: *"No issue with brakes (independent)"*.

16. Kevin Hicks has worked for Evraz since August 1997. As a bargaining unit member he worked in the Meltshop and in 2004 bid into the Yard where he worked as a Switchman and Locomotive Operator for two and one-half years before he left the bargaining unit in September 2012. He is responsible for scheduling and overseeing yard operations: bringing scrap from the CP line to the scrap bay and shipping. This area and all positions are safety sensitive.

17. Mr. Hicks obtained three statements from Danon and attended investigation meetings on April 4 and 12. At the April 4 meeting, the Grievor said that he did not know what happened or why he was unable to stop. He was working the brakes in an attempt not to lock them as this would result in sliding and not stopping. He never felt the jerk normally felt when starting braking; in running out cars, he normally puts a brake on the end to help him go out. At this meeting it was decided to put a limit of 8 loads to be pushed or pulled at any one time.

18. Mr. Hicks says that at the April 12 meeting, after separate discussions with the Union, the Grievor advised that two handbrakes were removed by Danon during the weighing; this took away the ability to stop the cars. Mr. Hicks says that it is the locomotive operator's responsibility to request handbrakes. The movement of twelve cars has been done subsequent to the April 2 derailment at Evraz; it can be done safely provided speed is reduced and the brakes utilized correctly to control the movement.

19. Mr. Hicks acknowledges that the scale is a high point and there is a downhill gradient to Pasqua Street and beyond. This is known and requires caution because of the weight of the movement. The use of partially applied handbrakes is not normal operating procedure. Special instructions must be given by the locomotive operator to the switchman to partially apply handbrakes. In his opinion it is not necessary to use a partially applied hand brake in pulling cars from the scale to spot them on the F1 track.

20. On April 26, Evraz conducted two controlled brake tests with locomotive No. 11. Twelve cars were pulled with a secondary safety locomotive behind. The purpose was to test the stopping ability of locomotive No. 11. The total weight of the cars and second locomotive was 1528 tonnes versus 1800 tonnes on April 2. Ten of the cars varied in weight from 90 tonnes to

124 tonnes. The other two cars weighed 187 tonnes and 191 tonnes. No handbrakes were applied to any of the cars.

21. During test 1 the independent brake was applied at or near the F1 switch in an attempt to replicate the Grievor's actions; the train was traveling at 16 kmph. This test demonstrated that the crews' ability to control the movement and stop the train at F1 was significantly decreased. During the test the brakes of the second locomotive were utilized to stop the movement; even with these brakes the train travelled an additional 15 to 20 car lengths before stopping.

22. During test 2 the locomotive operator reached a speed of 16 kmph and applied the brake approximately 2 car lengths prior to the F1 switch. The locomotive operator was able to stop the train without help from the second locomotive and the trailing end of the train stopped approximately two car lengths past the F1 switch.

23. On August 10, 2016 Evraz conducted a further test with locomotive No. 11 using 15 cars weighing 1841 tonnes; none of the loaded cars had brakes applied. Starting from the scale a maximum speed of 7 kmph was achieved. The locomotive operator started to brake at the F1 switch and was able to stop the train with the last car at the F1 switch.

24. Evraz tendered a number of corporate documents:

- Accident Prevention Manual – April 2009 – 62 pages, includes Occupational Health & Safety Policy
- Employee Class History for the Grievor – 10 pages showing courses taken and including January 5, 2005 Regina Steel New Employee Orientation
- IPSCO Safety and Occupational Health Program – April 2007 – the Grievor *"signed off"* on a number of JSAs including ones for switchman and locomotive operator retraining, safety and safety policy.
- Job Safety Analysis – Switchman May 10, 2013
- Job Safety Analysis – Locomotive Operator May 10, 2013

25. New employees are provided with a copy of the Accident Prevention Manual during orientation; the Grievor acknowledged receipt on January 5, 2005. On April 14, 2007 the Grievor acknowledged that he had read the Job Safety Analysis ("JSA") and completed all of the required training for a number of positions: Mobile Crane Operator; Switchman; Locomotive Operator; Lime Blower. The records do not include the name of any trainer; much of the training is done *"peer to peer"*. The Practical Skills Checklist shows that the Grievor was considered competent for each of these positions.

26. Evraz develops a JSA for each of its positions; its JSA policy is to develop a working program and ongoing tool of accident prevention. The JSA policy provides that JSAs are of critical importance to the elimination of accidents on the job and are the cornerstone of an effective safety program. Each JSA examines every job step (basic job function); it identifies potential hazards and provides detailed recommended action or procedure for each potential hazard. On April 25, 2013 the Grievor signed off on the April 11, 2013 revised JSAs for Locomotive Operator, Switchman, Yard Equipment Operator, Yard Material Handler and Lime Blower.

27. Mr. Hicks acknowledges that a *"draft"* Enablon Event Report had been prepared by his superior Mike Kish on April 2 and last modified by him on April 4. The report included the following statements: Primary Cause – Failure to operate property; Root Cause – No standard policy or control. It noted that the investigation was "in progress".

28. Brad Forster is the Superintendent, Meltshop Operations. He attended the investigation meetings with the Grievor on April 4 and 12. Mr. Forster understood the Grievor's explained application and release of the brake and reapplication in an attempt to stop the movement. He did not believe this to be *"fanning"* which is a quicker on/off which is not appropriate. He doesn't know if the Grievor was *"fanning"* or if the brakes *"locked up"*.

29. When Evraz terminated the Grievor's employment on April 15, it advised that it was its conclusion that the April 2 incident was *"... Due to Locomotive Operator negligence."* Mr. Forster says that after a significant investigation Evraz had ruled out other conditions such as

mechanical failure contributing and was left with the actions of the operator. He says: the Grievor made a poor/flawed decision to pull twelve cars if in his estimation the locomotive was not capable of controlling them; he could have pulled six or eight cars; after the cars were weighed he left the scale at a speed in excess of operating safely. The company cannot understand how the train got excessive speed and out of control; because of lost control there was a danger at Pasqua crossing; the contact with twelve CP railcars, derailment of six and the placing of another car on the CP main line. The locomotive operator is required to act appropriately to the weight of the load, the brakes and full communication is his responsibility.

30. Mr. Forster says that each employee is to review his JSAs every two years; he acknowledges that some may be missed. The JSAs are kept on-line and available for the employee through work stations. Revisions are reviewed with employees. Additionally, toolbox meetings are held two times per month; these focus on safety issues. The draft Enablon event report has not been finalized and will come to him for this purpose. The Enablon system is for incident recording to permit tracking and to notify and permit development of corrective action plans. He agrees that at the April 15 termination meeting he may have said the investigation was complete and the cause was operator negligence. He says that the *"pull test"* was still to be done, but the result did not change the Employer's conclusion. Mr. Forster understood that it was the end of the shift and Danon wanted to go home; he took the brakes off to speed up the process.

31. Mr. Forster was questioned about the MHI Report. He says all of the Report's recommendations are under consideration by the Employer. Initially, after the incident the Employer lowered the number of cars that could be pulled to eight; it now believes that this is not required and the restriction has been removed. He does agree that a maximum gross weight for each car would be a good idea and to have a process in place so as to not overload the cars. Evraz agrees there needs to be clear protocols for communication between the locomotive operator and switchman and has arranged for Mr. Assailly to do some training. It is also investigating the feasibility of having at least one rail car with an operable air brake for every movement. Evraz intends to do more training of locomotive operators and switchmen as recommended in the MHI Report: railway operating rules and railway communication rules; car

airbrake systems; car securement; core safety rules; locomotive operations (including locomotive operations in emergency situations). He acknowledges that there was nothing in the locomotive operator's JSA as to what to do in an emergency situation.

32. The Grievor worked as a Switchman for approximately 5 years. His training as a Locomotive Operator was done peer-to-peer; he says he had lots of training and has trained other switchmen. He says he can look at the JSAs if he chooses to and if he has time. With reference to the JSAs and revisions, he said *"Not going read all of this generic blah, blah, blah."* On April 25, 2013 he signed off on the revised JSAs for Switchman and Locomotive Operator.

33. The Grievor says that after getting a call from Kevin Hicks, he walked to the locomotive on the F2 loading track while Danon drove; he hooked up to and pulled the twelve cars forward through the F2 switch and was counted down; he then pushed the cars through the scale. After the weighing Danon said to go forward, *"take it away"*. He accelerated just to get the load moving, not over-accelerating or *"goose"*. There was a gliding period with no throttle and no brake; the train had enough momentum. He acknowledges that the glide was not mentioned to the Employer in either of the April 4 or 12 meetings, nor to Mr. Orb. He says this is what operators do and it is not written down. The Grievor does not believe he was going too fast; he was trying to be cautious all the time.

34. He says he could see F1 switch when he started to apply the brakes and immediately noticed the difference in braking; at one point after the F1 switch he informed Danon that it was not braking right. As the locomotive travelled toward Pasqua Street, he continued braking and trying to stop but with the downhill grade and with the weight the train picked up speed. He blew the horn as he approached the Pasqua Street crossing. After he was through Pasqua Street he informed Danon *"load not stopping"*. He acknowledges that Mr. Orb's report quotes him as saying he *"started testing the brakes when the locomotive was next to the F1 switch"*.

35. The Grievor says that he was always on the brake, constantly trying to stop. He kept *"working the brakes"*: slowly add brake until he felt it engage and then bring back slowly so a little pressure off the brakes as they were warming; he could feel them grabbing; did this on/off

so didn't lock the brakes. He was not *"fanning"* the brakes. He does not believe that the brakes *"locked up"*; he never felt any flat spots prior to the accident. He was unsure what to do as he had not previously been in a situation like this. He was never trained as to how to stop in an emergency situation and particularly he was not trained that in an emergency situation the train brake should be put into emergency and/or the traction motor reversed in direction. This recommended procedure was added to the JSA revision dated April 22, 2016.

36. The Grievor says that the run-away cars gave him a *"sick feeling"*. He hoped that the continuous braking would slow the train; if not, his option was to jump to get clear of the locomotive and twelve cars. The locomotive was in neutral from before the F1 switch; the independent brake was on when he jumped from the locomotive. He winded himself. He saw the last car go passed him; he started to run after it but he could not get to it. He then watched and heard the collision and the cars derail.

37. Following the collision the Grievor was at the derailment scene and then taken to the Yard Office where he received ice packs for his neck and waited for a drug and alcohol test which he passed. He was too shaken to write a statement so with the approval of the supervisor he shakily signed the brief statement made by Danon. The Grievor continues to receive physio for his injuries received when he jumped from the locomotive.

38. The Grievor attended the April 4 investigation meeting. He said he didn't know what happened; he was not going faster than the pull from the F2 line. He never felt the jerk that you usually do when braking starts. At the hearing the Grievor says that at this meeting it was not his position that he required a brake on the rear car for leaving scale; this decision is up to the switchman. After discussion, Evraz decided to put a limit of eight loads to be pulled at any one time. The Grievor was sent home pending a call from management.

39. During the April 12 investigation meeting the Grievor requested to meet separately with his Union representatives including Mike Day, President of the Local. Subsequently, the Grievor said he was advised by Danon in a phone conversation that Danon had removed two handbrakes from the cars while they were at the scale. This was done without his knowledge; this would

affect the way the train was pulled and stopped. His practice was to run with one brake for every four cars. If he wanted the brakes off, he would have asked.

40. In examination-in-chief the Grievor was referred to three prior occasions when he received a disciplinary written warning. On July 2, 2013 he failed to follow the procedure for securing the scrap bay; he signed the shift summary sheet that the bay was *"safe"* when the power was still on the cranes. On April 10, 2011 there was a derailed locomotive when the Grievor, as Mobile Crane Operator, did not remove a derail from the track; undue care and attention was alleged. It was noted that all JSA safety rules and procedures must be followed at all times. On December 18, 2006 as a Switchman, he failed to ensure that a switch was properly aligned and a locomotive was derailed. Undue care and attention was alleged. In cross-examination the Grievor acknowledged that as of April 2, 2016 that in the past ten years he had four incidents involving derailments.

41. The Grievor acknowledges that on April 2, prior to pulling the twelve cars, he never inspected the cars to see their condition or if the brakes were on or off or the number of brakes. He did not ask Danon if the brakes were on or off: *"why would I"*. He never asked for any brakes to be put on. He never saw Danon take the brakes off. Danon did *"without my knowledge"*. Taking the brakes off the first two cars would affect the pull in the weighing process. He did not feel any difference in moving cars during the weighing process. He began working with Danon shortly before April 2, 2016. He says that when running out cars with slabs, etc., he has one brake per four loaded cars going across Pasqua. He does not necessarily do this with loads of scrap from F2 to the scale.

42. After the weighing on April 2 the locomotive would have been approximately 230 meters from the scale and 70 meters from F1. Although the Grievor did not know the weight, he knew there was a heavy load with five split cars. This was his only twelve car run of the day. He says he had time to split the load. He felt comfortable and had no concerns with the movement prior to and during the weighing process when he never experienced any trouble stopping. There is a difference trying to stop at 8 kmph versus 4 kmph. The Grievor says that the independent brake may hold under load but that the downhill grade with weight changes everything.

43. The Grievor acknowledges that he did not complete the required Locomotive Checklist before operating the locomotive on April 2. He did not check to determine that the handbrakes on all of the cars were operational as required by the JSA. He was unaware there were brakes on the cars when he began his pull. The Locomotive Operator JSA identifies overloaded cars as a potential hazard and 12e provides: *"Always inspect cars prior to moving"*. He says the operators don't do this; switchmen do this. He was referred to the JSA he signed on April 2013 and the provision relating to potential hazard of overloaded cars and the recommended action or procedure: *" ... the cars must be transported at reduced speeds (5-10 kmph)... "*.

44. The Grievor agrees with Mr. Orb's statement that in a follow-up discussion with him he acknowledged: crews' responsible to determine how many cars to move; he was aware of the downhill gradient from the scale to Pasqua; he understood extra caution was required when moving twelve loaded cars westward from the scale; when he began to pull the railcars he believed some of the handbrakes on the cars had been partially applied to help control the movement; the switchman released all of the handbrakes without his direction or knowledge.

45. The Grievor doesn't know when he gave a written statement to Mr. Orb. He acknowledges Mr. Orb's evidence is that he believed it was received two to three weeks after April 2. In this statement the Grievor makes no reference to the handbrakes being on and taken off. Mr. Orb's Report says that the locomotive operator revised his statement to focus fault on the switchman for releasing handbrakes without his knowledge. The Grievor acknowledges: that the locomotive operator is ultimately responsible for controlling the movement; that it is crucial that positive and clear communication protocols be established between the locomotive operator and switchman; locomotive operator should never make an assumption on whether handbrakes have been applied or released. He agrees that the movement of twelve loads has been done many times on site and can be done safely provided speed is reduced and brakes are utilized correctly to control the movement. The Grievor says that handbrakes are used regularly during movements in the Yard. He did this movement without knowing if any brakes were on.

46. Jade Sagel previously worked for Evraz for nineteen years including the last ten as a Locomotive Operator; locomotive No. 11 was his machine. He says that its brakes did not grab as quickly as Evraz's other locomotives. He was trained peer-to-peer with some outside training in relation to air brakes. He never practiced nor was he trained in "emergency stopping"; he never put himself in a position to need it as he got used to the pull and operation with what was present on his train. He had experienced a "load push" when pulling eleven cars; the independent brake was applied but it kept pushing. He called the switchman to put on a brake and safely stopped. He never used the emergency brake nor put in reverse as he was scared to do so and did not think about it.

47. Mr. Sagel says if he was pulling a load you get a feel for it; coming out of the scale with a heavy load you know there would be a heavy push. There would be only five or six car lengths from the start at the scale to the F1 switch. The removal of two brakes at the scale would affect the stopping distance; the power and pull would be different than the pull from the F2 line. As a locomotive operator, he would want to be told if two brakes were removed.

48. Mr. Sagel says when using independent brakes to stop a train, he would put the brakes on half to three-quarters and back off to let the heat buildup and then put on to build air pressure. This process is not "fanning" although on/off to stop might have a bit of "fanning". He would prefer to use handbrakes when moving cars in the Yard as an extra brake helps to control movements. A locomotive operator is responsible to control the movement of the train; this is why he asks to leave a brake on. He agrees that it is crucial that positive, clear communication protocols be established between a locomotive operator and switchman.

III. POSITIONS OF THE PARTIES

Employer Position

49. The Employer says that discharge was the appropriate disciplinary penalty for the Grievor's misconduct. From the time he hooked up to the twelve cars, he committed a number of operational errors which were both negligent and reckless or extremely careless; these were the primary cause of the derailment. The potential and actual consequences support discharge.

Given the inherent dangers in the workplace, there is a need to comply with safety procedures in a safety sensitive workplace.

50. The Grievor was a highly experienced employee with five years' service as a locomotive operator yet in spite of this: he failed to complete the Locomotive Checklist; he failed to inspect the equipment when hooking up on the F2 line. The operator's JSA requires: check brakes before moving; ensure brakes work; ensure handbrakes operational. He never inspected the cars or handbrakes with the result that he did not know if the brakes were on/off. The Grievor says Danon was responsible to perform these inspections, but he knew he did not as he was not at the cars. If Danon was responsible, the Grievor was in charge and ought to have instructed him to do so; responsibility falls to the Grievor. He failed to follow the JSA direction in relation to the potential hazard of overloaded cars: *"Always inspect cars prior to moving"*.

51. The Grievor was aware of the downhill gradient and that extra caution was required to move twelve cars; as a locomotive operator he is responsible to control the train's movement at all times. He did not exercise the appropriate caution in light of the number of cars and he knew there were a number of split weights resulting in a heavy load. The Grievor must be aware of all factors and adjust his conduct prior to movement; here there was no plan or clear communication including about the brakes or weight with the switchman notwithstanding they had only worked together for a few months. It was the Grievor's decision to move twelve loaded cars; he could have divided the load.

52. The Grievor's response is that he felt comfortable with the load. At the hearing he offered a thousand dollars to any operator who could stop safely at the F1 switch without assistance of handbrakes; this means that he knew that he needed brakes and it was a serious error to not confirm brakes and the number of them before proceeding. He accelerated to get the load moving but did not brake until at or near the F1 switch and had no communication with the switchman until all cars cleared F1; then he said not stopping.

53. The Grievor's errors were reckless or extremely negligent resulting in the train getting into an uncontrolled situation; the locomotive operator ought never to act so as to have this

happen. Relying on the decision in *Orica Canada Inc. v. United Steelworkers of America, Local 2020 (MacCoubrey Grievance)* (2005), 137 L.A.C. (4th) 61, Evraz submits that an employee's actions need not be deliberate or willful to justify dismissal.

54. Evraz relies on the decision of Arbitrator Pekeles in *Southern Railway Vancouver Island Ltd. v. Council of Railway Unions (Boychuk Grievance)* (2007), 165 L.A.C. (4th) 272, wherein he accepted that there was a distinction between recklessness and negligence. While both involve a departure from the acceptable level of care, recklessness involves conduct that the perpetrator knew or ought to have known, involves an immediate risk. Termination was upheld in *Southern Railway* on the basis of the employee's significant culpable behaviour and reckless actions and failure to follow proper safety procedures resulting in an explosion which was reasonable for the employee to have foreseen.

55. Evraz references the decision in *Canadian Pacific Limited and Canadian Council of Railway Operating Unions (Brotherhood of Locomotive Engineers)* (1996), 60 L.A.C. (4th) 27, wherein the locomotive engineer was involved in a head-on collision after he applied the brakes too late. Arbitrator Picher concluded that the engineer was negligent in not taking the necessary steps to control his train's movements when he knew or ought to have known, that he was disoriented and unsure of his location as he approached an anticipated stop signal. The error was extremely grave and could have had fatal consequences. Neither the length of service (16 years), nor prior disciplinary record, provided any compelling reason from the standpoint of mitigation and the discharge was upheld.

56. In *Canadian National Railway Company and Brotherhood of Locomotive Engineers*, (1990) CarswellNat 1990, a locomotive engineer was gravely negligent in monitoring the speed of his train and being vigilant for oncoming movements. A collision with extensive economic loss and serious personal injuries occurred as a direct result of the violation of an operating rule which requires that trains using the main track to operate at restricted speed (where they can stop with one-half of the range of vision). Arbitrator Picher said at paragraph 2: *"... his own inattention placed his movement in a position from which it could not be saved by the normal operation of the braking system."* The grievor had a prior disciplinary infraction involving

dangerous and unauthorized train movement on a main line; it was concluded there was no basis to mitigate the discharge.

57. Evraz says that even if the Grievor's operating errors were not *"recklessness"* his conduct was such that at a minimum he was *"extremely careless"* and caused an accident; this provides culpable grounds for discharge.

58. Evraz cites the decision in *United Steel Workers (USW) Local 5795 v. Iron Ore Co. of Canada (Disciplinary Action Grievance)* (2015), 254 L.A.C. (4th) 362. The grievor made a mistake dumping ore in the wrong place; the mistake was due to her inattention – due to carelessness and lack of attentiveness and a degree of culpability was found to be present. The cost of repair exceeded $880,000 with production losses of $600,000 with potential for injury. The arbitrator held that to discipline you need culpable behaviour but such behaviour does not have to be intentional; if the event is purely accidental and there is no evidence of lack of care; discipline should not result. The arbitrator reviewed the factors which affect the severity of discipline: seriousness of the consequences; intentional versus unintentional; reckless and negligent is greater than errors in judgment; the grievor's remorse; blame of others is an aggravating factor; and was there a pattern of conduct. Evraz says that all of the factors noted in *Iron Ore Co.* case are present here: culpable conduct; serious financial impact; serious potential for injury.

59. Evraz references the decision in *Southern Ontario Railway Rail America and Teamsters Canada Rail Conference* (2011), 105 C.L.A.S. 266, where the grievor, an experienced, qualified locomotive engineer, was discharged following his failure to properly secure his train resulting in a derailment of nine cars and damage greater than $1.6 million dollars. The grievor failed to apply a handbrake and have a designated locomotive as a lead which would ensure the air brake application and permitted the train to roll away on a 1% grade. The grievor had a seven-day deferred suspension for a violation of the same rule a few months earlier when he left a train standing unsecured resulting in a collision; this was held to aggravate the matter. Although the company failed to take sufficient measures to ensure crews were following safety practices, this decision was held not to absolve the grievor from his own grave errors; the grievor knew or

ought to have known the importance of designating a lead locomotive as an essential part of securing the train.

60. Evraz says here: an independent brake was fully functional; similar pulls of twelve cars successfully completed many times; the stop tests show there is a critical difference depending on the time of the application of the brakes. If the operator waited to the F1 switch, it showed a *"significantly decreased"* ability to stop; whereas, if the brake was applied prior to the F1 switch the movement could be safely controlled.

61. The Grievor waited until the locomotive was at the F1 before he started to brake; this was an operational error or at least carelessness. Evraz says the Grievor engaged the throttle and achieved a speed which was greater than was reasonably necessary having regard to the ability to stop the train. The Grievor says that he was *"on the brakes all the way"*, however, there is no evidence of this on the GPS which suggests, on the balance of probabilities, that he was *"fanning"* the brakes. This decreases function and explains the continuous acceleration since the brakes had been shown to function properly. On the balance of probabilities, it is likely that the brakes locked up given the flat spots which were found after the accident and the Grievor testified that he noted nothing indicative of flat spots before the collision.

62. The Employer submits that having regard to the inherently dangerous nature of the Grievor's work, the workplace and the company's operations, and the Grievor's stated rejection of any individual responsibility to keep up with safety policy and his actual failure to follow procedure, Evraz had just cause for dismissal as these failures are a significant contributing cause to a potentially fatal accident.

63. Evraz takes safety very seriously. The Grievor had been properly trained; Evraz has in place an Accident Prevention Manual and JSAs on which the Grievor signed off in April 2013. There has been a violation of a safety policy and a risk of damage and injury in a safety-sensitive workplace; dismissal is appropriate. *Orica Canada* (supra).

64. In *Vale Canada Ltd. and USW, Local 6500 (Denny)* (2014), 119 C.L.A.S. 302 (Arbitrator Hayes) a train conductor was discharged for involvement in a serious safety incident: he negligently instructed the locomotive engineer to proceed to a skimmer track when it was not safe to do so and this lead to property damage and product loss of some $500,000 and could easily have led to injuries up to and including death. It was held that discharge was appropriate. Evraz says that the Grievor, as the locomotive operator, was primarily responsible for a breach of a fundamental safety procedure in a safety-sensitive workplace. As such termination is justified.

65. Evraz relies on the decision in *Inco Ltd. v. U.S.W.A., Local 6166*, 2002 CarswellMan 615) [2002] M.G.A.D. No. 8, 68 C.L.A.S. 106. Due to improper direction from the grievor trains collided. The employee did not follow company safety procedures which the company had in place and had taken steps to ensure the employee was aware of them. The accident was extremely dangerous and the employee did not appreciate his role; this hindered mitigation and his rehabilitative potential. The discharge was upheld. Evraz says that in this case the Grievor was in a safety sensitive position in the workplace. He had proper training but has been involved in four safety sensitive situations, including three derailments, in a period of ten years, including one discipline on his file. The Locomotive Operator JSA sets out the role and responsibilities of the position; it identifies hazards and what to do to avoid these. The Grievor reviewed his JSA in April 2013; after his discipline in May 2015 he was to review it.

66. The Grievor's attitude is that he was not responsible to review safety policies; it is up to the company to bring them to his attention. He is not going to read a bunch of *"blah blah blah"*. In cross-examination the Grievor did not know that the "S" in "JSA" means "Safety". This speaks volumes as to his attitude towards JSAs and the company's safety practices and procedures. He did not think that it is a locomotive operator's job as set out in the JSA to inspect the cars prior to moving; he put this responsibility on the switchman. Evraz says that there is a *"blatant disregard"* or *"cavalier attitude"* which flows through the behaviour of the Grievor as exhibited in the incident and in the investigation: failed to complete the Locomotive Checklist; failed to check the brakes on the cars; failed to check that the line was clear; failed to communicate with the switchman; took no steps to ensure brakes were on or off. Rather, he proceeded on his own subjective belief that he had confidence in the load. This is not sufficient.

Evraz expects more from its employees. Serious damage did occur. There are a number of reasons including deterrence to uphold the discharge.

67. Discharge is justified based on the Grievor's past history of serious safety-related instances. Four such incidents in the last ten years including three derailments; a one-day suspension in the previous year for his failure to follow policy, just like these circumstances.

68. Evraz says that the disciplinary suspension imposed on the Grievor for the incident of May 11, 2015 was given as a result of the Grievor's failure to follow operating procedures and secure the scrap bay. It is critical that a locomotive operator get authority to enter the scrap bay and not enter blind; the Grievor entered without authority and this resulted in a derailment. His actions in that incident included a failure to accept responsibility. He blamed it on: height of the railcar; light affected his vision; the crane operator did not tell him to stop in time. At the hearing he says that a number of people made mistakes. His conduct in May 2015, February 2013, April 2011 and December 2006 related to serious safety related matters in the steel yard just as the incident in the present circumstances does. In reaching its decision to terminate it relied on the Grievor's disciplinary record. The Employer relies upon the decisions in *Canadian National Railway Company and Brotherhood of Locomotive Engineers (Moore)*, 1990 CarswellNat 1990; *Southern Ontario Railway* (supra).

69. Evraz argues that the Grievor's failure to accept responsibility for his actions in respect of the historical discipline and this incident including dishonesty, in his failure to provide information to the Employer, Mr. Orb and at the hearing, is such that any continued trust is fundamentally and irreparably broken. No case to substitute a lesser penalty.

70. Evraz says that the Grievor gave a dishonest explanation as to what occurred to it, to MHI and at the hearing. He gave inconsistent and evasive answers including with respect to important details as to what occurred. This shows that he failed to appreciate how serious the incident was and the need to be honest in the investigation. He has attempted to focus fault on the switchman saying that he removed the brakes when he was not told to do so and did not tell the Grievor. He didn't give this explanation until April 12. Evraz points to Mr. Orb's

conclusion that the Grievor believed the partially applied brakes were on the cars to control the movement but were removed without his knowledge or direction. Locomotive operators are never to assume the brakes are on and there is no evidence that the brakes were on at F2 such that the Grievor was aware of this. The operator is responsible for the safe movement of the train yet he had not ascertained from the switchman if the brakes were on/off or the number. His inconsistency re critical conduct undermines the trust and destroys any rehabilitative potential.

71. Evraz says here there is nothing to suggest that there should be a substituted penalty. At three meetings with the company and at the hearing the Grievor was never heard to acknowledge any level of responsibility for the incident; there is no acknowledgment that his judgment or oversight caused a problem. He only offers excuses: switchman took the brakes off – but he did not follow the policy to inspect and determine if the brakes were on or working. He says that the company did not properly train him how to stop in an emergency and did not come to him about the JSAs. The same thing occurred in 2015 where he accepted partial responsibility but said that a number of people made mistakes.

Union Position

72. The Union says that while the Grievor's conduct during a ten minute period might be deserving of some punishment, discharge was excessive. He failed to tell the switchman to check the cars to determine if the brakes were on and to communicate this to him; there was no clear communication between the Grievor and the switchman. However, this was in the background where it was not the custom or practice to communicate if the brakes were removed. While Evraz talks a lot about a safety-sensitive workplace and position, the reality and the evidence is that the JSAs were not regularly reviewed and that the Grievor reviewed numerous JSAs in one day. The Grievor was never trained in how to stop a train in an emergency notwithstanding that there have been previous occasions of run-away trains.

73. The Union points to the evidence of Mr. Orb that peer-to-peer training in itself is not adequate. Mr. Orb makes five recommendations in his report following the investigation of the incident:

> 1. That Evraz establish a permanent restriction on the maximum number of cars for any movement on site which will minimize the rise of the crew underestimating the braking force and distance needed to control the movement.

An 8 loaded-car limit was set following the incident, but this limitation was subsequently removed. Evraz now operates without any limit on the number of cars or weight as recommended.

> 2. It is crucial that positive and clear communication protocols be established between the locomotive operator and switchman.

> 3. That Evraz consider using at least one rail car with an operable air brake system for every movement; this would add additional braking capability in an emergency situation.

Union counsel points to the fact that these railcars are scrap cars, no longer suitable for use in railway operating systems and it is unknown if the brakes work.

> 4. Having regard to the responsibility of the locomotive operator and switchman to ensure they can control each movement before initiating any switching operations, that in order to do their job safely crews must be adequately trained in regard to the factors affecting safe movement. Mr. Orb recommends that Evraz develop a more formal and comprehensive training program for switchman and locomotive operators that includes training and periodic recertification on:
>
> - Railway operating rules and railway radio communication rules
> - Car air brake systems
> - Car securement
> - Core safety rules
> - Locomotive operations (including locomotive operations in emergency situation)

The Grievor was only trained peer-to-peer which did not provide adequate training in respect of emergency stopping and core railway safety rules.

> 5. That Evraz develop a new railway Safety Management Plan and submit the same to MHI within six months.

74. The Union says that Evraz's pull tests did not replicate the incident either in terms of the number and/or weight of railway cars, or in that the locomotive operator was aware that these were tests and where to apply the brakes.

75. The Union says that the Grievor did not *"floor"* the locomotive, rather he accelerated slowly; at 8 kmph at the F1 switch and 12 kmph at F2, the speed was well within the speed limit for the Yard. He had successfully completed the pull from F2 and the push to place the cars on the scale. He says the train did not react the same way as on the previous pull/push; however the feeling for the pull comes with acceleration and stopping. He was not reckless and made continuous proper attempts to stop the train.

76. The Grievor did not know why he was unable to stop until he learned that the two brakes had been removed at the scale. This was the reason for the difference and why he was unable to stop. The locomotive operator definitely wants to know if brakes are taken off, but here the switchman never did tell the Grievor that he had removed two brakes. He did not insist that the switchman do his job – inspect the cars and communicate. Communication must be a two-way street. The switchman removed the brakes because he wanted to speed things up. There was no evidence as to when the small flat spot occurred, therefore it is not a factor in this incident.

77. The Union says that discharge is excessive in all of the circumstances. He has a nineteen-year career. Notwithstanding his discipline in 2015 for not following policy when he entered the scrap bay without permission, Evraz subsequently considered him to be trustworthy to be a locomotive engineer. He was not reckless. It is acknowledged that he did not fully communicate with the switchman. His conduct was not of such seriousness as to support termination. See *Smithrite Disposal Ltd. and Service Employees International Union, Local 244*, [1979] 2 W.L.A.C. 35 as to the seriousness of the nature of the breach.

78. The Union says it was not custom or practice to communicate if brakes were removed. It points to the entry in the preliminary Enablon report that the root cause of the accident was: *"No standard policy or control."* There was no emergency stopping procedure prescribed to address run-aways and the Grievor was not trained for such emergency.

79. The Union cites the decision of Arbitrator M. Picher in *Canadian National Railway Company and United Transportation Union* (2008) CarswellNat 6256, as to the role of mitigating factors and the role of the grievor in the circumstances leading up to the incident. In

that case a 23-day suspension was set aside and a penalty of 10 demerit points was substituted having regard to the grievor's role.

80. The Grievor's conduct did not show sufficient disregard for the immediate foreseeable consequences to constitute a form of recklessness. *Sysco Food Services of Toronto v. Teamsters, Local Union 419* (2011), 210 L.A.C. (4th) 376. The Union notes that in *Iron Ore* (supra) there was no issue of the employee not having adequate training.

IV. THE LAW AND ARBITRAL JURISPRUDENCE

81. Arbitral jurisprudence and the law provide that arbitral review of a grievor's dismissal ought to address three issues outlined in the *William Scott* decision: (1) Did the grievor's conduct give the employer just and reasonable cause to impose some form of discipline? (2) If so, was the employer's decision to terminate the employee an excessive response in all of the circumstances of the case? (3) If discharge was excessive, what alternative measure should be substituted as just and equitable? *Wm. Scott & Co. Ltd.* and *Canadian Food & Allied Workers Union, Local P-162,* [1977] 1 Can. L.R.B.R.1.

82. Evraz's termination letter says that the major incident on April 2, 2016 was *"due to Locomotive Operator negligence"* and that *"given the findings of the investigation and further, in review of your disciplinary record ..."* that the grievor's employment was terminated.

83. The law and arbitral jurisprudence recognizes that there are various forms or degrees of employee misconduct including: mere inadvertence, carelessness, negligence, gross negligence, recklessness and negligence in the extreme such that it could be considered to be willful conduct. All of these actions involve a departure from the acceptable level of care; recklessness involves conduct that the perpetrator knew or ought to have known involves an immediate risk of property damage and/or personal injury. *Southern Railway Vancouver Island*, at paragraph 55; *Orica Canada* at paragraph 31.

84. Arbitrators generally agree that it is in connection with the second question posed in *Wm. Scott,* that their evaluation of management's decision must be most searching. A number of factors are set out in *Southern Railway Vancouver Island* (supra) at paragraph 61:

> (i) How serious is the immediate offence of the employee which precipitated the discharge (for example, the contrast between theft and absenteeism)?
>
> (ii) Was the employee's conduct premeditated, or repetitive, or instead, was it a momentary and emotional aberration, perhaps provoked by someone else (for example, in a fight between two employees)?
>
> (iii) Does the employee have a record of long service with the employer in which he proved an able worker and enjoyed a relatively free disciplinary history?
>
> (iv) Has the employer attempted earlier and more moderate forms of corrective discipline of this employee which did not prove successful in solving the problem (for example, of persistent lateness or absenteeism)?
>
> (v) Is the discharge of this individual employee in accord with the consistent policies of the employer or does it appear to single out this person for arbitrary and harsh treatment (an issue which seems to arise particularly in cases of discipline for wildcat strikes)?

V. ANALYSIS AND DECISION

Was there just and reasonable cause for discipline?

85. I am satisfied that the Grievor's conduct on April 2, 2016 was culpable; it was of such a nature that it gave Evraz just and reasonable cause to impose some form of discipline. The Grievor failed to perform one of the primary duties owed to Evraz: to operate the locomotive in a safe manner such that he would not lose control of the train's movement.

86. The examination of the Grievor's conduct must commence when he hooked up his locomotive to the twelve loaded cars on the F2 line. He never inspected the cars to see their condition or if any handbrakes were on or off. He knew the switchman went to the switch and never inspected the cars. He says that he never asked the switchman to conduct this inspection: *"Why would I?"* Both the operator and the switchman JSAs provide that each must always inspect the cars prior to moving. Further, the JSAs provide that overloaded cars are not to be moved whenever necessary and *"When a car is found to be overweight, only at the time it is weighed it must be noted on paperwork for all operators to know, this will prevent*

accidental/unnecessary movement. The cars must be transported at reduced speeds (5-10 mph) and take the shortest and safest route to be unloaded." There is no question that some of these scrap cars were overloaded.

87. The Grievor knew or ought to have known that the twelve cars were a heavy load; five of those were split weights indicating a weight greater than 150,000 tonne. Notwithstanding this he never determined the weight of his load and had no communication with the switchman concerning the weight or whether or not any brakes were in place. He knew that the train had to be pulled forward past the F1 switch and in so doing the train would be on a downhill gradient. He knew that the heavy load would give a heavy push.

88. The Grievor acknowledges that he had no knowledge as to whether or not there were any brakes applied to these cars. At one point in his evidence he said that he liked to have one hand brake in place for every four cars being moved; at another point he said that it was not necessary in moving with scrap from F2 to the scale but rather it was his practice in running out slabs etc. to the Pasqua Street area. Whether or not his practice included one brake for each four cars is immaterial in that he made the movement without any enquiry or any knowledge of whether or not any brakes were applied.

89. The Grievor acknowledges: the crew was responsible to determine how many cars to move; he was aware of the downhill gradient from the scale to Pasqua Street; he understood that extra caution was required in moving twelve cars from the scale. He further acknowledges that the locomotive operator is ultimately responsible for controlling the movement of the train and that it is crucial to have clear communication between the operator and the switchman; an operator should never make an assumption about what brakes are applied or released. Significantly, he agrees that twelve loads have been done many times on site and can be done safely provided speed is reduced and the brakes utilized correctly to control movement.

90. At what point did the Grievor apply the locomotive's brakes? His evidence is that when he applied the brake he could see the F1 switch; in his statement to Mr. Orb, he said he started testing the brakes when *"next to the F1 switch"*. I accept Danon's evidence that he was at the F1

switch for the countdown of the cars and moments after the cars passed the switch he thought that he was going to have to go watch the Pasqua crossing. It is clear at that time he felt that the train was not going to stop. Subsequent to this, the Grievor radioed Danon that he was not stopping. The Grievor says that at one point after the F1 switch he informed Danon that the train was not braking right. He does not say that he so informed Danon prior to the countdown. I conclude that the first communication that he was having trouble with the brakes was made by the Grievor after the train had passed the F1 switch.

91. This evidence supports Evraz's submission that the Grievor never applied the brakes in a timely manner. If the brake had been applied at or before the F1 switch, the fact that the train was not stopping should have been apparent to the Grievor considerably prior to the countdown and the end car clearing F1 because the train was to have stopped within no more than a few car lengths of the F1 switch. By the time he had radioed, he was *"not stopping"* the train was past the point where it ought to have been stopped and the locomotive had travelled at least 230 meters past F1. The GPS shows that the train continuously accelerated up to 9 kmph at the F1 switch and 17 kmph when it was past the F2 switch.

92. Although the test pulls performed by Evraz made on April 26 do not replicate the weight, number of cars, the speed of the train, nor the point at which the pull on April 2 commenced they do demonstrate that there was significantly decreased ability to control a train's movements when the locomotive operator waited until reaching the F1 switch to apply the independent brake versus the application of the brake prior to the F1 switch. The tests showed that a crew pulling twelve cars towards the F1 switch at a speed of 16 kmph would need to start braking about 4 railcar lengths before the F1 switch in order to control the movement and to stop within one or two car lengths of the F1 switch. When the braking was delayed until at the F1 switch, even with the help of a second locomotive braking, the train went 10-15 cars past the F1 switch. In the second test, the locomotive was travelling at 16 kmph at a point approximately 75 meters before the F1 switch, when the brakes were applied; this at approximately the same position as the Grievor started the pull from the scale.

93. In the test performed August 10, there were 15 cars and the locomotive; the weight of the cars and locomotive was 1841 tonnes or 41 tonnes greater than the load on April 2. This test more closely represents events of April 2 including the departure point. Here the locomotive operator achieved a speed of 7 kmph and started to brake at the F1 switch; the locomotive was able to stop the train with the last car near the F1 switch. This test reflects other actual operations in which twelve cars have both before and since April 2, 2016 been safely moved.

94. The Grievor's behaviour was culpable; it was not merely inadvertent or simply careless and negligent. In the circumstance of this safety sensitive workplace where he was operating a locomotive with twelve cars, which he acknowledges had a heavy load, he ought reasonably to have foreseen that there was a reasonable possibility that in moving the train on the downhill gradient, without knowledge of its weight or if any brakes were on or not, or the number of them, and not applying the brakes sufficiently in time that significant property damage and serious personal injury to himself and others would occur. The Grievor's failure to take a number of steps which would be reasonable care in the circumstances to ensure that he could control the train's movement is a serious or grave error.

95. He knew that he needed to be able to control the train and ought to have known that if he could not do so, it posed serious risk of severe property damage, injury or death. As a result of the combination of his own inattention, lack of communication and recklessness he put the train into an uncontrolled situation re the speed, downhill gradient, and weight where it could not be controlled by the normal operation of its functioning braking system. Although the Grievor did not wish these results to happen (i.e. not deliberate), he was reckless in that he consciously disregarded the risks which were created by his actions and disregarded safety protocol. The Grievor was responsible to operate the train safely with skill and attention and to control its movement and to act in such a manner that this event did not occur. His errors were extremely grave and had very serious consequences causing an estimated $600,000 damage and presented risk of serious injury or death to the Grievor and others. In such circumstances Evraz had just cause to impose a very significant disciplinary penalty. The Grievor's conduct on the day in question was very serious.

96. The evidence leads to my conclusion on the balance of probabilities that the brake was not applied in a timely and/or appropriate manner having due regard to the weight, downhill grade, known heavy push, speed and the short distance required to move the train in order to stop it at the F1 switch.

97. In coming to my conclusion I have had regard to the safety sensitive nature of the workplace and of the Grievor's position. The various steps and procedures of the various positions are fraught with danger if they are not carried out with considerable care. To address this concern, Evraz has developed detailed JSAs which identify various job functions, related or potential hazards and provide recommended procedures or actions. Evraz has obviously invested a substantial amount of time and effort in the development of the JSAs.

98. I have taken into account that in some respects it does not appear that Evraz has as comprehensive and complete follow-up with its employees in respect of regular reviews of its JSAs; there is some evidence of group safety reviews at regular toolbox meetings. The evidence is that it could perhaps do a better job of having follow-up with its employees to ensure that there is a full and complete understanding and appreciation of how the employees can work safely. The Grievor had reviewed his JSA on April 25, 2013. While the Enablon Report noted the root cause of the accident to be *"no standard policy or control"* this was not explored or developed in any fashion, nor was there any questioning as to what policy or control was intended by the reference.

Was discharge excessive in all the circumstances?

99. How serious is the offence which precipitated the discharge? I agree with Arbitrator Bird that seriousness can be considered from two points of view: first, by the nature of the breach of duty; secondly, by the consequence. *Smithrite Disposal,* (supra). For the reasons outlined above. I consider the breach to be very serious. It is equally clear that the consequences were very great with damage of about $600,000, a blockage of the CP Rail main line and the Grievor having to jump from the locomotive to avoid serious injury.

100. Was the Grievor's conduct premeditated or repetitive, or was it a momentary aberration? The Grievor's conduct was not premeditated nor was it a momentary lapse. However, based on his testimony it is fair to conclude that he appears to have operated the locomotive in a similar fashion on other occasions. He saw no reason why he, or the switchman, would conduct an inspection of the cars to be moved from F2 to the scale and had no communication with the switchman about whether or not there were any brakes on the load as it moved from the scale. He commenced the pull based on his assumption that he could control the train's movement.

101. Does the Grievor have a record of long service in which he has proved to be an able worker and enjoyed a relatively disciplinary-free history? The Grievor has been employed with Evraz for a period of nineteen years; ten of these in the Yard. There is no evidence that he was otherwise than an able worker. The only discipline on the Grievor's record relates to an incident which occurred May 11, 2015. The Grievor, in violation of the Switching Scrap Bay procedure, drove his locomotive into the scrap bay without getting clear communication from the scrap crane operator to do so. This did not allow the crane operator to direct his movement; it resulted in the Grievor being unable to stop the train and derailment of a rail car when it hit the stops. The discipline noted this to be *"... A major safety infraction which had the potential to cause serious property damage and injury"*. At Step 3 the suspension was reduced to one day. The discipline noted: *"You are expected to follow the Switching Scrap Bay procedure and all other company procedures"* with the warning that future violations or infractions could result in further disciplinary action up to and including termination.

102. The Grievor's statement during that investigation said: *That a tall car was hooked to the locomotive that he couldn't see around or over; the crane operator was late calling the distance which resulted in hitting the stops causing it to derail.* The Grievor signed and acknowledged a review of the Switching Scrap Bay procedure on July 20, 2012, February 7, 2013 and on May 21, 2015 after this accident. The Grievor acknowledges that he was at fault in the May 11, 2015 incident but says that other things went wrong. He agrees that in his statement he never acknowledged it was his fault and blamed the height of the cars, not called and the lights affected his vision. He says he acknowledged his fault by not pursuing the grievance when the suspension was reduced to one day.

103. Has the Employer attempted earlier and more moderate forms of corrective discipline which did not solve the problem? Evraz has attempted earlier more moderate forms of discipline. Particulars of the May 11, 2015 incident, the discipline and Evraz's expectations are noted in paragraph 101 infra.

104. There is no evidence that the Grievor's discharge was other than in accordance with Evraz's consistent policies or that it singled him out for arbitrary or harsh treatment.

105. Evraz takes the position that the Grievor's conduct in the accident, in the earlier disciplinary proceedings, during the course of the investigation and at the hearing, confirms that the employment relationship has been irreparably broken and cannot be redressed. In considering this as a mitigating question, it is important to look at the previous employment history and also to assess the Grievor's attitude towards the company's efforts to have a safe work environment.

106. The Grievor testified that he felt that the corporation was responsible to ensure that the JSAs were in place and employees were trained on them. He does not see that he should accept any responsibility for knowing the contents of the JSAs. He does not display a positive attitude towards safety in the workplace. With reference to the JSA he did not know that the "S" stood for "safety". It is his attitude that he was not going to read *"a bunch of generic blah, blah, blah"* and in relation to communication with the switchman, he said *"Why would I ask him?"* if the brakes were on or off? This answer reflects the Grievor's attitude to the communication of information critical to controlling the movement of the train.

107. The Grievor has not acknowledged that he was responsible in any fashion for this accident or that he acted improperly but maintains that throughout he applied the brakes properly and the train would not stop. Once he learned the two brakes had been removed he then attempted to focus responsibility on the switchman. While the switchman did remove the brakes and did not communicate this to the Grievor, it was the Grievor's responsibility to have full communication with the switchman about the load and it was his responsibility for the safe

movement of the train. He proceeded on an assumption that the load was okay. It is well known that a locomotive operator should never proceed on an assumption. His actions reflect his attitude toward safety and his lack of concern. His failure to recognize or appreciate his role in the accident hinders mitigation and rehabilitation potential.

108. The Evraz termination letter referred to the Company's reliance on the Grievor's disciplinary record on file. Article 5.03 provides that: *"... Any warning and/or penalty (excluding dismissals) shall be cleared from the employee's record after a period of twelve months...."* It is my opinion that because of the provision in Article 5.03 Evraz is not entitled to rely upon any earlier disciplinary action except in relation to the incident of May 11, 2015 when a one-day suspension was imposed. The termination letter properly references the disciplinary record on file.

109. Mr. Link endeavoured to advance on behalf of Evraz that there was a pattern of conduct and violation of company policies and procedures as demonstrated by the earlier incidents and that this supported its conclusion that there was irreparable damage to the employment relationship. There is no evidence that this was the company position at the time of termination. The termination letter references: *"... in review of your disciplinary record on file."* The only disciplinary record on file relates to the May 11, 2015 incident.

110. It is not clear that the language of Article 5.03 permits the company to go behind it and seek to rely upon what it says was a course of conduct which would affect the company's decision that the relationship could not be restored for the future because of its uncertainty that it could trust the Grievor to follow safety procedures in the future. In these circumstances it is not necessary to make a decision on this issue.

111. Ms. McNabb notes that Evraz did trust the Grievor to be a locomotive operator after the May 2015 incident. While this may be true, in my opinion this does not help the Grievor because the company, this time, clearly made a decision that because of the repeated failures of the Grievor to follow its policy, it could no longer trust him to operate a locomotive and perform his duties in a safe manner; for this reason his employment was terminated.

112. In all of these circumstances, no basis has been established which would support the mitigation of the penalty of discharge. Any other conclusion in this matter would send the wrong message to the workforce. The grievance is dismissed.

113. Should I be wrong in my determination that the Grievor's conduct involved an element of recklessness, then in any event it would have been my conclusion that his negligence was of a sufficient nature that it was deserving of the significant disciplinary penalty of discharge. See *Vale Canada* (supra).

DATED at Saskatoon, Saskatchewan this 16th day of September, 2016.

Kenneth A. Stevenson, Q.C.
Sole Arbitrator.