CANADIAN RAILWAY OFFICE OF ARBITRATION

& DISPUTE RESOLUTION

CASE NO. 4415

Heard in Montreal, September 8, 2015

Concerning

CANADIAN NATIONAL RAILWAY

And

UNITED STEELWORKERS – LOCAL 2004

DISPUTE:

Anson MacMillan, discharge due to failure to properly change out defective rail and comply with CN Engineering Track Standards RM 1.7 when changing rail at mile 88.65 Ruel Subdivision on March 4, 2015, resulting in a derailment.

JOINT STATEMENT OF ISSUE:

On April 7, 2015 the grievor was discharged as indicated above. He has been working for the Company for nineteen years and has been in his current position for six years.

The Union filed a grievance regarding this matter in accordance with Articles 18.2, 18.5 and 18.6 of Agreement 10.1.

The Union and Company have met to discuss this grievance in a Joint Conference on June 23, 2015.

The Union has requested that he be immediately reinstated with full redress.

The Company has declined the grievance and disagrees with the Union's position.

The Parties have not been able to resolve the dispute to date.

FOR THE UNION:	FOR THE COMPANY:
(SGD.) B. Laidlaw	**(SGD.) M. Piche**
Manager Labour Relations	Staff Representative

There appeared on behalf of the Company:

S. Prudames	– Labour Relations Officer, Toronto
S. Grou	– Senior Manager Labour Relations, Montreal
D. Fisher	– Senior Director Labour Relations and Strategy, Montreal
J. Machado	– Assistant Chief Regional Engineer,

And on behalf of the Union:

M. G. Piché	– Staff Representative, Toronto
T. Cotie	– Chief Stward, Capreol
A. MacMillan	– Grievor, Chelmsford

AWARD OF THE ARBITRATOR

This matter concerns CN's ("the Company") discharge of Welding Gang Foreman Anson MacMillan ("the grievor') for his failure to properly change out a defective rail and comply with CN Engineering Track Standards RM 1.7 at Mile 88.65 Ruel Subdivision on March 4, 2015.

At the time of the incident the grievor occupied a temporary winter assignment at Gogama, Ontario. On winter assignment, the grievor's responsibilities included cold weather patrols, cleaning switches, protecting a winter broom (an on track snow plow) and cleaning sidings. Track work can also be performed, as it was in this case.

At all relevant times the grievor's supervisor was Stephane Veillette ("Supervisor Veillette"). Signals Maintainer Beaudry discovered the break in the rail at mileage point 88.65. The permanent location section workers who would have normally changed out the rail were close to being in an overtime position. It therefore fell to the grievor to do the change. He had never before changed out rail while working on any of his other six winter assignments, however, he changed rail out routinely as part of his permanent position.

On March 7, 2015, three days after the grievor had changed out the defective rail, a freight train carrying crude oil derailed a total of thirty-nine cars, causing the closure of the main line for over three days. Crude oil was released. It ignited. The fire burned the steel span bridge over the Makami River, which had to undergo major reconstruction impacting the Company's operations, resulting in delays as well as environmental damage.

The issue before me is whether the discharge imposed by the Company is the appropriate penalty or whether it should be substituted with a less harsh disciplinary response.

At the hearing the Company stated that the "only" thing the grievor had done wrong while changing out the defective rail was failing to use dye penetrant mandated pursuant to Track Standard ("TS") 1.7 - Rail Testing and Remedial Action for Broken Rail. Had the grievor carried out the mandatory testing, he would have been in a position to identify an additional flaw in the rail adjacent to the one he had changed out, which would, in turn have also had to have been changed out.

Dye penetrant testing is used to detect any defects that may not be visible to the naked eye. Track Standards ("TS") 1.7 reads, in part:

> TS 1.7 – Rail Testing and Remedial Action for Broken Rail
>
> 1. Each defective rail must be marked with a highly visible yellow paint marking on both sides of the web and base when possible.

2. When removing rail defects from track, careful examination of the adjacent rail ends of the parent rail must be performed to ensure that the defect has been completely removed.

3. Dye penetrant testing shall be performed on rail ends:

   a) In the event of an in-service real failure;
   b) When a defect is visually detected;
   c) When one of the following defects was not immediately removed from track after detection by an ultrasound test car:
      i. Vertical Split Head
      ii. Horizontal Split Head
      iii. Head Web Separation
      iv. Split Web
      v. Piped Rail…

Engineering Recommended Method, RM 1-7.3 – an operational document for the "Use of Dye Penetrant for Testing for Rail Defects - is dated January 15, 2015. The document is on the Company website in a section devoted to the Engineering Department. RM1-7.3 sets out what is needed to undertake the process, and describes what is in the Dye Testing Kit, which on the day in question was to be kept in the TFO truck.

The Note referenced after the Working Temperature Range (which is 10 - 50 degrees Celsius) at page 5 of RM1-7.3 reads:

> NOTE:
> ALWAYS have a spare testing kit on hand. If defect removal is not confirmed by the use of dye penetrant, the repair may be completed, however the defect must be protected as though it were still there (per ETS 1.7) until it has been confirmed, either by the use of ultrasonic testing or dye penetrant, that the entire defect has been removed. Report such instances to the track supervisor.

The reference to "must be protected" in the NOTE means that a 10 mph slow order is to be put in place – if the defect removal is not been confirmed by the dye penetrant testing.

The Union's evidence, which the Company did not contest, is that the use of dye penetrant is not common practice.

The record reveals that the grievor had never before used dye penetrant and, as can be ascertained from his statement reproduced in part below, the grievor was entirely unfamiliar with TFO trucks until minutes before he became aware that he would be changing out the rail. The investigation reveals that the grievor asked his supervisor whether a slow order was needed after he had changed out the rail.

At his investigative statement the grievor thoroughly described the events of March 4, 2014 at Q & A 27:

> Q. M. MacMillan, please describe the events that took place prior to the changing of the rail until after the rail was changed at mile 88.65 rule sub on March 4 2015?
>
> A. I got a call at 19:24 to go check a block outage, got into the truck with Matt Williams, had a job briefing then traveled to the crossing between switches at Gogama. Waited for track time, had to clear 328 I believe, Real Beaudry met us at the crossing. I did a job briefing with him, meanwhile I was in contact with Stephane, because I was unsure how to put a slow order on as I had never done one before. I got my 30 min's track time, traveled westward, inspecting track, drove over the defect and didn't even feel it. Once I reached the 144 crossing I seen the lights flashing, so I figured it would be in the crossing circuit. I concentrated on the West end of 144 and real concentrated on the East End. Real notified me he found the break at mile 88.65. I backed up to the location, got out to inspect it. I called Stephane, and he asked me the type of break and what the offset was. I did not know 100% what type of break it was and I did not know how to determine the offset. I sent Stephane a picture with a measuring tape in it to show the measurement. Steph told me it was impassable and the rail

> needed to be changed prior to further train traffic. Real Beaudry signal maintainer… He gave the head loss to myself and I related to that Gogoma section, because I was under the impression they were changing the rail. Mark told me he was close to being over his hours and he wasn't going to change the rail, I let him know I was not familiar with the TFO Truck and the location of plug rail. Mark loaded the rail on the TFO. I met them at the rail rack and they were loading the ramp onto the truck, they said this was a good rail. Mark gave me a quick rundown on how to operate the truck. After switching trucks with the Gogoma section, I get back on track with the TFO truck facing West I proceeded to the break location. At the location Matt handed me the shovel and I started to clear, once the snow was cleared Matt assisted me to take measurements, he held the one End. I pulled the spikes and removed all the anchors. Matt assisted me in digging holes for the cuts I took the rail off the truck and placed it on the field. I then put on all my PPE and made the cuts, I cut the west side approx. 5 feet from the defect and on the east side 7 feet from the defects, then rolled the rail out by rail roller. I remeasured everything before cutting the plug, rolled the plug into track, re-spiked and anchored. I then started drilling both and, Matt assisted me by holding the template in place as there were no securing screws I drilled both ends and then got bars and bolts from the back of the truck and applied on the West and first. That was when I discovered that one hole was not drilled properly on the plug so I re-drilled another hole. Applied the bars on both ends, despite the bars and applied temp. bonds. Made sure I had the proper info for both rail cut out and plugged in. While I was doing that Matt was loading the tools back onto the truck. Made sure everything was fine and I felt confident it was a job well done. We went to clear at HWY 144 crossing. I messaged Steph that rail was changed and we were heading to the clear. Cleared at approx. 23:00 when we cleared, Steph called me on the phone, let him know about the bolt hole, I asked how to proceed, do I need a slow order? Or anything like that. He said all good to go ahead and cancel, and to call him back afterwards. I drove back to the tool house by road and at approx. 23:20. I called Steph back, he wanted me to get the GPS coordinates so he could send the Sperry car back to test the location. After two trains I got the info Steph required and sent it to him.

When the grievor cleared on March 4, 2015 he provided to Supervisor Veillette information for a rail report, which Supervisor Veillette was required to complete. In the “corrective actions” portion of the report, the supervisor checks off whether or not dye penetrant testing has been performed. Supervisor Veillette did not fill out that portion of the report until after the derailment on March 7, 2015. Though a Sperry car was to be sent back to test the location, that did not occur. No slow order of 10 mph had been issued as it should have been.

On March 14, 2015, the Track Standard Bulletin was replaced with the intention to clarity the use of dye penetrant testing. It now states:

> When rail ends have NOT been confirmed to be defect free by the use of dye penetrant, a 10 mph TSO will be applied until testing is complete or until the rail has been ultrasonically tested. This TSO may only be removed under the authority of the Track Supervisor (or Senior officer), after it has been ascertained that the rail ends have been tested.

In support of the Company's position that the penalty of discharge should not be disturbed in this case, it argues the grievor was well aware of the requirement to use dye penetrant. His failure to undertake the testing, in the Company's submission, demonstrated "a serious and reckless" disregard for this basic safety measure, which caused what can only be described as a catastrophic incident. According to the Company, the grievor simply chose not to apply the dye penetrant resulting in his failure to determine that a defect remained in the adjacent rail to the new rail plug that he had installed.

The Company relies on a several facts in support of its position. First it points to a "Safety Flash" sent electronically to all track employees, including the grievor, with links to access a YouTube video showing the basic application and use of dye penetrant. All engineering employees would have been expected to read the Safety Flash, which was sent out in response to a derailment on December 2, 2014. In that derailment, the failure to use dye penetrant was identified as a significant factor in the cause of the derailment.

The Company points to the grievor's investigation statement, where he said that he was "somewhat" aware of the safety flash, knew about it (which may have been a comment about the derailment rather than the safety flash), but that he read the safety flash only briefly.

The Company also points to the fact that the grievor passed a "winter safety quiz" on January 27, 2015. On his second attempt at the fifty-question quiz the grievor answered two true/false questions correctly about circumstances relating to the required use of dye penetrant.

The Company submits that the grievor would also have been aware of another derailment on the same Subdivision as his, which took place on February 14, 2015. Though the February 2015 derailment was not linked to a failure to use dye penetrant, twenty-nine cars derailed, several caught fire and the mainline was out of service for over three days. This derailment should have reinforced the necessity of following the procedures for the use of dye penetrant, which the Company maintains the grievor knew were in place.

Decision

I have thoroughly read the grievor's investigative statement, that of his colleague Mathew Williams', together with Supervisor Veillette's answers to questions put to him during the grievor's investigative statement.

The grievor should have been aware of the requirement to use dye penetrant when he changed out the defective rail on March 4, 2015, as required by TS 1.7 – Rail Testing. There is no question that the grievor was accountable to ensure compliance with TS 1.7.

The fact that the grievor had never before had to change out a rail in his prior winter assignments, or that the fact that the use of dye penetrant may not have been "common place" does not detract from the grievor's accountability for compliance with a Track Standard crucial to the safe operation of the railroad. Nothing before me can justify the grievor's apparent ignorance that dye penetrant testing was to be used after he had changed out the rail at mileage point 88.65.

I cannot agree, however, that, as argued by the Company, the grievor in fact knew dye penetrant was to be used and that he was reckless in choosing not to apply it. The entirety of the record, the grievor's detailed and honest account of the events of March 4, 2014, and in particular the constant communication between the grievor and Supervisor Veillette by texts and phone throughout the changing of the rail process, demonstrate otherwise.

Clearly the grievor should have thoroughly read and absorbed the content of the Safety Flash sent to him by the Company following the December 2, 2014, derailment. He did not do so. He should have been able to apply TS 1.7 to the circumstances of the rail break at mileage 88.65. However, the grievor's correct answers to two true or false

questions on the subject of dye penetrant on a winter quiz, coupled with his acknowledgement in having read the safety flash “briefly” do not persuade me, in the face of the totality of the evidence that the grievor knew that dye penetrant testing was to be performed, but that he chose not to do the testing.

With respect to the Safety Flash, I note that the Company sets out the “actions” it intended to undertake in the wake of the December 2, 2014 derailment. One of them is a weeklong “blitz” on the use of dye penetrant. Such an undertaking makes good sense considering that its use is not common practice. The grievor was not the recipient of any such “blitz.”

Directing all engineering employees, including the grievor, to links of a YouTube video to demonstrate the basic application and use of dye penetrant via the Safety Flash did not in my view sufficiently emphasize the importance the Company sought to impart to the grievor – who was not performing rail change outs on the winter assignments (up to that point), who had never used dye penetrant before and considering that its use had not been not common practice. In the circumstances, something more direct and emphatic was required to bring to the attention of employees the importance of dye penetrant testing.

Since I have found that the grievor did not absorb the information from the Safety Flash about the use of dye penetrant following the December 2, 2014 derailment, I do not see how a derailment on the Ruel Subdivision that was not linked to the failure to use dye

penetrant would somehow awaken in the grievor knowledge that he should have had, but that I have found he did not possess on March 4, 2015.

I am cognizant of my role in this matter and it is not my intention to provide extensive commentary on the responsibility of others who played some role in the change out of the rail on March 4, 2015. I will say, however, that, considering the context of how the grievor came to change the rail on March 4, 2015 and the communication between him and Supervisor Veillette during the change out, sufficient “flags” went up such that one would have reasonably expected Supervisor Veillette to have asked the grievor whether dye penetrant testing had been done.

Additional failures, which resulted in the passing of many trains without any “slow order” in place or any discovery that dye penetrant testing had not taken place all while the grievor thought he had competed the rail change out correctly, the Company has undoubtedly sought to address. The March 14, 2015 Track Standard Bulletin is one example of a proactive step taken in the face of what very well may have been a preventable catastrophic incident.

The grievor has nineteen years of service with the Company. His disciplinary record stood at five demerits when he failed to properly change out the rail on March 4, 2015. The grievor’s misconduct is that he did not bring a sufficient degree of care to ensure compliance with TS 1.7. In that respect, he was negligent.

While the grievor's negligence is not to be minimized, there was clearly no deliberate or conscious wrongdoing on his part.

In these circumstances, there is reason to conclude that his termination was excessive. The grievance is therefore allowed in part. Considering the severity of the consequences of grievor's negligence, I direct the Company to reinstate him forthwith, without loss of seniority but without compensation for any wages or benefits lost.

September 18, 2015

CHRISTINE SCHMIDT
ARBITRATOR