Occupational Health and Safety Tribunal Canada

Tribunal de santé et sécurité au travail Canada

Ottawa, Canada K1A 0J2

File No.: 2007-23
Decision No.: OHSTC-09-028

CANADA LABOUR CODE
PART II
OCCUPATIONAL HEALTH AND SAFETY

Canadian National Railway Company
(CN Rail)
appellant

and

Teamsters Rail Canada Conference
(TCRC)
Respondent

and

James Poirier
Intervenor

July 21, 2009

This appeal has been decided by Appeals Officer Jean-Pierre Aubre.

For the appellant
Michael G. McFadden, counsel

For the respondent
Mike Wheten, National Legislative Director, TCRC

For the Intervenor
James Poirier

[1] The present appeal was filed on August 14, 2007, by the appellant CN Rail against three directions issued to the appellant on July 20, 2007, by Brian L. Abbott, a health and safety officer (HSO) designated by the Minister of Labour pursuant to subsection 140(1) of the *Canada Labour Code* (Code) and attached to Transport Canada. Mr. Abbott issued the said directions to the appellant at the conclusion of his investigation into a rail accident that had occurred on March 19, 2007, at Macmillan Yard, a CN Rail facility, more precisely the CN Halton subdivision, located in Concord Ontario. On the occasion of that accident, an employee of the appellant, one Michael Merson, suffered a very serious disabling injury to his right lower extremity.

[2] In the course of his investigation, HSO Abbott formed the opinion that the appellant, who was and remains the employer of the injured employee, was at the time in contravention of the Code on three counts to wit, failure to assess the hazard of the design of the winter footwear worn by the injured employee at the time of the accident, failure to have in place a proper fatigue management plan and finally, failure to provide appropriate information, instructions, training and supervision to employees such as the injured employee to wit, a supervisor engaged in performing operating employee tasks. Those directions will be more properly described further in the present decision. However, before going any further, it is necessary at this juncture to clarify the designation of some of the parties in this case, as it differs from what had been decided in a preliminary decision rendered by the undersigned appeals officer on July 31, 2008.

The Parties

[3] The original filing of the appeal clearly identified the appealing party. Since the three directions being challenged through the appeal process provided under the Code had been directed at the employer, Canadian National Railway Company, there was no difficulty from the outset in accepting said employer as the properly identified appellant in the case. Difficulties arose however in properly identifying the party or parties, if any, that would or could oppose the appeal, this primarily for two reasons.

[4] First, Michael Merson, who suffered the serious injury as a result of the accident mentioned above, was and indeed is an employee of CN Rail who was at that time employed as a Terminal Trainmaster at MacMillan Yard, a management position. However, at the actual time of the accident, due to a shortage of operating employees, he was engaged in executing operating employee bargaining unit tasks (yardman conductor), a bargaining unit for which the United Transportation Union (UTU) was at the time certified as bargaining agent. Upon being informed of the appeal, the UTU did inform the Tribunal that it would not be taking part in the hearing of the appeal.

[5] Second, the difficulty was compounded early in the preparatory process that would lead to this hearing by Mr Merson informing the Tribunal first, that he would "participate on behalf of CN in this matter" and later on that he would

"not need to be a co-appellant" and would take part solely as a witness in the hearing "as the items in the direction were not directed at (him) personally". Two other parties sought to be recognized as parties to the appeal in the capacity of intervenors and were authorized to take part in the appeal hearing in a decision rendered by the undersigned appeals officer on July 31, 2008. Those were Mr James Poirier as co-chair (employees) of the work place health and safety committee at MacMillan Yard, and the TCRC, as bargaining agent for the locomotive engineers at MacMillan Yard.

[6] On September 5, 2008, thus prior to this hearing convening, the Tribunal was informed by the TCRC that it had replaced the UTU as the certified bargaining agent for the "Conductors, Trainmen, Yardmen and Yardmasters at Canadian National Railway", the bargaining unit to which belonged the tasks at which Mr Merson was occupied at the time of the accident, and that it wanted to continue to take part in the hearing of the appeal. As a result of this, the undersigned chose to designate the TCRC as respondent in the appeal and maintained Mr Poirier in the already granted status of intervenor.

The occurrence

[7] While the particulars of the occurrence and the elements and conclusions of the investigation that was conducted as a consequence of said occurrence will be presented lower in recounting the various testimony and investigation report presented at the hearing, a brief summary of said occurrence at this time will facilitate understanding of the case.

[8] As such then, on March 19, 2007, at the appellant's facility known as MacMillan Yard, there occurred a work related accident involving a CN Rail employee which resulted in serious injury to the said employee. Mr Michael Merson, a Rail Operations Supervisor (Yard or Terminal Trainmaster), was engaged at that time in operating employees' tasks due to a shortage of such operating employees. He suffered a disabling injury to his right lower extremity. More specifically, while engaged in coupling rail cars as part of a two-man team, and attempting to apply the handbrake on a moving rail car on which he was riding, Mr Merson lost his footing and was unable to maintain his handgrip. As a result, the leading wheel of that railcar ran over and severed his right leg midway between the ankle and the knee. At the time of the accident, Mr Merson was acting in the capacity of foreman of the said two-man team which had been assigned to coupling rail cars in the pitch and catch mode, a part of operating employees tasks.

The directions

[9] As stated at paragraph one above, the investigation that followed was conducted by Transport Canada health and safety officer Brian L. Abbott. He testified to having a great deal of experience in the railway industry, having combined 44 years of experience in various duties, starting as an office boy in 1964 and transferring in 1975 to operating duties at CN Rail and VIA Rail

in capacities ranging from yardman/trainman, yard foreman, conductor, locomotive engineer, general yardmaster, trainmaster, master mechanic, transportation officer and manager customer services until 1997, when he became a Transport Canada railway inspector/health and safety officer, a position he continued to occupy at the time of the hearing into this appeal.

[10] Upon completion of the investigation into the accident and injury suffered by Mr Merson, Mr Abbott concluded that CN Rail was in violation of three provisions of the Code (section 124 and paragraphs 125(1)(c) and 125(1)(q)) and therefore issued three directions to CN Rail, the substance of which goes far beyond the specificity of the facts and investigation relative to the occurrence involving a single employee, ordering the employer to:

-investigate the hazard of winter footwear design worn by CN operating employees when riding equipment and performing switching activities;

-have a fatigue management plan in place to protect supervisors working excessive hours prior to performing operating employees work;

-provide to supervisors working as operating employees the information, instructions, training and supervision necessary to ensure their health and safety at work.

The evidence

[11] In addition to numerous documents adduced as evidence, including health and safety officer Abbott's investigation report, four witnesses were heard at the hearing. HSO Abbott testified at length about his investigation and the conclusions he reached. For the appellant, Michael Merson testified about the occurrence as well as the subject matter of all three directions, voicing repeatedly the opinion that none of the elements central to the directions issued to CN Rail by HSO Abbott had contributed to or were a factor in the accident. Also for the appellant, Ms Susan Seebeck, senior manager, training solutions at CN Rail, testified on the subject matter of training for supervisors and Mr Don Watts, senior manager, regulatory affairs, did the same regarding the issue of fatigue management. Finally, Mr Dewayne Rose, mechanical supervisor, MacMillan Yard, who at the time of the accident had been the second member of the two-man team with Mr. Merson, was called to testify by the respondent CTRC.

[12] HSO Abbott's report, which was filed as an exhibit (E-6, tab 10), offers a very detailed description of the actual occurrence as well as the rationale for the HSO's directions. As such, and since Mr Abbott did not detract in any significant manner from his report in his testimony, it is useful for a better understanding of the matter to quote at length from the salient parts of said report. Thus, on the actual circumstances, the report states quite lengthily:

On the night of the accident two CN Rail supervisors were advised that due

to a shortage of operating employees, that they would be working the 1800 East Control Assignment. At approximately 1815 hours supervisors M. Merson and D. Rose met at the East Control Office. It was decided at this time that the foreman of the assignment would be supervisor M. Merson and the helper would be D. Rose. This assignment is known as a Locomotive Control System (LCS) assignment or remote control assignment. The LCS system is comprised of three essential components:

1. Beltpack Controller-This is the Beltpack Operator's control device (...) which interfaces with onboard equipment. The Beltpack controller transmits the operator's (YOE, meaning an employee engaged in Yard operations usually operating a remote controlled locomotive for the purpose of switching railway equipment) *commands to a remote locomotive consist computer via radio link, allowing remote control operation when certain conditions are satisfied. The Beltpack controller is monitored by the on board computer and can detect and intervene if the operator is incapacitated. This component also includes fail-safe features such as tilt detector and reset safety control device.*

2. Radio Controlled Locomotive Consist-This is a standard unit equipped with the Locomotive Control System to operate as an unmanned Remote Controlled Locomotive. Control commands are received from the YOE's OCU and are converted by the on board computer to initiate the appropriate locomotive response in order to maintain communication.

3. Ground Based Equipment-This is used to protect movements on the hump pullback tracks (LCS hump units only while in remote mode) ("hump" is an incline over which rail cars are let roll free and by gravity directed through various classification tracks by opening and closing switches) *and also to provide optimum radio coverage for more than one remote consist.*

The supervisors then spoke with the East Control Yardmaster who advised them that they would be coupling up tracks in C yard and pulling the cars over to the East Departure yard to make up trains. This assignment would be working in the Pitch and Catch Mode (system for transferring control of the movement from one belt pack controller to the other). (...) *M. Merson and D. Rose conducted a job briefing with each other as required by CN Rail policy and checked their personal protective equipment (PPE).* (...) *The employees decided that Supervisor Rose would remain in the front of the locomotive to protect the point on movements when the locomotive was leading, and Supervisor Merson would control the movement while coupling cars in the tracks.*(In his testimony, Mr Merson indicated that he had opted to replace another supervisor (L. Brantnall) for that task as he was of the opinion that he was the better operator of the two and had more experience than Mr Brantnall and Mr Rose) (...) *At 2102 hours the crew on the 1800 East control assignment commenced coupling cars in track CO 71. After making 2 couplings in track CO 71, Supervisor Merson stretched the track and realized that all the cars were not coupled together. He had at this time*

18 cars (15 loads and 3 empties). He could visually see that there was a 10 to 12 car gap between the cars in his control and the next cut of cars to the north. Supervisor Merson needed to reverse the movement (...) *and ride the northernmost car* (...) *to the draft of cars not coupled.* (...) *The LCS download indicated that at 2108:23 hours the movement began to proceed northward towards the remaining cars in Track CO71. The download indicates that Supervisor Merson had requested a speed of 15 MPH, but after reaching only 13.5 MPH some 807 feet later he requested a speed of 7 MPH at 2109:36. At 2109:41 Supervisor Merson requested an application of the independent brake and the actual speed of the movement was 12.67 MPH. At 2109:46 he requested a stop and the actual speed of the movement was 12.57 MPH. The speed at 2110:06 dropped to 2.88 MPH only 20 seconds from when the stop command was requested. Canadian Railways Operating Rules (CROR) 105* (provides that) *"reduced speed" movements must be in control of the Operator and able to stop short of equipment (Supervisor Merson stated in his interview that he detrained from the movement* (18 cars) *after requesting the stop command, as he could see that the movement was going to couple to the remaining cars in the track at speed greater than intended). It is estimated that the attempted coupling was made between 2109:46 and 2110:06. The entire movement of 18 cars came to a stop at 2110:15, 9 feet* (sic) *after the speed dropped from 12.57 MPH to 2.88 MPH. At 2110:21 the tilt time warning message was transmitted from the locomotive. The warning indicated that something abnormal had happened.*

Supervisor Merson stated in his interview (and confirmed in his testimony at the hearing) *that when the joint (coupling) on his movement failed, the northern cars were propelled northward from the point of impact. In observing this he ran northward to entrain the last car of this movement in order to apply a handbrake, which would prevent the draft of cars moving out on the lead of the north end of C Yard and fouling other tracks. He successfully entrained on the north end of this car and swung himself around to the end ladder and reached over to apply the handbrake. As he was applying the handbrake he had his left hand on the handhold of the end ladder and both feet were positioned on the bottom rung of the ladder. His right hand was on the handbrake wheel. He lost his footing, and his handgrip was compromised by his weight.* (...) *His left hand slipped down two rungs on the end ladder before he was able to retain his grip with both hands. He was unable to maintain his grip on the end ladder rung as his legs were dragging on the ballast. When his torso hit the ballast, he tried to twist away from the rail. However, the leading wheel of the rail car caught his right leg midway between the ankle and knee, and severed his right leg.* (...).

At approximately the same time as the East Control Yardmaster was advising the Terminal Trainmaster to call the emergency services personnel, a blowback alarm indication appeared on the dual hump coordinator's console. This alarm advises the dual hump coordinator that there is movement on this track (Automatic protection is afforded tracks in C Yard at

MacMillan yard in that if a car or draft of cars roll by a designated portion of a track, an alarm called "blowback alarm" will sound in the office of the Dual Hump Coordinator and the track that set off the alarm will be lined out the north end of the yard and any cars directed to that track or group of tracks, will be redirected in order to avoid a collision). *At 2110:41, another alarm appeared on the dual hump coordinator's console which indicated that a car(s) had passed the fouling point of the movement at the north end of track CO 71.*

[13] As already mentioned above, upon completing his investigation, HSO Abbott issued three directions to CN Rail pursuant to the Code. These will now be dealt with separately.

Direction on winter footwear

[14] There really is no variance between HSO Abbott's report and his testimony at the hearing. In his investigation report, Officer Abbott stated that at the time of the accident, Mr Merson was wearing the prescribed personal protective equipment (PPE) as required by his employer CN Rail. More precisely, the report states that the footwear worn by Mr Merson at the time was CSA approved winter footwear.

[15] In testimony, HSO Abbott did point out that when he initiated his investigation, he never did get to see the actual boots that Mr Merson had been wearing, as he did not go to the hospital where the injured employee had been taken to retrieve or at least have a look at them. Later on, when he asked that they be produced by CN Rail personnel, this could not be done as they had been disposed of. However, he was shown the exact same model of footwear that was worn by another employee and he stated at the hearing that he was satisfied that what had been presented to him was an exact replica of the footwear that had been worn by Mr Merson and that this footwear was in compliance with the requisite applicable CSA Standard.

[16] According to Mr Abbott, there exists a variety of work boots, including winter types, that are available to employees in the work place and that as long as they meet the applicable CSA Standard, they are all acceptable. To refer to his own words, "there is no standard model of boot for everyone, as long as the model is CSA approved". He did point out however that winter boots differ from regular winter boots in certain ways. As such, his report states that "this footwear is different from CSA regular approved safety boots in that there is more insulation provided to protect against extreme weather conditions (cold). Also there is a different configuration with the laces. On the CSA approved winter footwear worn by CN Supervisors the laces are not continuous."

[17] HSO Abbott confirmed at the hearing that the applicable standard is Canadian Standards Association standard Z195-M1984 Protective Footwear which is referred to in both the *Canada Occupational Safety and Health*

Regulations (SOR/87-623 as amended), section 12.5 and the more specifically relevant *On-board Trains Safety and Health Regulations* (SOR/87-184 as amended), section 8.6, both made under the Code. He also voiced the opinion that the laces on the boots worn by Mr Merson were not a factor in the accident. He further indicated his awareness of the fact that CN Rail's Personal Protective Equipment Standard (exhibit E-2, tab 1A) states that "it defines minimum requirements for foot protection for all employees and other individual granted access to CN property", that "all employees are required to wear approved foot protection while on CN property and in other location while in service" and that "protective footwear shall meet or exceed the standards set out in Canadian Standards Association CSA Z 195."

[18] According to HSO Abbott, the difficulty in this case lies not with compliance with the applicable standard, a fact he readily acknowledged, although the sole footwear he had considered or examined was the one worn by Mr Merson at the time of the accident, but rather with the actual bulkiness of the boots involved, which caused him to direct that a hazard assessment of the design of footwear worn by all CN operating employees be conducted, having concluded in his report that "although the winter boots that were worn by the injured employee meet the requirements of the CSA Standard, the cumbersome nature of this type of footwear, combined with winter conditions, may have contributed to the injured employee's loss of footing. In his testimony, Mr Merson indicated however that he may not have completely inserted his feet on the rail car ladder rung, thus not ensuring a complete three points contact as required, and thus slipped on the occasion of a minor jolt.

[19] At the hearing, HSO Abbott was presented by counsel for the appellant with a document, which appears on the exhibit list as E-2, tab 4, titled Risk Assessment: James Bay Baffin Technology-CSA Grade 1 Winter Work Boot, consisting of 9 pictures of a winter boot model as well as 8 pages of text bearing the title CN Hazard/Risk Assessment, dated August 20, 2007. Having examined the document in question, Mr Abbott confirmed that the boot model represented in the document was the exact same model as that worn by Mr Merson, that the document represented an actual risk assessment of the footwear in question and that it had been completed following the accident suffered by Mr Merson. On the matter of whether the fact that the boots worn by Mr Merson at the time may not have been laced up, raising the question as to whether this could have been a factor in the accident, Mr Abbott stated that the applicable standard does not require that boots be laced up and added that the laces were not a factor in the accident.

[20] Finally, having reviewed the said risk assessment, the HSO opined that it satisfies and meets the requirements of the direction on winter footwear under appeal. In fact, this had already been brought to the attention of the appellant in a letter from HSO Abbott, dated October 11, 2007, (exhibit E-1, tab 6) to M. Farkouh, General Manager CN Rail, Concord, which stated in part:

(...) *As stated in your letter, Transport Canada will accept the risk assessment provided for the winter footwear as it was done on the type, style and make of boot that Mr Merson was wearing at the time of the accident. The Direction states "The employer has not investigated the hazard of winter footwear design, worn by CN Operating Employees when riding equipment and performing switching activities." It should be noted that there are many manufacturers of winter safety footwear and it is expected that CN would carefully analyze the different types of footwear prior to operating employees using them.* (...)

HSO Abbott completed his testimony on the question of winter footwear by stating that the question relative to winter safety footwear in this case was a "dead issue" in that the boots had not been a factor in the accident.

Withdrawal of appeal

[21] Following the end of HSO Abbott's testimony on the issue of winter safety footwear, Mr McFadden, for the appellant, presented to the undersigned appeals officer a motion seeking to withdraw the appellant's appeal on this particular issue. Referring to the actual text of the direction and the accompanying letter penned by the HSO, counsel pointed to subsection 146(1) of the Code as the basis for the right to appeal a direction. That provision states that "*an employer, employee or trade union that feels aggrieved by a direction issued by a health and safety officer under* (Part II of the Code) *may appeal the direction in writing to an appeals officer within thirty days after the date of the direction being issued or confirmed in writing.*" It was counsel's position that the circumstances of the case were very clear in that CN Rail was the sole appellant, that there were no other appellants relative to this or the other directions, and that there is nothing in law that prevents an appellant from withdrawing an appeal at any stage. It was Mr McFadden's view that in fact, an appellant would be the only party capable of withdrawing an appeal, which I took to mean withdrawing its own appeal.

[22] Mr Wheten, for the respondent, opposed the motion on the basis that CN Rail having appealed the direction, since the TCRC had been granted standing, first as intervenor and subsequently having been recognized as actual respondent, he believed that the TCRC would be allowed to act on the matter at the hearing in the same manner as if it had actually appealed the direction.

[23] Following a brief adjournment, I opted to render a decision verbally on the motion to withdraw by reading the following text at the hearing, remaining silent on the question, not raised by any party, as to whether there could exist exceptional circumstances at times that could justify denying such a motion to withdraw:

Mr McFadden for the employer/appellant in this case, following the evidence obtained yesterday through testimony by HSO Abbott, is seeking this morning to withdraw the employer's/appellant's appeal against one of the directions of which this tribunal is seized. The applicable statute, the Canada Labour Code, Part II, more specifically subsection 146(1), states that "an employer, employee or trade union that feels aggrieved by a direction issued by a health and safety officer under this Part may appeal the direction in writing to an appeals officer within thirty days after the date of the direction being issued or confirmed in writing". Under the legislation, it is the appellant that is the mover of the appeal, in other words it is the appellant's appeal against an order that has been directed at it to do certain things and comply with certain requirements.

At any time, for any reason, an appellant may choose to withdraw his or her appeal, regardless of the state of the case or whether or not, as in this case, there has or has not been compliance with the direction that is at the origin of the appeal. The effect of such a withdrawal, the consequence if I may use the word, is to leave the direction as formulated and binding on the party at which it is directed. While an appeal is lodged and active, the mere fact that parties are allowed to respond in some capacity to the appeal does not translate, of itself, into being effectively an added or additional appeal by those parties.

Consequently, as the appellant of the direction issued by HSO Abbott on the matter of "winter footwear" has opted to withdraw said appeal, I am of the view that I have no option but to grant that motion, thereby leaving the direction applicable as written and formulated. It has become clear to this tribunal this morning that no other appeal has been filed or could be considered to have been filed regarding the said direction and as such, as the withdrawal has the effect of leaving said direction as is, any difficulty or objection that could be formulated or entertained vis-à-vis said direction would have to be dealt with in another forum or through another appeal action.

Direction on fatigue management plan

[24] HSO Abbott's investigation report points out that employer records showed that Mr Merson had worked in his supervisory functions a total of 72 hours in the 144 hours that immediately preceded his taking on operating employee tasks on a 7th consecutive shift that would lead to the accident. Those 72 hours, six 12-hour shifts starting each day at 1800 hours to end on the following morning at 0600 hours, occurred in an office environment at MacMillan Yard where Mr Merson was responsible for train and yard operations at CN Rail's largest switching facility in Canada. It is during a seventh consecutive day of work, one that began at 1800 hours as the East Control assignment, where Mr Merson was to work with another supervisor (D. Rose) at operating employee tasks, that the accident occurred, more specifically three hours into the shift.

[25] The investigation report states that Mr Merson, when interviewed, indicated to HSO Abbott that he did not think fatigue had been a factor in the accident.

[26] In his testimony at the hearing, HSO Abbott first described the supervisory position of trainmaster held by Mr Merson at the time as requiring the person to constantly be on the move, always doing tasks, leaving the work station to go to other parts of the yard, and as such to be a fatigue engendering function. Mr Abbott would later qualify this by stating that the position is not as physically demanding as operating functions and thus not requiring as much rest. This would also be largely coloured by Mr. Merson's later testimony to the effect that on that particular day, when he arrived at work, he had had a twelve hour break from the end of his preceding 12 hour shift as a supervisor, during which he had slept 7 to 8 hours, thereby ensuring that he arrived at work well rested and in a good state of alertness. Mr Merson also pointed out that while the 72 hours of work during the preceding six days would constitute an abnormal situation caused by the accumulation of work brought about by a conductors' strike, his duties during that period had been conducted entirely from his desk situated in the terminal traffic control tower, where he could contact personnel such as other supervisors and train crews by cellular phone and radio units, supervise activities in the yard by operating mobile cameras and receive pictures on a TV set on his desk and where actual physical tasks on the ground would at that time be executed by a subbed mechanical supervisor.

[27] Set against this background, HSO Abbott testified being aware of a specific fatigue management plan adopted in accordance with the requirements of section 6 of the *Work/Rest Rules for Operating Employees* (TC O 0-50, June 29, 2005)) adopted under the *Railway Safety Act* (R.S. 1985, c.32, 4th Supp. as amended) and titled Specific Fatigue Management Plan For Supervisors Performing the Duties of Operating Employee(E-4,tab8). He was also aware that the plan in question was in place and in effect at the time of his investigation.

[28] This particular plan, dated August 15, 2006, had been put in place following an order to that effect by W.E. Hunter, a Railway Safety Inspector occupying the function of Manager, Railway Operations and Occupational Health and Safety at Transport Canada. That particular plan is part of a group of specific such plans put in place under the umbrella of a general plan titled General Fatigue Management Plan for Rail Operating Employees Canadian Lines. The order that led to the adoption of the specific plan for supervisors performing operating employee duties was based on the premise under the *Railway Safety Act* (RSA) that there existed a "hazard or condition that could reasonably be expected to develop into a situation in which a person could be injured or made ill (...)" (exhibit E-4, tab 6) and thus provided that CN Rail would:
-not permit supervisors to work in any job category of an operating employee to operate railway equipment unless said supervisor has been off duty for a

period of eight (8) continuous hours prior to accepting the call as an operating employee;
-ensure all supervisors and crew management staff are fully trained in the application of the Work Rest Rules;
-implement an electronic process to accurately record time worked by supervisors;
-develop specific fatigue management plans to address fatigue of supervisors when said supervisors are utilized in the job category of operating employees.

[29] Mr Abbott did not remember having seen that particular Hunter order although he recognized that the specific plan mentioned above had been created as a result of said order. He also had reviewed all the other specific plans and the general fatigue management plan previously mentioned which he recognized having been put in place as a result of the application of a regulatory regime under the RSA . He also recognized that in the circumstances prevailing at the time of the accident to Mr Merson, the latter had not been in any manner in violation of said plan. While being aware of the said specific fatigue management plan for supervisors, Mr Abbott recognized having paid little attention to it as his investigation into the accident had been conducted not pursuant to the said RSA, but rather under the Code and the applicable regulations, therefore a different legislative framework.

[30] In that respect, he pointed out that under the Code and the applicable *On Board Trains Occupational Safety and Health Regulations*, there are no similar requirements to manage employee fatigue as in the Work/Rest rules adopted pursuant to the RSA, although fatigue is always an issue in the work environment and thus he based his direction on the general protection duty of the employer at section 124 of the Code. It was his personal opinion that due to the seriousness and hazardous nature of the duties involved, there should be similar rules and a similar program under the Code. Also, given the numerous hours worked by Mr Merson prior to the accident and his errors when conducting switching activities, it was his opinion that Mr Merson had been fatigued and not properly rested when he started the 1800 East Control assignment.

[31] Mr Don Watts was called to testify on behalf of the appellant. Mr Watts occupies the position of senior manager, Regulatory Affairs, and has been in that position for approximately 12 years. He has been an employee at CN Rail since 1980 in various positions, including a period of 4 years in what he referred to as the Safety Department and points out that Regulatory Affairs used to be part of the Safety Department. He took an active part in the development of the various fatigue management plans for operating employees mentioned above and he testified at considerable length on that subject, both through examination-in-chief, cross-examination and re-examination. While the considerable information derived from his testimony has proven to be informative, not all is important or determinative as regards

the issue at hand. I have retained the following as having a direct impact on the issue raised by the Abbott direction to wit, the establishment of a specific fatigue management plan for supervisors performing the duties of operating employees.

[32] The various fatigue management plans mentioned above, including the one resulting from what I will refer to as the Hunter order also previously mentioned, all originate from application of the Canadian Rail Operating Rules (CROR) adopted under the RSA. In 2002, at the behest of the Railway Association of Canada (RAC), Work/Rest Rules for Railway Operating Employees were adopted, came into force on April 1, 2003, and were later revised in 2005. Those applied generally to constituent companies including CN Rail. Those rules, developed after the need for a consolidated set of rules of general application had been identified, were the result of the work by a multi-party consultative group including union representation as well as a number of studies, the marking one being from Circadian Technologies Inc. and titled Canalert 95/Alertness Assurance in Canadian Railways.

[33] Three main thinking points, what Mr Watts referred to as the general philosophy that was derived from that work, were that: 1) simply establishing prescribed time limits would not be sufficient, 2) other restrictions such as length and number of tours of duties, etc., referred to as "fences" by the witness, would need to be established, and 3) plan(s) to help mitigate fatigue needed to be established. This gave rise to concepts such as maximum duty times, mandatory off-duty times, and fatigue management plan(s). According to the witness, the RAC does not appear to have initially developed an actual fatigue management plan that would have been mandatory for all its constituents and thus each railway was left to devise its own plan "that would work for it".

[34] As a result, CN Rail developed a general plan as well as three specific such plans, all applying to operating employees (employees on-duty in excess of 64/7; employees in work train service; plan governing emergency situations). The plans however were and remain to be developed under the Work/Rest rules and it is under those rules that various time constraints or parameters that serve to base the limits that flow from such plan(s) are set, such as the 12 hours maximum continuous on-duty time, the 18 hours maximum combined on-duty time, the 64hours/7 days maximum duty time and others. Mr Watts pointed out that the Work/Rest rules were clearly developed to apply to the defined classification of "operating employee", which does not include persons in a supervisory position such as Mr Merson, although the "deeming" wording of the definition of "operating employee" in said rules clearly indicates that non-operating employees are to be considered operating employees while performing operating employee duties and thus, it can be derived from the rules that supervisors may be involved in operating tasks.

[35] In order to allow the various operating employees fatigue management plans to meet their purpose, the various time parameters mentioned above needed to be monitored. A system called Crew Assignment Timekeeping System (CATS) was put in place to monitor for each operating employee the number of hours worked, and thus the availability for additional work or the necessity for off-duty rest. As a general maximum on-duty time of 64 hours over a period of 7 consecutive days was the parameter established under the Work/Rest rules, the CATS time tracking system will automatically go back in time over a period of 168 hours (7 days) to calculate the total on-duty time over the period and thus, where the maximum 64 hours have been reached, will automatically require a 24 hours off-duty period.

[36] Mr Watts went on to note that the various fatigue management plans, and the ensuing CATS system, as they apply to operating employees as the term is defined in the Work/Rest rules, were initially designed to mitigate or end the practice of working excessive hours within as short a time period as possible to attain rapidly the monthly mileage maximum or cap established by the applicable collective agreement, so as to then being allowed an extra long time-off work period. Mr Watts noted that even though these plans and system were put in place, they did not apply to supervisors and the on-duty time of supervisors was not even tracked. However, an incident occurred whereby a supervisor doing operating employee tasks had worked a number of hours exceeding well over the 18 hours maximum combined on-duty time prescribed for operating employees under the Work/Rest rules (rule 5.1.3) and thus evidencing the lack of time tracking in the case of supervisors in any function. This was the starting point of the action taken by W.E Hunter and his ensuing order that a specific fatigue management plan for supervisors doing operating employee work be put in place. Mr Watts referred to rule 5.1.7 of Work/Rest rules as being the parameters that served as the basis for establishing the fatigue management plan for supervisors performing operating employee tasks. That rule reads as follows:

Where a supervisor, non-operating employee or third party is deemed (as per definition of "operating employee") *to be an operating employee, the on-duty times of the supervisor, non-operating employee or third party in the immediately preceding 24-hour period shall be taken into account in calculating maximum available on-duty time and mandatory off-duty time in section 5. Such persons must be able to demonstrate compliance with these Rules.*

Mr Watts noted that the "preceding 24-hour" parameter for supervisors retained in rule 5.1.7, differing as such from the operating employees 168-hours/7 days reference parameter, had been retained by the working group that developed those rules on the basis that from the standpoint of fatigue inducing functions, work in an office environment which is mostly that of supervisors, would not be as fatigue inducing as duties of regular train crews.

[37] Mr Watts distinguished between the general and specific fatigue management plans for operating employees, and the specific plan for supervisors. In the first instance, those plans applying to unionized employees were developed at CN Rail in consultation with the relevant unions while in the case of the supervisors plan, UTU or TCRC were not consulted as supervisors are members of management and not unionized. He went on to explain that because of the Hunter order previously mentioned and the wording of rule 5.1.7 of the Work/Rest rules for operating employees that at least "anticipates" that supervisors can be called to perform operating employee duties, CN Rail essentially developed a fatigue management plan that basically parallels that which was already in place for operating employees, albeit with a different previous work time reference to account for the different nature of supervisory work, but that subjects supervisors to the same constraints as operating employees when performing operating employee duties (maximum on-duty, mandatory off-duty, etc.).

[38] Furthermore, as the Hunter order had managed to show, supervisors could not be depended upon to comply diligently with the requirement of keeping a personal log of their on-duty time so as not to be put in a position to exceed the parameters of on-duty time when performing operating employee duties. In order to solve that problem and ensure compliance with the limits set in the Work/Rest rules as well as the requirement by rule 5.1.7 that supervisors be able to demonstrate compliance with the said rules, CN Rail established the Colog system, an electronic or computerized system that allows registering of supervisor on-duty time in the 24-hour period immediately preceding the start of operating employee duties and automatically indicates the amount of time a supervisor can work as an operating employee as well as the mandatory rest periods to be taken. The data is entered by a supervisor only when called upon to work as an operating employee, with the supervisor then becoming subject to the Work/Rest rules for operating employees upon commencing operating employee duties.

[39] Mr Watts went on to state that the plan devised under the Hunter order presented three essential features. First, it was designed to clearly inform supervisors of the regulatory requirements applying to them when working as operating employees. Second, it clearly established the need to make use of the CoLog system to tract the time spent at both supervisory and operating tasks. Third, that all the requirements derived from the Work/Rest rules for operating employees apply to supervisors as if they were operating employees when performing those tasks. According to the witness, there is no other railway part of the Railway Association of Canada that can boast having such a fatigue management plan for supervisors.

[40] Mr Watts was briefly cross-examined by the respondent and the intervenor. In essence, his answers did not result in any real or serious variance to what transpired from his examination-in-chief. On the question of whether the plan could be circumvented through what Mr Wheten referred to as "continuous

shifting" from supervisory shifts to operating shifts continuing indefinitely, Mr Watts opined that in theory, this could continue without triggering the 64/7 rule, although he could not say that this demonstrates the need for a different fatigue management plan as the duties would also be changing from operating to less demanding supervisory. Finally, the witness indicated not knowing whether as part of the Colog system, there are security measures to prevent tampering with the data registered, so as to, potentially after the fact, ensuring that on paper, there has been compliance with the rules.

Direction on supervision and training

[41] Once again, HSO Abbott's testimony does not stray very far from his report on the two items listed therein, that is training and experience on the one hand and supervision of supervisors performing operating employees duties. Curiously enough however, while these two subjects appear from the investigation report to base the direction issued pursuant to paragraph 125(1)(q) of the Code, upon considering the required regulations provision needed to complete and particularise the obligation that flows from that Code provision, that is paragraph 10.12(1)(a) of the *On Board Trains Occupational Safety and Health Regulations*, one comes to realize that quite apart from the words used by the HSO, it is essentially "training", the insufficiency of such, at least from the standpoint of HSO Abbott, that governed the issuance of the direction. It is useful to note before getting to the evidence on that subject, that while paragraph 125(1)(q) of the Code requires from the employer that it provide, as prescribed, the information, instruction, training and supervision necessary to ensure the health and safety of an employee while at work, paragraph 10.12(1)(a) of the regulations deals solely with training when providing that "every operator of self-propelled rolling stock shall be **instructed** and **trained** by the employer in the procedures to be followed for (a) the safe and proper use of rolling stock". With this set as background, the fact is that the testimony received at the hearing concerning this direction dealt for all intents and purposes mostly with training.

[42] The investigation report states under training and experience:

CN Rail employed supervisor Merson in February 2005. A review of training records indicated in 2005 he received 2.5 days of LCS training, which included 4 hours on the job training. In April 2005, he received 5 days Canadian Rail Operating Rules (CROR) *Training. He was appointed Terminal Trainmaster at MacMillan Yard February 22, 2005. As a Trainmaster, Mr Merson completed at least 16 hours per month riding with and accompanying assignments in MacMillan Yard. He worked 14 tours of duty on LCS assignments between August 31, 2006 and October 8, 2006 due to a shortage of operating employees.*

During the review of the Supervisor's training record it was noted that CN

Rail has no procedures in place to ensure the training received by supervisor's is adequate in order that the supervisor can safely perform the duties of an Operating Employee. Officers working as Operating Employees are not formally evaluated by an experienced Line Officer, and no record maintained on file, prior to being fully qualified. It was also noted that once qualified there is no process in place to monitor the work practices of these employees.

[43] The same report, this time under title Supervision of Supervisors Performing Operating Employees Duties, while noting a number of violations by Mr. Merson to both CROR rules and CN Operating Instructions, as it did as regards the discrepancy in training between supervisors and regular operating employees involved in executing the same operational tasks, draws attention to the discrepancy in supervision as regards those two groups of employees involved in the execution of the same tasks. It states:

CN Rail has a program in place to monitor regular operating employees in the course of their tours of duty. This program is called "Performance monitoring and Rules Compliance" (PMRC). CN Rail Supervisors who have Operating Employees under their supervision must do a certain number of PMRC's per month on their employees. These PMRC's cover the majority of Canadian Rail Operating Rules, General Operating Instructions, safe work practices, etc. . It was determined through this investigation that CN does not have a program in place to monitor Supervisors who are performing operating employees work, more specifically, inexperienced supervisors.

[44] At the risk of overly simplifying HSO Abbott's testimony at the hearing, the essence of his conclusions and testimony is to the effect that both in terms of training/experience as well as supervision, CN, as the employer, is requiring or doing less training and/or supervision of supervisors than it is in the case of operating employees even though the tasks either of those groups of employees are required to execute, albeit under possibly differing circumstances as in the case at hand, are the same. In other words, according to Mr Abbott, what the employer sees as being needed for regular operating employees, it does not consider as equally needed in the case of supervisors doing operating employee work. It was Mr Abbott's testimony that Mr Merson, being a supervisor, had received less training than a new operating employee would receive as per the employer's training program.

[45] According to Mr Abbott, on the night of the Merson accident, Mr Merson had violated a number of CROR rules and General Operating Instructions relative to speed, acceptable switching and coupling speeds and others, while operating on the beltpack, those evidencing Mr Merson's lack or insufficient training and experience and being at the root of the accident. It was his view that it was Mr Merson's actions that precipitated Mr Merson's accident and that these actions would not have occurred if the latter had been sufficiently trained and monitored.

[46] On the matter of the "unpublished protection" at MacMillan Yard, what is referred to as the "blow back" protection, Mr Abbott pointed out that in his meeting with Mr Merson, he received no indication from the latter as to whether he was or was not aware of said protection at the time, but noted that supervisor Merson recognized having forgotten its existence, thus explaining his actions in trying to apply manual brakes on a run-away rail car.

[47] On the subject of training program, HSO Abbott testified to being aware of another order by the same W.E. Hunter referred to earlier on the issue of fatigue management plan. This latest order in March 22, 2007, by the manager of Railway Operations and Occupational Health and Safety, had been the result of the latter's finding that there was "insufficient training given to employees and supervisors from a Non-Operating background, when such employees (were) required to work in the job category of Operating Employees". In fact, Mr Hunter had found that "CN permits Employees and Supervisors from a non Operating Employee Background to work in the job categories of Operating Employees without proper training to the extent of or equalling that of an operating employee."

[48] As a result of that finding, the Hunter order had been to the effect that CN Rail "not allow or permit Employees or Supervisors from a non-operating background to work in any job category of an operating employee unless said Supervisor (had) received a minimum of 10 days of classroom training respective of the duties and rules of an Operating Employee and a minimum of 20 days of on job training in the job category of an operating employee". The said order had brought about the creation of the A-B-C tiered training program wherein employees are progressively qualified as per the amount of training obtained, ending with Category A for those employees who have met the requirements of a minimum of 10 days of classroom training and a minimum of 20 days of on job training, becoming thus qualified to work in any capacity of an operating employee as indicated in 1987-3 Rail Regulation and those positions as defined as "operating employee" contained in the Work Rest Rules. This was the capacity in which Mr Merson was operating on the night of his accident. By comparison, documentary evidence obtained as part of the training record of both Mr Merson and Mr Rose (E-6, tab 3) indicated that in order to complete their training program, new trainmen (operating employees) would be required to complete between 45 and 60 tours of duty, with each trainee being required to complete a minimum 1/3 of this training on LCS assignments.

[49] Mr Abbott noted however that while the Hunter order had originated from authority derived from the *Railway Safety Act*, he on the other hand had based his direction on his authority under the Code and that the Hunter order did not actually concern belt pack proficiency which was at the root of the accident.

[50] Mr Merson's testimony was premised by his stated opinion that training was

not a factor in the accident. He has been an employee of CN Rail at MacMillan Yard since February 2005 in the capacity of trainmaster (now known as General Superintendant Transportation), a front line supervisor managerial position. At the time of the accident, he was filling in as a conductor, an operating employee function, whose primary purpose is the safe and efficient movement of rail cars over an assigned territory. As a conductor tasked with assembling trains in a yard, he was restricted to operating the locomotive by remote control, known as a "belt pack", since only an engineer can operate a locomotive from the cab of the engine . He recognized as accurate Officer Abbott's description of his training as well as that of what a new trainman would require. As such, where CROR and Operations rules are concerned, Mr Merson stated that he holds a certificate of qualification for conductor initially obtained in 2005 and re-issued in March 2008 after 40 hours of seminar involving instruction and testing on CROR rules and CN Rail specific train operation rules. As a supervisor, he is required to have a 95% passing mark because he is expected to mentor and teach said rules to operating personnel, as part of their structured training. They, however, are only held to an 80% passing mark.

[51] Mr Merson's LCS training was provided on-the-job by other trainmasters (2) shortly after becoming an employee at CN. It consisted in explicit instruction on belt packs, trouble shooting of locomotive control, proper set up of LCS unit as well as basic concepts of train control using the LCS belt pack and involved practical applications. He pointed out that following his actual training, which had been given at different time intervals by those two individuals, and always separately, he had completed between 25 and 30 shifts where he was the primary operator with belt pack. Mr Merson had brought a belt pack at the hearing and demonstrated what appeared to be a fairly complete command of the apparatus, although when cross-examined by Intervenor Poirier, he also demonstrated that he did not have total knowledge of all the functions of the apparatus.

[52] Mr Merson's description of the accident does not differ from the one made by Safety Officer Abbott. In his view, central to the occurrence was his misjudging the distance to a cut of cars that he was to couple, resulting in the speed at which this was attempted to have been too high, and coupling to have failed. There followed that the said cut of cars did begin to run freely and Mr Merson, wanting to avoid the free running cars fouling a track and colliding with other cars, chose to attempt to stop the movement by running alongside and jumping on the closest car to apply the hand brake. In doing so, he recognized having somewhat panicked, never having been in a potential collision situation, and thus given what he termed to have been a "unique situation", failed to think of or remember the other means of protection available, such as the "blow back" protection that he otherwise was familiar with. Mr Merson also pointed out that in his haste to stop the movement of the run away cars, he may not have positioned himself properly aboard the car on which he was attempting to apply the brakes, and thus, not having a proper three points of contact stance, had lost his footing.

Mr. Merson also did not dispute Safety Officer Abbott's conclusion that he had failed to comply with CROR rules by violating rules on coupling speed. However, this was due to his misjudging the distance to the cut of cars he wanted to couple, not ignorance of the rules since he was quite aware of what the coupling speed should be. As for General Operating Instructions, Mr Merson stated that he was aware of all applicable instructions and had fully observed them.

[53] When cross-examined, Mr Merson expressed the view that supervisory personnel do not receive differing training for operations tasks, but that their training is more hands-on, on-the-job training as opposed to the more traditional classroom/meeting room training offered others as per the training program in place. He recognized however that in receiving 2.5 days of LCS training early on in his employment (3-5 months), 5 days of CROR training, 16 hours/month of actual hands on training and having completed 14 tours of duty on LCS assignments, his training had been less than what is received by new trainmen who, as part of their training program, must complete between 45 to 60 tours of operations duty with a minimum 1/3 on LCS assignments. However, while not contesting that he had received less training than what is considered necessary for regular operations employees doing the same task that he was involved in at the time of the accident, Mr Merson expressed the view that his 2.5 days of LCS training was sufficient, that he was more competent than his peers, including his partner of that evening (D. Rose), and that more training would not have made any difference, the accident being attributable to an error on his part, although more experience might have brought another result.

[54] Susan Seebeck testified for the appellant. She has been an employee of CN Rail for 36 years, the last 8 years as Senior Manager, Training Solutions. Generally, she manages training at CN, with the exception of technical training delivery, which is done in region and by the regions because of job specificity. As part of her responsibilities, she develops or sees to the development of all training at CN and she manages the delivery of training destined for managers within CN. She did point out that she does not see to the development of training for conductors and she does not develop rules training. She indicated that she was aware of the Hunter letter/order of March 22, 2007, therefore subsequent to the accident suffered by Mr Merson, that had been issued pursuant to the RSA and ordered that a training program be established for personnel of a non-operating background since that personnel had insufficient training when it came to doing operations work. She was also aware that the Hunter letter/order referred to the work stoppage of February 2007 at CN Rail and had noted that CN " permits Employees and Supervisors from a non Operating Employee background to work in the job categories of Operating Employees without proper training to the extent of or equalling that of an operating employee".

[55] Ms Seebeck was consequently instrumental in developing, after March 22,

2007, a training program that would answer the Hunter order in particular for non-operating managers. As such, she put together a schedule for training managers as conductors, she developed a web site that would allow non-operating managers to view the training schedule, register and become cognizant of the training content and the obligations to be met. Finally, she developed an electronic data base making it possible to monitor whether non-operating or operating managers are qualified as conductors as well as their progress within the training program. As the program she developed is largely based on hands-on training requiring a number of qualification tours of duty (also known as trips or assignments), it is coupled with the Company Officer Log (COLOG) which records the number of assignments a supervisor will have done as conductor/engineer to reach the qualification level, and the Railroader Trainee Log, a document that trainees and coaches use to record the fulfilment of tasks towards achieving completion of the training and coaches' observations on the progress of trainees.

[56] The program that has been developed has come to be known as the ABC program, whereby a participant will progress from step C to A with each training step needing to be completed prior to being allowed to access the next. This program, officially titled Railroader Certification Program, is mirrored in a number of aspects on the Railroader Trainee Program for new hires and recently promoted employees to first line supervisor positions and its sample timeline calling, among other training blocks, for 15 days of Rules (CROR) training and 5 days of beltpack training. In the case of the ABC/Railroader Certification Program, successful completion of all three levels does not qualify a supervisor to operate the belt pack and 5 extra days of training are required (2 days of classroom and 3 days of hands on training with an instructor) once the three levels have been completed, in addition to the required 16 tours of duty or assignment regarding the actual function (such as yard conductor) for which qualification is sought.

[57] Ms Seebeck indicated that all training programs are developed following the same course of development, regardless of whether applicable to new hires or newly promoted employees or intended for supervisors destined to do operations work. In the case of the Railroader Trainee Program, the actual sample time line provides for a number of subject blocks of varying duration (Rules -15 days; Beltpack-5 days, etc.) to be completed over an initial 6 months period, to be followed by actual on-the-job training with coaching for a total duration of 12-18 months. In the case of the Railroader Certification Program, a voluntary program presented as a career asset for supervisors, the Program ABC path is made up of rules classroom training blocks of varying duration (2-5 days) with the required exam pass rate being 90%, to which must be added 16 tours of duty (yard trips and mainline trips) that need to be entered in the COLOG system for verification of program completion. As stated by the witness, completion of the classroom training and the 16 tours of duty provided under the program path needs to be complemented by an evaluation by the Operating Practices Manager who is responsible for the application/interpretation of the CROR as well as

determining whether the actual supervisor is ABC qualified. This may result in additional tours of duty being required. As stated earlier, completion of this program would not qualify one for beltpack operation, the training for which falls outside of this program and requires an additional 5 days of training split between 2 days of classroom and 3 days of practical training. Under the Railroader Certification Program, one is also required to do 4 tours of duty each year in order to maintain one's rules qualification.

[58] Dewayne Rose was called to testify by the respondent. On the date of the accident to Mr Merson, he was the other member of the two man team that comprised Mr Merson. Mr Rose became an employee of CN Rail in March 2006 and initially occupied the position of supervisor-in-training for a duration of approximately six months. At the time of the accident and to this day, he holds the position of mechanical supervisor. In that capacity, he does not provide assistance to operating employees. This would be restricted to supervisors such as Mr Merson. Mr Rose received his LCS training during the course of his initial 6/7 months of training, in fact his first months as an employee of CN Rail. During those months, he was initially trained on many subjects, including CROR, specific CN departments and CN systems in use. Where CROR rules are concerned, his training lasted three weeks. While he did not remember how much of those initial 6/7 months that he was on training were devoted to conductor training, he did point out that since it was part of transportation, it was the longest part of the training he received. On beltpack operation, Mr Rose testified to receiving three days of training (1day classroom and 2 days practical on the job), following which he was immediately certified. His training record (E-6, tab 3) indicates that he completed 2 days LCS in class/on site training, followed by a number of belt pack shifts from that date. In addition to his belt pack certificate, he is also a qualified/certified conductor. He clarified his belt pack experience by stating that all his belt pack shifts, and he does not remember exactly how many, occurred from the date that the work stoppage began at CN Rail, that is February 7, 2009, to the date of the accident. In answer to a question by the intervenor, Mr Rose indicated not being aware that the normal training for operations yard personnel would entail 30 road trips or assignments. On the subject of supervisor training for operating employee work, Mr Rose did not disagree with the position put forth by the intervenor to the effect that work safety would be enhanced should supervisors get the same amount of training in operations as regular yard workers, commenting that "more training is always good". He did comment further however that in this case, more training would not have made any difference to the occurrence.

[59] On the night of the accident, Mr Rose pointed out that it was Mr Merson, not he, who had control of the movement and that while they were in radio contact, Mr Merson did not inform him specifically of what had happened, that the cars had not coupled and that they were going back. As he was not aware of the distance that had to be covered to complete the coupling, Mr Rose did not offer an opinion as to whether the speed ordered by Mr Merson

to initiate the movement to couple, 13.5mph as per the LCS download (E-5, tab-2), was excessive. He did not have control of the movement as he was protecting the point (riding the locomotive) and thus had no idea of the distance to cover. That speed however did not appear excessive to him and consequently, he saw no need to contact Mr Merson by radio.

[60] When cross-examined by Mr McFadden, Mr Rose acknowledged that it would not be typical to have constant communication between the two members of the team. In his opinion, it would be normal that he be informed when "pulling out" as he was protecting the point, but that when going in the other direction, he did not need to be informed. It was his opinion that it was not necessary for him to be informed of every back and forth movement since he was not in control of the movement on the belt pack.

The Submissions

[61] At the request of the undersigned Appeals Officer, all parties provided a written rendering of their oral submissions and both have been considered by the tribunal. What follows is not an attempt at reproducing those submissions in their entirety, but rather an abbreviated recounting of what the tribunal considers to be the salient points of each.

Appellant

[62] Mr McFadden for the appellant recognized at the outset the severity of the consequences of the accident for Mr Merson. He pointed out however that the appeal is one directed at two specific and particular directions, "not an attempt by CN to minimize the severity of the accident or dispute the necessity of maintaining a high degree of care and compliance with established safety rules and safe practices at all times", and that it should be recognized that the occurrence of the accident is not in and of itself justification for the issuance of directions.

[63] Counsel structured the appellant's submissions along two essentially parallel trusts, the first being the more particularized situation of Mr Merson and the second, the more general employer situation. In essence, as concerns Mr Merson, the position set forth by counsel is that at the time of the accident, Mr Merson had been properly and sufficiently trained in accordance with existing training program and additional work experience, that he was not fatigued and prior to commencing his shift had had a sufficiently restful period of sleep, all in accordance with a fatigue management plan for supervisors working as operating employees already in place at the employer's. With regard to the more general employer situation, the trust of the appellant's submissions was again twofold. First, as regards fatigue management, it was pointed out that at the time of the accident, CN Rail already had in place a specific fatigue management plan for supervisors working as operating employees, said plan having been established in accordance with existing Work/Rest rules and pursuant to an

order under the *Railway Safety Act*, a statute that while not the *Canada Labour Code*, was similar in purpose to the Code, had to be looked at and interpreted in conjunction with the said Code and although structured to take into account the particular situation of supervisors, tied into all of the other fatigue management plans for operating employees once a supervisor began working in operating employee tasks.

[64] Second, on the matter of training, which was presented as the sole element that the investigation report of the health and safety officer dealt with, the submissions focused on the fact that the employer had had in place for a number of years prior to Mr Merson's hiring, an exhaustive training program for newly hired front-line supervisors, the Railroader Trainee Program, that a new program to supplement the latter, the Railroader Certification Program (known as the ABC program) had been put in place shortly after the Merson accident, and that there was no basis for the assertion put forth by the health and safety officer that supervisors working as operating personnel should have at least the same amount of training as those persons hired to work as operating personnel.

[65] Counsel did recount the main points of the occurrence, as summarized previously. He did recognize that because of Mr Merson misjudging the distance he needed to travel to effectuate the desired coupling, the selected speed of 15 mph on the belt pack proved to be above the recommended coupling speed, thereby resulting in a failed coupling that caused the free movement of the rail cars he intended to couple, his subsequent excessive haste to attempt to stop the movement, his failure to ensure for himself a proper "3-point grip" on the rail car he boarded for that purpose and his injury. Counsel linked Mr Merson forgetting "momentarily" about the "blow-back" fail safe system to his momentary haste (Mr Merson described it as somewhat panicking) at preventing a rail car collision, and his exceeding the maximum advised coupling speed to a distance misjudgement error rather than ignorance of what that speed should be.

[66] On the subject of Mr Merson's training, counsel pointed out that in addition to his formal conductor qualifications and belt-pack training, as well as 14 full shifts worked with a belt-pack controller between August and October 2006, he had worked an additional 25-30 shifts with the said belt-pack by the time of the accident. Thus, as such, while he may not have received the full prescribed formal belt-pack training required for new front-line supervisors (5 days), at the time of the accident, he had acquired as much experience operating the said apparatus as newly-hired operating personnel would have upon the completion of their belt-pack training.

[67] On the subject of the potential fatigue of Mr Merson, counsel submitted that although supervisor Merson had worked 6 consecutive12 hour shifts immediately prior to the night of the accident, he was not physically tired because those previous shifts did not involve physically taxing work, having been essentially spent at his desk. Further, as regards the fatigue

management plans at CN, and in particular the plan that was in existence for supervisors doing operating employee work, counsel noted that when the Railway Association of Canada Work/Rest rules for supervisors working as operating employees were being developed (rule 5.1.7), the 24-hour period immediately prior to working as operating personnel was considered the preferred reference time period to evaluate potential fatigue because supervisors tend to work as operating personnel on an exceptional basis, the safeguards that needed to be established had to be manageable and requiring supervisors to go beyond the 24-hour period would in effect require supervisors to do so based on their recollection of the previous period since there is no timekeeping system for supervisors.

[68] On the more general matter of the employer's training program(s) and the direction issued by health and safety officer Abbott under appeal, counsel submitted that for at least 5 years prior to Mr Merson's accident on March 19, 2007, CN Rail had in place a railroader trainee program (RRTP) for newly hired front-line supervisors, which included a detailed and sophisticated set of courses and practical training on a wide aspect of operating personnel activities, including CROR training, yardmaster activities and other similar activities including a 5 day package on belt-pack operation. He added that after Mr Merson's accident, and as a result of an order from Transport Canada under Rule 3 pursuant to the RSA, but prior to the July 20, 2007, direction by health and safety Abbott in respect of training, CN developed and put in place an additional training program called Railroader Certification program which provided for qualification levels of varying degrees of sophistication, sometimes referred to as the "ABC Program", with level A being the level of highest capability and qualification capacity, said program being also intended for first-line supervisors.

[69] As regards the more general issue of the direction to the employer to establish a fatigue management plan (FMP) for supervisors doing operating employee work, counsel argued that in intending to protect supervisors from working "excessive hours" prior to engaging in operating employee work, the direction used language that was too vague, but that regardless of this, there already was in place such a plan when the health and safety officer opted to issue the direction.

[70] He argued that in its essential outline, this specific fatigue management plan, established pursuant to an order issued pursuant to the RSA, but disregarded by health and safety officer Abbott as not issued pursuant to the Code, requires supervisors who are to work as operating personnel to record their work activities in the 24 hour period immediately prior to commencing work as operating personnel in a system called "COLOG", a system created for the supervisors specific FMP, and to include that 24 hours previous period for all purposes when determining the particular supervisors' Work/Rest rules and limits as an operating personnel. In addition, all of the other general and specific FMPs for operating personnel apply to a supervisor once he or she commences working in an operating

personnel capacity. On that point, the gist of the appellant's submission is that at the time of the accident and subsequent direction, there was already in place a FMP that met all the requirements of the direction by health and safety Abbott, short of having been established pursuant to the *Canada Labour Code*.

[71] In short CN submitted, concerning the supervisors specific FMP, that the tribunal should not interfere with the nuanced and sophisticated approach that the Railway Association of Canada working group developed over a 6-year period to design and put into place work/rest rules for supervisors who find themselves working as operating personnel. Similarly, it was submitted that the tribunal should be reluctant to uphold health and safety officer Abbott's direction on training given the detailed training program that CN not only already had in place at the time of Mr Merson's accident, but in particular because of the training it has developed since the accident, and the lack of any connection between said accident and Mr Merson's level of training and experience at the time.

[72] In closing his submissions, counsel for the appellant pointed to a number of options available to the undersigned in deciding on the two remaining issues.

[73] First, as regards the direction on the subject of a fatigue management plan, counsel was of the view that it should be revoked on the basis that there was no evidence that Mr Merson was fatigued or that fatigue played any role in the accident, thereby providing no basis for the direction. In the alternative, counsel was of the view that the direction should be rescinded as moot and redundant since the employer had already in place a supervisor specific FMP that effectively complied with the direction. He further added that should I be of the view that the existing FMP did not render the direction moot and redundant, I should nonetheless rescind the said direction as complied with by the fact of the existing FMP. Finally, counsel further added that the direction should be rescinded based on the doctrine of "officially induced error".

[74] Second, concerning the direction relative to training, counsel argued that it should be rescinded due to the complete lack of evidence that Mr Merson's training or alleged lack thereof had played any role in the accident, such that there had been no foundational basis for the issuance of the said direction. In the alternative, it was counsel's opinion that regardless of the presence of such evidence, the direction should still be rescinded as redundant and moot given the employer having put in place, since the said accident, a specific training program for first-line supervisors, as mandated and approved by Transport Canada. Finally, counsel put forth the view that the direction should nonetheless be rescinded on the basis of the doctrine of "officially induced error".

[75] Representative of the respondent initiated his submissions by going over the

evidence adduced at the hearing, targeting primarily the testimony offered by Mr Merson set against data derived from material submitted as exhibit. As such, generally, the respondent had no issue with the general description of the occurrence, as recounted in the investigation report as well as through testimony given at the hearing. Furthermore, respondent recognized that while the central element of the occurrence related to Mr Merson's misjudgement of the distance between the equipment he was controlling and the stationary equipment he was attempting to couple, the latter had been fairly accurate if not slightly conservative in his estimation of 600/800 feet (10 to 12 car lengths) between the two. Respondent pointed out however regarding the coupling attempt and the speed at which it occurred, that the belt pack commands testified to by Mr Merson were not consistent with those recorded through the LCS download, and more importantly in the respondent's opinion, neither the download nor Mr Merson's statement comply with the coupling instructions found in the employer's training manual on belt pack operations.

[76] Respondent further submitted that in addition to this first mistake, Mr Merson had also violated CROR rule 105 (speed on other than main track) which required the engine using a non-main track to be operated at reduced speed, meaning a speed that would permit stopping within one-half the range of vision of the equipment, which had obviously not been the case. Respondent pointed out that if rule 105 had been complied with, all other things being equal, the collision would not have happened, thereby implying that the accident would not have happened as the undesired movement of the stationary equipment would not have occurred. Respondent went on to point out another failure to adhere to CROR rules by Mr Merson. This time, it was contended that the undesired movement of the stationary equipment could have further been prevented if Mr Merson had complied with CROR rule 113 dealing with "coupling to equipment" and which requires that "before coupling to equipment at any point, care must be taken to ensure that such equipment is properly secured", which had not been the case. To complete the list of errors raised by respondent, representative pointed out Mr Merson forgetting the existence of the safety feature referred to as "blowback protection" and the latter's admission that while he was aware of said safety feature, he had not thought of it at the time of the accident and that he would not have put himself in a position to be injured if he had remembered the existence of the said safety feature. In completing the review of those errors by Mr Merson, respondent pointed out his failure to ensure proper positioning on the rail car he had boarded in order to attempt to apply the handbrake and the fact that he failed to observe the safe operating practice of providing 3 points of contact when riding on railway equipment.

[77] This led respondent to formulate the following comment, leading into what respondent is claiming as justification to maintain the directions and dismiss the appeal, that is Mr Merson's insufficient training and fatigue:

We met Mr. Merson and heard his testimony. Mr. Merson appeared to be a knowledgeable, conscientious employee. And given Mr. Merson's current position and the responsibilities bestowed on him it is obvious CN has confidence in his abilities and values him as an employee. It would be very hard to believe his actions were a result of negligence and even harder to believe any wilful intent. But something affected Mr. Merson's abilities, decision making and situational awareness to bypass so many safeguards, each on their own may have well prevented this unfortunate accident from occurring.

[78] On training, respondent referred to the training records for both Mr Merson and D. Rose, the other member of the team on the night of the accident, as well as to their testimony at the hearing. According to those, Mr Merson received 2.5 days LCS training and Mr Rose received 3 days of such training made up of 1 day of classroom and 2 days practical training. It is respondent's position that it is undisputable that both employees failed to receive the same amount of training in working with LCS equipment as that of regular operating employees, although they were expected to perform the same duties. Furthermore, respondent's view is to the effect that while those two employees may have received comparable training material to that of operating employees, their training was delivered in an abbreviated time frame and they were not afforded the same amount of trips or assignments working with a qualified crew to learn the practical application of the LCS equipment as an operating employee learning belt pack operations would. Set against the fact that both Mr Merson and Mr Rose occupy supervisor positions and are required to operate LCS equipment only on infrequent occasions such as manpower shortages, they do not gain the same familiarity with the equipment as operating employees using said equipment on a daily basis, thus the need for at least the same basic training as those employees.

[79] On the same issue of training, respondent referred to the testimony of Ms Susan Seebeck, CN's senior manager of training solutions, who testified that the program she designed to be delivered to new managers contained a 5 day component on belt pack operations which included 2 days classroom training and 3 days hands-on training and that this had been in place for at least five years. This would be at odds with the statements of the two employees to the effect that they had not received the said amount of training, although hired within the last three years. Pointing out to the statements by both Mr Merson and Mr Rose to the effect that they felt they had received adequate training on LCS equipment, respondent referred to Mr Merson's actions while operating the LCS unit and his many rule violations and questioned whether the level of training had contributed to the accident and whether more training could reduce the risk of this type of accident from recurring.

[80] On the subject of fatigue, respondent did not dispute that the work/rest rules for railway operating employees apply solely to operating employees, and as

such, that supervisors are brought under the coverage of these rules only when they actually perform the duties of an operating employee, save for rule 5.1.7 which looks only at the amount of on-duty time worked by a supervisor in the 24 hours immediately preceding start of work as an operating employee and this, for the purpose of calculating maximum on-duty and mandatory off-duty times identified in section 5 of those rules.

[81] Respondent did not dispute either that the requirement for the development of specific fatigue management plans defined under section 6 of the said rules only applies to operating employees. In the case of Mr Merson's work history for the ten days preceding the accident, respondent did not dispute that even though Mr Merson had worked 72 hours in the 6 days preceding the accident, he was not in violation of the rules when starting work as an operating employee and actually was entitled to work as such for 10 hours under the provisions of section 5 of the rules. Respondent however drew attention to the fact that this contrasts clearly with the fact that the rules require that the fatigue factor be addressed in the case of regular operating employees when such employees work in excess of 64 hours in a 7 day period, and that this criteria had been developed following a lengthy study that based its conclusions on an occupational group (locomotive engineers) whose duties presented physical demands closely akin to those of a trainmaster, a group to which belonged Mr Merson.

[82] Putting in perspective the fact that Mr Merson, who claimed that fatigue had not been a factor in the accident, had worked six consecutive 12 hour night shifts totalling 72 hours in a 6 day period prior to the accident, and considering what respondent referred to as Mr Merson's decision making and situational awareness demonstrated leading up to that accident, respondent opined that this would raise the question as to whether fatigue could have contributed to the accident and whether measures could be put in place to prevent its recurrence.

[83] In concluding, respondent opined that health and safety officer Abbott had correctly identified that training and fatigue had contributed to the occurrence and that his directions had correctly addressed those issues and should not be disturbed.

[84] As Intervenor, Mr Poirier was also afforded the opportunity to formulate final submissions. In doing so, Mr Poirier closely associated with the submissions formulated by the Respondent, and as such it is not necessary at this juncture to present at length what would essentially be a repetition of those submissions. That being said, Mr Poirier did however adopt a slightly more precise, if not different, tack on the issue of fatigue and fatigue management. According to Mr Poirier, CN Rail does have in place a plan to monitor management and to prevent members of management from working in excess of 64 hours in a 7 day period. However, he opined that this is not the problem identified by health and safety officer Abbott, but rather that there was no plan in place to monitor or prevent employees from working

"excessive hours prior to performing operating employee work". Intervenor Poirier referred to the testimony of Don Watts that a supervisor can work an infinite number of shifts in a row as long as operating work was not being performed, and that in the cases where a supervisor does work as an operating employee, that work record can be expunged after 24 hours as long as the supervisor goes back to his normal management duties.

[85] Referring to Mr Merson's expressed opinion that he was not fatigued at the time of the accident even though he had worked 72 hours in the preceding 6 days and felt "better skilled" than Mr Rose and "more confident" than a supervisor with much more experience than him, Mr Poirier pointed to the testimony of Mr Abbott and his report to the effect that fatigue can lead to slowed reactions to normal or emergency stimuli, in effect requiring more time to perceive and interpret, understand and react to objects and events. Mr Poirier opined that the information garnered by investigator Abbott shows that fatigued operators may take procedural shortcuts that they would not consider when they are alert because they do not recognize an increased level of risk and, being fatigued, fail to reliably estimate their alertness and performance. Referring to the 6 shifts/72 hours of work by Mr Merson, what amounted to almost double that of a 40 hour work week, Mr Poirier questioned how Mr Merson could have possibly known his level of fatigue. Added to this, the various mistakes made by supervisor Merson combined with the fact that there was on his part disregard for some of the very rules and practices that he is supposed to mentor regular assigned employees about, demonstrated an erring judgment that, in Mr Poirier's opinion, can be attributed to fatigue.

[86] ON the subject of training, Intervenor Poirier reiterated Respondent"s position, pointing out again that even though, as testified by Ms Seebeck, for at least 5 years there has been in place a beltpack training requirement of 5 days in a classroom and one on one setting to be followed by 8 road assignments and 8 yard assignments before a supervisor can work on one's own, in the case of Mr Rose and Mr Merson, this had not been adhered to, specifically in Mr Merson's case that the training was reduced to hands-on and a two day course with instructors Madigan and Karn. In Mr Poirier's opinion, the fact that Mr Merson had not been given any classroom instruction may cause one to conclude that the disregard for rules operating instructions and proper train handling practices played a major role in the occurrence of this accident. According to Intervenor Poirier, there may be training programs and material in place at CN Rail but the problem lies in the fact that those programs are not being adhered to.

[87] In his conclusion, Mr Poirier pointed to the intelligence and capacities of Mr Merson who, at the time, had been in charge of running one of the largest yards in America and questioned the assumption that training and fatigue had not been a factor, asking how a "highly praised supervisor" could have made so many errors ranging from non compliance to rules and train handling practices to something as simple as having 3 points of contact on a

moving piece of equipment, unless fatigue and insufficient training were part of the equation. As such, he opined that I should not disrupt the conclusions arrived at by health and safety Abbott, a man whose 44 years of experience in various fields of the railroad industry should command respect.

Analysis and Decision

[88] A brief initial comment. The directions that were issued by health and safety Abbott in this case, came at the conclusion of his investigation into the accident suffered by Mr Merson that has been discussed at length in the preceding pages. Those directions are based on information obtained by the health and safety officer on the occasion of that investigation but, as became apparent from reading the investigation report, considering the testimony received at the hearing, and noting the actual wording of said directions, demonstrate an intended coverage that goes beyond the actual particulars of the actual accident and specific circumstances of the injured employee. As I stated at the outset in paragraph 5 of this decision, "the substance of (the directions) goes far beyond the specificity of the facts and investigation relative to the occurrence involving a single individual". As such, while the accident may have provided the occasion that allowed for the collection of information that is presented as basis for the directions, I share the view expressed by counsel for the appellant that the mere fact that there was an accident is not in and of itself to be seen as justification for the issuance of the directions under review.

[89] I shall deal first with the direction concerning fatigue management. The text of the direction, or rather the contravention that the direction is intended to have corrected, is quite precise and it is important to have it clearly in mind given that much of the evidence was specific to the personal situation of one individual employee. That text reads as follows:

CN Rail failed to have a fatigue management plan in place to protect ***supervisors*** *from working* ***excessive*** *hours* ***prior*** *to performing operating employees work.* (emphasis added)

At the risk of repeating myself, it is clear from that wording, and in particular the plural of the word "supervisors", that what was/is intended by the direction goes beyond the application to the situation or circumstances of the single employee/supervisor involved in the accident, and was to be applicable to the whole employer organization whenever a supervisor is to be assigned temporarily to operating employee work. Furthermore, the use of the word "prior" in the same text makes it abundantly clear that the intended purpose of the directed fatigue management plan in the particular circumstances of a supervisor becoming engaged in operating employee tasks is the taking into account of the time spent by the supervisor(s) at his or her normal duties before commencing the operational tasks, so as to ensure that the supervisor does not suffer from fatigue, accumulated fatigue, due to long working hours in one's own tasks at the point of starting those

non-habitual tasks that are operating employee tasks. Finally, there is the use of the word "excessive" as a qualifier to the word "hours" in the partial phrasing of the cited text above, reading as: "...protect supervisors from working excessive hours prior to...". The Canadian Oxford Dictionary defines the word "excessive" as meaning: "too much or too great" and yet again "more than what is normal or necessary", a definition which in itself is vague and where the word "excessive" itself or its definition become meaningful only when data or information is provided to allow to characterise what, in any given circumstance, is too much, more than normal or excessive. In other words, there needs to be reference information provided or available for the word "excessive" or the terms used to define it, to take on any meaningful sense.

[90] I have read in its entirety the investigation report by health and safety officer Abbott, reviewed his entire testimony as well as that of all the other witnesses, examined the exhibits submitted and considered the arguments formulated by all parties. From those, I have derived no meaningful information or data that would indicate to the undersigned, or even more importantly to the party being directed to establish a fatigue management plan for supervisors engaging in operating employee tasks, what would constitute prior excessive work hours, so as to trigger the application of the various elements of a fatigue management plan such as, for example, those that have been referred to repeatedly and testified about in this case as being in place within CN Rail, save possibly for the inference to be drawn from the repeated reference to the 72 hours in 6 days worked by Mr Merson prior to engaging in operating employee tasks that such a number might represent something excessive. Given the perspective of a direction intended through its wording to apply generally to the employer and its complement of supervisors, I am not prepared to accept and formulate such an interpretation based on the factual situation of a single employee where no evidence, certainly no conclusive evidence, was brought forth to the effect that the said employee had even been fatigued at the time of engaging in operating employee tasks due to having worked 72 hours within a 6 day period. On this, I share the view expressed by the appellant in its submissions to the effect that a difficulty with the direction issued by health and safety Abbott is that it is "too vague" and that "there is no basis for determining what would constitute "excessive hours".

[91] While it may have been made obvious from all that precedes, it bears mentioning here that the obligation that derives from the direction of health and safety officer Abbott is not merely for the employer to cease a contravention of the Code by putting in place a fatigue management plan for supervisors, but rather to do so by having "a fatigue management in place to protect supervisors from working excessive hours prior to performing operating employees work."

[92] This being said, the Code, at paragraph 125(1) (x), makes it very clear that compliance with a direction such as the one fashioned by health and safety

officer Abbott in this case, is mandatory. The provision reads as follows:

125.(1) Without restricting the generality of section 124, every employer shall, (...)
(x) comply with every oral or written direction given to the employer by an appeals officer or a health and safety officer concerning the health and safety of employees;

Furthermore, while compliance with a direction issued by a health and safety officer may be obtained through various administrative actions, a reading of sections 148 and 149 of the Code makes it very obvious that the obligations that stem from a direction issued by a health and safety officer, are enforceable by way of prosecution where the Minister of Labour authorizes the institution of such proceedings within a year after the time when the subject-matter of such proceedings arose. It is trite law that enforceability of an obligation, particularly an obligation formulated through the application of a statutory regime, is conditional upon compliance being possible through the party subjected to the obligation being sufficiently informed of the nature and extent of the obligation it is subjected to so as to be able, and therefore obliged, to act in compliance. In the case at hand, it is my opinion that as a result of the formulation of the direction as it stands, it does not sufficiently inform the party to which it is directed of what it is required to do in order to enable it to comply in a manner that would not be error inducible.

[93] It has been established through the evidence adduced at the hearing that the appellant employer has had in place, since 2005, a number of fatigue management plans directed at operating employees. Of those four plans, one is a general plan established pursuant to CROR work/rest rule 6.1.1 and three are specific plans established under CROR work/rest rule 6.2.4 to address three sets of specific circumstances to wit, where continuous on-duty hours exceed 12 hours, where there are more than 64 hours on-duty in a 7 day period, and in the case of emergency situations. It should be noted that the CROR rules in general and those under which those four fatigue management plans were established, are rules approved by the Minister of Transport pursuant to his authority under section 19, more specifically subsection 19(1), of the RSA. As such then, the exercise of the ministerial authority under the *Railway Safety Act* that sanctions those rules by way of a statutory regime, serves to attach to those rules developed by railway companies the authority of subordinate legislation akin to regulatory text.

[94] While the direction formulated by health and safety officer Abbott under appeal directs the appellant to establish a fatigue management plan for supervisors to protect them "from working excessive hours prior to performing operating employees work", it has been established through evidence that following an order pursuant to section 31 of the same RSA, an additional specific fatigue management plan was already established under those same work/rest rules to apply to supervisors who are called upon to perform the duties of operating employees. It is important to note here that

pursuant to those CROR work/rest rules, any person, inclusive of supervisors, who is required to temporarily perform the duties of an operating employee, is deemed to be an operating employee. While it is not necessary to go over all of the elements of this plan, for a better understanding of the decision on this matter, it should be noted that in this latest plan, the 24 hour period that immediately precedes the beginning of operating employee tasks by a supervisor has been included as the reference period of control of work hours and mandatory off-duty time, to prevent a supervisor from being fatigued when starting operating employees work. This 24 hour criteria however, did not originate with the drafters of the said fatigue management plan. Rather, it was inserted in the plan in compliance with CROR rule 5.1.7 which reads as follows:

5.1.7 Where a supervisor, non-operating employee or third party is deemed to be an operating employee, the on-duty times of the supervisor, non-operating employee or third party in the ***immediately preceding 24-hour period*** *shall be taken into account in calculating maximum available on-duty time and mandatory off-duty times in section 5. (...)* (emphasis added)

The supervisor plan itself, with the exception of the preceding 24 hour criteria, ties the fatigue management of supervisors to that of the operating employees, as stated in the following excerpt from the plan:

As such, all such supervisory time, in addition to the time actually worked as an operating employee, is to be treated as on-duty time under the Work/Rest Rules and ***must*** *be taken into account when determining whether or not the supervisor has had sufficient rest under the rules,* ***prior to*** *performing the operating employee duties, and to determine the amount of time available under the maximum duty times (12, 16, 18, 64/7 "clocks")to complete the operating employee duties.*

It needs to be repeated here that the mandatory off-duty times resulting from those various plans are set by the CROR work/rest rules in relations to the "clocks" mentioned above. As such, the point of contention that is at the root of the direction and of the position of the respondent and intervenor relates to the 64/7 so-called "clock" for operating employees whereby an operating employee who would work in excess of 64 hours over a 7 day period would be required to be off-duty for a period of 24 hours, while in the case of a supervisor assigned to begin performing operating employee tasks, having solely the preceding 24 hour reference period to consider, would essentially be subjected to only an 8 hour mandatory off-duty period, regardless of the amount of on-duty hours performed over a longer preceding period. In that context, one must keep in mind that prior to commencing operating tasks on the night of his accident, Mr Merson had worked 6 consecutive 12 hour shifts, and yet had been off-duty for only 12 hours.

[95] Quite surprisingly, in his testimony health and safety officer Abbott recognized having been made aware of the fatigue management for

supervisors put in place pursuant to the *Railway Safety Act* and the CROR Work/rest rules, but, as he testified, paid little attention or gave little consideration to it because it originated from a legislative regime that was not the one he was operating under. In other words, since it had not been established pursuant to the Code, it could not be said to meet the purpose sought by the direction issued pursuant to the Code. His intention is made clear in a letter that he sent to the General Manager of CN Rail on October 11, 2007 (E-1, tab 6) in reaction to being informed by the latter of the specific fatigue management plan for supervisors performing operating employees work. It reads as follows:

The "specific Fatigue Management Plan for Supervisors Performing the duties of Operating Employees" that was submitted, requires that only Supervisory time in the 24 hours immediately preceding assuming "operating employee" duties be considered when calculating the amount of time available under the maximum duty times. TC's (health and safety officer Abbott) *expectation of this Direction is that CN Rail will implement a plan* ***similar to that of the Work/Rest Rules For Railway Operating Employees*** *for Supervisors, subject to being called to work as an operating employee.* (emphasis added)

It is obvious from those words, in particular those emphasized, that while Mr Abbott is of the view that a 24 hour reference period is not sufficient, he ignores the fact that this criteria is actually set by those work/rest rules (rule 5.1.7) that he wants to see serve as basis for the fatigue management plan for supervisors, and even more so, he pays no attention to the binding legal nature of those rules that have been approved by the Minister of Transport. One could actually state that should CN, in complying with the Abbott direction in the manner sought by the health and safety officer, adopt a different reference time frame for supervisors, it would in fact be violating the rule sanctioned by the Minister.

[96] Officer Abbott's position is based on the fact, as stated earlier, that in issuing his direction, he was acting under a different and separate statutory regime, that which is set by the Code, and thus could order the establishment of a plan that would parallel the one already in place from the standpoint of purpose, but would impose different application conditions. A question that comes to mind, if one is to accept that the two statutes are to be interpreted as independent water-tight silos, is how is the employer to manage complying with one plan while not contravening the other. In order to address this, one has to look at the objectives of both, and even more so, the specificities or generalities of either. The purpose clause (s.122.1) of the Code reads as follows:

122.1 *The purpose of this Part is to prevent accidents and injury to health arising out of, linked with or occurring in the course of employment to which this Part applies.*

In addition, the Abbott direction is based on section 124 of the same legislation, the most general provision governing employer obligations pursuant to the Code. This is not surprising as there are no specific employer obligations under the Code, or even under the applicable *On Board Trains Occupational Safety and Health Regulations* regarding rest and the management of rest periods in relation to safety of employees. Section 124 reads as follows:

124. *Every employer shall ensure that the health and safety at work of every person employed by the employer is protected.*

By comparison, the "Objectives" section of the *Railway Safety Act* (s.3) reads in part as follows:

3.(a) *promote and provide for the safety of the public and personnel, and the protection of property and the environment, in the operation of railways;*(...)
(c) *recognize the responsibility of railway companies in ensuring the safety of their operations.*

These words take on a very specific meaning when read with sections 18 and 19 of the same statute. As such, section 18 reads in part:

18.(1) *The Governor in Council may make regulations*
(c) respecting the following matters, in so far as they relate to safe railway operations, in relations to persons employed in positions referred to in paragraph (b):
(ii) hours of work and rest periods to be observed by those persons,(...)

19.(1) *The Minister may, by order, require a railway company*
(a) *to formulate rules respecting any matter referred to in subsection 18(1) or (2.1) or to revise its rules respecting that matter;* (...)

Furthermore, subsection 20(4) of the *Railway Safety Act* makes it clear that rules voluntarily filed wit the Minister for approval have the same force and effect, when approved by the Minister, as rules that have been formulated following a ministerial order under section 19.

[97] Given that the two legislations mentioned above present a commonality of purpose as regards work safety and personnel safety which cannot be ignored, that essentially when considering the matter of fatigue management, provisions in and pursuant to the *Railway Safety Act* present a greater specificity than the Code and finally that what is sought through the direction by health and safety officer Abbott is for all intents and purposes the same as what does exist pursuant to the CROR work/rest rules, I am of the opinion, and in this I share the view expressed by counsel for the appellant that while the Code and the *Railway Safety Act* are in essence two separate and independent legislation, they should not be interpreted as if separate water-tight silos. As such then, I am of the opinion that in deciding

whether to uphold or not the direction issued by officer Abbott, I cannot ignore what has already been put in place by CN Rail and can question whether anything more could be achieved by essentially, as noted earlier, approving the putting in place under one legislation what would be mirroring what already exists under another one.

[98] Finally, a brief word on fatigue itself. First, in the case of Mr Merson. Despite the opinion expressed by health and safety officer Abbott regarding the fatigue generating tasks of the work of supervisors such as Mr Merson, and his conclusion that the latter must have been fatigued after having worked six 12 hour shifts preceding the day of the accident, as well as the assertions by respondent and intervenor that he must have been fatigued since the accident happened in the circumstances that it did with the errors committed by Mr Merson, in the end absolutely no direct evidence was adduced to the effect that supervisor Merson was suffering from fatigue at the time. In fact, the evidence was to the contrary in that Mr Merson had worked from his desk during all those shifts and had had a twelve hours off-duty period prior to the fateful shift of his injury. As concerns fatigue in general as relates to the function of supervisor/yardmaster, except for general affirmations, no direct persuasive evidence was presented that such duties would be fatiguing to the extent that would warrant modifying the parameters set in the CROR work/rest rules as regards supervisors called to execute operating employee tasks.

[99] Considering all of the above, I am of the opinion that at the conclusion of his investigation into the accident of supervisor Merson, health and safety officer Abbott had no foundational basis for issuing, as he did, the direction to CN Rail that it implement a fatigue management plan for supervisors called to work as operating employees similar to that of the work/rest rules for railway operating employees. Consequently, the appeal is granted and the direction is rescinded.

[100] I now turn to the direction on training and supervision. I must start by mentioning anew that while the direction by health and safety officer Abbott may have stated that CN Rail had "failed to provide supervisors working as operating employees the information, instruction, training and supervision necessary to ensure their health and safety at work", words that effectively repeat exactly the text of paragraph 125(1)(q) of the Code, which states the employer obligation on which the direction is based, when one takes into consideration the appended regulations provision necessitated by the words "in the prescribed manner" that are found in the said paragraph, the necessary conclusion is that the direction applies solely to training and instruction. On the whole, when all the evidence has been considered, one also has to recognize that for all practical purposes, the evidence adduced concerned only training and instruction.

[101] Furthermore, to return to officer Abbott's stated position that his authority stems from the Code and not from the *Railway Safety Act*, it needs to be

stated that on this matter, the two legislations are complementary rather than in conflict, as the Code is the basis for the obligation to ensure work safety through training, and the *Railway Safety Act* is the seat of authority for the taking of measures and establishment of programs necessitated for compliance with the obligation.

[102] With this said, on this issue of training and instruction, despite the fact that both Mr Merson and Mr Rose did offer the opinion that they had been sufficiently trained and instructed and were competent to perform the operating employee tasks they had been assigned to on the night of the accident, a number of evidentiary elements stand out as uncontested.

[103] First, as regards the existence of a training program, it was established that for at least 5 years prior to the Merson accident of March 19, 2007, the appellant CN Rail had had in place a training program called Railroader Trainee Program (RRTP) directed at newly hired front line supervisors. This program, which would have applied to both Mr Merson and Mr Rose, included a detailed and sophisticated set of courses and practical training on a wide array of operating personnel activities, including the subjects at the heart of the present matter, Canadian Railway Operating Rules (CROR) and LCS/belt-pack operations. As stated by Ms Seebeck, who testified for the appellant, the RRTP program includes a 5 day component on belt-pack operations made up of 2 days classroom training and 3 days hands-on practical training, said program to be completed over an initial period of 6 months followed by actual on-the-job training with coaching for a total duration of 12-18 months.

[104] Second, following the Merson accident, but before health and safety officer Abbott had issued his direction, a new program was put in place as a result of an order issued pursuant to the RSA. This program, referred to through this decision as the Railroader Certification Program, or "ABC Program", a voluntary program described as a "career asset" for first-line supervisors wanting eligibility to perform operating employee tasks, would need to be complemented by 5 days of LCS/belt-pack operations training divided into 2 days classroom and 3 days hands-on training supplemented by 16 tours of duty on the belt-pack and evaluation by an Operating Practices Manager who can order additional tours of training duty before certifying a supervisor as qualified. The Company Officer Log (Colog) and the Railroader Trainee Log are part of this program and make it possible to track assignments or tours of duty, as well as completed elements of the training taken by individual employees.

[105] Third, the evidence adduced at the hearing, be it the training records of both Mr Merson and Mr Rose, the testimony and admission of both as well as that of officer Abbott, undisputedly establishes that at the time of the occurrence, the training received by both in working with LCS equipment fell considerably short of the training required for regular operating employees in time, form and substance, although the two supervisors had been expected

to perform the same duties as that of operating employees. In this, I share the view expressed by the respondent to the effect that while the two supervisors "may have received comparable training material to that of an operating employee", their actual training was conducted in an abbreviated time frame and they did not participate in the same number of actual trial trips or assignments working with a qualified crew to learn the practical application of the LCS equipment as an operating employee learning belt pack operations. It should be pointed out that at the time of the accident, the Railroader Certification Program instituted as a result of the Hunter order had not yet been established. Furthermore, the training received by both was conducted in a manner that differed considerably from the methodology formulated by the training program, Mr Merson having received 2.5 days of LCS training divided into 4 hours on-the-job training and one-on-one training with two train masters, and Mr Rose receiving 3 days of the same training divided into one day of classroom and two days of practical training.

[106] It has been the position of the appellant that the real issue vis-à-vis training in this instance is whether the training offered supervisors assigned to operating employee duties was or is "sufficient", and that there is no foundation to the proposition that there should be equal training for supervisors doing operating employee duties and actual operating employees.

[107] On the question of "sufficient", I would draw attention to the wording of paragraph 125(1) (q) of the Code which makes it an obligation for the employer to provide each employee, and it makes no distinction on the basis of supervisory or managerial functions, with the training **necessary** to ensure their health and safety at work, thus what is requisite or essential to attain that purpose. In my opinion, this goes beyond what is merely sufficient. Furthermore, I strongly disagree with the proposition that there should not be equality of training where the same tasks are required to be performed by different groups of employees. It needs to be recalled that in instituting the Railroader Certification Program, the appellant employer acted in response to an order issued pursuant to the *Railway Safety Act*, an order that it agreed to follow and not dispute, effectively requiring that the proper training to be provided to supervisors assigned to operating employee tasks be to "the extent of or equalling that of an operating employee". In my opinion, since the protection of all employees at work is the purpose of the Code, the training required pursuant to the legislation is intended as a means of ensuring that protection, and thus it is the tasks and the risks or hazards inherent to those tasks that must be at the center of the protection sought through training. Since the tasks remain the same, regardless of who performs them, the training needed to eliminate or alleviate the hazards needs to be generally the same.

[108] This being said, counsel for the appellant is of the opinion that I should revoke the direction for a total lack of evidence that Mr Merson's training or lack of such played any role in the accident, thus depriving the direction of

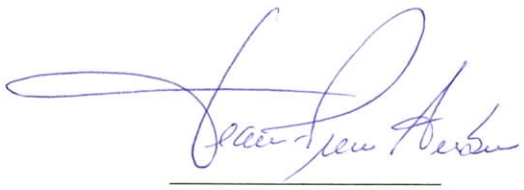
any foundational basis. The appellant did also argue that the mere fact that the accident occurred did not constitute, in and of itself, a justification for the issuance of the direction. I do agree that at best, the evidence that would link the two is tenuous to the point of being insignificant. At the same time, obtaining such persuasive evidence would appear to the undersigned to be very difficult. Such evidence however is not, in my opinion, necessary in the circumstances as in my view, the occurrence of the accident constitutes simply the triggering event to bring about consideration as to whether the employer has complied with its statutory obligation to provide its employees with the training envisaged by law to ensure their protection, regardless of whether an accident has occurred or not.

[109] The evidence on this score is that at the time of the accident, despite having in place a training program (Railroader Trainee Program) that envisaged a minimum of 5 days of LCS training, the employer failed to dispense to those two employees the complete programmed training prior to assigning them to operating employee tasks. Furthermore, no comprehensive evidence was adduced to demonstrate the existence of controls to verify the adequacy of the training or measures to monitor the work practices of the trained employees, or the performance of supervisors when working as operating employees. However, there is also in evidence that the employer has since put in place a new training program for first line supervisors to properly qualify them for operating employee tasks, the Railroader Certification Program, and that separate but in addition to this program, an LCS training program of 5 days duration (2 days classroom and 3 days practical) has also been established, to all of which is added a minimum 16 days assignments that also includes those elements that had been found lacking by officer Abbott, elements that allow monitoring of hours of work or assignments, progress of individual training and coaching. As a whole, I find that those two programs, one being mandatory for all new supervisors and the other also being mandatory for all front line or newly promoted supervisors wanting assignments in operating employee tasks, with added LCS training, afford training that would be generally the same as regular operating employees.

[110] Counsel for the appellant has suggested that the Abbott direction should be revoked as moot because of CN Rail putting in place, since the accident to Mr Merson, and actually prior to the issuance of the direction, a specific training program for first-line supervisors, the Railroader Certification Program. Having examined said program in light of the direction issued by health and safety officer Abbott, I find that while it may have been justified prior to the establishment of the new program, the said program coupled with the additional 5 days mandatory LCS training essentially satisfies what had been required through the direction. As a result, I find that there is no further remedial action that I could direct as regards the direction as formulated. As such therefore, I find the direction moot and consequently grant the appeal.

[111] This should normally put an end to this matter. However, I cannot ignore the

fact, as shown by the evidence, of the employer's less than complete adherence to its own training program as concerns LCS/belt pack training in the case of Mr Merson and Mr Rose. There is no need to repeat the details of this shortcoming, as it has been made very clear through the recital of the evidence in the decision. However, I cannot avoid being troubled by the fact that the employer, under a program itself found to have been unsatisfactory or even incomplete under another authority, itself vested with the statutory authority to consider the safety at work of rail personnel, failed to provide said training in the manner, substance and duration envisaged by said program. One should not forget that where the Code states that the employer has the obligation to provide the training necessary to ensure the health and safety at work, it does not suffice to formulate programs in this regard and have those accepted. The most important part of the obligation is the actual provision of the training in substance, form and duration as programmed, to those who are supposed to receive it. In my opinion, to fail to do so could constitute a contravention of the Code that could bring about a direction, among other possible actions, a course of action I have opted not to follow in this case because of the passage of time since the accident, the change in circumstances in the case of the principal proponent in the case, that being Mr Merson, and the instituting of a new training program that satisfies, in my opinion, the direction issued by health and safety Abbott.



Jean-Pierre Aubre
Appeals Officer