Canada Appeals Office on Occupational Health and Safety | Bureau d'appel canadien en santé et sécurité au travail

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Case No.: 2005-66
Decision No.: CAO-06-041

Canada Labour Code
Part II
Occupational Health and Safety

Canadian Pacific Railway Company
appellant

and

Canadian Auto Workers
respondent

Decision No.: CAO-06-041
November 22, 2006

This case was decided by Katia Néron, Appeals Officer, based on the written submissions provided by the parties and the documents supplied by the health and safety officer.

For the appellant

Katherine E. Bilson, Counsel, Legal Services, Canadian Pacific Railway Company (CPR)
Robert Tully, Mechanical Services Safety Specialist, Canadian Pacific Railway Company

For the respondent

Jim Wilson, National Health and Safety Coordinator, Canadian Auto Workers (CAW), Local 101

Health and Safety Officer

Todd Campbell, Labour Program, Human Resources and Skills Development Canada (HRSDC), Vancouver, British Colombia

[1] Following the investigation of an accident that occurred at the Canadian Pacific Railway Company rail yard in Port Coquitlam, British Columbia, on January 10, 2005, and resulted in the death of Dennis Sokoliuk, a labourer/switchman[1] employed by CPR, health and safety officer (HSO) Todd Campbell issued, on November 28, 2005, a direction to CPR under subsection 145(1) of the *Canada Labour Code*, Part II (the *Code*).

[1] Port Coquitlam Car Shop employs a labourer/switchman to perform a dual role around the rail yard. As a switchman, the employee executes switching moves, operates switches, aligns couplers, couples and uncouples cars trackmobile/locomotive in conjunction with a trackmobile/ locomotive operator to marshal cars around the yard. Whenever switching moves are not requested, the employee acts as a labourer and periodically performs general labourer/ maintenance duties.

The direction stated that there were three violations by CPR under section 124 of the *Code* and ordered CPR to terminate them by January 31, 2006. On November 28, 2005, Robert Tully, Mechanical Services Safety Specialist, appealed the direction pursuant to subsection 146(1) of the *Code*, on behalf of CPR.

[2] HSO Campbell's direction reads as follows:

IN THE MATTER OF THE *CANADA LABOUR CODE* PART II – OCCUPATIONAL HEALTH AND SAFETY

DIRECTION TO THE EMPLOYER UNDER SUBSESCTION 145(1)

On 10 January, 2005, the undersigned health and safety officer conducted an investigation into the workplace fatality of Dennis Sokoliuk, a Labourer / Switchman employed by Canadian Pacific Railway Company, an employer subject to the *Canada Labour Code*, at the rail yard located at 1250 Lougheed Highway, Port Coquitlam B.C., a work place operated by the employer.

The said health and safety officer is of the opinion that the following provisions of the *Canada Labour Code* Part II, have been contravened:

1. Section 124 of the *Canada Labour Code* Part II, (training / assessment)

   The employer failed to ensure that the health and safety of employees performing Switchman duties, who have not performed these duties for a significant period of time, is protected, by failing to establish the acceptable period between formal re-training of these employees, including an objective assessment of their ability to safely perform these duties.

2. Section 124 of the *Canada Labour Code* Part II, (physician's report)

   The employer failed to ensure that the health and safety of employees returning to work following a medical leave, is protected, by not abiding by, or seeking clarification of, a physician's negative assessment of the employee's ability to return to work, as indicated on the employer provided **Medical Report to be Completed by the Treating Physician.**

3. Section 124 of the *Canada Labour Code* Part II, (directional terms)

   The employer failed to ensure that the health and safety of employees performing Switchman duties, is protected, by training these employees to use imprecise terms such as "forward", "backward", "ahead", and "back", to indicate the direction of railcar movement requested from the Locomotive Operator. Given that the meaning of these terms depends on the orientation of the locomotive, which may change over time, and which may not be readily visible to the Switchman, the Switchman's instruction

> may be misinterpreted as having the opposite meaning by the Locomotive Operator.
>
> Therefore, you are HEREBY DIRECTED, pursuant to subsection 145(1)(*a*) of the *Canada Labour Code*, Part II, to terminate the contraventions no later than January 31, 2006.

[3] An application for stay with regard to the third item of the direction was submitted by CPR on January 18, 2006. The request was heard by Appeals Officer Douglas Malanka on January 26, 2006. The stay was granted.

[4] I retain the following from HSO Campbell's investigation report and the documents attached to it with regard to the three items of the direction.

First item of the direction

[5] Based on documentation provided by CPR during his investigation, HSO Campbell found the following concerning Mr. Sokoliuk's work history.

[6] Mr. Sokoliuk was hired by CPR at the Port Coquitlam CPR site on July 1976 as a labourer. In 1990, he became a carman helper[2] in the car shop. In February 1993, Mr. Sokoliuk was trained as fieldman[3] and became a qualified fieldman on March 1st, 1993. In March 1993, he was trained as a trackmobile[4] operator and became a qualified trackmobile operator on April 1st, 1993.

[7] Between April 1993 and September 2003, Mr. Sokoliuk worked as a trackmobile operator and was not significantly involved in switching tasks during that time.

[8] In September 2003, the carman helper classification was abolished and Mr. Sokoliuk was reclassified as a labourer. This resulted in loss of seniority and loss of his position as a trackmobile operator. He was subsequently transferred to the diesel shop as an engine attendant[5], working evening shifts. Mr. Sokoliuk found it difficult to adjust to the engine attendant position and evening shift schedule. From October 2003 to November 2004, he was on "weekly indemnity"[6] due to a major medical condition.

[9] On November 8, 2004, Mr. Sokoliuk returned to work as a switchman. He was paired up with an experienced switchman, Dan White, and worked alongside him for four days to re-accustom himself to the switchman job. After those four days of mentoring, Mr. Sokoliuk performed his switchman duties alone for a total of 18 days before going on three weeks of annual leave from December 9, 2004 to January 4, 2005.

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[2] The term carman refers to the position held by the employees who inspect, maintain and repair structural and mechanical components of railway freight, passenger and urban transit railcars.

[3] The terms switchman and fieldman are used interchangeably and refer to the same position.

[4] A trackmobile is a machine used in a rail yard to move a small number of cars instead of using a locomotive.

[5] An engine attendant operates locomotives and marshals same on the shop tracks.

[6] The "weekly indemnity", also called "short term disability", is a benefit given *in lieu* of salary during an employee's brief absence from work due to illness or injury.

[10] Mr. Sokoliuk returned to work on January 5, 2005. He was fatally injured on January 10, 2005 which was his 22nd day of performing switchman duties alone.

[11] Based on the above, HSO Campbell concluded that when Mr. Sokoliuk returned to work as a switchman in November 2004, he was essentially starting a new position since he had performed switchman duties for approximately only one month in March 1993.

[12] According to D. White's statement taken by HSO Campbell on September 15, 2005, D. White was asked to give Mr. Sokoliuk a refresher on switchman duties. D. White stated that he had done similar mentoring in the past. He believed that four days of mentoring, as opposed to the usual three weeks, was not sufficient to retrain an employee to do proper switching operations. He assumed that, following the mentoring, Mr. Sokoliuk would be tested to see if he was capable of doing the job but he is not sure if the test ever happened.

[13] According to the statement taken from Mike Gans, Process Coordinator at the Port Coquitlam CPR rail yard, on January 13, 2005, by Randy Congdon and Bob Tully, on behalf of CPR, and by Jim Wilson, on behalf of CAW Local 101, Mike Gans closely monitored and talked to Mr. Sokoliuk during his four days under mentoring. Mr. Gans felt that, at the end of the re-orientation, Mr. Sokoliuk was fully capable to perform the switchman tasks in a safe and reliable manner.

[14] HSO Campbell noted during his investigation that M. Gans had conducted some audits of trackmobile operation employees, including Mr. Sokoliuk. However, these audits did not provide any details regarding switching procedures and mostly addressed personal protective equipment issues. Also, no documentation was kept on Mr. Sokoliuk's mentoring training.

[15] In addition, according to the statement taken on September 30, 2005 by HSO Campbell from Douglas Evans, Mr. Sokoliuk's co-worker at the time, D. Evans had some concerns about Mr. Sokoliuk's ability to perform switchman tasks safely, from the time he started working with Mr. Sokoliuk up to November 2004, because he saw him climbing on coupler levers, getting between railcars and attempting to align couplers by wrapping the alignment strap around a knuckle and manually pulling on it.

[16] Based on the above, HSO Campbell concluded that Mr. Sokoliuk had not been adequately trained to perform switchman duties.

[17] HSO Campbell also concluded that in November 2004, no formal assessment had been conducted when Mr. Sokoliuk was assigned to the switchman position, to verify his ability to perform this job safely. The employer assigned D. White to work with Mr. Sokoliuk for four days because he recognized that Mr. Sokoliuk would benefit from receiving some re-orientation. However, Mr. White was not provided with any written curriculum to follow when giving this re-orientation. Therefore, HSO Campbell determined that, since no oral, written or practical test had been conducted following the four days of mentoring, nor were Mr. White or Mr. Evans asked for their feedback on

Mr. Sokoliuk's ability, CPR had not tested or objectively assessed Mr. Sokoliuk's ability to do the job and had relied on self reporting by Mr. Sokoliuk to do so.

[18] Therefore, as indicated in the initial item of the direction, HSO Campbell generally concluded that the employer had failed to ensure the health and safety of employees since CPR had not established an acceptable period of time whereby employees who had not performed switchman duties for a significant period of time would be retrained, including an objective assessment of their ability to safely perform these duties.

Second item of the direction

[19] HSO Campbell also examined the two medical reports completed by Mr. Sokoliuk's treating psychologist, Mr. O. James, and by his physician, Dr. Wilson, prior to Mr. Sokoliuk's return to work. CPR received Mr. James' report on October 25, 2004 and Dr. Wilson's report on November 4, 2004.

[20] On one hand, Mr. James stated that Mr. Sokoliuk was capable of performing duties that were critical to his own safety or the safety of others. He also indicated that Mr. Sokoliuk was fit to return to work with no restriction on November 8, 2004.

[21] On the other hand, Dr. Wilson stated that Mr. Sokoliuk was not capable of performing duties that were critical to his own safety or the safety of others. He also specified that Mr. Sokoliuk was unfit to return to his pre-accident/illness duties. However, to Dr. R. Wilson's opinion, neither Mr. Sokoliuk's medical condition nor his prescribed medication negatively impacted on his alertness, attention, orientation, judgment, memory, mood or psychomotor functions. Dr. Wilson also stated that Mr. Sokoliuk was fit to return to modified duties on November 8, 2004, and that they should be limited to occasionally lifting up to 50 lbs, with frequent lifting and/or carrying up to 20 lbs work, until a next re-assessment be conducted on December 8, 2004.

[22] According to his written responses to HSO Campbell's questions, Dr. Wilson was never consulted about the estimated work restrictions and the suggested re-assessment of December 8, 2004.

[23] According to a letter transmitted to HSO Campbell by Jacqui Bartkiewicz, Employee Health Advisor for CPR Occupational Health Services, Ms. Bartkiewicz contacted Mr. Sokoliuk following receipt of both medical reports, to clarify his position and the listed restrictions indicated in Dr. Wilson's medical report. Mr. Sokoliuk informed her that he was to be reassessed one month later and would notify her if any changes to his work restrictions were required. He also told her that he could not be required to lift anything over fifty pounds and that he had no apprehensions about his ability to perform his carman/labourer duties.

[24] However, as mentioned previously, Mr. Sokoliuk returned to work on November 8, 2004 as a switchman.

[25] Based on the above, HSO Campbell concluded, as indicated in the second item of the direction, that CPR generally failed to protect the health and safety of employees, by not seeking further clarification about the second medical opinion with regard to Mr. Sokoliuk's ability to return to work. HSO Campbell also concluded that CPR failed to abide by the treating physician's negative assessment of Mr. Sokoliuk's ability to return to work.

Third item of the direction

[26] HSO Campbell's report also refers to the following instructions being part of CPR's training program for trackmobile operations and engine attendants concerning radio communications between a switchman and a trackmobile/locomotive operator:

5th Bullet: Shop Track Operations Curriculum (February 1999) 1-1

Ensure all communication and instructions between working personnel is clear.

2nd Bullet: Trackmobile Operations (February 1999) 1-1

Make sure all signals are clearly understood by both the Fieldman and the operator prior to making the movement.

2nd Bullet: Shop Track Operations Curriculum (February 1999) 2-6

Trackmobile Operations (February 1999) pg 11

(Provide) The direction and distance of the movement.

8th Bullet: Trackmobile Operations (February 1999) 1-1

Both operator and Fieldman must be aware of and agree on the communication to be used for the movement.

5th Bullet: Shop Track Operations Curriculum (March 1996) Pg 8

First identify the front and rear of the locomotive: - the letter F will be painted on the side of the engine to indicate the "Front" of the locomotive.

3rd Bullet: Shop Track Operations Curriculum (February 1999) 2-5

Trackmobile Operations (February 1999) 1-1, Pg 10

Radio signals must be given in such a manner that they can be clearly understood and MUST BE REPEATED CLEARLY by the employee operating the locomotive or trackmobile. If this is not done, the message will not be acted on and will be treated as though it was not sent.

Rule 5: Trackmobile Operations (February 1999) 1-8

Repeat the instructions of the Fieldman before carrying them out. This way, the Fieldman can be sure that you have understood the message correctly. This is especially true with radio signals which include direction such as forward, reverse, east, and west.

4th Bullet: Shop Track Operations Curriculum (February 1999) 2-5

Trackmobile Operations (February 1999) 1-1, Pg 10

An Acknowledgement of receipt must not be given until the receiving person is certain that the transmitted message or information has been completely and correctly received and understood.

[27] Based on the above mentioned instructions, HSO Campbell concluded that CPR did not establish standard terms to indicate the direction of the equipment movement and left it up to the locomotive operator and the switchman to establish what terms would be used at any given time.

[28] In addition, according to D. Evans' statement given on January 13, 2005 to R. Congdon and J. Wilson, at the time of the January 10 accident, Mr. Sokoliuk and D. Evans, who was operating locomotive CP 1203, were working in the car shop yard (*i.e.* X-Yard) near the east end of track X29, to perform switching operations. At approximately 3:10 p.m., Mr. Sokoliuk lined the switch for track X29 and instructed D. Evans to push the 21 cars west into track X29 with railcar GTW504088[7] on the west end toward a cut of standing equipment.

[29] D. Evans also declared that his last radio communications from Mr. Sokoliuk was the "counted down" distance "1 car…½ car…5 feet" remaining to push moving west railcar GTW504088 in order to reach the stationary railcar 3DTTX64527 on track X29. D. Evans said that this "countdown" was typically used by the switchman to inform the locomotive operator of the remaining distance between cars, rather than give an instruction to stop.

[30] D. Evans also stated that Mr. Sokoliuk gave him no "stop signal". Without this signal, D. Evans said that it was his intention to couple and then to continue shoving west, since if they stopped they might not get going again. D. Evans added that he responded over the radio to the last signal of "5 feet" by asking Mr. Sokoliuk if he wanted him to stop. He asked Mr. Sokoliuk this several times and, since he received no response, he stopped the movement.

[31] On September 30, 2005, D. Evans provided a second statement to HSO Campbell in which he stated that further communications did occur between him and Mr. Sokoliuk after the "5 feet" signal. However, he could not remember clearly what they were.

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[7] Railcar GTW504088 was one of the 21 railcars connected to locomotive CP 1203, operated by D. Evans.

[32] According to D. Evans' second statement, Mr. Sokoliuk had remarked prior to the accident that the orientation of the locomotive on the track had been changed during the year that he was off on leave.

[33] D. Evans also stated in this second statement, given nine months later, that, during the final westward movement of the cars onto track X29 and after he called out the remaining distances between the cars as "1 car…½ car…5 feet", Mr. Sokoliuk asked D. Evans to back up 20 feet. D. Evans assumed this was so that Mr. Sokoliuk could more safely get between the cars to make whatever adjustments were required to the knuckles so that the cars could be coupled. D. Evans said that he then moved the 20 feet eastward and stopped to await further instructions. After a few minutes, he received instruction from Mr. Sokoliuk to move ahead 20 feet, which he did. He then asked Mr. Sokoliuk if he wanted him to stop but did not receive a reply. He repeated his question to Mr. Sokoliuk several times and finally stopped when he received no reply.

[34] Based on this, D. Evans opined that maybe Mr. Sokoliuk did not give him the right instruction on the direction of the equipment movement given the orientation of the locomotive.

[35] D. Evans added that, at the time of the accident, Mr. Sokoliuk never told him of his intention to go between the railcars to align the coupler. He further said that, prior to the accident, Mr. Sokoliuk often asked him to stop during a move, but D. Evans did not know why, for example if it was to adjust a knuckle. He did not usually question why a switchman would give the command to stop or other commands, nor did he typically repeat the instructions given by a switchman, but he would ask for clarification or confirmation if he did not understand an instruction.

[36] D. Evans added that there was no consistency of location given the use by switchmen of directional terms such as "forward/backward", "ahead/back" or "east/west".

[37] Based on this, HSO Campbell concluded that since the meaning of the directional terms depended on the orientation of the locomotive, which Mr. Sokoliuk remarked had been changed over the year he was off on leave and which could not be readily visible to him, the last instruction given by Mr. Sokoliuk for the direction of movement may not have been the right one or may have been misinterpreted by his co-worker.

[38] HSO Campbell also concluded that since CPR had not specified directional standard terms, as a result, different directional terms such as "forward/backward" and "ahead/back" were used by employees instead of the specific ones of "east/west". This, in his opinion, increased the risk of miscommunication between the switchman and the locomotive operator and therefore failed to protect the safety of employees.

[39] Based on the above, HSO Campbell concluded, as indicated in the third item of the direction, that CPR generally failed to protect the health and safety of employees, by training them to use imprecise terms such as “forward /backward”, or “ahead/back” to indicate the direction of railcar movements requested from the locomotive operator. As a consequence, the switchman’s instruction could be misinterpreted by the locomotive operator as having the opposite meaning.

Additional investigation notes from HSO Campbell

[40] During his investigation, HSO Campbell examined various documents that were part of CPR training material for trackmobile operations and engine attendants. They were in place prior to the accident and prescribed procedures to protect employees from the hazard of being struck by the unintentional movement of railcars.

[41] Following this review, HSO Campbell concluded that CPR instructions regarding procedures to adjust knuckles, which were part of Mr. Sokoliuk’s initial fieldman training in 1993, were generic and did not indicate what was considered an appropriate safe distance between railcar couplers.

[42] According to HSO Campbell, the most detailed CPR instructions regarding alignment of knuckles that he found stated the following:

> 30th Bullet: When necessary to align couplers the trackmobile must come to a complete stop before attempting to align couplers. After the cars have come to a complete stop the following guidelines will apply
>
> (a) <u>Ensure 1 car length of room for yourself to work between cars</u>
>
> (b) <u>Ensure operator is fully aware you are aligning couplers</u>
>
> (c) Ensure one foot is on the outside of the rail
>
> (d) Grasp the coupler and sliding is preferred unless it won’t slide then you may have to ask the operator for assistance to lift and slide it into position. Don’t jerk it!
>
> (e) If you have to lift it keeps your back straight, firm grip, and lift with your legs.
>
> (My underline)

[43] HSO Campbell also referred in his report to the *Safety Related Investigation - Fatality Report* issued by CPR concerning Mr. Sokoliuk’s fatality. This report had been issued following a joint investigation of the accident conducted by CPR and the CAW. It states, in the *Executive Summary*:

> The training program had no requirement for the switch person to notify the Operator when he/she was going in between rail equipment. There was no

> requirement for securing the locomotive end. The initial training program that Mr. Sokoliuk attended discussed the requirement for a 50-foot separation between equipment before stepping between. The most recent training package omitted the groundman material, including the 50-foot separation requirement. Although the 50-foot separation requirement was never rescinded, some confusion was created when a 9-foot alignment strap was introduced onto the property to help employees align couplers.

[44] Based on the above, HSO Campbell concluded that the instruction on the requirement for a "50-foot separation between equipment" received by Mr. Sokoliuk went back to his initial training in 1993.

[45] HSO Campbell also indicated in his report that the "coupler alignment strap" practice that CPR had introduced in 2000 was not in accordance with the "1 car length clearance requirement". This strap was a fabric loop of approximately 9 feet in length that was used by switchmen to align knuckles. The strap would be looped around the misaligned knuckles of two rail cars. The locomotive operator would then pull the cars and the knuckles would be aligned by the strap being pulled tight. According to the *Employee Current Training Record*, Mr. Sokoliuk received one hour of instruction on the use of this strap on September 19, 2000. However, the use of this strap required the two rail cars to be separated by no more than approximately 8 feet, which contradicted the previous policy requiring one car length clearance (approximately 50 feet).

[46] The other document examined by HSO Campbell and mentioned in his report is entitled *Safety and Accident Prevention 300-3*. It consists of 32 safety rules and prohibitions. HSO Campbell refers to the three following prohibitions as being contradictory and not specific as to the minimum safe clearance between cars:

> 28. Being between engine and car or between cars which are moving or about to move EXCEPT when necessary to operate handbrake and only then with extreme caution.
> 29. Being between engine or car or between cars while coupling is being made.
> 30. Adjusting knuckles or couplers before movement has completely stopped, slack is out and all concerned are aware of your intentions.

[47] Based on those previous instructions, HSO Campbell concluded that CPR's procedures for going between railcars were vague and contradictory and failed to protect the health and safety of employees.

[48] Nevertheless, HSO Campbell decided not to mention these findings in his direction because, following the fatal accident, CPR abolished the coupler alignment strap practice and issued, on January 12, 2005, a new instruction entitled *General Safety Information – Aligning Coupler during Switching Operations*, which stated that the alignment straps were removed from service. In addition, CPR issued on January 18, 2005 another instruction entitled *Switching Operations for Mechanical Services Employees*. This instructs employees to advise the locomotive operator/trackmobile operator prior to going

between equipment and to ensure that the equipment is immobilized and secured before doing tasks between rail cars. Those instructions read in part as follows:

General Safety Information
Aligning Coupler during Switching Operations

Whenever an employee is required to align a coupler during switching operations they must follow the safety rules outlined below:

1. Ensure required track protection is applied.
2. Separate equipment by 50 feet and ensure the equipment is secured prior to stepping foul of equipment.
3. Do not adjust coupler by kicking with foot.
4. Adhere to local practices during switching operations.
5. Proper radio communications must be followed during all switching operations.

[…]

NOTE: It has been brought to our attention that alignment straps do not provide the required 50 foot clearance between cars. Therefore, alignment straps are to be quarantined until further advised.

SWITCHING OPERATIONS FOR MECHANICAL SERVICES EMPLOYEES

[…]

1. Ensure proper track protection is in place (blue flag, derails)
2. Conduct job briefing with entire crew, prior to commencing work.

Before Going Between Equipment

3. Communicate with coworkers regarding the work to be completed.
4. Secure all equipment connected to locomotive or trackmobile using **3-point protection***.
5. Secure all standing equipment (handbrakes – as per local procedures)
6. Complete required task.

Recommended Practices

- Ensure secure footing
- Keep fingers and hands clear of pinch points
- Listen to what is going on around you. If you hear any equipment move, step clear immediately.

***3-point protection:** A procedure used to protect employees when fouling equipment. This procedure requires both the employee being protected and

> the employee providing the protection to act together when providing and releasing the protection.
> […]

[49] Based on the positions of the knuckles of the cars and the location of Mr. Sokoliuk's body as well as the injuries he sustained [8], it was assumed that, as the movement approached the east end of standing equipment on track X29, Mr. Sokoliuk went in front of the approaching equipment to align the coupler and was subsequently pinned between the cars' couplers.

Appellant's Arguments

[50] I retain the following from the written submissions provided by counsel Katherine E. Bilson on behalf of the appellant.

[51] With regard to the first two items of the direction, counsel Bilson stated that CPR accepted the underlying merit of HSO Campbell's concerns and recognized that there was need for improvements in the context of developing a more formalized re-orientation process for employees who have been away from the workplace for a period of time, as well as of developing a better bridge to the service area into which an employee will return. CPR agreed to comply with these first two items of the direction.

[52] However, counsel Bilson declared that CPR disagreed with HSO Campbell's beginning statement in the first two items of the direction, where he said that "the employer failed to ensure the health and safety of employees … is protected …", because CPR disagreed that the first two items described in the direction were a contributing factor and believed that they would not have ultimately prevented Mr. Sokoliuk's fatal accident.

[53] To support this position, K.E. Bilson stated that HSO Campbell based the initial finding in his direction on comments and opinions gathered from interviews that were conducted well after the accident and which implied that Mr. Sokoliuk was not qualified to perform switching functions on his return to work.

[54] Counsel Bilson added that, even though CPR did not have a formal reorientation process for employees who had not performed switching duties for an extended period of time prior to the accident, CPR *Shop Track Operation Curriculum* (STOC) training regime acted as a built-in safeguard, as employees have to be recertified every three years.

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[8] According to HSO Campbell's report, the knuckles of the two cars DTTX645427 and GTW504088 were uncoupled and separated by several inches. The couplers of both knuckles were in the closed position, which would prevent them from coupling. The knuckle of GTW504088 was pushed to northern most position in the coupler pocket. This misalignment of the knuckle would also prevent the knuckles from coupling even if one of the couplers was open. Mr. Sokoliuk's body was found lying on the ground directly between the knuckles of railcars DTTX645427 and GTW504088. He had fatal traumatic crushing injuries to the left side of the abdomen, crushed internal organs and crushed right hand. Mr. Sokoliuk's hard hat was located approximately 180 feet east of his body between the rails of track 29. The motorized buggy Mr. Sokoliuk had been using was found parked on the south side of track 29, approximately 3 car lengths east of where Mr. Sokoliuk's body was found, at approximately the same location as Mr. Sokoliuk's hard hat. There were also two parallel drag marks in the snow between the rails of track 29, running the length between where Mr. Sokoliuk's hard hat and his body were found.

[55] In addition, K. E. Bilson pointed out that Mr. Sokoliuk was assigned to work with a mentor for four days in order to reacquaint himself with switching functions.

[56] For these reasons, K. E. Bilson maintained that the re-orientation program in place when Mr. Sokoliuk returned to work was not a causal factor of the fatal accident and that CPR did not fail to ensure the health and safety of the employees in this instance. Nevertheless, CPR recognized that such mentorship could be improved by including an objective assessment of an employee's ability and level of re-acquaintance with the job standards.

[57] In addition, counsel Bilson stated that HSO Campbell based the second finding of his direction on Dr. Wilson's medical opinion that Mr. Sokoliuk was not capable of performing duties that were critical to his own safety or the safety of others.

[58] However, according to K. E. Bilson, Dr. Wilson was specifically asked to provide an opinion on whether Mr. Sokoliuk's medical condition or prescribed medication negatively impacted on his coordination, alertness, judgment or ability to perform work duties safely in any way. Dr. R. Wilson answered that neither Mr. Sokoliuk's medical condition nor his prescribed medication negatively impacted on his alertness, attention, orientation, judgment, memory, mood or psychomotor functions.

[59] To counsel Bilson' opinion, the only limitations placed on Mr. Sokoliuk by Dr. Wilson was that any physical work demands not exceed the "medium" level, which meant that these limits included occasional lifting up to 50 pounds, with frequent lifting and/or carrying up to 20 pounds.

[60] Counsel Bilson added that a subsequent phone call to Mr. Sokoliuk by J. Bartkiewicz confirmed that these physical limitations were due to lower back pain.

[61] Therefore, counsel Bilson believed that Dr. Wilson's opinion that Mr. Sokoliuk was not capable of performing duties that were critical to his safety or the safety of others was related directly to the need for modified duties arising from the limitation that any physical demands not exceed the "medium" level.

[62] Counsel Bilson also stated that CPR Occupational Health Services anticipated that Dr. R. Wilson would reassess Mr. Sokoliuk's ability to perform above the "medium" level during the appointment scheduled for December 8, 2004. Any further medical opinion regarding fitness for work would be provided by Dr. Wilson at that time.

[63] Counsel Bilson added that when Mr. Sokoliuk confirmed to J. Bartkiewicz that his limitations were due to lower back pain, it was planned that he would return to work as a carman/labourer, a non safety sensitive position that required no new training. There was no indication at the time that any of his duties would include switching operations or duties requiring new or additional training prior to his return.

[64] Given these circumstances, K. E. Bilson maintained that the physician negative assessment was not a contributing cause to the fatality and, as a consequence, CPR did not fail to ensure the health and safety of its employees in this instance.

[65] With regard to the third item of the direction, counsel Bilson stated that HSO Campbell finding was essentially based on D. Evans' recollection of the events which, according to D. Evans himself, remained unclear nine months after the accident.

[66] K. E. Bilson also stated that the terms used by Mr. Sokoliuk and D. Evans at the time to communicate on movement direction, such as "ahead" and "back", had no bearing on the fatality and were consistent with the terms used throughout the railway industry.

[67] To support this position, counsel Bilson referred to the portion of Rule 12.2 of the *Canadian Railway Operating Rules* (CROR), which deals with switching by radio. Rule 12.2 reads in part as follows:

> **12.2 Switching by Radio**
>
> When radio is used to control a switching movement, and after positive identification has been established, the following procedures are required:
>
> (i) direction in relation to the front of the controlling unit must be given in the initial instruction and from then on whenever the direction of the movement is to change;

[68] Counsel Bilson also referred to section 7 of the CROR, which deals with procedures regarding Rule 12.2 and provides examples of movement direction terms such as "backward". It reads in part as follows:

> **7.0 CROR Rule 12.2**
>
> **7.1** In the application of CROR Rule 12.2 and Rule 123, the following is an acceptable example, after positive identification has been established:
>
> **Conductor**
> "Engine 5550 move *backward* five car lengths."
>
> **Locomotive Engineer**
> "Engine 5550 move *backward* five car lengths."
> […]
>
> (Emphasis added)

[69] K. E. Bilson added that proper radio communication procedures were predominantly outlined in module two of the *Shop Track Operation Curriculum* training package.

[70] Counsel Bilson stated that this second STCO module requires training for anyone involved in switching operations. In addition to this training, employees receive instruction via and/or during initial familiarization shifts, regarding local content specific to each facility.

[71] Counsel Bilson also said that, in Port Coquitlam, employees are taught that the mechanical location ”X yard” runs east/west and switching moves are referred to in this manner.

[72] Counsel Bilson added that since the accident, CPR has taken steps to reinforce the importance and necessity of clear communication procedures amongst its employees. For example, bulletins have been posted at work sites to clarify the directional terminology to be used at a particular site. In addition, employee training now includes discrete modules on communication. For example, in learning how to use the three-point protection protocol, employees must learn the specific language to be used to communicate with their co-workers in order to properly achieve the three-point protection.

[73] For these reasons, counsel Bilson stated that CPR disagreed with the assumptions that formed the basis for the third part of the direction.

Respondent’s Arguments

[74] Jim Wilson responded to counsel Bilson’s written submissions on behalf of CAW. I retain the following from his written submissions.

[75] With regard to the first item of the direction, J. Wilson pointed out that Mr. Sokoliuk was trained as switchman in 1993 where he used those skills for a maximum of two months. He then worked as an operator and did not work as a switchman again until November 2004.

[76] J. Wilson stated that Mr. Sokoliuk was never re-certified or re-qualified since his original qualification in 1993. Mr. Wilson did not consider mentoring as qualifying or re-certifying a worker whose certificate has expired in excess of seven years.

[77] J. Wilson contended that the *Shop Track Operation Curriculum* training did not include switchman training and that he was not aware of any CPR formal mentoring program. He stated that it was only after the fatality and the investigation, where the gap in training was discovered, that the STOC training was updated to include a module for fieldmen and switchmen. He added that, at the time of the accident, Mr. Sokoliuk was up to date in the current STOC training but not his fieldman training. Mr. Sokoliuk had not been trained on the “lockout protection” (three point protection) procedure even though, at the time, this procedure was used elsewhere for exactly the same purposes.

[78] Concerning the second item of the direction, J. Wilson declared that he had not seen the medical documents referred to in this part.

[79] Nevertheless, J. Wilson stated that the position of switchman had been deemed a safety sensitive position through joint discussions between CPR and CAW many years before. The purpose was to flag duties that were critical to the safety of workers themselves, to other workers and/or to the public.

[80] J. Wilson also referred to CPR's policy entitled *Fitness to Work Medical Policy for Safety Critical and Safety Sensitive Positions (Canada)*, which was revised in conjunction with the medical rules formulated under the *Railway Safety Act*[9]. This policy existed prior to the accident. It defines a safety sensitive position as being a railway position where impaired performance may put public safety at occasional risk as well as put at risk the safety of employees, customers, customers' employees, property or the environment. It also requires that, prior to being allowed to work in any safety critical and safety sensitive position, an employee must meet specific medical requirements to ensure that she or he is fit to occupy or perform any of the tasks related with the position. Relative to this requirement, J. Wilson pointed out that Dr. Wilson's medical report clearly indicated that Mr. Sokoliuk was not capable of performing duties critical to his or to the others' safety.

[81] J. Wilson added that Mr. Sokoliuk should not have been returned to a switchman position and that, in fact, J. Bartkiewicz had discussed the carman/labourer position with Mr. Sokoliuk, not the switchman position. He also pointed out that Mr. Sokoliuk's employment records clearly stated that when Mr. Sokoliuk returned to work on November 8, 2004, he was awarded the position of labourer/switchman in the car shop.

[82] Concerning the third item of the direction, J. Wilson supported the appellant's request that this part of the direction be amended.

[83] As already mentioned by counsel Bilson, J. Wilson stated that the *Canadian Railway Operating Rules* identifies direction movements as "forward" and "backward". However, he added that employees who switch and operate in a shop track are trained on the *Shop Track Operation Curriculum*, not the CROR. Regardless, he contended that both procedures are similar in nature on radio communication use.

[84] J. Wilson also agreed with K. E. Bilson, stating that, in Port Coquitlam, the employees are taught that the mechanical location "X yard" runs east/west and switching moves are referred to in this manner.

[85] J. Wilson added that the movement direction terms used at the time by the switchman and the locomotive engineer to communicate were not a factor to the accident and that the present movement direction terms used during shop track switching does not create any hazards.

Analysis and Decision

[86] The issue to be addressed in this case is whether or not the three items in HSO Campbell's direction were justified and appropriate.

[87] For deciding these matters, I have to consider the factual evidence submitted and the circumstances of the case, as well as the relevant legislation.

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[9] The specific medical guidelines for safety critical positions are federally mandated and contained in the Medical Rules formulated under the *Railway Safety Act* (Medical Rules).

[88] With regard to the first two items of the direction, the evidence shows that CPR did not have a formal reorientation process for employees who had not performed switching duties for an extended period of time, including a formal and objective assessment to evaluate whether they were capable to perform these duties safely.

[89] In addition, the evidence shows that two medical reports with contradictory opinions were provided to CPR prior to the employee's return to work. Contrary to his treating psychologist, Mr. Sokoliuk's treating physician opined that his patient was not capable of performing duties that were critical to his own safety or the safety of others and was unfit to return to pre-accident/illness duties.

[90] The evidence also shows that CPR had relied on the employee's opinion to determine whether he was capable to return to work, without seeking further clarification about the two opposite medical opinions.

[91] I am also of the view that the employee's fitness work limitations due to a lower back pain should have been interpreted separately from the medical opinion that the patient was not capable to perform critical safety duties.

[92] In addition, the evidence shows that it was planned that Mr. Sokoliuk would return to work as a carman/labourer, a position that CPR had specified as not being safety sensitive. There was also no indication at the time that any of Mr. Sokoliuk job functions would include switching duties or duties that would require any new or additional training prior to his return to work. However, the evidence shows that Mr. Sokoliuk returned to work as a switchman, a job that he had not performed since 1993.

[93] Based on all of the above evidence, even if I believe that the second item of the direction should have been more specific given the singularity of the employee, instead of being general in nature, I agree with HSO Campbell's first two items of the direction, for the following reasons:

- As specified in section 122.1 of the Code, the purpose of the Code is to prevent accidents linked with or occurring in the course of employment. This section reads:

  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.

- To meet this purpose, section 124 of the Code requires that every employer ensure the protection of the health and safety of his employees. Section 124 reads:

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

- However, as mentioned previously, Mr. Sokoliuk had not performed the switchman position since 1993 and, prior to his return to work as a switchman in 2004, CPR did not objectively reassess his ability and level of re-acquaintance with the job, since there was no standard reassessment developed on this matter;

- In addition, CPR did not abide by Dr. Wilson's negative assessment of Mr. Sokoliuk's ability to return to work nor did the employer seek clarification with regard to the two contradictory medical opinions.

[94] I am therefore of the view that the meaning of the two first items of the direction are clear, when read in the context of the above mentioned evidence and Code provisions.

[95] Since CPR agrees to comply with the two first items of the direction, I will not add more comments on these issues.

[96] With regard to the third item of the direction, the evidence shows that, in Port Coquitlam, CPR's employees were taught that the mechanical location "X yard" runs "east/west" and switching moves were referred to in this manner.

[97] However, the evidence shows that at the time, not only Mr. Sokoliuk but also other switchmen used other direction commands, such as "back-up/ahead", instead of the specific ones that were taught to be used at the location.

[98] Based on this, I find that HSO Campbell's third item in the direction is incorrect and should have stated more specifically that CPR did not ensure that the directional terms used by switchmen working at the mechanical location "X yard" were the same ones that are taught in the location, in order to ensure that no misinterpreted communication will occur during switching operations.

[99] Therefore, as authorized pursuant to paragraph 146.1(1) of the Code, I am varying the third item of HOS Campbell's direction as indicated in the appended new direction.

____

Katia Néron
Appeals Officer

APPENDIX

IN THE MATTER OF THE *CANADA LABOUR CODE* PART II – OCCUPATIONAL HEALTH AND SAFETY

DIRECTION TO THE EMPLOYER UNDER PARAGRAPHS 145(1)(*a*) AND (*b*)

Following an appeal brought under section 146, the undersigned Appeals Officer conducted an inquiry, pursuant to section 146.1 of the *Canada Labour Code*, Part II, into the direction issued by health and safety officer Todd Campbell on November 28, 2005, following his investigation into the workplace fatality of Dennis Sokoliuk, a labourer/switchman employed by Canadian Pacific Railway Company, an employer subject to the *Canada Labour Code*, at the rail yard located at 1250 Lougheed Highway, Port Coquitlam B.C., a work place operated by the employer.

As a result of the Appeals Officer's inquiry made on the basis of the documents submitted by the parties and health and safety officer Todd Campbell, the undersigned Appeals Officer is of the opinion that the following provision of the *Canada Labour Code*, Part II, has been contravened:

Section 124 of the *Canada Labour Code*, Part II, regarding the use of directional terms

> *The employer did not ensure that, at the mechanical location "X yard", the directional terms used by switchmen to indicate the direction of railcar movement requested from the locomotive operator/trackmobile operator were the specific ones that are taught in the location to ensure that no misinterpreted communication will occur during switching operations. Given that the meaning of these terms depends on the orientation of the locomotive, which may change over time and which may not be readily visible to the switchman, the switchman's instruction may be misinterpreted as having the opposite meaning by the locomotive operator.*

Therefore, the employer is HEREBY DIRECTED, pursuant to subsection 145(1)(*a*) of the *Canada Labour Code*, Part II, to terminate the contravention no later than December 7, 2006.

The employer is also HEREBY DIRECTED, pursuant to paragraph 145(1)(*b*) of the *Canada Labour Code*, Part II, to take steps no later than December 7, 2006, to ensure that the contravention does not continue or reoccur.

Furthermore, the employer is HEREBY DIRECTED, pursuant to subsection 145(5) of the *Canada Labour Code*, Part II, to post, without delay, a copy of this direction in a conspicuous place in the work place and to give a copy to the work place health and safety committee.

Issued in Ottawa, on November 22, 2006.

Katia Néron
Appeals Officer

To: Canadian Pacific Railway Company
1250 Lougheed Highway
Port Coquitlam, B.C.
V3B 5C8

Summary of Appeals Officer's Decision

Decision No.: CAO-06-041

Appellant: Canadian Pacific Railway Company

Respondent: Canadian Auto Workers

Provisions: *Canada Labour Code*, Part II 145(1), 146(1), 122.1, 124
Canadian Railway Operating Rules, Rule 12.2, section 7.0,

Keywords: Switchman duties, fatal accident, training, confirmed, third item varied.

Summary:

On January 10th, 2005 the health and safety officer (HSO) issued a direction with three items following his investigation into the fatal accident of a switchman operator in Port Coquitlam, British Columbia. A man was fatally injured while he performed switchman duties in which he did not have proper training and certification once he had returned from extended sick leave. The Appeals officer confirmed the first two items in the direction of the HSO. The HSO stated that," The employer failed to ensure that the health and safety of employees performing Switchman duties, who have not performed these duties for a significant period of time, is protected, by failing to establish the acceptable period between formal re-training of these employees, including an objective assessment of their ability to safely perform these duties." (at Para. 2) and "[t]he employer failed to ensure that the health and safety of employees returning to work following a medical leave, is protected, by not abiding by, or seeking clarification of, a physician's negative assessment of the employee's ability to return to work, as indicated on the employer provided **Medical Report to be Completed by the Treating Physician.**"

The Appeals Officer varied item three stating that, the HSO needed to be more specific to say that CPR did not ensure that the directional terms used by switchmen working at the mechanical location "X yard" were the same ones that are taught in the location, in order to ensure that no misinterpreted communication will occur during switching operations. Therefore item three of the direction was varied.