



TRANSPORTATION APPEAL TRIBUNAL OF CANADA

Citation: *Canadian National Railway v. Canada (Minister of Transport)*, 2021 TATCE 45 (Review)

TATC File No.: RO-0048-41

Sector: Rail

BETWEEN:

Canadian National Railway, Applicant

- and -

Canada (Minister of Transport), Respondent

Heard by: Videoconference on September 22 and 23 and October 5, 2021

Before: Mark Conrad, Member

Rendered: December 24, 2021

REVIEW DETERMINATION AND REASONS

Held: The Minister of Transport's decision to impose a monetary penalty is upheld. The Minister has proven, on a balance of probabilities, that the applicant violated section 17.2 of the *Railway Safety Act*. However, the monetary penalty is reduced to \$33,760.

The total amount of \$33,760 is payable to the Receiver General for Canada and must be received by the Transportation Appeal Tribunal of Canada within 35 days of service of this determination.

I. BACKGROUND

[1] On July 17, 2020, Transport Canada (TC) issued a Notice of Violation – Contravention of Designated Provision – Issuance of Monetary Penalty (Rail Safety) (Notice of Violation) to Canadian National Railway (CN).

[2] Schedule A to the Notice of Violation stated:

On or about August 18, 2019, in or near Parry Sound, Ontario, Canadian National Railway operated railway equipment on a railway otherwise than in accordance with Rule 439 of the Canadian Rail Operating Rules that apply to Canadian National Railway, when its employees failed to stop a movement at Signal 1476 on the Bala subdivision displaying Stop, thereby violating section 17.2 of the Railway Safety Act.

Administrative Monetary Penalty amount: \$74,800.00

[3] On August 4, 2020, CN made a request for review to the Transportation Appeal Tribunal of Canada (Tribunal or TATC).

II. ANALYSIS

A. Issue

[4] The Tribunal must determine whether CN failed to stop a movement in violation of section 17.2 of the *Railway Safety Act (RSA)*. If the violation is confirmed, the Tribunal must determine if CN can establish a defence of due diligence.

B. Legal framework

[5] Section 17.2 of the *RSA* identifies:

17.2 No railway company shall operate or maintain a railway, including any railway work or railway equipment, and no local railway company shall operate railway equipment on a railway, otherwise than in accordance with a railway operating certificate and — except to the extent that the company is exempt from their application under section 22 or 22.1 — with the regulations and the rules made under sections 19 and 20 that apply to the company.

[6] It is alleged that CN failed to comply with Rule 439 of the *Canadian Rail Operating Rules (CROR)*. This rule requires a railway to stop at least 300 feet in advance of the STOP signal unless the movement has been authorized by Rule 564 or unless required to clear a switch, crossing, controlled equipment or spotting passenger equipment on station platforms.

[7] Rule 564 of the *CROR*, Authority to Pass Stop Signal, paragraph (a), provides that a train or transfer must have authority to pass a block signal indicating STOP.

[8] Pursuant to subsection 40.16(4) of the *RSA*, the burden is on the Minister to prove that the violation has been committed. The standard of proof is on the balance of probabilities, as per subsection 15(5) of the *Transportation Appeal Tribunal of Canada Act*.

C. Did CN violate section 17.2 of the RSA?

[9] Introduced into the evidentiary record as Exhibit M-1 is the Rail Daily Notification Report for August 18, 2019. This report, prepared by the Transportation Safety Board of Canada and distributed, in part, to TC Rail Safety identifies “[a]s reported by CN ... was travelling east at 30 MPH when the crew put the train into emergency due to signal 1476 displaying Stop. Train traveled two car lengths past the signal.” I note that, given the average car length of a rail car is in the range of 50 to 60 feet (with exceptions both longer and shorter), this would indicate the car travelled roughly 400 feet beyond where it was required to stop.

[10] Introduced into the evidentiary record as Exhibits M-4 and M-5, and testified to by Mr. Peter Hopper, Railway Safety Inspector at TC, were Inspector Hopper’s interview notes of the train crew members in question, Engineer Pietro (Peter)¹ Cimetta and Conductor Kevin Morrissey. These were supplemented and corroborated by the Minister’s Exhibits M-11 and M-12, the interview notes of Messrs. Cimetta and Morrissey taken by Inspector Jeff Creighton, who was also present during the crew interviews.

[11] In Exhibit M-4, Mr. Cimetta states, “... by the time we identified the signal it was too late, I placed the train into emergency.” In Exhibit M-5, Mr. Morrissey states, “We went by the stop signal and I broadcast the emergency call on both channels.”

[12] Additionally, CN introduced a number of documents into the evidentiary record that support the occurrence of the violation, among them:

- Exhibit A-1, Email from Donald Mackenzie to Peter Hopper, dated August 21, 2019
- Exhibit A-11, Formal Employee Statement of Kevin Morrissey, dated August 20, 2019
- Exhibit A-12, Formal Employee Statement of Peter Cimetta, dated August 20, 2019
- Exhibit A-22, Locomotive Event Recorder Data, dated August 18, 2019
- Exhibit A-24, Evidence Package for Formal Statements for Kevin Morrissey and Peter Cimetta
- Exhibit A-26, Discipline History for Kevin Morrissey
- Exhibit A-28, Discipline History for Peter Cimetta

[13] Finally, in the applicant’s opening statement (reiterated in the applicant’s closing statement), the applicant’s representative stated that CN does not dispute the incident occurred, that CN self-reported the incident, and that the issue is CN due diligence.

[14] The Minister of Transport has demonstrated – and CN submissions support – that CN violated *CROR* 439 on August 18, 2019, in contravention of section 17.2 of the *RSA*, as identified in the Notice of Violation dated July 17, 2020.

¹ Pietro Cimetta is intermittently referred to within the evidentiary record as either Pietro or Peter. The Tribunal was informed that he goes by both names.

(1) Significance of incident

[15] To commence, I wish to make clear the relative seriousness with which the two parties viewed this incident, which was a violation of *CROR* 439.

[16] CN introduced various items into the evidentiary record, including Exhibit A-5 (New Conductor Train Room Binder) which identified 10 “Life Critical Rules,” defined by CN as “[a] Rule or Action that failure to properly comply with could lead to a Life Changing Event” and have “[t]he potential for catastrophic results if not adhered to” (Exhibit A-8, Mid-Certification PowerPoint, page 7). Within the Life Critical Rules identified is #10, “Locations where trains must stop.” This includes Rule 439. This training, held for newly hired conductors-in-training, identifies in six specific topics the requirement for students to list or apply the 10 Life Critical Rules. In the testimony of Mr. Bruce Hoyt (Manager of Training for Transportation at CN), he specifically speaks to this, noting that CN wants to move past knowledge to one of attitude and emotion. These themes (the importance of Life Critical Rules) are repeated within other evidentiary items, including Exhibit A-7 (Recertification PowerPoint) and Exhibit A-8 (Mid-Certification PowerPoint).

[17] In Exhibit A-11, the Formal Employee Statement of Mr. Kevin Morrissey, taken during CN’s investigation into the violation, Mr. Morrissey is asked, “Do you understand how close your situation came to being a life changing event?” The identical question was asked to Mr. Cimetta in his Employee Statement (Exhibit A-12). By including this question in its investigation, it is clear that CN understood this incident was a serious rule violation.

[18] In testimony by Mr. Bill Glass (Senior Engine Service Officer for Eastern Canada at CN), he notes there is always a risk of harm when you go by a stop signal, although he further specifies this incident had a low risk of collision. I concur that this incident had a relatively low risk of collision. However, I note that within the various training excerpts introduced into the evidentiary record by CN is a continued reference to the Hinton and Aldershot derailments, both of which resulted in significant loss of life and both of which involved signal violations. So, while the potential for collision in this incident may not have been high, that does not negate the tragic consequences that can occur with signal violation.

[19] TC also identifies this as a critically important rule. TC issued a notice to CN (Exhibit M-9, Notice Issued by Mr. Hopper on July 30, 2018) prior to the incident identifying that “a threat to safe railway operations exists” due to the “frequency of CN operating employees failing to recognize, follow and adhere to proper signal sequencing” which “elevates the risk of derailments and collisions, leading to possible injuries/fatalities...”.

[20] In his testimony, Inspector Hopper referenced Exhibit M-8 (Rail Safety Enforcement Decision-Making Checklist, dated October 7, 2019, RDIMS #15817006) in which he noted that there was a high potential for harm. In this exhibit, Inspector Hopper also noted that “Engineer Cimetta had formed a mental picture based on previous practice therefore obscuring his situational awareness.” The loss of situational awareness is referenced within other exhibits and testimony.

[21] Also introduced into the evidentiary record was Exhibit A-2 (Justification for Enforcement Action Form), which identifies a “low” assessment of harm with respect to this incident. This document, prepared by TC, does not correspond to either CN or other TC testimony or documentation. Further, I would note the form, specifically the section headed “Actual or Potential Harm,” lists only actual harms and not those that could potentially occur. I find the form itself to be poorly developed and give it little weight.

[22] It is clear, from the evidentiary record, that both CN and TC view this as a serious infraction with potentially disastrous consequences.

(2) ***CN’s system: Training***

[23] To support its claim of due diligence, CN introduced numerous documents into the evidentiary record outlining its training program for conductors and locomotive engineers, as well as testimony from Mr. Hoyt and Mr. Glass.

[24] As a note, Mr. Hoyt identified his specific responsibilities at the Winnipeg Training Centre as “We look after all the induction training and recertification training for conductors, locomotive engineers, rail traffic controllers.” Mr. Glass noted that a large portion of his job as a Senior Engine Service Officer is administering the student locomotive training program in the Southwestern Ontario territory. Both individuals’ duties are focused on the training of staff, not the operational management of transportation and train crews. CN did not produce witnesses who had line authority over crew members.

[25] In summary, but not limited to, major components of CN training include:

- Six months of conductor training for new hires involving classroom, practical and simulator training (Exhibit A-3, Canada Conductor Training Program)
- Three weeks of locomotive engineer training and required check rides upon completion (per testimony of both Mr. Glass and Mr. Hoyt)
- Three-year recertification training focused on rules (Exhibit A-7, Recertification PowerPoint) consisting of three days of training focused on rules
- Life Critical Rule of the month testing (per testimony of Mr. Hoyt)

[26] Mr. Hoyt and Mr. Glass spoke extensively to various exhibits pertaining to CN’s training program. Their testimony included:

- CN’s initial conductor training program contains a mix of both practical and classroom training, in which they are required to score 100% on signal recognition. This training, largely held on CN’s Winnipeg campus, includes the use of eight tracks behind the campus for hands-on applications, simulators for student use (both individually and, at times, in teams) and use of an extensive model train set for use in teaching rules and illustrating various situations the students may face in the field.
- With Exhibit A-4 (Conductor Training PowerPoint), which Mr. Hoyt testified includes signals training and (in the past 18 months) training regarding the importance of Critical

Focus Zones – areas where the cab environment must focus solely on train operations – introduced after the August 18, 2019, incident at Parry Sound.

- With Exhibit A-5 (New Conductor Train Room Binder) in which students review Life Critical Rules “almost daily,” as well as rules pertaining to other items.
- That conductors are not able to apply for locomotive engineer training until they have two years’ seniority, and once qualified as an engineer, they must be recertified every three years via a three-day program that includes material reviewing all rules, but specifically Life Critical Rules.
- Of note were the initiatives identified as Transportation Employee Mid-Certification Training and Leading with Safety (Exhibits A-8 and A-9, respectively). Mr. Hoyt identified that, in combination, the two initiatives have resulted in (approximately) a Federal Railroad Administrator (FRA – the United States regulator of railroads) injury rate reduction from 2.5 to 1.3 over the past year. Within Exhibit A-9, of specific interest was the discussion on hazard and exposure, and the need to work in “slow brain mode” versus “fast brain mode.” However, Mr. Hoyt also noted these initiatives commenced after the incident of August 18, 2019. As such, while noteworthy, are not part of the due diligence decision framework.

[27] Mr. Hoyt also noted, in cross-examination that, while the concepts around working in fast versus slow brain mode were introduced in training after August 2019, the concepts had been present in training prior to the rule violation, and that this is simply a more structured approach.

[28] I do not see a clear linkage between material submitted into the evidentiary record and important material contained within Exhibit A-9. Specifically, material on how vulnerability occurs and how the brain works are difficult to find elsewhere in the evidentiary record. As well, I question, given Mr. Hoyt’s testimony as to the subsequent reduction in the FRA injury rate data after the introduction of this initiative, that this concept was effectively covered in earlier training efforts. The general reduction in the injury rate of CN staff after the implementation of this training would speak to their efficacy once introduced. Nothing was introduced into the evidentiary record in terms of analysis to speak to early, general, safety trends when similar material was covered in earlier training efforts.

[29] Simulator training is an important part of crew training for both conductors and locomotive engineers. With reference to engineers, Mr. Glass spoke of simulator training while discussing Exhibit A-16 (Locomotive Engineer Training Instructor Workbook), stating that 20 different runs are simulated and 17 involve stopping the train. He also noted the presence of a mobile simulator that can be used if the training situation requires it.

[30] In contrast, we see in Exhibit M-4 that Mr. Cimetta’s last simulator training was “4 years ago,” when he qualified as a locomotive engineer. According to Exhibit M-5, his conductor, Mr. Morrissey, had received simulator training in the “spring of 2018,” over a year prior to the incident.

[31] In Exhibit A-5, the evidentiary record notes students are presented with various emergency situations, including where the conductor must react to a locomotive engineer having a heart attack and becoming incapacitated. These are important lessons for students, but they do

not, in any of those identified, involve a conductor having to place the train into emergency when the locomotive engineer is responding correctly to all called signals but is failing to take action. This was the situation that occurred on August 18, 2019.

[32] With respect to the three-day recertification for engineers, Mr. Hoyt noted it consists as follows:

- Day 1: eight hours of online self-study.
- Days 2 and 3: with an instructor, focused on the *Canadian Rail Operating Rules*, signals recognition and qualifying standards for operating crews.
- The recertification is focused on rules and not on actual in-cab performance.

[33] With respect to training for focus and situational awareness, both Mr. Hoyt and Mr. Glass spoke to the subject, noting various items where situational awareness was noted in various training modules. Outside of the recent “Leading with Safety” and fast brain, slow brain material, it was difficult to determine precisely where students were specifically taught how to remain focused and maintain situational awareness, as opposed to where it was stressed as being important to maintain focus. Certainly, in Mr. Glass’s testimony, he was asked in cross-examination, “Are you surprised by the fact we’re not asking Mr. Cimetta to take further situational awareness training? Anything that has to do with dealing with human factor issues?” Mr. Glass responded that he was “not really surprised ... maybe in a perfect world, an ideal world, where cost and time isn’t a factor ... maybe that’s what we should be doing.” He also noted that “we can talk about situational awareness ... until we’re blue in the face with some employees and it just doesn’t seem to register. ... If I could learn how to teach focus ... my job would be so much easier.” Finally, while Mr. Glass noted the video “Keeping Ahead of the Train” as also speaking to situational awareness, this video was not introduced into the evidentiary record and cannot be examined.

[34] Training is an important component of a proper system to prevent commission of an offence. CN has invested significantly into its training system and the testimony of its two witnesses, both part of the training function, speak to this. However, there remain gaps within its training:

- The lack of specific training pertaining to how to maintain situational awareness, as opposed to simply reiterating the importance of situational awareness, is troubling. The material introduced after the incident of August 2019, on fast brain, slow brain and Critical Focus Zones may address this gap, but it was absent at the time of the incident. And while I concur with Mr. Glass, that teaching situational awareness is not easy, that does not permit the lack of focus on such essential training.
- The lack of a mid-certification training program for transportation staff at the time of the incident would have moved training from a “once every three years for three days” after you’re qualified to a much more constant reminder by the employer of acceptable operational practices.
- Within the existing three-day recertification that transportation staff undertake every three years, the focus strictly on self-study and in-class teaching miss an important opportunity to observe crew performance within an actual locomotive. Knowing rules

and passing tests are important, but also important is the demonstration of being able to apply the knowledge. This is a concern.

- Simulator training is an important element of learning, and one where the cost of a mistake is limited to student embarrassment and not a life-threatening incident. That Mr. Cimetta had not had simulator training in four years is concerning, as is the absence in simulation modules of a situation where a junior conductor must take control of a train from a more senior engineer who is orally responding correctly, but not acting in accordance with the situational needs. Applying an emergency brake when your conductor is incapacitated due to heart attack (as one scenario envisioned) is one matter. Applying the emergency brake when the engineer is seemingly alert and responding verbally is a more demanding situation for a conductor – and one where simulations would increase the comfort of conductors to take this, at times, essential action.

(3) *CN's system: Identifying employees for training as locomotive engineers*

[35] In part, this is a subset of CN's training program, but it also stands on its own given the important role a locomotive engineer plays in ensuring safe railway operations.

[36] In Exhibit A-14 (Locomotive Engineer Training Course Module 2), I was advised that CN has identified the following attributes as being required by locomotive engineers:

- Willingness to take responsibility
- Ability to remain calm and take charge in stressful situations
- Ability to assess situations quickly and make appropriate decisions (situational awareness)
- Ability to plan and focus on your environment (situation awareness)
- Ability to approach train handling with patience
- Ability to keep up to date with operating instructions, operating bulletins, etc.

[37] I was also advised, through the testimony of Mr. Glass, that entry into the Locomotive Engineer Program is "simply by seniority."

[38] Given that the company does not screen for these six attributes in the acceptance stage for training as a locomotive engineer, one would expect to see a clear, obvious, and continuous linkage between introductory training, ongoing monitoring and testing on these items. While some reliance can certainly be placed on the training that is embedded within the overall program and monitoring for rules compliance, it is less clear where items such as the "ability to approach train handling with patience," the "willingness to take responsibility" and the "ability to remain calm" are linked to these attributes. While the scenarios engineers are put through in the simulator may require such attributes, the focus seems very much on the technical side of running a train (starting, using a throttle, stopping and controlling speed). As previously noted, while the importance of situational awareness is stressed throughout CN's formal training programs, the lack of specific training on how to both achieve and maintain it is a concern. Equally, while situational awareness is noted as being required "at all times" in Exhibit A-15

(Locomotive Engineer Training Course Module 7), stressing it as being important is not the same as training to achieve something.

[39] A fully functioning system would have obvious linkages with training and crew monitoring by both training staff and line management when entrance into the Locomotive Engineer Program is strictly based on seniority and does not consider possession of needed personal attributes on admission. If those personal attributes are not present when an employee is admitted to locomotive engineer training, yet are required for the position, it is imperative they be clearly taught and monitored.

(4) CN's system: Monitoring staff

[40] In summary, major components of CN's staff monitoring program include, but are not limited to, the following:

- Safety audits and blitzes (per testimony of both Messrs. Hoyt and Glass)
- Efficiency testing and safety observations (per testimony of Messrs. Hoyt and Glass and Exhibits A-18 and A-20, respectively Safety Observations for Mr. Morrissey and Mr. Cimetta)
- Occasional crew "ride-alongs"² by supervisory staff (per testimony of Mr. Hoyt)
- The use of disciplinary measures as required to serve as deterrents (Exhibits A-26, A-27, A-28, A-29 and A-30)

[41] Both Mr. Hoyt and Mr. Glass spoke to safety audits in their testimony. Mr. Hoyt noted the benefit of observing crews in the work environment when they are unaware an examiner is present. Mr. Glass in turn noted that in response to *CROR* 439 incidents prior to that of August 18, 2019, CN had conducted safety blitzes at two terminals (and that no such blitz was undertaken for the incident before us). Further, Mr. Glass noted that CN conducts approximately 12 safety audits per year.

[42] With respect to efficiency testing and safety observations, the evidentiary record includes:

- Exhibit A-18, Safety Engagement, Observations by Rule for Kevin Morrissey: This document identified, over a two-year period, that there were 38 rule observations on a variety of topics, including peer-to-peer communication and distractions and personal communication devices. There were no observations pertaining to *CROR* 34(c) requiring a conductor to act if the employee controlling the engine is incapacitated or no action is being taken and only one at risk behaviour was identified. In Exhibit M-5, Mr. Morrissey noted his most recent efficiency test had been a year and a half ago.
- Exhibit A-20, Safety Engagement, Observations by Rule for Peter Cimetta: This document identifies 52 observations of Mr. Cimetta between September 2017 and July

² Note: A ride-along is when a company officer or other supervisory person physically joins the train crew while they operate a train.

2019, four of which involved peer-to-peer communications. Not one of these observations was found to demonstrate “at risk” behaviour.

- It is unclear from the record if the level of observations for these employees was high, low, or normal when compared to other employees.
- Mr. Glass also spoke to random monitoring being in place for qualified engineers, but that outside of three-year recertification there was no formal re-education program in place for engineers.

[43] From testimony, we understand that CN company officers conducted at least occasional train rides with crew members:

- In Mr. Cimetta’s interview (Exhibit M-4), he noted his last train ride with a company officer was “last spring.”
- In Mr. Morrissey’s interview (Exhibit M-5), he noted his last train ride with a company officer was in 2016.

[44] We also understand, from Mr. Hoyt, that ride-alongs are not “anywhere nearly as effective” as safety observations made when the crew member was unaware of the presence of the examiner.

[45] Testimony by Inspector Hopper, at least in part, corresponds with Mr. Hoyt’s thoughts in that he noted in-cab supervision to not be as useful as the crew would be aware they were being tested. This was tempered, in part, through Exhibit M-8, which states:

- “... Transport Canada has recognized CN had not been diligent with respect to oversight and supervision. ... Locomotive Engineer Cimetta related that the last manager riding with him was a diesel manager. (Not an operational supervisor and providing no oversight).” With respect to Mr. Morrissey, Exhibit M-8 notes “Conductor Morrissey relates the last time he had been ridden with was in 2016. Three years ago.”

It was also tempered, in part, by Inspector Hopper’s testimony under cross-examination, when he stated, with respect to crews being on their best behaviour during ride-alongs “they can only keep that up for ... a certain amount of time.”

[46] Within this, I turn to the disciplinary history of Locomotive Engineer Cimetta, Exhibit A-28 (Discipline History for Peter Cimetta).

[47] Between 1999 and December 2018, Mr. Cimetta had 16 specific situations identified on his record that led to disciplinary action, including demerits, deferred suspensions, written reprimands and an actual suspension due to his role in a yard derailment. Given his history, it would be reasonable, as a minimum, to see an increased level of monitoring on the individual. This is amplified by the fact his history included an incident that led to the injury of another employee, three separate derailments, a situation of failing to protect a movement properly by missing a call and running through a switch while assigned as a conductor. All of these would seem to have included possible – in whole or in part – loss of situational awareness.

[48] With this, I note that Exhibit A-29 (Letter from Scott Mumby to Peter Cimetta, dated August 28, 2019) shows that after the *CROR* 439 violation of August 18, 2019, Mr. Cimetta was

advised he would be subject to increased monitoring, including: two train rides by an Engine Service Officer, at least three random locomotive downloads with analysis and feedback by the Engine Service Officer and one Dynamic Stop Test or Restricted Speed Rules per month for a six-month period on his return to work. Exhibit A-21, (Safety Engagement, Observations by Rule for Peter Cimetta, January 2020 to December 2020) confirms that Mr. Cimetta had a higher level of monitoring following the incident before us. It is not clear from the evidentiary record that such increased monitoring was undertaken with any of Mr. Cimetta's previous 16 disciplinable situations.

[49] None of the 16 incidents speak positively to the attributes CN identified as being needed by a locomotive engineer. At the time of his promotion to locomotive engineer in October 2015, Mr. Cimetta had 12 specific incidents involving disciplinary action. In the 38 months between his promotion to the position and December 23, 2018, Mr. Cimetta had four further specific incidents involving demerits, including the above-noted "failure to protect" and a violation of *CROR* 33 (where a crew member fails to take immediate action to ensure the safety of the movement, including stopping in emergency if required).

[50] Despite this significant disciplinary record, and in returning to Exhibit A-20, not one of the 52 observations made on his performance over an almost two-year period found "at risk" behaviour.

[51] With reference to Mr. Cimetta's training as a locomotive engineer, Exhibit A-17 (Student Locomotive Engineer Check Ride Reports for Pietro Cimetta from 2015) was introduced. Mr. R. S. Romain, Engine Service Officer, took Mr. Cimetta on his first check ride (April 2015) functioning as a locomotive engineer. In his report, he notes that Mr. Cimetta "has trouble prioritizing," and that previous remarks indicated that he has "trouble focusing." Mr. Romain was of the opinion that these issues could stem from Mr. Cimetta "being overwhelmed." On October 6, 2015, in a subsequent check ride with Mr. Cimetta, Mr. Joe Lucifora, Engine Service Officer, found that he did not "see any areas of concern with Peitro [*sic*] being qualified as a locomotive engineer" and completed his performance evaluation report. It need be noted that Mr. Glass also testified that Mr. Cimetta received two additional train rides by himself, as well as additional training before being found "safe to qualify."

[52] Monitoring is an important component of a proper system to prevent commission of an offence. While CN undertakes various monitoring efforts, there are concerning gaps in its process.

[53] With respect to safety observations and efficiency testing, both are integral to ensuring employee performance. However, when noting that Mr. Cimetta, with a significant history of disciplinary actions, had 52 observations over a period of roughly two years and not one had found at-risk behaviour, it is reasonable to ask if the safety observations are effective as a monitoring tool, and if so, are they being delivered effectively by CN supervisory and training staff. Additionally, it would seem to contradict testimony by both Messrs. Glass and Hoyt regarding the efficacy of safety observations when crews were not aware they were being observed.

[54] With reference to the lack of consistent crew ride-alongs by supervisory staff, while I agree that the presence of an examiner within the cab can heighten the probability of a crew upping its game, I contrast that with the observations that came from ride-alongs by training staff during Mr. Cimetta's training as a locomotive engineer – that he has trouble focusing and prioritizing. It would seem the benefit of someone riding within the cab is that they can directly observe the actions of the crew member in question, something that a supervisor posted outside the cab and monitoring would not be able to do.

[55] I also take into consideration, as submitted by the Minister, *Canadian Pacific Railway v. Canada (Minister of Transport)*, 2019 TATCE 35 (Appeal) in which testimony by senior officers of Canadian Pacific Railway noted that “train rides are ‘what our officers, our management staff do’”. It was also noted that CP has a standard that operating crew members are ridden with “at least once a year.” If CN has a standard for ride-along frequency, it was absent from the evidentiary record.

[56] Disciplinary measures are a tool that can be used to promote adherence to rules. However, if a crew member is struggling with making correct decisions, with focusing, with prioritizing and (in essence) with maintaining situational awareness, then discipline may not correct the behaviours in question. CN made extensive use of its disciplinary tool with Engineer Cimetta, yet the mistakes continued. This speaks to the limited ability of discipline to correct certain conditions and the need for corrective training of staff outside of the formalized training periods.

(5) CN's system: Analysis of “Life Critical Rule” infractions

[57] Given CN repeatedly identified signal recognition as a “Life Critical Rule,” it would also seem that a complete system to prevent the incident in question would analyze and track infractions of those specific rules. While Mr. Hoyt noted in his testimony the reduction in the FRA reportable injury rate and that, within the training function of CN, a review of incident trends in the field does occur and is considered in program delivery, there were no other metrics introduced with respect to safety in general and no specific analysis with respect to signal recognition. Nor was there any testimony or documentation in the evidentiary record as to how such feedback loops function, the depth of their consideration, nor the timeliness of their impact.

[58] Given the importance CN placed in its base training on Life Critical Rules, the absence of metrics in the evidentiary record would appear to be a concerning gap in its system to ensure compliance with Rule 439.

(6) CN's system: Ensuring effective operation of its system

[59] Through Exhibit M-10 (Letter of Warning Issued by TC dated October 12, 2018) and Exhibit M-9, TC formally identified safety concerns to CN with respect to other incidents where trains passed stop signals within the province of Ontario. These were:

- January 20, 2017 – Bala Subdivision
- April 11, 2017 – Redditt Subdivision
- June 24, 2017 – Whitby Service Track

- August 27, 2017 – Near Atikokan
- December 15, 2017 – Kingston Subdivision
- December 17, 2017 – Halton Subdivision
- January 11, 2018 – Ruel Subdivision
- March 26, 2018 – Blackwell
- July 23, 2018 – Sioux Lookout
- June 27, 2018 – Oba

[60] With respect to the introduction of these incidents, the applicant referred to the Supreme Court of Canada case of *R. v. Handy*, 2002 SCC 56, in its closing argument. CN argued that simply because these alleged violations had occurred in the past, that is not to say that CN's defence of due diligence cannot be successful with respect to the incidents in question. CN cautioned that these alleged violations should not be relevant to whether it took all reasonable steps to prevent the violation in question, and that appropriate weight should be applied to this evidence.

[61] I would note the following: CN did not contest the occurrence of these incidents. They did not introduce, as an example, any correspondence back to TC to note the incidents did not occur or to clarify the nature of the incidents, nor did they call witnesses to provide testimony as to the occurrence or lack of occurrence of these 10 other incidents. Additionally, through the introduction of Exhibit A-10 (Educational Notice – Rule 439 / Stop Signal Violation, dated April 4, 2019), CN itself referenced its concern over “a marked increase in incidents across the CN System ... in violation of CROR Rule 439.”

[62] As such, there is nothing in the evidentiary record to cast doubt on the accuracy of TC's identification of these incidents. It would be imprudent to cast this as “discreditable,” particularly when CN itself introduced material referencing these incidents into the evidentiary record.

[63] Finally, as noted by the applicant, the admissibility of similar fact evidence “generally depends on whether its probative value outweighs its potential prejudice.” I find, given we are examining whether CN had in place an effective system to prevent precisely the type of infraction that did occur on August 18, 2019, that the probative value certainly outweighs any prejudicial effect.

[64] In support of this, I note that the Minister submitted the Supreme Court case of *R. v. Sault Ste. Marie*, [1978] 2 SCR 1299 (*Sault Ste. Marie*), where the defendant is a corporation and defends itself by maintaining it “exercised all reasonable care by establishing a proper system to prevent commission of the offence” and must show that it took “reasonable steps to ensure the effective operation of the system.” Finally, I again note that CN itself introduced documentation into the evidentiary record regarding its concern over an increase in Rule 439 violations.

(7) ***CN's system: Accident investigation***

[65] I address this subject not as a component of my deliberations as to CN's display of due diligence (given the investigation occurred after the August 2019 accident) but out of concern in general as to the handling of the investigation for the Rule 439 violation of August 2019.

[66] Within the evidentiary record, I turn to Exhibit A-25, the Field Investigation Report of the August 2019 incident. In this report was a page entitled "Analysis (5-why's)" which specifically notes a lack of positive communication between crew members, a failure by the crew to anticipate and a failure to recognize where they were and possible fatigue issues. The conclusion of the report noted the misunderstanding as to location by the crew. It also notes the corrective actions to include using the incident in future crew briefings, **continuing** to perform safety audits and **continuing** to hold dynamic safety engagements. Fundamentally, CN viewed the corrective action as doing more of the same. It did not consider, as an example, the need to reduce train speeds in certain zones, retraining staff with respect to either communication or situational awareness, nor increasing ride-alongs on an ongoing basis. As well, CN did not pursue "possible fatigue issues." (Though in fairness, this was addressed in the disciplinary hearings of Messrs. Morrissey and Cimetta and the results of these hearings may have been known at the time of the investigation. However, the investigation report is silent in this regard.)

[67] With regard to the issue of "a marked increase in incidents across the CN System," there was no evidence to suggest that the investigation into this specific incident made any attempt to find commonalities between it and the other similar violations. To function effectively, a system should include the search for – and addressing of – common factors and systemic issues. In fact, this would be a key ingredient of any complete system. To instead view the investigation as a discrete entity negates the idea of a systems approach to safety and to seeking to prevent commission of the offence in question.

(8) ***Precedents regarding due diligence***

[68] The applicant cited several cases in support of the notion that the test for due diligence is reasonableness, and not perfection. In *R v Deforest*, 2013 SKPC 30 (CanLII) (*Deforest*), I note that the Court found Ms. Deforest failed to take "all reasonable steps" and had not met the requirements of a due diligence defence. Within this, the abject failure of Ms. Deforest to have even a rudimentary system in place to have prevented the offence in question does not establish a hurdle where anyone stepping over it can be seen to meet the requirements of due diligence, as established in *Sault Ste. Marie*. I find *Deforest* to be of limited value in the matter at hand, outside of the correct test being one of reasonableness.

[69] The applicant introduced *Ontario (Ministry of Labour) v. Con-Strada Construction Inc.*, 2009 ONCJ 143 (CanLII). In this case, the applicant argued that the correct legal test had not been applied, that test being taking "all reasonable steps" versus "not doing everything it could" to avoid the accident. I accept this argument. The correct legal test is one of reasonableness.

[70] The applicant also introduced *R. v. Procrane Inc.*, 1991 CanLII 7728 (SK QB), noting that the standard is one of "reasonableness." I agree, that is the standard before us.

[71] The Minister introduced *Canadian National Railway Company v. Canada (Attorney General)*, 2020 FC 1119, to argue that “[i]t will not suffice for a defendant simply to show that it acted reasonably in general. Rather, the defendant must establish that it took all reasonable steps to avoid the particular deficiency that is alleged...”. I concur; the defence must demonstrate that it took all **reasonable** steps to avoid the incident.

(9) *Did CN establish that it exercised due diligence?*

[72] In using the test of *Sault Ste. Marie* to establish due diligence, the applicant must demonstrate that it exercised all reasonable care:

- by establishing a proper system to prevent commission of the offence, and
- by taking reasonable steps to ensure the effective operation of the system.

[73] A system contains a series of interlocking component parts, including items such as (as identified by CN) training, monitoring and discipline.

[74] CN’s training program was extensive; however, a proper system to prevent the commission of the offence (or in this case, the violation) would reasonably be expected to:

- train staff as to how to maintain situational awareness and not just on the importance of doing so;
- have a recertification program that moves beyond self-study and classroom training to include ride-alongs, either by trainers or supervisory staff, to verify application of knowledge in the field; and
- have formalized training for experienced engineers who are experiencing documented difficulties and that this would include simulator training at a frequency that does not leave an employee (with a significant discipline history for performance issues) going four years between use of a simulator for performance improvement.

[75] CN’s system for identifying employees for locomotive training is strictly based on seniority. It is reasonable for any organization, when identifying staff for more demanding positions, to ensure either that the employee possesses the personal suitability required for success at the time of admission or has a clear plan to develop and monitor these suitabilities in the individual. CN did not have evidence of such development plans or training.

[76] CN’s system for monitoring staff makes extensive use of discipline and safety observations. A reasonable monitoring system would identify and correct actions that can lead to accidents and negative incidents. However, the evidentiary record shows, in the case of Engineer Cimetta, that 52 safety observations (over a period of less than two years) found no at-risk behaviour despite him having been involved in 16 incidents over his career up to December 2018 that led to disciplinary measures, employee injury and three separate derailments. That not one safety observation found at-risk behaviour speaks either to: an inadequate frequency of monitoring, an inadequate form of monitoring, or monitoring being done by individuals who are not fulfilling the requirements of this important responsibility. Regardless, despite Mr. Cimetta’s significant disciplinary history, the incidents continued. This is not indicative of an effective monitoring system.

[77] With respect to CN taking reasonable steps to ensure the effectiveness of the system it had in place, the evidentiary record speaks to a concerning number of Rule 439 violations. While it is clear from Exhibit A-10 that CN's system picked up on this concerning trend, and clear from Exhibits A-8 and A-9 that CN took steps to remedy the concerns, the introduction of important changes identified within these two exhibits took place after the August 18, 2019, incident. At the time of the incident, CN did not display that it was taking reasonable steps to ensure the effectiveness of its system. The evidentiary record instead speaks to a system that was not working in an effective manner.

[78] As such, I do not find that CN exercised all reasonable care “by establishing a proper system to prevent commission of the offence” and “by taking reasonable steps to ensure the effective operation of the system.”

(10) Amount of the administrative monetary penalty

[79] Through testimony by Mr. Lee Panchyshyn (Enforcement Investigator, TC Rail Safety, Ontario Region) and as described in Exhibit M-8, TC outlined how it established the amount of the penalty. Commencing with a base amount of \$125,000 for this type of violation, it was multiplied by 60% (the percent of the maximum that is allocated for a second violation), resulting in a penalty of \$75,000. This was further adjusted as follows: an additional \$10,000 was levied given Aggravating Factor 3 (potential for harm), and the total was then reduced by \$10,200 for two mitigating factors valued at \$5,100 each (the factors being Mitigating Factor 2, provision of assistance to the Minister and Mitigating Factor 3, bringing the violation to the attention of the Minister). This resulted in a total penalty of \$74,800. Mr. Panchyshyn further testified that TC did not add a second aggravating factor, given that it had already considered this as a second offence and did not wish to double-penalize CN.

[80] The applicant argued *Ontario (Labour) v. New Mex Canada Inc.*, 2019 ONCA 30 (CanLII), to suggest that the penalty was too high. In this decision, the Court stated that “the principle of proportionality requires that there be ‘just proportion’ between the offence and the sentence.... More precisely, it holds that a ‘sentence must be proportionate to both the gravity of the offence and the degree of responsibility of the offender’ ...”.

[81] Again, I concur, noting specifically that both CN and TC view a *CROR* 439 violation seriously – with CN referring to it as a Life Critical Rule. The Ontario Court of Appeal decision also noted that “a \$250,000 fine far exceeded what was required to send this deterrent message to employers”, further noting the fine to be “more than twice the gross profit New Mex showed in its last profitable year.” The penalty imposed by TC for the August 18, 2019, incident was \$74,800 while CN self-reported gross revenue of over \$13 billion for the fiscal year ending December 31, 2020. As such, I fail to see an issue with the penalty exceeding the deterrence effect envisioned by TC in the manner as displayed with New Mex.

[82] The applicant argued that the baseline penalty should not have been assigned a percentage based on this being a second violation, given that the alleged first violation is

currently before the Tribunal and a decision has not yet been rendered.³ In support of this argument, *Patrice Caissy v. Canada (Minister of Transport)*, 2017 TATCE 29 (review) (*Caissy*) was introduced. In *Caissy*, the finding centred around a warning letter provided to Mr. Caissy, determining that the letter cannot be seen as a conviction, as “the Minister decided not to start any kind of legal proceedings at that time, for example by sending something like a Notice of Violation.” In his determination, the review member notes the (translated) French-language definition of recidivism as “the commission of a new offence punishable by a conviction, after having been irrevocably sentenced for an offence of the same nature.”

[83] Although TATC decisions are not binding, I will accept the definition as above and concur with the principle established in *Caissy*; while CN may currently be awaiting a decision on a previous alleged violation of Rule 439, there has not been one. As such, this monetary penalty should not be considered as a second offence. I will recalculate the penalty as if it were a first offence.

[84] TC had chosen not to apply a second aggravating factor of previous similar incidents in its calculation of the penalty, as it felt it would be doubly penalizing CN for the same incidents if it considered this a second offence and used earlier incidents to add in an additional aggravating factor. However, with the exclusion of this as a second violation, previous incidents should be considered as aggravating factors. As CN’s own introduction into the evidentiary record, Exhibit A-10, notes “a marked increase in incidents across the CN System in which movements have passed block and interlocking signals displaying ‘Stop’ indications in violation of CROR Rule 439”, the evidentiary record clearly speaks to previous Rule 439 violations. I will recalculate the penalty in consideration of a second aggravating factor.

[85] The applicant further argued that additional mitigating factors should have been considered, specifically:

- Mitigating Factor 1 – reasonable efforts were made to mitigate or reverse the violation’s effects, and
- Mitigating Factor 4 – admission of the violation.

[86] With respect to Mitigating Factor 1, were reasonable efforts made to mitigate or reverse the violation’s effects? In his testimony, while explaining how such penalties are calculated, Mr. Panchyshyn noted this would be applied, as an example, in a case where “there’s a derailment and there’s an explosion; if they’re jumping on that right away to reduce the impact...”. This seems to me in no way different than what happened in the matter at hand where the crew, in realizing the violation, immediately broadcast the incident on the emergency channel to warn other trains or crews in the vicinity. As such, I reduce this penalty accordingly.

[87] With respect to Mitigating Factor 4, the applicant argued that CN admitted the violation, as they were the body that informed the Minister, through the Transportation Safety Board, that

³ While no documentation on this first violation was submitted into the evidentiary record, both Mr. Panchyshyn (witness for the Minister) and Ms. Buhler (counsel for the applicant) discussed the previous Notice of Violation issued on June 4, 2019. Both acknowledged that this matter was heard by the Tribunal in June 2021 and is still under deliberation.

the incident occurred. Further, the applicant referenced *City of Ottawa carrying business as Capital Railway v. Canada (Minister of Transport)*, 2019 TATCE 38 (Review) (*Capital Railway*), in which TC adjusted the monetary penalty in recognition that Capital Railway had reported the incident. Ms. Madaire-Poisson further noted, in her testimony for TC in *Capital Railway*, that “admitting to the violation does not necessarily entail admitting responsibility for the violation.” As such, I find the Minister to be inconsistent in its application of mitigating factors and reduce this penalty accordingly.

[88] To calculate the revised monetary penalty, I will follow the process outlined by Mr. Panchyshyn:

- The base amount of \$125,000 will be multiplied by 30% (the percentage assigned to a first offence) to reach \$37,500.
- This will be adjusted upward by two aggravating factors of \$8,333 each (\$50,000 divided by six aggravating factors, rounded down to the nearest dollar).
- Then adjusted downward by four mitigating factors valued at \$5,100 each, for a downward adjustment of \$20,400.
- This results in a revised administrative monetary penalty of $\$37,500 + \$8,333 + \$8,333 - \$20,400 = \$33,760$.

III. DETERMINATION

[89] The Minister of Transport’s decision to impose a monetary penalty is upheld. The Minister has proven, on a balance of probabilities, that the applicant violated section 17.2 of the *Railway Safety Act*. However, the monetary penalty is reduced to \$33,760.

[90] The total amount of \$33,760 is payable to the Receiver General for Canada and must be received by the Transportation Appeal Tribunal of Canada within 35 days of service of this determination.

December 24, 2021

(Original signed)

Mark Conrad
Member

Appearances

For the Minister:	Eric Villemure
For the Applicant:	Jessica Buhler
	Erica Klassen

