Ms. Cari Waldenberger
10633-81 Ave,
Grand Prairie, AB., T8W 2H2

March 11, 2020

Mr. Keith E. Creel
CEO
Canadian Pacific Railway Limited
7550 Ogden Dale Road S.E.
Calgary, Alberta, T2C 4X9

Dear Mr. Creel,

Do you care that three of your finest, most hard working, dedicated, valuable employees died while at work doing their jobs the best that they could do? How much do you care?
If you do care then why aren't you showing that you do indeed care enough to have the incident of Feb.4/19 properly investigated by the RCMP? Who was responsible for keeping my son Daniel Waldenberger-Bulmer from harm that night on Train 301?

I live in constant, torturous pain from the death of my son Daniel! For the rest of my life I will be heart broken with grief & I will not have peace with what happened that night until I have the answers to all the questions that I deserve to have! You owe it to my son and his two crew mates to find the truth as to why they were killed!

This should not have happened! Why were our three men pressured to get on that train that night? I have screen shots of my son Daniel's conversation with his best friend that says "there was an emergency on the field hill" and he also said what was happening that night was a “gong show"!

My other son Jeremy, Daniel's twin brother called me at 6am that morning to tell me that his brother was dead. He told me that he didn't want the CPP to call to tell me what had happened so he called me. No one should ever have to call their mother to tell her that her son was killed in a tragic horrifying incident on a runaway train! I know this has traumatized Jeremy & will haunt him the rest of his life! I am still in shock about this and I'm sure Jeremy is too!

Mr. Creel will you please do the right thing by having the RCMP do a proper investigation as to why Train 301 derailed and killed these three honourable men on Feb. 4/19! We, the families of Daniel, Dylan and Andrew, deserve to know the truth! We owe it to our three men to have the truth! I'm sure if it was your son who died on that train you would want to know the truth and have justice for him!

Yours truly,

Cari Waldenberger

Mr. Leslie Paradis
P.O. Box 271
Schreiber, ON., P0T 2S0

March 12, 2020

Mr. Keith E. Creel
CEO
Canadian Pacific Railway Limited
7550 Ogden Dale Road S.E.
Calgary, Alberta, T2C 4X9

Dear Mr Creel,

I am Leslie Paradis, the father of Dylan Paradis, who was tragically killed on Train 301 with his crew mates Andrew Dockrell and Daniel Waldenberger-Bulmer on February 4, 2019.

I worked as a CPR conductor for forty years. Since this tragic derailment my life has been torn apart by grief, anger and resentment.

My last words to my son Dylan on the night before he left for his last trip were “be safe at work” and his reply was “I know Dad” like railroaders say to each other. He never came home again. I got a call from his mother telling me he was killed on the train.

I have spent many sleepless nights imagining the fear that these men must have felt in their final minutes on that train with no brakes going 40 mph over the speed limit, through a tunnel and over those winding curves, in the darkness with just a headlight and the sound of the rails screeching. It would have been pure terror.

It’s been over a year now since this senseless runaway train and my family and I have not received any answers from CPR. In my opinion this should have been treated as a crime scene from the start and I want the RCMP to investigate. My family has been shattered, I want the truth and I want justice for my son.

Yours truly,

Leslie Paradis

Ms. Pam Fraser
515 Home Pl S.E.
High River, AB., T1V 1KI

September 8, 2020

Mr. Keith E. Creel, CEO
Canadian Pacific Railway Limited
7550 Ogden Dale Road S.E.
Calgary, Alberta, T2C 4X9

RE: Victims' families' call for accountability and closure regarding Field B.C. deaths while working for CP Rail.

Dear Mr. Creel,

It has been well over a year since the February 4, 2019 Canadian Pacific Rail ("CP Rail") derailment that cost us the lives of our loved ones, and I personally lost my son, Dylan. No parent imagines having to outlive their children. No partner imagines facing the untimely and tragic death of their spouse nor can the children imagine navigating life without their father. Our lives have been torn apart by grief and anger and we are tormented by nagging questions and unimaginable pain. Words do not do justice in describing the incredible stress, the inability to think, to sleep, to work. It is shocking how difficult it is in carrying on with mundane daily activities or even to maintain coherence while carrying on a simple conversation.

We continue to live with overwhelming pain. More than nineteen months later there are still unanswered questions and confusion that continue to victimize us. The not knowing and the sleepless nights imagining the fear that our loved ones must have felt in their final minutes on that train with no brakes going 68 km per hour over the speed limit, through a tunnel and over those winding curves, in the darkness with just a headlight and the sound of the rails screeching. It must have been pure terror.

Mr. Creel, you have within your power the ability to help us. You spoke with us at length in Dylan's family home shortly after Dylan's death. You assured us that "everything in CP's power [would] be done to get to the bottom of how this happened" and that you "[would] treat us as you would treat your own family".

Despite your promises, we are not aware of anything that CP has done to get to the bottom of what happened. If our loved ones had truly been your family, I'm sure that there would have been a thorough investigation and the responsible people held accountable. To date there has been no independent criminal investigation conducted that rules out criminal negligence or other potential misdeeds under the Westray laws. In your response to the Canadian Broadcasting Corporation, you stated:

> "The RCMP can investigate whatever it sees fit in Canada, and they have been involved from the very beginning. As I said to the CBC previously, we are open and willing to discuss anything with the RCMP, the TSB and all other agencies involved. We have been cooperating fully and will continue to do so."

> “We’ve worked in lockstep with the RCMP from the very beginning. They still retain jurisdiction over that investigation. If they’re [going to] step in or research or investigate anything that they haven’t looked at prior to [that], they’re certainly welcome to do that and we’ll work in partnership to make sure we the facts available to them as we know it.”

To our knowledge, CP Police is the only police body that has investigated this matter- and despite your press statements that the RCMP has “been involved from the very beginning”, it appears that there was never an RCMP investigation. Imagine yourself in our position with so many unanswered questions, unable to move past our grief without any type of closure.

As the CEO of a company that owns the police force that handled the investigation into our loved one’s deaths, you have the duty to provide us with justice and accountability. WE need you to formally request the RCMP, WorkSafe BC, and working with the Attorney General of British Columbia to mount an independent criminal investigation into the Field BC derailment.

As Dylan’s mother, I also ask you offer Workplace BC and the RCMP any financial support they need to mount what is likely to be a lengthily and expensive investigation. For this to be done right, we need to make sure that the officers investigating the disaster that killed our loved ones have the specialized technical know-how to properly investigate.

We also ask you to make yourself, your management, employees, and board members available and cooperative with any investigation. It is important to us that no one with important knowledge about this case feels intimidated or discouraged from helping a criminal investigation. Your promise to that effect will go a long way in assuring us that the investigation will be thorough, independent, transparent, and fair. Finally, we also ask that you, your management, and your board of directors to commit to preserving all electronic and physical records that CP Rail generated regarding the Field, BC incident. The scene of the derailment was never secured by an independent police force so we are concerned about the further tainting or loss of evidence that may be important to independent investigators.

I have instructed my counsel, Tavengwa Runyowa to write you a separate letter asking for your response to questions that are in your power to answer so we know more about how CP Rail has handled the Field, BC investigation and plans to do so going forward. Your active cooperation with our requests would truly show that CP Rail is committed to justice and accountability.

Thank you,

Pam Fraser, Mother, on behalf of:

Leslie Paradis, Father
Jennifer Paradis, Wife
Cari Waldenberger, Mother
Albe Bulmer, Father
Tanner Paradis, Brother
Jasmine Paradis, Sister
Ethel Nesbitt, Grandmother
Neil Nesbitt, Grandfather
Niki Atherton, Partner
Carol Huard Paradis

Encl: CP Rail Deadly Operations: Criminal Justice Again Denied? Author: Robert B. Stewart

Ms. Pam Fraser
515 Home Pl S.E.
High River, AB., T1V 1K1

March 11, 2020

Mr. Keith E. Creel
CEO
Canadian Pacific Railway Limited
7550 Ogden Dale Road S.E.
Calgary, Alberta, T2C 4X9

Dear Mr. Creel

I, Dylan's mom, am grief-stricken. I am unable to sleep full nights and I wake to thoughts of the terror I know my son & his crew experienced while they careened to their gruesome deaths.

I've had to relive learning the horrible details of how Dylan died in FOUR stages as new information came to light:::

1./ You were first. On Feb 6/19 you came to my sons home and told all of us that you'd been to the site and that one man was found in the engine, one man was found away from the engine and that my Dylan was found in the river. I needed to know, "Did he survive the crash? Did he drown? Did he suffer??" You didn't have those answers, we'd have to wait for the coroner to give us those. The hours that followed were hellish as I imagined so many different ways my son spent his last moments and breaths.

2./ The next day the coroner told us that, in fact, Dylan was not found in the river but that he was the one in the engine. We were told that it appeared to be blunt force trauma but more than that he couldn't say as, due to the frigid temperature and length of time before anyone could attend to them, the crew's bodies were deeply frozen. The picture in my mind then of my son was of him curled up and frozen in the nose of the engine, as that's supposed to be the safest place to if you're going to crash.

3./ Mid December 2020 CBC is investigating the derailment. I'm having to relive everything all over again, not that there'd been any peace since February anyway, but it gave me hope that maybe they would uncover details of what led up to everybody on Train 301 being killed! It was their documentary that released that Dylan had been 'crushed to death' and now, instead of him curled up in a frozen ball sleeping, I see him bruised and beaten and covered in blood.

4./ Finally, this past February 2020, media coverage stated that he was 'crushed between his seat and the roof of his engine' and I thought I might lose my mind completely with this new revelation. Please read that description again give some thought to what I imagine now when I think of my beautiful son! I cannot utter the words - it is sickening movie that plays over and over in my mind!

We all continue to be re-victimized and there is no peace or healing that can be done. Mr Creel you spoke with us, Dylan's family, in his home at length that day. You assured us that "everything in CP's power will be done to get to the bottom of how this happened" and that you "will treat us as you would treat your own family". We've gotten some details about Train 301 but they've been from the CBC and intermittent TSB updates. I'm left with serious questions and suspicions about the before, during and aftermath of this tragedy and find the whole thing suspect!

I've been so traumatized, I struggle with a significant lack of physical energy and cognitive function where on many days, even now, I have difficulty stringing thoughts together to hold an intelligent conversation. This has hindered the operation of my business to the point that I've had to retire it. It has been 13 months since my son was killed and I am unable to live a productive life. I am haunted by unanswered questions into the HOW, WHY & WHO IS RESPONSIBLE, of my son being killed on his train. An independent investigation by the RCMP could shed light on these. You told us we could expect answers. Your dead crew are due transparency and those they've left behind deserve it.

Sincerely,

Pam Fraser

Mrs. Marie Armstrong

214 Diamond Bay S.E.

Calgary, AB, T2R7B4

Mr. Keith E. Creel

CEO

Canadian Pacific Railway Limited

7550 Ogden Dale Road S.E.

Calgary, Alberta T2C4X9

RE: Victims' Families Closure Field B.C. Deaths

Dear Mr. Creel,

My name is Marie Armstrong. My husband Matthew and I were Dylan and Jen's best friends. I have known Dylan for nearly 10 years. I helped him propose to Jen. They came to our house to celebrate after he asked her to marry him. They were with us when they found out they were expecting their first baby. I was with them the days they met their baby girls Meadow and Molly.

We watched as he built a life of love. And we were there the day it was ripped away. We've been there every day since. I lay with his daughter in her bed as his wife howled endlessly in the other room. She was frightened and couldn't understand what was happening. We witnessed a family die. A family died that day. Jen mourns her life alongside Dylan's. Her youngest has already forgotten some of the best moments she's had with him. Him falling asleep beside her after a long shift. Reading to her every night. Laughing, playing, dancing……she's losing him.

Lives were destroyed. Dylan's of course, everything he had worked towards, wanted, dreamed of, destroyed. But Jen has completely lost herself, forgotten herself, and the rebuild at times feels insurmountable. I wonder all the time, if you would've sent someone you love into those circumstances that night. Knowing what you know about the impact of cold weather on air brakes, the grade of that hill, the weight of those cars, the age of the machinery, the history of derailments, the risk.

My heart is broken. For Jen and Pam first. For Dylan's brother and sister and father. For his daughters. And for me, my husband, and our children. I look at the chair at the end of our table and think of the last

time he sat there. New Year's Even 2018, weeks before he died. He was full of life. He had quick wit, and easy smile, and love for everyone. He didn't deserve to die. And his family deserves whatever closure might still be attainable.

That, Mr. Creel, is yours and CP's ultimate responsibility. To provide as much closure as you possibly can by inviting the RCMP to investigate this accident. Please, I ask of you, request an investigation so that his family might find themselves returning their focus to the man he was, and not to the tragedy that took him. To date there has not been an investigation conducted that rules out negligence as a possible cause.

Thank you for your time,

Marie Armstrong

Mr. and Mrs. Neil Nesbitt
P.O. Box 137
Schreiber, ON., P0T 2S0

March 11, 2020

Mr. Keith E. Creel
CEO
Canadian Pacific Railway Limited
7550 Ogden Dale Road S.E.
Calgary, Alberta, T2C 4X9

I, Neil Nesbitt, Dylan Paradis' Grandfather, have a hard time accepting that a well functioning train could not make it to the terminal in the allotted time frame and then get passed on to another crew, at the most dangerous section on your rail system and then have them killed within the hour. There has to be some rail personnel that knew there was something terribly wrong with it. It makes me think it had no maintenance whatsoever.
The deaths of those three men was absolutely unnecessary.
You told us the RCMP would investigate and that hasn't happened.

Mr. Creel,

I am Ethel Nesbitt, Dylan Paradis' Grandmother.
You and I, along with Dylan's parents, Pam Fraser & Les Paradis, his siblings Tanner and Jasmine Paradis, Jen Paradis' parents met at Dylan's home.

You told us you were at the crash scene and lead us to believe you'd actually seen our Dylan in the river. This was a lie. Dylan was found dead inside the unit. We anguished over that thought ..oh our poor sweet boy freezing in the river. Now knowing the truth we are just overwhelmed at the thought of him being crushed to death.

If you remember I hugged you before you left and made the comment that you had a very hard job to do....telling the families "Your Loved One is Dead". Also at that time I did say this all boils down to money.. Looks like I nailed it on the head.
Do you remember my saying that Mr. Creel?

I am a Christian woman and have been taught to forgive, forgive you your lies and forgive you I will try. But forget that you promised to treat us as you would your own family? No, Mr Creel, I do not see that happening. I do beg to you to actually do as promised. Have a complete, transparent, full investigation done by the RCMP.

Dylans' death has played very negative rolls in our lives.

My husband Neil's health is a great worry to us as a family.
He has not been getting full nights sleep or proper rest which has lead to 3 accidents, re: falls resulting in injured head, ribs, shoulder and hip.

His cognitive well being has deteriorated as he is reliving and trying to figure out how this tragedy was allowed to happen. The stress of not having our exceptional young grandson alive and well is so stressful on him that we worry about him having a stroke or heart attack.

For myself I am unable to dismiss the phone call we got from Pam, our daughter, that morning. She was screaming and crying. “Dylan is DEAD !!!! You have to come right now! I can’t do this again”. You see she had recently lost her husband. With the help of friends we flew to Calgary from Texas.

I cry relentlessly. ANY emotion will bring on the continuous tears. I am unable to express my feelings without breaking down. Everyday, every day is just like it was yesterday and we are unable to believe that Dylan will not be coming home. Thirteen long months have passed and it is just like we get that call over and over.

To keep my sanity I keep telling myself that Andrew, Dylan and Daniel were too busy doing all they possibly could to get that train under control - that they were too busy to think they were about to die and not ever see their families again.

Mr Creel, I beg you to please ask the RCMP to do a full investigation and make all your records and reports available . It appears that full transparency is lacking on your part.
For some closure and peace for all of us, including you Mr Creel, Please Help

Yours truly,

Dylan Paradis’ Grandparents,
Neil and Ethel Nesbitt

CP Rail Deadly Operations:
Criminal Justice Again Denied?

Abstract

Paper outlines the failed legacy of Westray and the enforcement of Criminal Code into workplace serious injuries and fatalities. It examines the public information available from news reports into the CP Rail fatalities that occurred on February 4th, 2019. The paper addresses the issues with a lack of a criminal investigation into this case and frames the information through the lens of the Criminal Code. The paper questions whether justice will be served or if it will continue to be denied by failing to have a thorough and unbiased investigation? It calls upon CP Police Service Chief, Al Sauve and/or CP Rail CEO Keith Creel to ask the RCMP to conduct an investigation into this incident.

Author:

Robert B. Stewart
BA, MSc., MBPsS Occupational Psychology
E: RobertB.Stewart@outlook.com

"…When I first started thinking about this, it didn't seem possible that… the burden of holding the culprits responsible would fall to the bereaved relatives of the dead. But not only was it possible, it's exactly what happened…"

Dr. Susan Dodd Testimony on Westray Tragedy Wednesday, May 22, 2002
37th Parliament, 1st Session
Standing Committee on Justice and Human Rights

Daniel Waldenberger- Bulmer
26 years old

Andrew Dockrell
54 years old

Dylan Paradis
33 years old

CP Rail Victims Facebook Photos published by CBC News January 24, 2020

Contents

Failed Legacy of Westray

On May 9th, 1992 at 5:18 a.m., a methane fueled fireball blasted through the Westray Mine. The explosion was so powerful it rocked the town of Plymouth N.S., more than a kilometer away. There were 26 miners underground, all of whom were killed, leaving over 20 women widowed and over 40 children fatherless. The blast was so destructive that eleven bodies were never recovered.

Coal mine operators have known about the hazards of methane gas and coal dust explosions for years, and how to prevent them for over two hundred years [1], [2]. Dr. Edward Kavazanjian Jr., a professor of civil engineering, in a NY Times article said "I don't think it is a big secret about how to deal with the problem; it's time and money… it is not a technical problem but is cumbersome[3] ."

It would be easy to presume that Westray was 'just an accident'. Coal mining is known to be dangerous work, and this would be another tragic example. Immediately following the accident, Westray's Chief Executive Officer, the Mine Manager and the Government of Nova Scotia blamed miners unsafe work practices as the cause of the explosion.

However, contrary to this charge were numerous "realistic accounts" [4] raised by miners that safety had "deteriorated" and the belief was that an explosion or cave in was inevitable:

Society demanded answers and the Government of Nova Scotia struck a Public Inquiry presided by Justice Kenneth Peter Richard of the Trial Division of the Supreme Court of Nova Scotia. The report titled "The Westray Story: A Predictable Path to Disaster"[4] was released on November 1997. The report uncovered widespread and systemic disregard for safety soon after operations began:

- Basic safety measures were ignored or performed inadequately;
- Numerous prior serious incidents (roof falls) that were minimized as posing little threat to miners or production;
- Inadequate ventilation design and maintenance that failed to keep methane and coal dust at safe levels;
- Unauthorized mine layout, forcing miners to work risky tunnels to get the coal out faster;
- Methane detectors that were disconnected because of frequent alarms;
- Procedures to "stonedust" coal to render it non-explosive which were done only sporadically, usually before inspections;
- An "appalling lack of safety training and indoctrination" of miners;
- Worker safety concerns were trivialized and some miners quit their jobs or were threatened with being fired;
- Safety policies, procedures and processes were mere window dressing; and
- Production bonus system that was based solely on productivity and not conducive to safety.

Senior leadership infused a culture of risk taking [5], communicated through their actions and attitudes, sending a message that Westray was to produce coal at the expense of worker safety. The result is that this disaster was an accident waiting to happen.

The Westray Mine disaster remains a part of the Canadian social consciousness. It is representative of a tragic and unnecessary disaster that stands as an example of corporate profit taking with a total disregard for the lives of the workers.

Despite this damning report, no one was ever charged or held legally accountable for the deaths of the 26 miners. The Inquiry did, however, recommend that the "Government of Canada through the Department of Justice amend legislation necessary to ensure that corporate executives and directors are held properly accountable for wrongful and negligent acts of the corporation[4]."

The Law

In response to the Westray Mine Public Inquiry, the Government of Canada passed legislation that amended the Criminal Code of Canada and became law on March 31, 2004.

Deterrent

> "… the Government believes that the criminal law can provide an important *additional level of deterrence if effectively targeted at – and enforced against -- companies and individuals that show a reckless disregard for the safety of workers and the public*. The Government shares the sentiment expressed by many members of the Committee, and by most of the witnesses during the course of the hearings, *that our current approach to corporate criminal liability has deprived the criminal law of much of its deterrent effect in this area*[6]."
>
> Emphasis Added

Criminal Code

Section 217.1 of the Criminal Code makes it easier to criminally convict a company for the acts or omissions of its corporate decision makers by creating a *legal duty* for all persons who direct or supervise work in the workplace. The intent of the law is to elevate responsibility for health and safety matters to senior officers so that they could be held to account [7]:

Section 217.1

> "Every one who undertakes, or has the authority, to direct how another person does work or performs a task is under a *legal duty* to take *reasonable steps* to prevent bodily harm to that person, or any other person, arising from that work or task."
>
> Emphasis Added

Section 22.1

> In respect of an offence that requires the prosecution to prove negligence, an organization is a party to the offence if
>
> (a) acting within the scope of their authority
>
> (i) one of its representatives is a party to the offence, or
>
> (ii) two or more of its representatives engage in conduct, whether by act or omission, such that, if it had been the conduct

> of only one representative, that representative would have been a party to the offence; and
>
> (b) the senior officer who is responsible of the aspect of the organizations' activities that is relevant to the offence departs – or the senior officers, collectively, depart – markedly from the standard of care that, in the circumstances, could reasonably be expected to prevent a representative of the organization from being a party to the offence.

Section 22.2

> In respect of an offence that requires the prosecution to prove fault – other than negligence – an organization is a party to the offence if, with the intent at least in part to benefit the organization, one of its senior officers
>
> (a) acting within the scope of their authority, is a party to the offence;
>
> (b) having the mental state required to be a party to the offence and acting within the scope of their authority, directs the work of other representatives of the organization so that they do the act or make the omission specified in the offence; or
>
> (c) knowing that a representative of the organization is or is about to be a party to the offence, does not take all reasonable steps to prevent bodily harm to that person, or any other person, arising from that work or task.

"Criminal Code sections 22.1, 22.2 and 217.1 are not themselves offences under which individuals or organizations can be criminally charged. Rather, these sections assist in making it easier for the Crown to prove other criminal offences. In particular, the new duties created by sections 22.1, 22.2 and 217.1 would likely dovetail with *Criminal Code sections 219 ("criminal negligence") and 220 ("criminal negligence causing death")* [7]

For detailed explanation on the Criminal Code amendments refer to:

- "Criminal liability for workplace deaths and injuries – Background on the Westray Law"[8]
- "A Plain Language Guide: Bill C-45 - Amendments to the Criminal Code Affecting the Criminal Liability of Organizations"[9]

Zero Effectiveness

To have a deterrent effect where it creates behaviour change two conditions must occur:

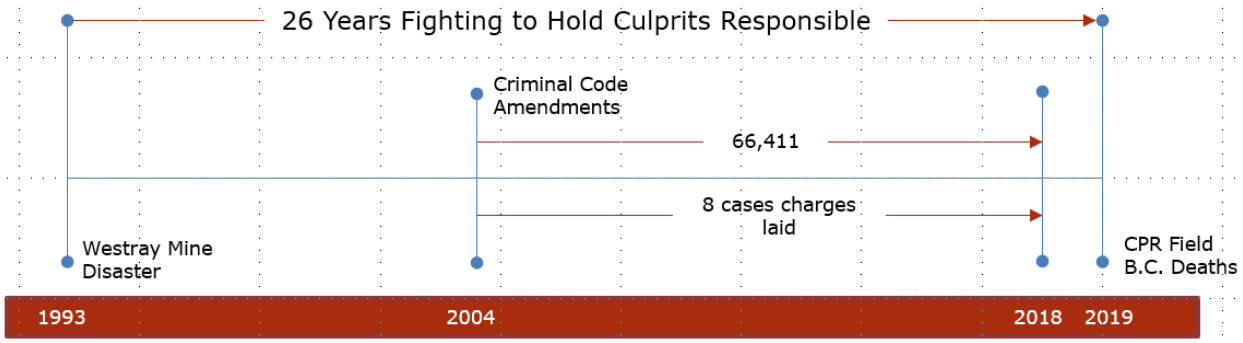
1. There is a strong likelihood of being caught, and
2. The consequences are significant enough to make decision-makers care.

While the Criminal Code provides significant consequences, the laws have not been enforced. As a result, there is no accountability and the *laws are not being taken seriously* and have

become nothing more than window dressing for *"companies and individuals that show a reckless disregard for the safety of workers and the public".*

It has been 15 years since the Criminal Code amendment became law. To date, there have been eight [10] cases where charges have been laid under the Criminal Code. Since the law came into effect, there have been 6,037 fatalities[1] in Canada, as reported by The Association of Workers' Compensation Boards of Canada. Data is not kept on the number of serious injuries; however, using Bird's accident triangle ratio of 10 serious injuries for every fatality[11], this calculates to a staggering 66,411 of serious injuries and fatalities*. Simply put, the odds of being charged after a worker is seriously injured or killed is .01% a statistical zero.*

Figure 1: *Justice Denied*



Real World Impact

The near-zero criminal investigations into workplace serious injuries and death means that organizational shortcutting with a reckless disregard for safety has been allowed to continue. These types of behaviours and decisions have killed and maimed tens of thousands with an unfathomable impact on the victims, loved ones and our communities. The fact that this has been allowed to continue unchecked is a Canadian embarrassment*. "Canada has been publicly criticized at the G20, and at the Organisation for Economic Co-operation and Development for being soft on white-collar crime* [12]*."*

The amendments "have had no meaningful deterrent effect on reducing workplace fatalities. Therefore, *it remains to be seen whether the police, Crown attorneys and employers are taking the attention of the law seriously* [12]*."*

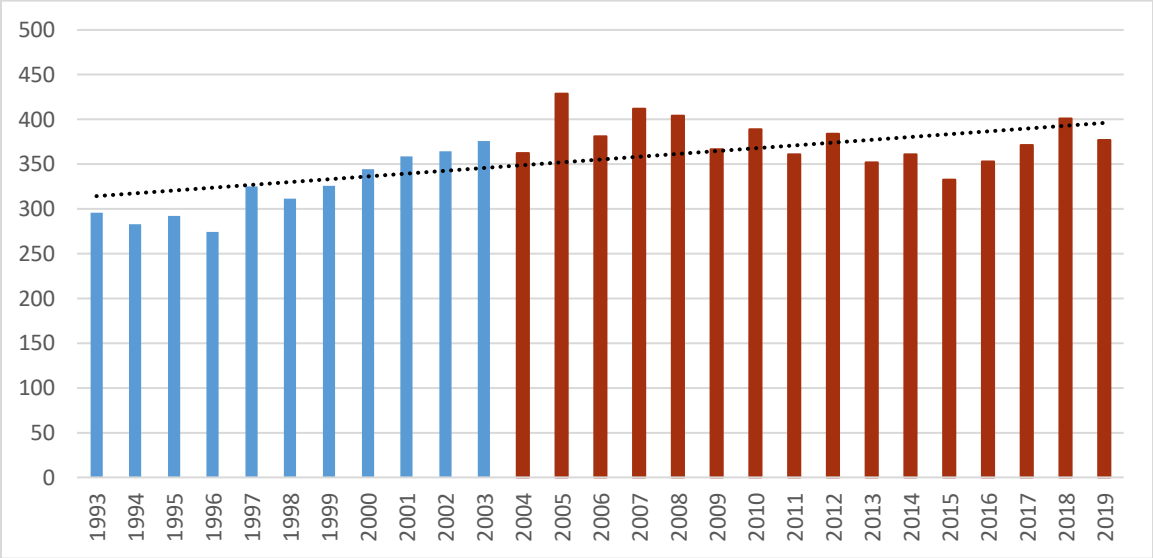
In contrast the UK's fatality rate [13] has been significantly decreasing – See Figure 2. For comparison purposes 2014 data was used and converted to serious injury and fatality (SIF) rates per million of population. The results are remarkable as illustrated in Figure 4.

Their success can be attributed to the UK Government being serious about workplace safety passing into law and *enforcing* the "Corporate Homicide and Corporate Manslaughter Act 2007", criminalizing failure to take reasonable steps to protect lives. The result is a deterrence

[1] These statistics do not include occupational disease deaths. Workplace deaths for 2019 were prorated as actual figures have not yet been released.

effect which resulted in the required behaviour change with organizational decision makers, to ensure that no one is seriously injured or killed on the job.

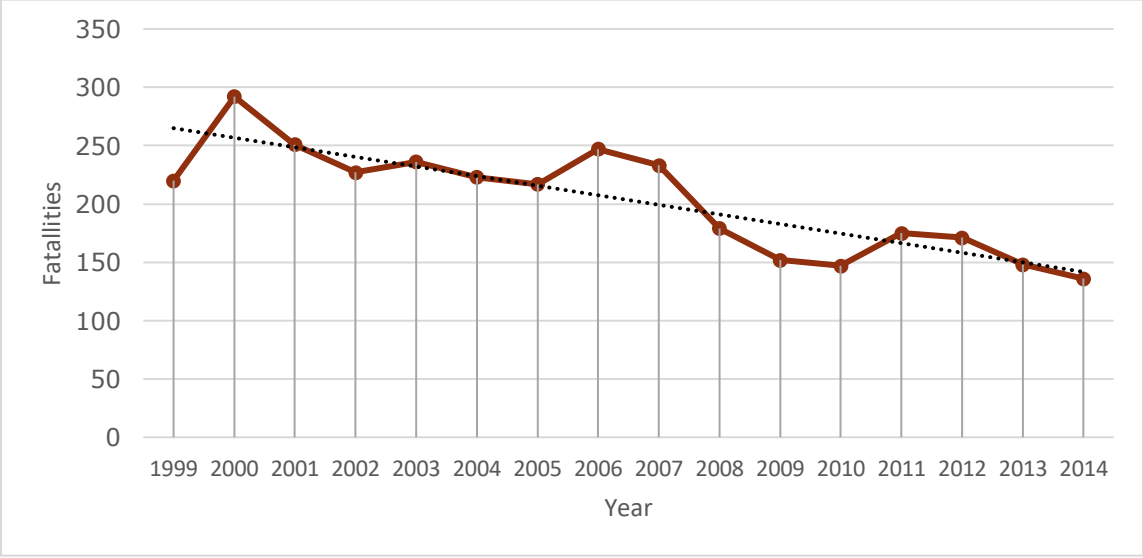
Figure 2: – *Canada Workplace Fatality Rate*[2] *1993 to 2014*



Note, red bars are fatality rates since the passing of the Criminal Code amendment. 2019 data is extrapolated from prior years given it is not yet reported

The Canadian experience is opposite of what the UK has been able to achieve with similar industry risk and workforce demographics. UK fatality rates have decreased significantly, with raw numbers less than Canada, despite a much larger workforce. Figure 3 demonstrates their success with a strong downward trendline.

Figure 3: *UK Fatality Rates*[3]



[2] Does not include occupational disease fatalities.
[3] UK data based on RIDDOR does not include work related motor vehicle fatalities.

Figure 4: *SIF Rate*[4] *Comparison for 2014*

	Canada	United Kingdom
Population	35.7	64.6
Total Number SIF	3971	2519
SIF RATE 2014 per Million People	111.2	39.0

Putting an End to Recklessness

The disturbing pattern with a lack of Criminal Code investigations continues to put lives in jeopardy. This needs to end. The three deaths caused by the derailment of CP Rail Train 301 on February 4th, 2019 provides an opportunity for Government to ensure that Criminal Justice is no longer denied and re-establish the promise of the Westray legacy.

Holding organizations and decision makers accountable to the Criminal Code ensures they face similar life altering consequences for their reckless acts or omissions that impact the lives of others by way of a criminal record and jail. Creating this deterrent helps to ensure lives and communities are not heedlessly put at risk. This is vital for governing organizations like CP Rail that have operations in the middle of our towns and cities. While the loss of three lives is tragic this incident had the potential for even greater catastrophe as reported by CBC news.

> "Next month, we will mark the 25th anniversary of the Westray mine disaster. In remembering that terrible day, our government commits to working to ensure the Westray Law is applied effectively, and negligent employers are held responsible"
>
> Statement by the Prime Minister of Canada on the National Day of Mourning
> April 28, 2017

[4] Work related motor vehicle SIFs were added to the UK numbers allowing for direct comparison.

Catastrophic Near Miss

As the two-kilometer, 112 loaded grain cars and three locomotives, weighing in excess of 15,000 tons, sped down the mountainside it was feared that the out of control train would slam into the community of Field B.C. and strike a second train of tanker cars loaded with explosive fuel blocking the line. If it hit it was reported that "it could have blown up and caused a major disaster… it would have blown up the whole valley, and it would have been like another Quebec scenario. Likening it to the Lac-Mégantic disaster in 2013 that killed 47 people…Pretty insane [14]."

Photo Credited to David Charron published in Maclean's July 12, 2013 Lac Mégantic

The derailment that killed Dylan Paradis, Andrew Dockrell and Daniel Waldenberger-Bulmer likely prevented a similar catastrophe in Field B.C.

Frighteningly, there have been two more CP derailments December 9, 2019 and February 6, 2020 resulting in explosions near the hamlet of Guernsey, SK requiring evacuations.

Dec. 9, 2019, (Photo courtesy Melanie Loessl / Facebook) PHOTO COURTESY MELANIE LOESSL / FACEBOOK

February 6, 2020 LIAM RICHARDS / SASKATOON STARPHOENIX

Police Jurisdiction Uncertainty

In all cases of sudden death, it is incumbent upon police to rule out criminality. In this case the scene was attended by the RCMP Golden detachment that attended the scene and provided assistance. In an RCMP press release dated February 4, 2019 it was stated that:

> RCMP in Golden are assisting the Transportation Safety Board of Canada (TSB) in investigating a train derailment which occurred early this morning.
>
> Just after midnight (MST) on February 4, 2019, Golden RCMP officers were called to investigate a possible Canadian Pacific train derailment near Field, BC.
>
> Upon arrival at the site, officers discovered a train carrying grain hopper cars had derailed near Spiral Tunnels in Yoho National Parks, Field, B.C.
>
> Three people were found unresponsive and pronounced dead at the scene. Their identities have not been confirmed.
>
> TSB is investigating along with the Employment Safety Standards Canada, RCMP and the BC Coroners Service.

CP Rail is adamant that the RCMP has jurisdiction throughout Canada citing in a press release dated January 25, 2020 that the RCMP Act sections 18(a) and Section 11.1(1) that "the RCMP not only have jurisdiction to investigate offences that occur on CP property but are duty-bound to do so [15]."

However, while the RCMP acknowledges their responsibilities under the RCMP Act their stance is that the CP Rail Police (CPPS) are the "Police of Jurisdiction" along the CP Rail right-of-way. Therefore, in order to investigate a request needs to be made by the CPPS to the RCMP. Indeed, this has been the protocol followed in the past with CP Police with incidents of suspicious death occurring within CP Rail jurisdiction. The CPPS in these cases have requested that the local Police Service investigate. Following this standard operating protocol, the RCMP stated in an email that

> "The incident occurred on CP property; as such, that agency has jurisdiction. No independent investigation was commenced by the RCMP…but would of course would be willing to step in if asked [14]."

To date RCMP involvement into this event has been limited to assisting the various Regulators and the BC Coroners Service.

News reporting provides that the CP Rail Police did investigate however, "the scope of the investigation was to determine actions of the crew members prior to the event regarding any outside factors that may have led or contributed to the incident itself [16]." As stated, this investigation is limited to "outside factors" and does not look at CP Rail operations that may have contributed however, this presents an obvious conflict of interest given that CP Rail is their employer. This is a well-known issue and was extensively written about by then CPPS Chief Ivan McClelland, in a report entitled "An Exploratory Study of the Accountability and Governance of Railway Police within Canadian Pacific". His recommendations notably include:

- Bringing Railway Police under the Police Act to ensure that CP management will "no longer be applying its own interpretation of effective police management,
- Creating the CP Police as a separate legal entity, and even
- "CP could consider disbanding the CPPS and move to a more traditional security model utilizing security technology and security guards [17]."

McClelland's report foreshadowed the issues with CPPS investigating this incident with serious allegations by one of the CP Rail Police investigators with:

- limiting the scope of the investigation to narrowly focus on the train crew and no involvement with the company actions or negligence,
- denied access to key witnesses as far as managers,
- denied access to safety records,
- denied access to maintenance history,
- denied access to recordings of calls between the crew and rail traffic control, and
- a cover-up including investigation files removed from CPPS computer system [16], [18], [19].

The CPPS investigator making the allegations believes this was due to "looking out for the better interests of the company." CPPS stated they conducted a thorough investigation over one month and that it resulted in no charges [14], [18]. However, this was limited to the actions of the crew prior to the crash.

Given the serious allegations of cover-up and possible obstruction by the CPPS *should form a reason for a RCMP investigation into their conduct?* There are no jurisdictional issues here and merely requires a filing of a complaint with the RCMP to start the process of looking into the allegations.

Additionally, the Transportation Safety Board (TSB) Lead Investigator has expressed concerns with the case and negligence that merit further examination by a proper authority [20] This situation seems to have been anticipated with a memorandum of understanding between the TSB and the RCMP [21] likely because Criminal Code investigations are not part their mandate which states in part:

> "the Act that governs its work—is *to advance safety* in air, marine, pipeline, and rail transportation… To *instill public confidence* in the TSB, it is essential that the *agency be free of any conflict of interest* when investigating accidents, identifying safety deficiencies and making recommendations... [22]" (emphasis added)

The concerns of the two investigators are supported by a review of the evidence presented later in this paper that is based on information from news reporting with interviews and documentation. This case has similar criminal indicators as Westray and appears to be a classic example of criminal negligence causing death S. 220 CC and possibly manslaughter by means of an unlawful act, S. 222(5)(a) CC.

It is important to note that the TSB advised CBC late on Jan. 27, 2020, that it does not share the view of this investigator. Further to this, the TSB issued a statement on January 28, 2020 saying it was *"completely inappropriate"* for its investigator to voice any opinion implying civil

or criminal liability. "(It's) very clear that it is not the function of the board to assign fault or determine civil or criminal liability [20]."

In spite of this statement, the TSB is obligated under the memorandum of understanding with the RCMP to apply section 7.2 which directs that "the TSB will notify forthwith the RCMP of any occurrence in which the RCMP may have a direct interest, including occurrences in which there are indications of possible criminal activity… " This obligation does not mean that the board is assigning fault or determining criminal liability. This is the role of Police. However, by not notifying the RCMP of potential criminal concerns they are in effect making the decision not to investigate on behalf of the police. In effect, the TSB statement appears to be at odds with their memorandum of understanding obligations. *Again, resulting in no investigation examining signs of criminality.*

Faye Ackermans

Reappointed Member of the Transportation Safety Board of Canada in July 2018

Appointed Member of the Transportation Safety Board of Canada in July 2014

Faye Ackermans had 25 years of experience in the rail industry, with over 15 of those years with senior positions in rail safety and regulatory affairs, before being appointed a member of the Board on 02 July 2014.

Mrs. Ackermans began her career with Canadian Pacific Railway in 1982. From 1996 to 2008, as General Manager of Safety & Regulatory Affairs, she was responsible for corporate-wide oversight for safety management, security planning, operations regulatory compliance and occurrence investigations. Over that period, Canadian Pacific reduced train accidents by 65% and personal injuries by over 70%.

She has held several rail industry committee memberships over her career, including the Safety & Operations Management Committees of both the Railway Association of Canada and the American Association of Railroads.

Mrs. Ackermans received a Master of Business Administration from Concordia University in Montreal and an Honours Bachelor of Arts in Psychology from Carleton University in Ottawa.

From the Transportation Safety Board website

Could this be an issue of regulatory capture? "Capture exists where regulation is systematically directed to benefit the private interest of the regulated industry at the expense of public interest. Characteristically, industry is able to shape the regulations governing it operations. It regularly blocks or delays new regulations, and seeks to remove or dilute existing regulations deemed to be adversely affecting profits [23]."

The TSB Lead investigator has been demoted, stripping him of his responsibilities as investigator in charge given his concerns. [20]

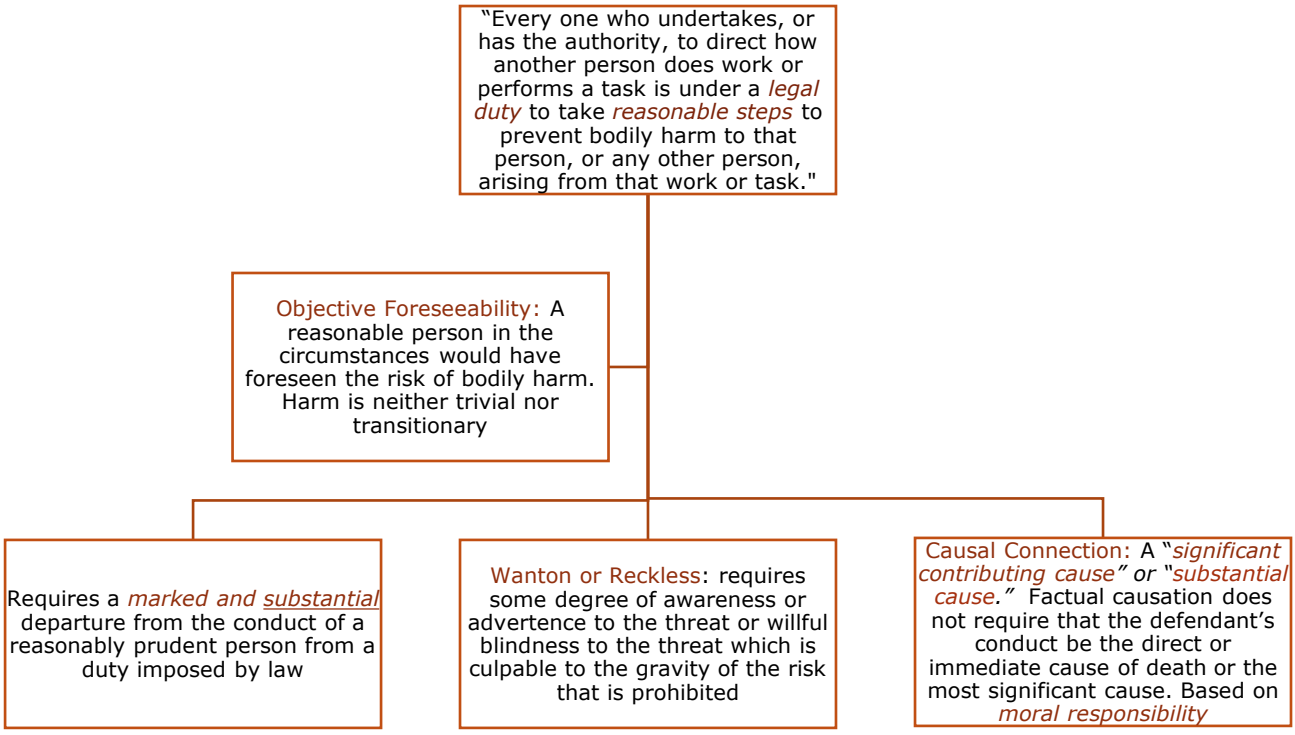
What follows is based purely on the evidence as reported through the media. It is examined through the lens of the Criminal Code with criminal negligence. This doesn't mean that other Criminal Code charges are not possible based upon findings from a police investigation; should that decision be granted.

Understanding Criminal Negligence

In the pursuit of ever greater profits and the desire of organizational members to rise through the corporate ranks, organizations and their decision makers, can drift into unintentional consequences resulting in serious workplace injuries and fatalities. This drift is most often caused by acts or omissions attributable to poor management [24] and/or operational shortcutting which is a time-tested profit booster and an indicator of a dysfunctional safety culture putting production before people [25]–[31]. This becomes a concern when this drift crosses the Rubicon into criminal negligence.

To prove criminal negligence, the Crown must demonstrate the defendant adverted to an obvious and serious risk to the lives or safety of the victims and failed to act, or that gave no thought to the risk and the need to take care. There are four criteria that need to be met for criminal negligence:

Figure 5: *Overview of Criteria for Criminal Negligence Case*



Note: this is not intended to be a legal exposition citing details of case law and how it is to be applied. For details please see the Criminal Law Response to Workplace Safety Incidents [32].

There are two immediate areas of concern that would bear examination through the Criminal Code:

1. Issues with the effectiveness of air brakes in cold temperatures and the requirement for repair and maintenance especially with the grain fleet.
2. Issues with the Field Hill Special Instructions and the change from the mandatory use of handbrakes rewritten to put the decision into the hands of the train master.

However, for clarity and brevity in making a case for investigation the focus will be limited to the air brakes given this situation is easily understandable without having to be an expert on organizational incident causation.

Also, there are numerous other issues such as fatigue which do not necessarily meet standard of a significant or substantial contributing cause and are merely contributing factors or are not relevant to obtaining a conviction. However, these factors may be considered as aggravating factors for purposes of sentencing and determining penalties. These items are considered later.

Criminal Negligence Indicators: CP Rail Deaths Train 301

To reiterate, this information is in the public domain primarily through reports by CBC and The Fifth Estate. It is presented in bullet point with little editorializing except to provide clarity with technical issues. The end of the document contains a list of exhibits with links so the information can easily be sourced.

The intent is that anyone reading the information, as reported, along with the supporting documentation, will understand the concerns with possible criminality and need for a criminal investigation.

Details Leading up to Derailment

- CP Rail Train 301 consisting of 3 locomotives and 112 fully loaded grain cars weighing in excess of 15,000 tons was travelling westbound towards Field B.C. on February 3, 2019.
- The train was travelling down along a grade of 2.2%. Mountain grades are 1.8% or greater.
- Weather was blowing snow and -28 C temperature – colder with the windchill.
- In the extreme cold the engineer was having trouble controlling the train's speed with the air brakes, according to TSB.
- Fearing a runaway, the engineer applied the last emergency reserves of air pressure to bring the train to a stop.
- "Train was blocking main route to Vancouver."
- The engineer and conductor contacted a CP manager for instructions. It isn't known what was said in that conversation.
- No hand brakes were applied, instead the crew set "retainers" a temporary measure to hold the air brakes. Handbrakes would have held the train. But applying them takes time, requiring a crew member to walk the length of the train to crank down the brakes on each car.

- The manager summoned a replacement crew to take over because the emergency stop was about to push workers on 301 past their maximum allowable hours.
- The crew changeover took a long time. CP's bunkhouse was 20 minutes away by car.
- The harsh weather had brought down power and telephone lines as well as cell service.
- With no power crews were unable to get proper meals and rest. To stay warm, they huddled around a kitchen gas stove.
- When a van arrived to drive the replacement crew up the mountain, the men were taken by surprise. They asked for their two-hour notice to allow more time to get ready
- By the time the new crew arrived at the train and took over, 301 had been sitting for almost three hours.
- After a job briefing with the manager, the relief crew began work on the train. Andy Dockrell, the engineer, took the controls while conductor Dylan Paradis and trainee Daniel Waldenberger-Bulmer stepped off to apply the hand brakes.
- Train 301 suddenly started to roll on its own and the crew climbed aboard. The train was out of control with no air brakes and was gaining speed.
- The last words of the engineer heard on the radio was the declaration that the train had hit 92 km/h on a stretch where the limit is 24 km/h.
- The train derailed in the early morning of February 4, 2019 with the train falling down a 60-meter embankment resulting in the deaths of three workers.

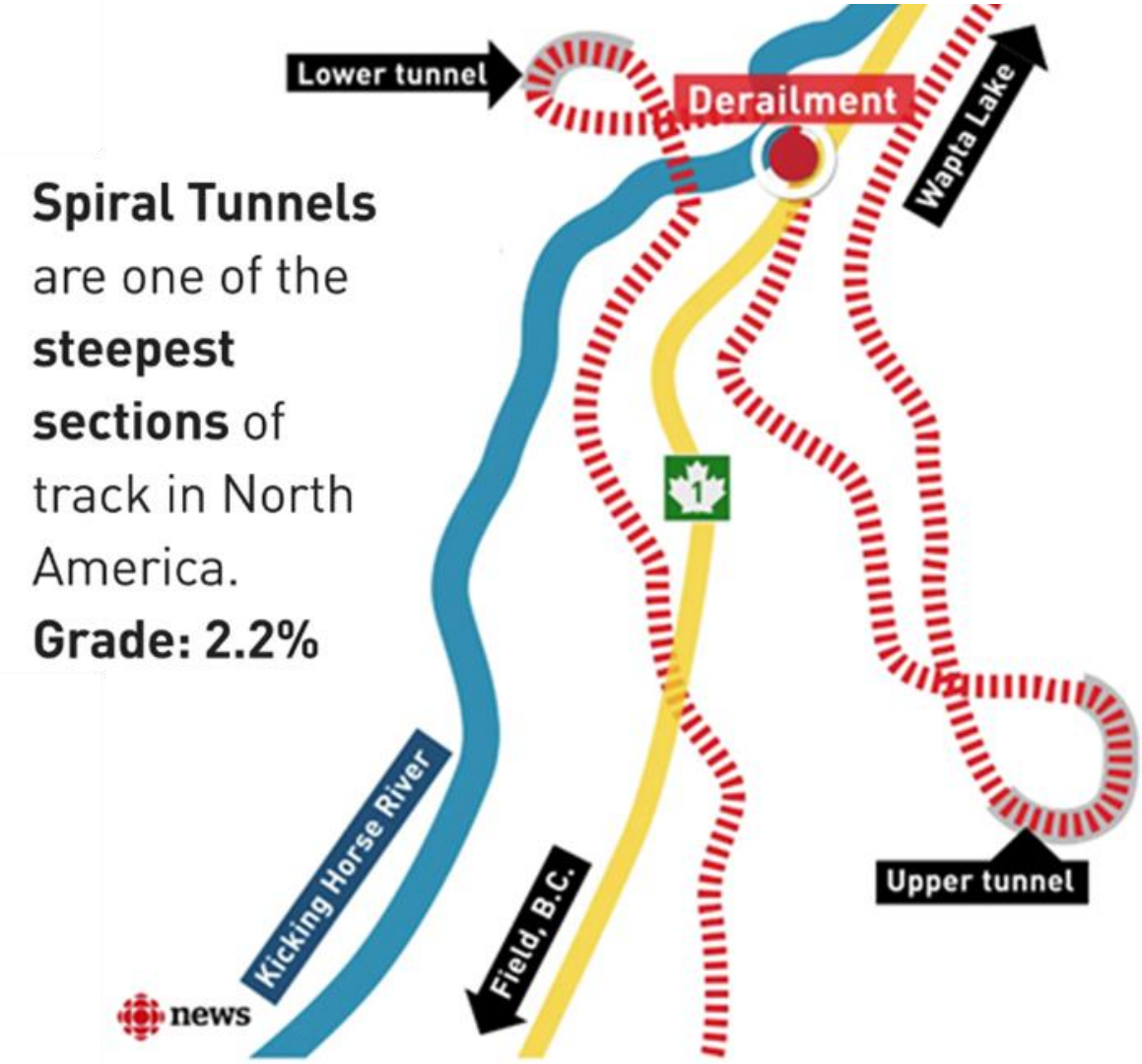
Objective Forseeability of Harm

In making the decision(s) would a reasonable person in the circumstances have foreseen the risk of serious bodily harm i.e. is neither trivial nor transitory (*serious injury or death*)? (In this case a reasonable person would be someone with a knowledge of railroad operations)

- CP Rail Train 301 consisting of 3 locomotives and 112 fully loaded grain cars weighing in excess of 15,000 tons was travelling westbound on February 3, 2019. *(Note: the longer the train and the greater the weight the harder it is to stop)*

Graphic from CBC News
Representation of Train 301, red are locomotives

- The train was travelling along a grade of *2.2%, one of the highest rail slopes anywhere in North America with two tunnels and sharp turns*. According to the Encyclopedia of North American Railroads it is described as *arduous*.



Graphic from CBC News

- Weather was blowing snow and *-28 C temperature* – colder with the windchill.
- "CP's own manuals detail *how cold weather increases air leakage in a train's air brake system calling it a major challenge*."
- By the time the new crew arrived to take over 301 had been *sitting in minus 28-degree temperatures for almost three hours"*
- The combination of train length and weight, the cold and the state of the airbrakes caused the train to suddenly move on its own down the mountain.
- "Any movement descending a Heavy or Mountain grade that attains a speed 5 MPH (8KPH) above permissible speed is considered an uncontrolled movement and must be stopped immediately by whatever means available [33]."

- Train 301 suddenly started to roll on its own and the crew climbed aboard. The train was *out of control* with *no air brakes* and was *gaining speed*.
- Given the conditions the train accelerated to *nearly 4 times the safe speed*
- A properly functioning air brake system is of the utmost importance in mountain territory from a safety standpoint [33].
- *Days after the crash, the TSB discovered problems with the air brakes. Of the 112 grain cars, 13 cars remained undamaged. TSB tested them in similar conditions and found that all 13 cars brakes were incapable of holding the train on the hill. TSB issued a warning to Transport Canada to take action* [34]. This is *11% of all the cars* which is enough of a sample to *be representative of the condition of the brakes on all the cars* [33] and conclude that *none of the cars* had brakes capable of holding the train. (*This explains why the train suddenly started rolling down the mountain*.)

Marked and Substantial Departure from the Standard of Care

Do the decisions made constitute a marked and substantial departure from the conduct of a reasonably prudent person? (Again, a reasonable person would be at a level with someone with a knowledge of railroad operations)

Transport Canada rules state that:

- The train must have at least *95% of the cars have operative brakes*, once every *reasonable effort* has been to maintain *100% operative brakes*.
- No more than *two consecutive cars must have inoperative brakes*, and
- *The tail-end three cars* must all have operative brakes,
- A freight train shall operate with *no less than eight-five (85%)* percent of the train brakes operative,
- *The No.1 Break Test* shall be performed by a certified car inspector(s) at safety inspection locations.
- All brake equipment shall be maintained in a safe and serviceable condition [35], [36].

White Paper: Railroading in the Canadian Winter:

- "Severe winter weather requires adjustments to railway operations in order to ensure *safety – which is always CP's number one priority*. When temperatures drop below negative 25 degrees Celsius, *a train's speed and length must be reduced*."
- "Cold weather *increases air leakage in a train's air brake system* between the head end and a tail end of a train. This is a major challenge… therefore, trains must be shortened when the temperature is below negative 25 degrees Celsius [37] ."

2018 – 2019 Winter Contingency Plan

- "CP uses an outside weather service to provide the railway necessary information and guidance on existing and future winter weather. The suite of products provided to CP is extensive. *They include twice daily weather condition/forecast planning reports by subdivision, real time monitoring and warning protocols, meteorologist network surveillance and consultation services, which are disseminated across the railway. In addition, our Hot Box Detectors give us real time track level monitoring of ambient temperatures across our network.* This provides situational awareness of changing

temperatures and winter operating conditions *which informs our on the ground decisions in implementing the winter plan*." [38]

The No.1 Brake Test Inadequacies [36], [39], [40]

- To ensure safe rail operation and meet the train brake effectiveness the *No.1 Brake Test* is used as per Transport Canada rules [36].
- This is a *subjective manual* and *visual* inspection performed by qualified employees on *stationary* trains. [36], [39]
- The No.1 Brake Test is performed in a yard, *air brakes are applied only as long as it takes the railcar mechanic to drive the length of the train* on an ATV (All-Terrain Vehicle), *this allows for momentarily inspection* of air brake application [40]."
- The No.1 Brake Test "only confirms the application and release of the brakes, not brake effectiveness" with the application of brake force. [36]
- The No.1 Brake Test *has significant limitations* "with defects which cannot be seen during visual inspection". "*These defects have a direct impact on braking* performance because they decrease the applied brake force and *therefore cause ineffective braking* and cold wheels." [40]

Automated Train Brake Effectiveness (ATBE) [36], [39], [40]

- *Since 2008* to overcome the limitations with the No.1 Brake test Canadian Railways, "in particular the Canadian Pacific (CP) Railway has developed and implemented an Automated Train Brake Effectiveness (ATBE) process [36]."
- "Given a scenario where train brakes should be applied for a lengthy duration, for example to control speed on a long descending grade, wheel temperatures measured by a HWD (hot wheel detector) that are substantially cooler than the average wheel temperature would indicate a brake not properly applying [39]."
- *All wheels on the train should increase in temperature over the course of the descent due to brake shoe friction on the wheel tread* [39]."
- "The process uses infrared based wheel temperature detectors (WTD) located at the foot of descending grades *to identify railcars in the movement with cold wheels, which are then flagged to be inspected for ineffective brakes* [36]."
- "The ATBE process *found air brake defects that were almost impossible to find during a No.1 Brake Test.* These brake malfunctions would only be apparent during the actual braking of a train. The defects found by the Carmen were mainly minor leakage conditions that would not be extremely detrimental to the proper braking effectiveness of a train [39]."
- The ATBE approach to evaluating brake performance is not only equivalent to the existing Train Brake Rules No.1 Brake Test, but exceeds it in its ability to evaluate beyond brake responsiveness and tests for brake effectiveness [39]."
- The ATBE process "provide *near real-time information about the state of the braking systems.* This allows for equipment health monitoring to evaluate trains under movement or dynamic conditions which *move beyond current government-regulated inspection requirements* [40]."
- "The key reason why the ATBE process enhances rail safety is the frequency of the inspection and the high detection rate… *the method which bad orders more railcars*

(sent for repairs) which are then inspected and tested in the shop is preferred from a safety point of view [40]."

- Air Brake failure components include:
  - Minimum application and quick service action defect [36]
  - Brake cylinder leakage [36]
  - Defective slack adjusters [36]
  - Brake rigging wear and angularity [36]
  - Defective service portion of control valve [36]
  - Auxiliary reservoir leakage [36]
  - Broken and defective brake beams and brake beam guides [36]
  - Body mounted brake rigging and uneven brake shoe force [36]
  - Most frequent valid *leakage is gasket leakage* [40]
- "These defects have a direct impact on braking performance because they decrease the applied brake force and therefore cause ineffective braking and cold wheels [40]."
- "*Failures of these components*, which are not found either during the safety maintenance inspection nor during the No.1 Brake Test, *may pose safety risks* [40]."
- "The ATBE process provides a condition based approach to maintenance rather than a reactive approach This saves time and money through increased efficiency of the operation and improved railcar health, *increases the number of brake related repairs*, and reduces the need for manual inspection due to a perceived increase in the standard of safety [40]."

Preventative Maintenance: Competing Priorities Safety vs Profits

- All brake equipment *shall be maintained in a safe and serviceable condition* [35], [36].
- "Severe winter weather requires adjustments to railway operations *in order to ensure safety – which is always CP's number one priority* [38]."
- Lower detection rates of the (No.1 Brake Test) manual/visual air brake inspection method impact the amount of B/O (requiring repairs) railcars resulting in less cars to be more thoroughly inspected for mechanical defects and SCABT testing. *A high B/O (requiring repair) rate has a positive impact on rail safety and improving the health and reliability of the railcars*. Moreover, it decreases yard dwell by removing the component of the long manual inspection performed by railcar mechanics. *On the other hand, it increases mechanical shop dwell by shopping more railcars, which leads to the higher down time and a decrease in the operation effectiveness and productivity* [40]."

Grain Car Air Brake Effectiveness Health [36], [40]

- "The grain fleet consist of *19,183 cars* [36]." Of these *8406* are Government of Canada and are *reaching the end of their useful service life* (50 years) and will be *bulk retired over the next 15 years* [41].
- Contrary to the coal fleet, *the primary inspection method of the grain fleet is the No.1 Brake Test*. Therefore, *only the railcars which failed the No.1 Brake Test are bad ordered* (sent for repair) [40]."
- The No.1 Brake Test produces the highest percentage of qualified trains which allows CP to keep trains moving. "The *ATBE process is able to bad order more cars per qualified train in the winter than in other months*. This indicates that the ATBE process is effective in winter as air brake issues happen more often in winter. *Although*

unqualified trains will be defaulted to the No.1 Brake Test, further improvement of qualified train percentage in the winter is important [36].

"During the period of interest, 44 unique grain trains, with an average of 112 railcars per train, passed the… detection sites and the No.1 Brake Test. *ATBE detectors flagged 695 railcars as defective*, while railcar mechanics during the *No.1 Brake Test flagged only 5 railcars* [40]."

- "The ATBE methods *indicates that there are many grain cars in need of the brake related maintenance*. The application of ATBE process would meet such need and make the fleet healthier [36]."
- However, ATBE processes would *greatly increase workloads of maintenance shops with repairs.* Using conservative results of ATBE process, if regulated, would have resulted in repairs to *4,697 cars*. Whereas the regulated No.1 Brake Test *only repaired 696 cars.* Using the same numbers from this study *the grain fleet is only 75.5% qualified* well below the requirement that *95% of the cars have operative brakes* [36].

Wanton or Reckless

Do the decisions made constitute a wonton (heedless, ungoverned, undisciplined unrestrained disregard for consequences) or reckless (heedless of consequences, headlong, irresponsible) disregard or willful blindness to the threat posed with serious injury or fatality to the lives of others? *(Only one condition needs to be demonstrated, not both)*

- *Since 2004* there have been 64 CP Rail derailments on the 220-kilometre stretch of railway between Field, B.C., and Calgary, *nearly half of which happened within 30 kilometres of the treacherous area near Spiral Tunnels*.
- "Field Hill has *been the scene of 25 derailments and runaways in the last 25 years* [14], [42]."
- "We found research reports published in 2018 where they (CP) knew that their inspections of these grain cars were letting all sorts of problems pass [18]."
- *Since 2011 CP results demonstrated the effectiveness of the parallel process that consisted of using both the No.1 Brake Test and the ATBE process* "and the high percentage of brake defects found after inspection with 6 years of coal loop operation haven't reported any incidences of runaway and or over speed coal trains."[36] *The 6 years of safe operation shows that the safety has been maintained by validly repairing more cars so as to improve the fleet health* [36]."
- "So the day before he (Andy Dockrell) *had virtually the same identical problem with the air brakes. He came down, he managed to bring it to a stop*. He filled out a field safety hazard report. He had it and investigators found it among the wreckage. Our research has found that *there were similar safety hazard reports from other railroaders about the cold...the brakes. These are things the company knew about...they had to have* [18]."
- "CP workers filed *more than a dozen similar reports* to CP's joint union-management health and safety committee in recent years. They document a range of concerns — from *problems in the cold, to poorly maintained grain trains with failing brakes, to issues specific to Field Hill* [14]."
- An experienced railroader commented: "To me and I'm sure a lot of other people this was an excessive weigh (sic) and car amount for this weather and terrain… I can really not understand how they could allow a 100 car grain train to operate in the extreme

cold weather on that particular subdivision. *Rather than reduce it and run in 2 sections they just took a chance and crossed their fingers everything would be fine*. These types of rail cars are know (sic) to have trainline problems and air leaks."

- *The railroaders are under pressure*, the faster they can get the cargo to market, to their point of destination*, the more efficient, the more money is made by the railway*. CP Rail is also under pressure from the Federal Government when it comes to transporting prairie grain. A couple of years ago snowstorms slowed up the system to the point where grain was not getting to market and the government stepped in and started levying fines against the railways for not moving it fast enough. *The railroaders are always under pressure, always under pressure to keep the trains moving don't do things that will slow it down...* the reality is stopping that train and blocking traffic is going to hold up and have a ripple effect right across the system"[19]
- A CP conductor identified as John Doe said, *"Of course we are" when asked if crews are under pressure to keep the trains running. When asked how, he replied, "You're told. You will take that train* [18]."
- "Immediately after the crash, CN and CP Rail conducted a more *concentrated inspection blitz* of the aging fleet of government-owned grain cars like those involved in the crash and *discovered widespread problems, pulling thousands out of service for repairs, retiring more than 500 of them permanently* [14]."

Causal Connection

The decision-making that was a significant contributing or substantial cause to the incident. The courts have decided that this decision is based on "concepts of *moral responsibility* and is not a mechanical or mathematical exercise (***R. v. Nette***, at para. 83) [32].

In this case the evidence suggests that the *lack of preventative maintenance* with the air brakes as well as the knowledge of the conditions with cold weather and steep mountain grades *exceeds the causation standard* and is rather *a direct or significant cause* of the deaths.

There are several decision-making failures that bear examination:

1. Decision with relying on the No.1 Brake Test when it was known to have serious limitations impacting safety.
    - Could have run the No.1 Brake Test and ATBE process in parallel which successful improved health of the coal fleet for six years

2. Decision not to do a safety blitz similar pre-incident on the grain cars to identify and repair defects and to retire dangerous cars. This would have reduced risk especially with gaskets which were identified as the most common brake component requiring replacement [40].
    - "Notably, CP and the Western Grain Elevators Association (WGEA) collaborated on a study with the CaRRL, which suggested winter operating performance could be improved with new gasket materials for air brake components, and procedures to ensure air hose coupling components are equipped with new gaskets when cars are repaired [37]."

3. Decision not to install new control values with "brake cylinder monitoring that "compensates for changes in brake cylinder leakage made worse by cold weather." If these values were installed, then the conditions leading up to the uncontrolled runaway would not have occurred [43], [44]. See YouTube video.
4. Decision not to follow recommendations from "White Paper: Railroading in the Canadian Winter" given safety is a stated priority with shortening a train's speed and length. "When temperatures drop below negative 25 degrees Celsius, *a train's speed and length must be reduced* [37]."

Potential Aggravating Factors

Are there any aggravating factors that would impact sentencing if convicted? For example, discouraging reporting, history of similar incidents, not following audit recommendations, numerous OHS orders/convictions and other items that may impact sentencing.

- 10 workplace deaths in the last 24 months [45].
- December 2, 2019: Worker fatality in Port Coquitlam [46].
- December 9, 2019: Derailment with train hauling crude oil derails and explodes near Guernsey Saskatchewan [47].
- March 8, 2019: Derailment in southeast Calgary [48].
- January 23, 2020: Grain cars rolls out of control and derails near Field B.C. [49]
- February 6, 2020 Saskatchewan hamlet dealing with second fiery derailment in two months [50].
- January 29, 2020: Canadian Pacific Railway reports 4th quarter results with record revenues which increased 7% to a record $7.79 billion [51].

Exhibits

1. Transport Canada, "Railway Freight and Passenger Train Brake Inspection and Safety Rules," Transport Canada TC oO-0-165, 2017. Access: https://www.tc.gc.ca/eng/railsafety/rules-tco0184-137.htm
2. "25 Derailments and runaways in the last 25 years," CP Rail. Access: https://www.documentcloud.org/documents/6670673-TSB-Data-Base-CP-Laggan-Subdivision-Stephen-to.html
3. K. Mulligan, Y. Wang, Y. Liu, L. Steiginga, and A. Aronian, "Automated Train Brake Effectiveness (ATBE) Test Technology Demonstration and Assessment," 2018.M. Access: https://www.documentcloud.org/documents/6670674-NRC-CNRC-Automated-Train-Brake-Effectiveneess.html
4. Jamieson, A. Aronian, and K. Wachs, "JRC2012-74035 Automated Train Brake Effectiveness (ATBE) Test Process at Canadian Pacific," 2012, pp. 1–9. Access: https://asmedigitalcollection.asme.org/JRC/proceedings-abstract/JRC2012/44656/173/266763
5. D. (University of A. Jhuaszova, "Reliability of North American Freight Railcar Air Brake Inspection Method Using Wheel Temperature Detectors," 2018. Access: https://era.library.ualberta.ca/items/78aa2a9d-9fee-46ca-8b1b-76be54f048ac

6. Transport Canada, "Government of Canada Hopper Car Fleet 2015 Annual Report Prairie and Northern Region," 2015. Access: http://static.producer.com/wp-content/uploads/2016/08/2015-Government-of-Canada-Hopper-Car-report-English1.pdf
7. Transportation Safety Board, "Rail Safety Advisory 617-04/19 Prevention of uncontrolled train movements for trains stopped in emergency on grades of less than 1.8%" Access: https://www.tsb.gc.ca/eng/securite-safety/rail/2019/r19c0015/r19c0015-617-04-19-20190411.html
8. Transportation Safety Board, "Rail Safety Advisory 617-05/19 Air brake system inspection and maintenance on grain hopper cars used in CP unit train operation," Access: https://www.tsb.gc.ca/eng/securite-safety/rail/2019/r19c0015/r19c0015-617-05-19-20190411.html
9. Transportation Safety Board, "Rail Safety Advisory Letter 04/20 "Effectiveness of No.1 Brake Test" Access: https://www.bst-tsb.gc.ca/eng/securite-safety/rail/2019/r19c0015/r19c0015-617-04-20-20200417.html
10. C. P. Railway, "White Paper: Railroading in the Canadian Winter," 2012. Access: https://www.cpr.ca/en/about-cp-site/Documents/CP-2018-19-WhitePaper.pdf
11. C. P. Railway, "Winter Contingency Plan," 2018. Access: https://www.cpr.ca/en/about-cp-site/Documents/CP-2018-19-Winter-Contingency-Plan.pdf
12. DB-60 II Control Valve with Brake Cylinder Monitoring Access: https://www.nyabproducts.com/db-60-ii/
13. CP reports record fourth-quarter and full-year results Access: https://s21.q4cdn.com/736796105/files/doc_financials/2019/q4/Exhibit-99.1-Q4-2019-Earnings-Release-r117.pdf

Call for RCMP Investigation

Canadians value the rule of law which must be applied equally to all. Failing to rule out criminality where Criminal Code laws may apply is intolerable. These principles are being usurped given the questions of jurisdiction and uncertainty with who should be investigating, CPPS or the RCMP? *The result is that no one is conducting a criminal investigation examining the actions of CP Rail and negligence*. Confounding this issue is that there is no Government authority that can simply order the RCMP to investigate while jurisdictional issues are resolved.

The result is there has not been a proper investigation to rule out criminality by a Police Service with no apprehension of bias. Criminal Justice is *yet again being denied* with family members and *loved ones further victimized.* The most expedient remedy to rectify confusion and delays over questions of jurisdictional issues and save victims' families and loved ones further suffering is for the Chief of the Canadian Pacific Police Service, Al Sauve, or CP Rail CEO Keith Creel request the RCMP conduct an investigation.

Al Sauve Chief, Canadian Pacific Police Service:

It is incumbent upon Police to rule out criminality in cases of serious injuries and fatalities. This applies to the Canadian Pacific Rail Police (CPPS) *in that they have a duty to uphold all*

the laws of Canada. It begs the question why this decision has not already been made as it is self-evident given the:

- CPPS investigation was limited to the actions of the crew and outside factors,
- CPPS lack of experience and expertise in investigating fatality incidents, and
- CPPS conflict of interest given the relationship with CP Rail.

As the Chief of Police, he is duty bound to request the RCMP to investigate. *The question however is whether he will follow his duty?*

CP Rail CEO Keith Creel

Keith Creel in his position of CEO has the authority to request the RCMP investigate this incident. He has stated that they would welcome an RCMP investigation "to look into anything they haven't looked at prior and they will work in partnership to make the facts available to them [18]." *The question is whether he backs his statements up with action?*

Political & Public Pressure

A criminal investigation entails collecting evidence to determine if a crime has taken place. An investigation will either:

1. Rule out criminality by CP and their decision-makers, or
2. Hold them to account through the Criminal Code as intended by the Westray amendments.

With the potential jeopardy associated with a criminal investigation this may be unpalatable for CP Rail and their police force to request the RCMP investigate. The only other recourse to serve justice is to apply political and public pressure to behave in accordance with the expressed statement and duty.

The question remains, is justice to be served or continued to be denied?

References

[1] G. Samuel Rice, J. C. W. Frazer, A. Larsen, F. Haas, and C. Scholz, "The Explosibility of Coal Dust," Dep. Inter. US Geol. Surv. Bull. 425, pp. 14–15, 1910.

[2] B. W. P. Diamond, "Methane Control for Underground Coal Mines," Bur. Mines Inf. Circ., 1994.

[3] M. L. Wald, "Diligence Is a Factor in Controlling Risks From Methane," New York Times.

[4] K. P. Richard, "The Westray Story: A Predicatable Path to Disaster," Westray Mine Public Inq., 1997.

[5] D. L. Cooke, "A system dynamics analysis of the Westray mine disaster," Syst. Dyn. Rev., vol. 19, no. 2, pp. 139–166, 2003.

[6] "Government Response to the Fifteenth Report of the Standing Committee on Justice and Human Rights," Corp. Liabil., pp. 10–12, 2002.

[7] R. W. Morasiewicz and P. A. Devine, "BILL C-45 AND CRIMINAL LIABILITIY FOR Workplace Accidents," Millar Thomson LLP, 2007.

[8] "Criminal liability for workplace deaths and injuries – Background on the Westray Law," Government of Canada Department of Justice, 2020. [Online]. Available: https://www.justice.gc.ca/eng/rp-pr/other-autre/westray/p1.html. [Accessed: 09-Feb-2020].

[9] "A Plain Language Guide: Bill C-45 - Amendments to the Criminal Code Affecting the Criminal Liability of Organizations," Government of Canada Department of Justice, 2020. [Online]. Available: https://www.justice.gc.ca/eng/rp-pr/other-autre/c45/p02.html. [Accessed: 09-Feb-2020].

[10] "Bill C-45 overview." Canadian Centre for Occupational Health and Safety, 2020.

[11] F. E. Bird and G. L. Germain, Practical Loss Control Leadership. Loganville, GA.: Institute Publishing, a Division of the International Loss Control Institute, 1986.

[12] N. Keith, "After 10 years, Bill C-45 yields few prosecutions," 2014.

[13] Great Britain Health and Safety Executive (HSE), "Statistics on fatal injuries in the workplace in Great Britain 2015," Health and Safety Executive. pp. 1–13, 2015.

[14] D. Seglins and J. Loiero, "Families of CP Rail workers killed in B.C. mountain crash demand investigation be reopened," CBC News, Jan-2020.

[15] "CP corrects inaccuracies in CBC reporting of Field, B.C. derailment," CP Press Release, 2020. [Online]. Available: https://www.cpr.ca/en/media/cp-corrects-inaccuracies-in-cbc-reporting-of-field-b-c-derailment. [Accessed: 07-Feb-2020].

[16] D. Seglins, "Police officer suspects internal 'coverup' by CP Rail in fatal B.C. mountain crash," CBC News, 2020. [Online]. Available: https://www.cbc.ca/news/canada/cp-derailment-investigation-coverup-alleged-1.5436018. [Accessed: 07-Feb-2020].

[17] I. Mcclelland and C. L. Cortis, "APPLIED PROJECT APRJ 699 An Exploratory Study of the Accountability and Governance of Railway Police within Canadian Pacific Submitted 2009. http://dtpr.lib.athabascau.ca/action/download.php?filename=mba-09/open/McClellandIvanproject.pdf

[18] "Runaway train: Investigating a fatal CP Rail Crash," The Fifth Estate - CBC, 2020. https://www.cbc.ca/fifth/episodes/2019-2020/runaway-train-investigating-a-fatal-cp-rail-crash

[19] "A controversial police probe into fatal B.C. train derailment," CBC Front Burner Podcast, 2020. [Online]. Available: https://www.cbc.ca/radio/frontburner/a-controversial-police-probe-into-fatal-b-c-train-derailment-1.5453743. [Accessed: 09-Feb-2020].

[20] D. Seglins and J. Loiero, "Rail disaster video surfaces on anniversary of CP crash amid controversy over police probe," CBC News, 2020. [Online]. Available: https://www.cbc.ca/news/canada/video-derailment-canadian-pacific-railway-field-1.5449758. [Accessed: 05-Feb-2020].

[21] "Memorandum of Understanding between the Royal Canadian Mounted Police and the Canadian Transportation Safety Board," no. August. 2015.

[22] "Transportation Safety Board of Canada: Mandate." [Online]. https://www.tsb.gc.ca/eng/qui-about/index.html. [Accessed: 07-Feb-2020].

[23] B. Campbell, "Regulatory Capture Compromising rail safety in the wake of Lac-Mégantic?," Canadian Centre for Policy Alternatives, 2016. [Online]. Available: https://www.policyalternatives.ca/publications/commentary/regulatory-capture. [Accessed: 16-Sep-2020].

[24] B. A. Turner, "Causes of Disaster: Sloppy Management," vol. 5, no. September 1993, pp. 215–219, 1994.

[25] N. Leveson, "A new accident model for engineering safer systems," Saf. Sci., vol. 42, no. 4, pp. 237–270, 2004.

[26] J. Reason, Managing the Risks of Organizational Accidents. Taylor and Francis. Kindle Edition, 1997.

[27] D. Cooper, Navigating the Safety Culture Construct : A Review of the Evidence. B-Safe Management Solutions Inc., 2016.

[28] J. Hovden, E. Albrechtsen, and I. A. Herrera, "Is there a need for new theories, models and approaches to occupational accident prevention?," Saf. Sci., vol. 48, no. 8, pp. 950–956, 2010.

[29] A. Flynn and J. Shaw, Safety Matters: A Guide to Health & Safety at Work. Management Briefs, 2008.

[30] W. C. Li and D. Harris, "Pilot error and its relationship with higher organizational levels: HFACS analysis of 523 accidents," Aviat. Sp. Environ. Med., vol. 77, no. 10, pp. 1056–1061, 2006.

[31] A. O'Dea, R. Flin, and A. Dea, "The Role of Managerial Leadership in Determining Workplace Safety Outcomes," Heal. Saf. Inf., pp. 1–77, 2003.

[32] J. Hak and R. B. Stewart, "The criminal law response to workplace safety incidents," Calgary, Alberta, 2018.

[33] T. S. Board, "Rail Safety Advisory 617-05/19 Air brake system inspection and maintenance on grain hopper cars used in CP unit train operation," 2019. [Online]. Available: https://www.tsb.gc.ca/eng/securite-safety/rail/2019/r19c0015/r19c0015-617-05-19-20190411.html. [Accessed: 28-Jan-2020].

[34] T. S. B. of Canada, "Rail Safety Advisory 617-04/19 Prevention of uncontorolled train movements for trains stopped in emergency on grades of less than 1.8%." [Online]. Available: https://www.tsb.gc.ca/eng/securite-safety/rail/2019/r19c0015/r19c0015-617-04-19-20190411.html. [Accessed: 06-Feb-2020].

[35] T. Canada, "Railway Freight and Passenger Train Brake Inspection and Safety Rules," Transport Canada TC oO-0-165, 2017. [Online]. Available: https://tc.canada.ca/en/rail-transportation/rules/railway-freight-passenger-train-brake-inspection-safety-rules. A

[36] K. Mulligan, Y. Wang, Y. Liu, L. Steiginga, and A. Aronian, "Automated Train Brake Effectiveness (ATBE) Test Technology Demonstration and Assessment," 2018.

[37] C. P. Railway, "White Paper: Railroading in the Canadian Winter," 2012.

[38] C. P. Railway, "Winter Contingency Plan," 2018.

[39] M. Jamieson, A. Aronian, and K. Wachs, "JRC2012-74035 Automated Train Brake Effectiveness (ATBE) Test Process at Canadian Pacific," 2012, pp. 1–9.

[40] D. (Univesity of A. Juhaszova, "Reliability of North American Freight Railcar Air Brake Inspection Method Using Wheel Temperature Detectors," 2018.

[41] T. Canada, "Government of Canada Hopper Car Fleet 2015 Annual Report Prairie and Northern Region," 2015.

[42] "25 Derailments and runaways in the last 25 years," CP Rail. [Online]. Available: https://www.documentcloud.org/documents/6670673-TSB-Data-Base-CP-Laggan-Subdivision-Stephen-to.html. [Accessed: 09-Feb-2020].

[43] S. Chirls, "Pumped up about high tech," Railway Age, no. December, pp. 29–31, 2017.

[44] "New York Air Brake." [Online]. Available: https://www.nyabproducts.com/db-60-ii/. [Accessed: 10-Feb-2020].

[45] "Canadian Pacific worker dies at B.C. railyard," CBC News, 2019. [Online]. Available: https://www.cbc.ca/news/canada/british-columbia/cp-rail-workers-dies-port-coquitlam-1.5382806. [Accessed: 09-Feb-2020].

[46] E. Atkins, "Canadian Pacific train operator dies in rail-yard accident, marking sixth fatality of 2019," The Globe and Mail, 03-Dec-2019.

[47] D. Deibert, "'How many more lives put at risk?' asks Sask. MP after train derailment," Saskatoon Starphoenix, Saskatoon, 11-Dec-2019.

[48] "Train derailment in southeast Calgary Tuesday," Global News, 2019. [Online]. Available: https://globalnews.ca/video/5706601/train-derailment-in-southeast-calgary-on-tuesday/. [Accessed: 09-Feb-2020].

[49] "Canadian Pacific grain cars rolls out of control, derails near Field B.C.," CBC News, 2020. [Online]. Available: https://www.cbc.ca/news/canada/calgary/train-car-derailment-canadian-pacific-railway-field-bc-1.5438045. [Accessed: 09-Feb-2020].

[50] "2 CP crude oil train crashes 2 months apart in same Sask. area: 'Coincidence' or 'deeper problem'?," CBC News, 2020. [Online]. Available: https://www.cbc.ca/news/canada/saskatoon/cp-train-crash-oil-guernsey-saskatoon-1.5454341. [Accessed: 09-Feb-2020].

[51] J. Berry and M. Albiston, "CP reports record forth-quarter and full-year results; carries momentum into 2020," CP Press Release, 2020. [Online]. Available: https://s21.q4cdn.com/736796105/files/doc_financials/2019/q4/Exhibit-99.1-Q4-2019-Earnings-Release-r117.pdf. [Accessed: 09-Feb-2020].

Appendix – Author Biography

Robert B. Stewart

BA, MSc, MBPsS Occupational Psychology

Rob was engaged as a senior subject matter expert charged with the development and delivery of a training workshop in employing socio-technical (organizational incidents) investigative techniques with application of case law for Calgary Police Service Detectives. The protocol and training ensure high quality investigations with a reasonable likelihood of conviction. The Royal Newfoundland Constabulary has adopted this protocol along with training delivered in May 2019. These are the only two Police Services in Canada with a standardized method for investigating workplace serious injuries and fatalities through the lens of the Criminal Code. However, the Federal Government is in the process of developing e-training to be delivered to all Police Services, Crown Prosecutors and Regulators. Rob sits on the workgroup tasked with this development as a subject matter expert.

Rob's education background and 20 years of work experience has been in occupational psychology. He has 20 years working in applied research both to understand traditional safety and its failure points, and to create new methodologies to embrace risk management and operational excellence

Expertise:
Organizational Investigations, Evidence Based Safety, Safety Culture