PUBLIC LAW BOARD N0. 6564

BROTHERHOOD OF MAINTENANCE OF WAY EMPLOYEES

AND

CSX TRANSPORTATION, INC.

Case No. 40

Statement of Claim:

In this case, it is the claim of the System Committee of the Brotherhood that the dismissal of Machine Operator C. A. Robinson for alleged safety and performance violations on April 29, 2002 was without just and sufficient cause. The relief sought is the reinstatement of C. A. Robinson with full back pay and seniority and with all other rights and benefits unimpaired.

Background

On April 29, 2002, Claimant C. A. Robinson, a Machine Operator, was involved in the derailment of Ballast Regulator BR-9439, which he was operating. The accident resulted in minor injuries to Claimant as well as extensive damage to the machine, damage to the bridge structure, damage to the track structure, and delays and re-crews to trains. The incident occurred on the Lineville Subdivision, Milepost ANJ 960.6.

By letter dated May 1, 2002, Regional Engineer D. B. Spainhower charged Claimant Robinson with failure to secure auxiliary equipment on the ballast regulator for safe movement, in violation of CSXT On-Track Workers Safety Rule 712, MWI M-018 Part (6), along with violation of CSXT Operating Rules 501 (7 and 8).

PLB 6564
Awd 40

On-Track Workers Safety Rule 712 provides, in relevant part:

> The employee, to whom the on-track equipment is assigned, is responsible for the inspection, use, operation and care of such equipment. Before on-track equipment may be operated, an inspection must be made to determine the condition of the equipment.
>
> 1. The brakes must be tested.
> 2. Lock-up devices must be in place.
> 3. Any defects must be corrected before proceeding.
>
> On-track equipment must not be operated when it is in an unsafe condition. A report must be made to the supervising officer when on-track equipment is in need of repair. A lockout/tagout tag placed on the ignition switch or other control indicates that the equipment is under repair....
>
> To secure the wing on the regulator involves bringing the cables up and lowering the wing into what we call a "cradle", which is a cut off section there of steel that allows the wing to rest in position when in the midst of traveling or not in use.

MWI M 018 Part (6) states:

> The operator must inspect the equipment, including: filters, fluid levels, cables, lock up devices, lights, gauges, horn, brakes, mirrors, doors and windows, latches, first aid kits, fire extinguishers, radio, back up alarm, lock out tags.

Operating Rule #501 (parts 7 and 8) provides:

> All employees must behave in a civil and courteous manner when dealing with customers, fellow employees and the public. Employees must not:
> 7. Make any false statements, or
> 8. Conceal facts concerning matters under investigation.

There were no witnesses to the accident, but it is undisputed that on the morning of April 29, 2002, Claimant was operating the ballast regulator with a surfacing unit when it derailed at a bridge and wound up sideways on the bridge. Investigation revealed that the ballast regulator's west wing collided with the bridge and, in fact, fell off after a cable

broke. It was determined that the wing was in an extended position when it hit the bridge instead of resting in its cradle. Moreover, the lock-up device had not been used. Damage to the machinery was estimated to run between $30,000 and $35.000. (Tr. at 16).

Following a hearing that was held on May 16, 2002, Claimant was dismissed from the Carrier's service. The dismissal was based on the seriousness of the April 29 accident and other recent incidents in which Claimant put at risk not only his own safety, but the well-being and safety of co-workers and the general public. The Organization appealed the dismissal, and following failure by the parties to reach a mutually acceptable resolution, the dispute was submitted to this Board for adjudication.

Findings

While Claimant testified that he had both of the ballast regulator's wings secured into their cradles, his testimony was not persuasive. This is because he had no logical explanation for how the accident occurred. Given the more credible testimony of Regional Engineer Track D. B. Spainhower, Regional Manager of Work Equipment J. S. Sorensen, and Production Foreman C. B. Curvin, it is clear that the mishap occurred because Claimant failed to secure his auxiliary equipment, i.e. the machinery's wings.

Claimant insisted that the wings were secured up into their cradles, but undisputedly, the west wing came out of the cradle and hit the bridge. It is unlikely that this would have occurred without the operator moving the controls. The Organization suggested that the cable might have been "in a bind" that "allowed slack in the cable" which, in turn, permitted the wing bucket to drop and hit the bridge. (Tr., at 44 and 48). But this argument is highly speculative and not supported by an reliable evidence in the Record.

PLB 6564
Awd 40

Furthermore, Claimant testified that he had checked the cable on the ballast regulator and it was in good shape.

The Board is mindful that Claimant had 27 years of service with the Carrier. However, the Board is obligated to consider not only Claimant's seniority but also his record. That record reflects that shortly before the April 29 accident, Claimant received a 5-day suspension and then a 30-day suspension for safety-related incidents. Given these prior disciplines and the seriousness of the April 29 accident, the Carrier did not abuse its managerial discretion in concluding that Claimant's performance was no longer acceptable and that he posed a safety risk to himself, co-workers, and the general public. The Carrier has met its burden of proof in the instant matter and the Board, therefore, must respect its judgment.

Award

The claim is denied.

Joan Parker, Neutral Member

Carrier Member

Dated: 06-21-05

Organization Member

Dated: 6-21-05