IN THE MATTER OF THE *CANADA LABOUR CODE*

AND IN THE MATTER OF AN ARBITRATION

BETWEEN:

NAV CANADA

(hereinafter referred to as "Nav Can" or the "employer")

AND:

THE CANADIAN AIR TRAFFIC CONTROL ASSOCIATION

(hereinafter referred to as "CATCA" or the "association")

(Ron Schroeter and Mike Dooling Discipline Grievances)

BOARD OF ARBITRATION

Mervin I. Chertkow - Single Arbitrator

COUNSEL

Colin Gibson - for the employer
Peter Barnacle - for the association

DATE AND PLACE OF HEARINGS

August 19th and 20th, September 17th, October 5th and 6th, 1999 all at Vancouver, BC

DATE OF AWARD

November 30th, 1999

AWARD

I

The grievors are both Air Traffic Controllers, who work out of the Vancouver Area Control Centre. On July 14th, 1998 at approximately 18:49Z time an operating irregularity occurred in the vicinity of Vancouver Airport involving Canadian Regional Flight 1369 when it was vectored at 5,000 ft. into restricted military airspace in the Nanoose Bay area known as CYR107. It is a restricted area approximately 28 miles west of the Vancouver Airport. It is active from the surface to 10,000 ft. and occasionally to 13,500 ft. CYR107 was active at the time in question to 10,000 ft. and aircraft are required to maintain a vertical separation of 1,000 ft. and a lateral separation of three nautical miles outside the boundaries of that restricted airspace.

Mr. Dooling was the Team Leader on that shift. He allegedly failed to properly brief the relieving Controller, Mr. Schroeter, as to the active status of CYR107. As a result, he was suspended by the employer for three shifts. As to Mr. Schroeter, it is alleged he was negligent in his duties when he failed to properly brief himself before assuming control responsibilities and as a result, placed CDR1369 in restricted airspace potentially endangering the aircraft and its passengers. He too received a three day suspension.

It is the position of the employer that both grievors were guilty of breach of procedures and were negligent in the carrying out of their duties. As Team Leader, Mr. Dooling failed to brief Mr. Schroeter that CYR107 was active to 10,000 ft. at the material time in question and in the case of Mr. Schroeter, he had the duty to check the Notice to Airmen (NOTAM) and the Operational Information Display System (OIDS) above his console, both of which would have confirmed the active status of CYR107. Further, the employer said it is entitled to discipline employees who commit acts of negligence, as was the case here, and the penalty of a three day suspension imposed on each of them was neither excessive nor inappropriate in all the circumstances of this case.

The association takes the position that the discipline given to the grievors by the employer was made without just cause. It does not dispute that CDR1369 went into CYR107 when the NOTAM showed

it was active to 10,000 ft. However, it says a disciplinary response should only be invoked by the employer where there is egregious or significant culpable misconduct in circumstances where a controller has consciously omitted or failed to do something he ought to have done. The association suggests that discipline, in an aviation environment, is inappropriate in the circumstances of this case. However, if I were to hold the grievors were guilty of an employment offence then it is urged the penalty of a three day suspension was excessive and inappropriate given the extensive mitigating circumstances as to the situation at the Control Centre at the material time in question. One runway was out of use and weather was deteriorating rapidly. The flow control for aircraft about to land were lined up on the wrong runway (the one not in use) and for unknown reasons two other aircraft were allowed into the landing traffic pattern 30 minutes early. That added to the volume of aircraft preparing to land so that the pace level had reached the maximum degree of busyness to the extent that it was almost unmanageable.

In those circumstances, it is urged by the association that the three day suspensions ought to be reduced to oral warnings. Both grievors operated in extreme conditions and notwithstanding the error in incorrectly allowing CDR1369 to enter the restricted military airspace, the facts were such that no aircraft or persons were placed in any immediate jeopardy as a result thereof.

II

There is, to a large extent, no disagreement as to the facts surrounding the incident in question. Where there is a disagreement arising out of the testimony of the various witnesses who gave evidence in these proceedings, any conflicts of a significant nature will be noted by me in this Award. From the testimony of the witnesses and from the report of a Fact Finding Board (Exhibit A-5) and from an Administrative Inquiry (Exhibit 1-E-18) in respect to the operating irregularity, I make the following findings of fact.

As noted previously, CDR1369, a Focker 28 jet, was vectored by Mr. Schroeter into CYR107, a military restricted area, which was active during that day to 10,000 ft.

Vancouver Area Control Centre had been notified by NOTAM the previous day that this area would be active. On the morning of July 14th a NOTAM was processed to advise the various control sectors in the Area Control Centre that that was the case. The NOTAM, for July 14th stated as follows;

CYR-107 ACTIVE

14	July	1500/1630	SFC	TO	10000	FT	MSL
		1630/1745	SFC	TO	3000	FT	MSL
		1745/1915	SFC	TO	10000	FT	MSL
		2100/2300	SFC	TO	10000	FT	MSL

The Vancouver Terminal Team Leader, Mr. Glen Graves, at the start of this shift made himself aware of the fact that the area would be active. He turned responsibility for the Vancouver Terminal for the rest of his shift to Mr. Dooling and briefed him that the restricted area would be active. He gave him a copy of the NOTAM.

The information on the NOTAM was also displayed on the bottom half of the OIDS screen. As well as the NOTAM information, other information such as weather, etc., appears on the top half of the screen. However, on the day in question, the OIDS display screen was positioned above and behind Mr. Schroeter's display area such that he could not see the bottom half of the OIDS from his sitting and operating position. He could only see the bottom half of the screen if he stood up from his chair. It also is of some significance, in my view, that subsequent to the incident in question, a new OIDS display was incorporated in the console from which the controller operates. He, therefore, has full vision of the OIDS, along with the radar screen, which is his main operating tool.

It is also not in dispute that traffic volume at the material time in question was "high" and "very complex", anywhere from Level 6 to Level 7 on the Pace Level Description which measures degree of busyness on a scale of 1 (lowest) to 7 (highest). Levels 6 and 7, as appears in Exhibit A-6 reveal the following;

6. Traffic demands <u>continuous and complete</u> attention. Proplanning is an ongoing requirement. *Full flight information services may not be provided due to workload, communications, congestion, etc. Airfile would probably not be accommodated during this period. Signs of periodic anxiety may be apparent. Communications and coordination may occasionally be untimely.*

7. The frequency of control decisions, coordination and communication is demanding to the point of straining the position/Sector beyond its capability and if this heavy demand is sustained or increased, a complex breakdown would occur. *Flight information routinely not provided. Flow may be becoming disorderly. Probably some control transfers are not timely. Coordination probably not as complete or timely as would be normal. Flow control measures may be implemented. Extraordinary requests/situations would likely require assistance (i.e., supervisor). A sustained period of this level of activity would be approximately 20 – 30 minutes.*

At the time of the incident, staffing consisted of eight Controllers and a Team Leader, Mr. Dooling. The Arrival Low position was staffed by Mr. Schroeter, who was undergoing a Quality Assurance Check Ride from Mr. Dooling.

CDR1369 was an IFR flight from Prince George to Vancouver. The Arrival High Controller vectored and reduced the speed of CDR1369 for spacing on the final approach course to runway 08 left and handed it over to Mr. Schroeter.

At 14:30Z a runway change from the runway 26's to the runway 08's occurred. However, the Air Traffic Flow Management unit continued to flow aircraft for the runway 26's. The ATFM unit's failure to flow aircraft for the active runways resulted in longer than expected sector flight times for aircraft operating within the Terminal Area. The flow rate for the Vancouver Airport was 36 aircraft per hour based on the availability of two landing runways and the reported weather conditions.

The problems were further compounded in that the Instrument Landing System (ILS) for runway 08 right was inoperative and unavailable due to scheduled maintenance shutdown. The Distance Measuring Equipment (DME) for runway 08 left was unserviceable.

Another factor which added to the problems occurred approximately 30 minutes prior to the incident when the first Terminal Coordinator initiated the cancellation of ATFM assigned meter times for two aircraft (CDN168 and CDN516) which permitted those aircraft to enter the terminal control area approximately 30 minutes prior to their approved meter times.

Weather conditions were such that approximately 30 minutes prior to the incident an aircraft reported the airport in sight approximately 20 miles to the south at 3,000 ft. and conducted a visual approach. Weather conditions subsequently deteriorated rapidly to the point where visual approaches could not be conducted until aircraft were within 10 minutes of the airport at an altitude of 2,000 ft.

Mr. Schroeter assumed the Arrival Low position which he took over from Mr. Dooling. Mr. Dooling did not inform him during the position hand over that CYR107 was active to 10,000 ft. However, Mr. Schroeter was aware that CYR107 would be active to various altitudes during the duration of his shift. At the time of the incident, Mr. Schroeter believed CYR107 was active from the surface to 3,000 ft.

The Arrival High Controller handed off CDR1369 to Mr. Schroeter on a heading of 250° cleared to altitude of 5,000 ft. with an assigned speed of 190 knots. Recorded radar data indicated CDR1369 entered the protected airspace for CYR107 on the downwind leg on a heading of 250°. CDR1369 was subsequently turned by Mr. Schroeter to a heading of 120° and penetrated CYR107. Mr. Dooling directed Mr. Schroeter to take action to re-establish separation between CDR1369 and CYR107. Recorded radar data indicated no spacing existed between CDR1369 and CYR107 in an area where 1,000 ft. vertical separation or three nautical miles lateral separation is required from an active restricted area.

The Fact Finding Board Report (Exhibit A-5) came to the following conclusions;

1. A loss of separation occurred involving CDR1369 and CYR107 when the Arrival Low controller vectored CDR1369 at 5,000 feet into the protected airspace for CYR107.

2. The cause of this loss of separation is that the Arrival Low controller was not aware CYR107 was active from the surface to 10,000 feet.

3. Factors contributing to this loss of separation are the incomplete sector briefing given by the team leader to the Arrival Low controller during the position handover, the high volume of aircraft in the Terminal Area due ATFM metering to the incorrect runways and the first coordinator canceling ATFM assigned meter times for two aircraft, and the Arrival Low controller being distracted by vectoring aircraft to runway 08 right for visual approaches in marginal weather conditions.

The subsequent Administrative Enquiry Report concluded, with respect to Mr. Dooling, that;

> As the Team Leader for the shift, Mr. Dooling knew or should have known the status of CYR107. He should have known that when he sat in the Arrival Low position. It was on the OIDS. He should have looked at OIDS prior to sitting down. When he handed the sector over to Mr. Ron Schroeter, he should have passed this information on to him but he didn't. He confirmed that he did not tell Mr. Schroeter this in specific question 2. *"You were working Arrival Low prior to the sector hand over to Ron Schroeter. Did you alert him that CYR107 was active to 10,000 feet?"* Answer *"Prior to the sector hand-over, I was working Arrival Low and did not alert him that CYR107 was active to 10,000 feet because I was not aware it was active."*

And as to the actions of Mr. Schroeter it concluded;

> The fact that he [Mr. Dooling] did not tell Mr. Schroeter that the area was active does not absolve Mr. Schroeter from his responsibility to have known such information. In general question 13, Mr. Schroeter confirm that he was aware that the area was active. 13. *"Had you been notified that CYR107 was active?" "YES". How: "I was briefed in the morning that it was active to 3000 feet. I also worked Departure earlier and saw 3000 feet on the OIDS. I became aware that it was active to 10,000 feet just as I issued a turn to 130 degrees or 120 degrees to CDR1369. At that moment I took no other action because of a fear the right turn would take him deeper in CYR107."* Notwithstanding his assertion that he did not know, the fact is, he should have known. He should have checked the OIDS prior to sitting down. This was a high profile activity and the information was there for all to see. In question 45 of the general questions he was asked Mr Schroeter acknowledges that he should have briefed himself better. 45. *"Do you feel you failed to properly brief yourself when taking over the sector?"* Answer: *"<u>In retrospect, Yes</u>."*

The Administrative Enquiry Board also came to certain Other Findings as follow;

1. Traffic volume was reported as "High" by those interviewed.
2. Complexity was reported as "Very-Complex"
3. Pace Level on a scale of one to seven was reported as "Seven" to "Seven Plus".
4. There was some confusion among the staff as to who the Team leader was for the shift. Was it Mr. Graves or was it Mr. Dooling?
5. The controllers all knew the location of CYR107.
6. The controllers all knew the separation requirements from CYR107.
7. The FLOW rate was 36 aircraft per hour.

8. In the first half-hour of the hour in which the operating irregularity occurred, eleven aircraft landed.
9. In the second half-hour of the hour in which the operating irregularity occurred, twenty aircraft landed.
10. The FLOW controllers had the FLOW computer calculating FLOW times for runway 26. The aircraft were landing on 08.
11. The Coordinator cancelled two thirty-minute restrictions on two aircraft, which caused them to arrive, in the middle of the heavy traffic session.
12. The ILS equipment available did not permit the full use of both runways.
13. The weather did not permit the full use of both runways.
14. The Terminal was at full staff minus the Monitor position capability.
15. Some confusion existed on who should assign an arriving aircraft the use of the south runway.
16. Notwithstanding all the errors, and heavy volume and the complexity of the situation, the Arrival High Controller John Murphy did an excellent job of coping with what came his way.
17. There was no conflicting activity in CYR107, because of poor weather (low ceiling), at the time the aircraft had been vectored into it. The Shift Manager had verified this immediately after the operating irregularity occurred and had the Military amend the NOTAM making it active to 3000 feet only.

And finally, it came to the following conclusions;

An Operating Irregularity occurred when Mr. Ron Schroeter, the Arrival Controller vectored CDR1369 into CYR107. Mr. Schroeter should have known the Restricted Area was active to 10,000 feet. He failed to take advantage of the available data, which was being displayed on OIDS. From a sitting position, this data is awkward to access, but was there for him to easily see while he was still erect just prior to assuming control of the Arrival position. He was negligent by failing to adhere to unit sector hand-over procedures, which would have informed him of the active Restricted Area.

His Team Leader Mr. Mike Dooling, from whom he took control of the position, failed to tell him in the sector-hand-over briefing, that the Restricted Area was active. He claims he did not know, but he should have known. He had seen the NOTAM; he had been briefed by Mr. Glen Graves from whom he assumed Team Leader responsibility and it was on the OIDS. He too was negligent when he failed to adhere to unit directives, through the incomplete briefing-procedure that he followed.

Mr. Al Ballantyne and Mr. Jamie Pottinger, the two flow controllers of the shift were Flowing traffic for runway 26 while traffic was landing on 08. The

> Runway, the computer works to, is clearly displayed on their computer screen but neither one of them picked up the error. They were aware that runway 08 was in use. Their logbook reflected that. Aircraft that should have landed five to seven minutes earlier were still in flight to final and this may have contributed to the extended 25-mile downwind, high volume and complexity. If the downwind did not extend as far as it did, it is likely that CDR1369 would not have been brought anywhere near CYR107.
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> Mr. Lindsay Beggs, the Coordinator prior to Mr. Dave Colwell's assumption of Coordinator duties, cancelled two thirty-minute restrictions on two aircraft. He did so without searching out sufficient information to make such a decision. His attitude, when questioned about this, was defensive, evasive and matter-of-fact. He did not appear to comprehend the compounding effect of his action. Had these two aircraft, CDN516 and CDN168 who arrived just before CDR1369, not been there, it is also likely that there would have been room for CDR1369 to be vectored clear of the CYR107. This is, notwithstanding the FLOW error. The Coordinator did not breach any unit procedures. He made a poor decision without sufficient information.

I now turn to a brief synopsis of the relevant evidence of various witnesses who testified in these proceedings in order to complete the picture of the events surrounding the operating irregularity.

Mr. Joe Russo was the Shift Manager on the day in question. He identified as Exhibit E-3 an Information Bulletin that focuses on safety. It requires Controllers to follow the three "P's"; adherence to procedures, phraseology and to pay attention. All staff and managers have that information.

He commented on separation standards for aircraft in the system. The object is to keep aircraft apart. In a radar environment they are separated anywhere from three to six miles depending on conditions at any given time.

Mr. Russo then gave a detailed description of the five geographical speciality areas in the Vancouver region. The Vancouver Terminal speciality area has jurisdiction for 35 miles around the Vancouver Airport. It now controls aircraft up to 16,000 ft. but at the date in question it was to 23,000 ft. Above those ceilings, aircraft are controlled by other controllers. He observed further that the Vancouver Airport Control Tower has jurisdiction for airspace seven miles around the airport up to 2,500 ft.

He then described the various position that controllers operate at in the Vancouver Terminal. The Departure Controller is responsible for traffic departing Vancouver after they are airborne. The Terminal Data Controller coordinates adjacent control units and transfers information to receiving unit. The Terminal Coordinator works with a radar screen set at 60 miles. It is his function to maintain an overview of problems mainly associated with arrivals and departures. His job is to anticipate situations before they become problems; e.g., congestion. He regulates the aircraft by adjusting flow rates. If congestion becomes a problem he can order the opening of a second arrival position if the workload is too high for a single controller. As well, it is his duty to communicate to the tower about runway changes. He has authority to postpone runway changes until the workload diminishes.

He then described the Arrival High position. When one position is open the Controller accepts traffic at predetermined points from an on-route sector. He provides route and altitude to pilots and vectors them for final approach. If a second arrival position is opened and he remains in Arrival High, he still accepts traffic but does not vector aircraft to the runway. He is also responsible for clearing conflicts between arrivals and departures. As Arrival High Controller he guides descending aircraft to 5,000 ft. before handing them off to the Arrival Low Controller if that position has been opened. The witness pointed out that the bulk of traffic arriving at the Vancouver Airport comes from the east.

Next, he described the Arrival Low Controller position. He is responsible for accepting and fine tuning the speed of aircraft approaching the runway to keep minimum required separation. He issues approach clearances and hands off the aircraft to Vancouver Tower for final approach. He operates aircraft to an altitude of 5,000 ft. and up to 25 miles depending on how far the downwinds leg is for aircraft preparing to land at the airport.

After describing the duties of Final Monitor Controllers and the VTA Controller, Mr. Russo described the duties of the Supervisor (Team Leader) as being responsible for deploying staff and coordinating flow rates in conjunction with the Shift Manager. On the date in question Mr. Dooling was the appointed Team Leader.

Next the witness described Air Traffic Flow Management. He described that system as a “regulator valve”. At a busy airport, like Vancouver, where there are many scheduled flights as well as business and private flying, without such a valve aircraft could be departing and arriving at the airport at the same time. Arrivals and departures are, therefore, metered so that there is no conflict between departing and arriving aircraft. For example, if the meter is set for 36 aircraft per hour, and if traffic exceeds that number, it would be rejected.

Finally, the witness observed that the Shift Manager, an excluded position, is responsible for running the shop. There are Duty Shift Managers at any particular time and he is one of them.

He then described the restricted military airspace, being the Nanoose Bay testing range, known as CYR107. It is used by the Canadian and United States military. There are various military operations taking place there which are not known to Controllers. It is a firing range for torpedoes, rockets, projectiles as well as aircraft carrying out flying manouvers. Aircraft in CYR107 that operate below 1,000 ft. are not a concern for Arrival Controllers. They are controlled by the Vancouver Terminal. It is only when there is military activity above 3,000 ft. does it become of serious interest for Controllers. It is the military that issues the NOTAM but no information is given about what activity they are carrying on. It is the responsibility of the Controllers to keep aircraft out of the separation boundaries of that airspace. When the military is active to higher altitudes that information is essential for Controllers because, depending on what runway at Vancouver Airport is in use, it could be a major factor for arrivals on runway 08 right or left or for departures on runway 26 right or left. Controllers need to separate aircraft on their final approach course. He commented further that since the end of the cold war there has been a lot less activity in CYR107.

Turning to the OIDS display system, the witness agreed the television monitor used to be placed on top of the Controller’s console but that has now been changed. The information is now re-routed to a monitor on the console. The OIDS system displays weather, altimeter settings, unserviceable equipment (ILS, DME, running lights) and other information, if required, as well as NOTAMS for CYR107.

Mr. Russo then described his involvement with respect to the incident that occurred at 18:50Z on July 14th, 1998. He was not involved in the Fact Finding Board but was a member of the Administrative Inquiry which took place on July 21st and 22nd, 1998. He authored the report and confirmed the conclusions reached in that report as previously noted. He also acknowledged that the Fact Finding Board Report found that as a result of the incident there was “no risk of collision”. He disagreed with conclusion #3 reached by the Fact Finding Board with respect to the factors it said contributed to the loss of separation.

The next witness who testified on behalf of the employer was Mr. Rick Johannson, who is General Manager, IFR, at the Vancouver Airport Control Centre.

He commented that he read the report of the Fact Finding Board and after considering all factors he decided that because the grievors failed to follow procedures there was a potential for serious jeopardy to aircraft and passengers and thus, discipline was warranted. It was one of the more serious infractions he has seen.

In the case of Mr. Schroeter, he failed to properly prepare himself for duty when he took over the Arrival Low position. He considered all of the contributing factors but had Messrs. Schroeter and Dooling been aware that CYR107 was “hot”, the incident would not have occurred. Mr. Schroeter would never have turned aircraft into that restricted area. In the case of Mr. Dooling, he either forgot or did not know the area was hot and he too failed to properly prepare himself for duty. None of the contributing facts, in his view, would have made a difference. All Mr. Schroeter had to do was to turn the aircraft to the right, not to the left into the restricted military area.

Mr. Johannson said further, that it was very fortunate no aircraft were flying in CYR107. However, the grievors should have known it was hot. When asked to comment on the Fact Finding Board’s Report which stated “no risk of collision”, Mr. Russo said that was a conclusion after the fact. However, the grievor still put an aircraft in jeopardy. Had the grievors followed the “three P’s” – the incident would not have occurred. In the case of Mr. Schroeter, he did not read the NOTAM, he did not look at the OIDS display prior to sitting down at his Arrival Low position and thus, did not have all the information he required for his duties. In the case of Mr. Dooling, he did not keep himself

aware that CYR107 was hot when he was so advised previous to the incident. He was not aware of the status of CYR107 when he handed off to Mr. Schroeter but the information was there for both of them. He commented further that Mr. Dooling was the Team Leader and at one point he considered a lesser discipline for him because he was not in the control position. However, he came to the conclusion that Mr. Dooling had a higher responsibility. He controlled the sector and he did not make Mr. Schroeter aware of all the information necessary for him to operate the Arrival Low position.

The witness was then questioned as to the quantum of discipline for both grievors – three day suspensions. He said that was a difficult decision. He noted that Controllers had been briefed only two weeks prior to the incident and that there needed to be a change in work habits and that they would be held responsible for their actions. He said NAV Canada is a new private organization, not the Ministry of Transport that operated the system previously, and he had to send a message or a signal to all Controllers. He felt that a three day suspension would be the minimum given the seriousness of the error. Anything less would not send the proper signal.

In cross-examination, Mr. Johannson agreed that when the system was operated by the Department of Transport a no-fault system was in place and there was no process for an administrative inquiry. He was asked about the meetings with Controllers which he said took place during the first two weeks of July prior to the incident in question. When it was put to him the grievors say they did not attend such meetings, Mr. Russo replied he was quite sure Mr. Schroeter attended and he knows for sure Mr. Dooling was there. He also agreed with counsel for the association that Controllers sign off on rules, procedures and staff memoranda. He agreed there is nothing in writing about the new policy for discipline as instituted by NAV Canada.

In response to further questioning, the witness agreed a number of things can occur which could lead to an operating irregularity; “a chain of causation”. Minor items can build up in a dynamic environment and the human factor is the key to reacting to the dynamics in any given situation. If everything is running smoothly Controllers can do their job. When things do not go right operating incidents occur.

The witness was then questioned on the factors that contributed to the incident in question. Only one runway was in use (O8L), there was no DME and thus, pilots slowed down. Runway O8R was off-line because the ILS was down and could be used for visual approaches only. The weather dropped rapidly from 4,000 ft. to 1,500 ft. so that aircraft could not get in on visual approach rules. He agreed the situation became more complex which required a longer downwind leg for aircraft arriving at the airport. He agreed there were equipment failures – the DME and ILS. As for the metering system for aircraft flow, it was being metered for landings on Runway 26 but that runway was not in use. He conceded there was a change in runways just before the incident. Aircraft on the ground would be at the wrong end of the runway and would lose their place in line while aircraft arriving had to change runways. He agreed that given the situation with the runways, the deteriorating weather and the metering problems, aircraft approaching Vancouver Airport were getting a longer downwind leg. He agreed that the two aircraft that were allowed to come into the system 30 minutes early also contributed to a breakdown in procedures for coordination between Controllers. It made it a lot more complex situation.

As to the pace level description (6 to 7 plus), he said he is not in a position to agree or disagree with that assessment and he could not say if he had any reason to dispute the reports of Controllers that it was a Level 7. As for the OIDS display that was in place at the time of the incident, he agreed that a person sitting in the Arrival Low position could not see the bottom of the screen that contains the NOTAM information. That did not make the Controllers' job any easier. He also agreed that subsequently, when the OIDS display screen was placed on the console in front of the Controller, it would be unlikely he would forget to look at the NOTAM information on the screen.

The witness was asked to compare the findings of the Fact Finding Board with those of the Administrative Inquiry and he agreed there were no obvious differences between them.

I now turn to the evidence adduced on behalf of the association. The first witness was Mr. John Murphy, who is a Controller working at the Vancouver Terminal. He has had previously experience as a supervisor in the Victoria Tower as well as at the Vancouver Control Centre. He is fully qualified in all terminal specialities and has worked in that capacity at the Vancouver Control Centre since 1997. On the date of the incident he was working the Arrival High and Departure South positions.

Controllers rotate to different positions during a shift. He commented that he knew CYR107 was active when he started his shift working Departure Control. He noted that about an hour after he started he advised other Controllers that CYR107 had been closed. He was not briefed that CYR107 had become active again when he took over the Arrival High position. Because of the build up of traffic, the deteriorating weather conditions, the fact that the ILS was down and DME was out of service and with increasing traffic he felt it prudent to get assistance so he called for the opening of the Arrival Low position. He said CYR107 was only active occasionally and to the best of his recollection only five times in the past year when he was on shift. Further, he said, he did not know aircraft were being metered to Runway 026. He said that when he called for a split in the arrival positions he told Mr. Dooling about the conditions he was facing and Mr. Dooling accepted the hand off of aircraft in the Arrival Low position. He became aware that CYR107 was active about five minutes after the incident occurred and he recalled saying "you're kidding" – it was a big surprise to him. He observed further, that the flow rate was too high for the runway configuration and the fact that two more aircraft were being allowed into the system ahead of time created a snowball effect which would cause the kind of problem that it did with respect to controlling CDR1369.

In cross-examination, the witness agreed that when CYR107 is hot (above 1,000 ft.) he is responsible for knowing that is the case. He must keep all traffic outside of the restricted area by at least three miles from the outer boundaries. He agreed there are no exceptions to that rule but he said if it was necessary to avoid a mid-air collision he would do it even if it was contrary to the rules.

The next witness was the grievor, Mr. Ron Schroeter. He testified that he has worked all positions at the Vancouver Air Traffic Control Centre since April of 1982. CYR107 has been active above 1,000 ft. less often than previously, only once or twice a year.

On July 14th, 1998 he was working the day shift. He started work in the Departure position. Mr. Dooling was giving him a Quality Assurance check and followed him around watching him in Departure and later on in the Arrival position.

The witness said he was aware CYR107 was active to 3,000 ft. between 16:30 and 16:75. He took a break and Mr. Dooling relieved him in the Arrival position. When he came back from his break he

resumed the Arrival position. Mr. Dooling did not brief him on CYR107. However, he did brief him on weather and the situation with the DME, ILS, etc. He then described the condition of the runways, the ILS, DME and the problems he encountered when those facilities were not operating. As well, he noted the flow computer was metering aircraft to the wrong runway. As to the level of traffic when he returned from his break, it was very busy with three or four aircraft in the process of being handed off from Arrival High. He said he did not see the OIDS display on the top and back from the edge of his console. He could not see it from his sitting position. He confirmed that the OIDS display is now installed on the console on a larger screen at eye level. When Mr. Dooling handed off the Arrival Low position to him he told him Runway O8L had no ILS. The visuals on Runway 08 became a problem and aircraft could not do a visual approach. At that point aircraft descending to the airport were on the westbound, downwind leg which extended about 10 miles before they were being turned to final approach. As traffic built up the trail went further west; the final approach got longer and longer as traffic built up.

Mr. Schroeter went on to say he was under the assumption that CYR107 was active to 3,000 ft. That was its activity when he was in the Departure position previously during his shift and he assumed it had not changed. He went on to say that just as CDR1369 was about to enter the area of CYR107, Mr. Graves came over to him and told him that CYR107 was active to 10,000 ft. At that point, Mr. Dooling told him to get out of the area. Just seconds before he had issued instructions for a 120° turn and the aircraft was already in the turn into the corner of CYR107. As it was about to exit CYR107 almost immediately, there was no point in changing the instructions to the aircraft he said. Had he changed the instructions it would have caused the aircraft to go further into the restricted military area. Mr. Schroeter said CDR1369 was in the restricted military airspace "a matter of seconds". After the incident he was relieved by Supervisor Glen Graves. He was shook up and in a mild state of shock. An investigation began immediately and he was concerned about what might happen to him. Mr. Schroeter said he was surprised CYR107 was active to 10,000 ft. He thought it was only to 3,000 ft. Mr. Dooling also told him he was not aware it was active to that altitude.

In cross-examination, Mr. Schroeter agreed he learned all about CYR107 during his training. His job is to keep traffic out of that area at all times with three miles separation from its boundaries. He agreed that failure to do so could result in grave consequences. He agreed further, that when the area

was hot everyone should be aware of it. When questioned about the location of the OIDS screen, he said he had mentioned it previous to the incident to Mr. Graves who told him technicians were working on it. If he had been aware that CYR107 was active to 10,000 ft. he would not have turned CDR1369 to the left into the area. He would have turned it to the right. When it was suggested to him regardless of weather, traffic, unserviceable instruments, etc., he must not vector aircraft into CYR107, he replied that he was so busy getting aircraft on the ground that he did not have time to check the NOTAMS or the OIDS – the situation was "too complex".

Mr. Mike Dooling has worked at the Vancouver Terminal since 1980. He was a Supervisor until September, 1998 when, for personal reasons, asked to be returned to Line Control.

He then described the situation on July 14th, 1998. He said he set the flow rate for the day based on two runways in operation and a weather forecast well above VIR. The ILS was inoperative. He set the flow rate at 36 which is standard. That worked well throughout the day and 45 minutes before the incident in question there was no cloud below 4,000 ft. He said he felt the arrival rate for aircraft was appropriate for a two runway operation. The flow rate of 36 arrivals per hour would be too much for a one runway operation. When only one runway is operative, the flow rate should be 32 arrivals per hour.

Mr. Dooling then described what happened when Mr. Schroeter came back from his break and took over the Arrival Low position from him. Mr. Schroeter immediately started to talk to arriving aircraft. The weather was deteriorating rapidly and aircraft reported they could not see the runway from 20 miles away. The Coordinator on that shift had his radar set at 80 miles and he was responsible for bring arriving aircraft into the system. He had let two aircraft in early, something he was not aware of at the time. As well, the flow control computer was metering to runway 26 instead of 08. The effect of that was that the Controller was working more aircraft than what had been established as the maximum allowable for the airport. An excessive amount of aircraft had been allowed into the arrival system given the deteriorating weather conditions and the availability of runways. The final downwind leg should not have exceeded 15 miles but at the time of the incident, aircraft were out past 25 miles - almost at the maximum any Controller could work. It was a Pace Level 7 situation. The

Arrival High position was so busy that he could not talk to him because he was talking to so many aircraft.

Mr. Dooling also commented that CYR107 is a VFR operation. At that time he said he knew the weather was below what was reported. It was below 3,000 ft. and because CYR107 is a VFR operation, they would have to operate below that cloud level. In his experience, he said, it is very infrequent that CYR107 is active above 3,000 ft. For the last five years only infrequently was it active above 1,000 ft. Military exercises in CYR107 have dropped off significantly. It is more of a problem for Victoria Airport Control Centre because it infringes on their airspace. Only about once a month was it active at 3,000 ft. and only once or twice per year above that altitude, he said.

Mr. Dooling said that prior to the incident on July 14th, 1998 and when Transport Canada ran the system, operating irregularities were subject to a Fact Finding Inquiry and employees were protected from discipline by that procedure. When discipline was given its purpose was corrective, not punitive. Mr. Dooling said he could not recall anyone being disciplined for an operating irregularity when the fact finding process was in place. He is certain that is so for the Vancouver Terminal but could not say it was a fact in other parts of the country. Mr. Dooling said he had been briefed that CYR107 was active and he had read the NOTAM for that day. After Mr. Schroeter finished his break and started to work the Arrival Low position he did not say anything about CYR107 because he had forgotten about it. Earlier in the day Victoria Control Centre had told him it was not active because aircraft could not get in from the U.S. Whitby Island Naval Base. Mr. Dooling said he did not expect the final downwind leg to go beyond 15 miles. However, it did because weather deteriorated quickly and unexpectedly, Runway 08R was lost and aircraft were being metered for that runway. In reality, there were far more aircraft than the flow rate had been set for. He said he was unaware two aircraft had been allowed in early and the flow rate computer was in error. All Controllers had expected that Runway 08R would be available. However, things happened so quickly that arriving aircraft at 2,000 ft. could not see the runway. Mr. Schroeter was operating at the maximum aircraft he could handle and his sequence was perfect and packed to the hilt. No one said anything about CYR107. Victoria Control Centre voice message said “are you watching CYR107?”, the response was it was active to 3,000 ft. to which Victoria responded “no – to 10,000 ft.”. I was surprised, said Mr. Dooling, and he told Mr. Schroeter to turn them and get them out of there. Mr. Dooling said he felt angry the situation

had been allowed to develop and had an argument with the Coordinator because "we got caught with too many aircraft and with the deteriorating weather situation I forgot about CYR107". However, he said, aircraft were not in imminent collision danger.

When shown the results of the administrative inquiry, Mr. Dooling said he confirmed he had forgotten CYR107 was active and because of that had not briefed Mr. Schroeter. CYR107 had not been a factor all day but had metering been properly done, aircraft on the downwind leg should not have gone out that far.

Mr. Dooling said he was surprised how he had been dealt with. When he was given a three day suspension he could not believe it. The same applied to Mr. Schroeter. He did an extremely good job with the aircraft involved in arriving at the Vancouver Airport and in his opinion, he had not seen a better job done by a Controller in a long time. He cannot believe the employer's approach to this situation. Controllers always think of safety first notwithstanding the pressure on them to get more aircraft down to the runway. He was told he got a three day suspension without consideration of the principle of progressive discipline because of the seriousness of the situation.

I now turn to the cross-examination of Mr. Dooling. He agreed he is a highly trained Controller. He is aware that all traffic must be kept out of CYR107 a distance of three miles from its borders for safety reasons and failure to do so could result in potentially grave consequences. However, he said, NAV Canada does not practice safety as well as it writes it. Controllers are aware that traffic in CYR107 is VFR but they are not aware of the actual physical activity going on there. When CYR107 is hot every Controller must be aware of it. Controllers are also aware they should check the OIDS display system. As well as the NOTAMS, the OIDS display gives weather information, runway status and equipment status. He agreed the OIDS display gives Controllers information which allows them to operate as safely as possible. When it was suggested to Mr. Dooling that a Controller who operates without NOTAM information is taking a risk, he said it depends on the circumstances. It is not an inherent risk, it is a potential risk. He agreed that when the CYR107 is hot, as Team Leader he is responsible for advising Controllers of that fact.

With respect to Mr. Johannson's evidence that in early July of 1998 he held briefings with Controllers to advise them of a change in the disciplinary process, he said he could not recall attending those briefings. As to the message from management that there were a lot of operational irregularities and something had to be done about it, he did recall feedback for suggestions to reduce operational irregularities, the emphasis on the three P's and if Controllers did not follow them, they will be held accountable. However, he could not recall a meeting that dealt with a change in the disciplinary process. He agreed in July of 1998 he was a Shop Steward.

As Team Leader on July 14th, 1998, Mr. Dooling said he was satisfied he had taken care of all his responsibilities. When asked if the situation at the time of the incident was out of control, Mr. Dooling said that as a result of his discussion with the Coordinator he was satisfied too many aircraft had been allowed into the system and he was not aware that the flow rate of 36 had been exceeded. As the situation unfolded he tried to get the arriving aircraft in position notwithstanding the rate had been exceeded and "we were losing a runway". In hindsight, he said, he could have reduced the flow rate had he not forgotten about CYR107. However, Mr. Dooling said although he felt the volume of aircraft arriving was excessive, it was being managed. Mr. Schroeter had all his aircraft separated and there was no reason to hold any of them.

As to the OIDS display, he said it could not be seen from the Arrival Low sitting position. If he could have seen it, he said, it would have refreshed his memory. It was suggested to the witness that even though the OIDS display could not be seen from a sitting position at Arrival Low that did not relieve his obligation to check it. He agreed that was so and that he had to work within that limitation.

The employer called Mr. Wayne Heal, the General Manager IFR Vancouver Control Centre, in rebuttal with respect to the meetings held with Controllers in July of 1998. He said the employer became very concerned about the increase in operating irregularities. There were 39 operating incidents in the previous year and based on the pace of irregularities for 1998, if it continued, there would be 85 operational irregularities at the end of the year.

He said the meetings started on July 2nd, 1998 with Controllers. The focus was to advise them that if they do not follow the three P's safety would be jeopardized. They were told that if it was determined

in a preliminary investigation that there had been a breach of those procedures they would be held accountable with the possibility of disciplinary action. The meetings, he said, were impromptu and not advertized. The Shift Manager took people off the floor as they became available. He recalled there were five meetings a day for nine days and they were held in the boardroom. Usually there were eight to ten or twelve Controllers at a meeting although some of them only had one or two employees. As for Mr. Dooling, he believed he attended one of the first meetings. He specifically recalls his being there.

In cross-examination, Mr. Heal agreed that Controllers were always accountable for their actions prior to those meetings. He suggested in response to further questioning that NAV Canada focuses more on safety than did Transport Canada. That is because of potential liability issues.

Mr. Heal agreed with counsel for the association that no agenda was set for those meetings and attendance was not required. No notes were kept of the meetings. Nor were there written summaries after they were finished. Further, he said, there was no disciplinary policy published by the employer. As well, no check list was kept as to who attended the meetings. He said the union was advised of the change in procedures verbally, but not in writing. Finally, to his knowledge, no Controller had previously been disciplined for failing to brief another Controller.

III

I now turn to a brief summary of the arguments presented by counsel in support of their respective positions in this dispute.

Mr. Barnacle commenced by stating the primary objective of safety is consistent with association principles but Controllers are human beings who are required to make split second decisions in a dynamic environment that changes minute to minute. They are dependent on other Controllers for proper information when accepting or handing off aircraft. What other Controllers do impacts on what they are doing. As well as those direct factors there are indirect factors which impact on their work. That includes the volume of traffic coming down the pipe, weather conditions, equipment failures and deficiencies and procedural issues.

He suggested the human mind cannot retain everything it needs to know without written cues. Safety is left to the Controller, not the employer. One Controller cannot set the table and walk away because it is the “other guys problem”. That applies to management too. The OIDS location was such that had it been installed on the Arrival Low position console prior to this incident, the operating irregularity would, in all likelihood, not have occurred. So too, insofar as the incident in question is concerned, had both runways been operating, had flow control been properly metered, had the ILS and DME been operational and had the weather not suddenly deteriorated, the incident would not have happened because there would not have been a 25 mile downwind leg for arriving aircraft.

Counsel for the association went on to suggest that what happened on July 14th, 1998 was an extremely unusual situation. A 25 mile trail of aircraft arriving in the downwind leg together a restricted military area which is only active twice a year was a most unusual situation. Given all the contributing factors, if any one of them had not been present, the incident would not have happened.

He goes on to urge that the facts in this case do not disclose a cause for discipline. He argued that in the past, when Transport Canada took discipline for an operating irregularity, it was only in the context of very serious culpable conduct.

Counsel for the association disputed the employer’s argument that the need for deterrence supported a three day suspension, without use of the progressive discipline principle. Controllers have no need for deterrence in order to operate safely. Nor is punishment or penalty appropriate in the instant case because it is highly unlikely such an incident could happen again unless a Controller would be guilty of gross negligence or recklessness. Counsel points out that the OIDS display is now right in the face of the Arrival Low Controller sitting at his console. As well, further procedural changes have improved the situation. Controllers are now placing range bearing lines on their radar screen showing CYR107. There has been a change in Coordinators’ duties with respect to runway usage. There has been a re-focus on allowing aircraft in early. Had all the recommendations of the Administrative Inquiry Report been in place on the date of this incident, it would not have occurred.

Mr. Barnacle pointed out that no discipline was imposed by the employer on the Coordinator or the Flow Rate persons. Mr. Schroeter was the last link in the chain of events which were impacted on by those other persons.

He argued that discipline is only appropriate in cases of culpable misconduct which is something more than ordinary human error caused by inadvertence as was the case here. He urges the grievances be allowed with reimbursement of lost pay or alternatively, the three day suspension be reduced to oral reprimands.

In support of those views counsel cited the following decisions: *Choquette and Treasury Board (Department of Transport), Canada Public Service Staff Relations Board* before Vice-Chairman J.M. Cantin, Q.C. dated March 21st, 1983 (unreported); *Drapeau and Treasury Board (Transport Canada), Canada Public Service Staff Relations Board* before Deputy Chairman G. D'Avignon dated March 24th, 1987 (unreported); *Chase and Treasury Board (Transport Canada), Canada Public Service Staff Relations Board* before R. Young, Board Member, dated September 7th, 1988 (unreported); *Pinsent and Treasury Board (Transport Canada) Canada Public Service Staff Relations Board* before R. Young, Board Member, dated July 7th, 1989 (unreported); *Caruana and Treasury Board (Transport Canada), Canada Public Service Staff Relations Board* before T.W. Brown, Board Member, dated January 26th, 1995 (unreported); *Brode and Treasury Board (Transport Canada), Canada Public Service Staff Relations Board* before J. Korngold Wexler, Deputy Chairperson, dated February 15th, 1995 (unreported) and finally *Boulianne and Treasury Board (Transport Canada), Canada Public Service Staff Relations Board* before M.K. Wexler, Deputy Chairman, dated December 12th, 1990 (unreported).

Mr. Gibson commenced by suggesting the principles set out in *Wm. Scott* (1977) 1 Can. L.R.B.R. 1 are applicable in this case. The first question that must be answered is whether the employee has given just and reasonable cause for some form of discipline. If the answer to that question is in the affirmative, the adjudicator must then determine whether the penalty imposed is an excessive or inappropriate response in all the circumstances of the case. If the answer to that second question is in the affirmative, then the question becomes what alternative measure should be substituted as just and equitable?

Next, he urged that Controllers perform duties of the utmost importance to public safety and will, at times, operate under stressful conditions which demand absolute attention to the procedures for insuring a safe operation of the control of aircraft. He suggested the union was incorrect when it argued that disciplinary action was not appropriate in a situation where "human errors" occur. He argued current labour jurisprudence in Canada supports the proposition that an employer has the right to impose discipline for negligent breach of safety procedures. That right is not restricted only to cases of culpable misconduct. It applies to conduct which is careless or inadvertent. That is particularly so where a potentially dangerous situation might have occurred.

Turning to the quantum of discipline imposed by the employer in this case, he argued that when a safety infraction carries with it potentially severe consequences, an employer is entitled to bypass the principles of progressive discipline and apply a severe disciplinary penalty even in circumstances where the employee has no previous discipline.

Mr. Gibson suggested NAV Canada, is entitled demand a high standard of conduct from employees, like Controllers, who are highly trained professionals.

Next, counsel argued deterrence is an important factor in deciding upon the appropriate level of discipline for a safety infraction. That is particularly so where an employee commits a careless or negligent act which exposes others to a risk of injury or loss of life. Here, the grievors committed safety infractions which placed members of the public in potentially grave jeopardy. The evidence is clear that both grievors are highly trained and highly experienced Controllers who were fully aware of procedures and in particular, their obligation to know when CYR107 was "hot" to altitudes above 1,000 ft. The operating irregularity involving CDR1369 occurred when Mr. Schroeter turned that aircraft five miles inside the separation boundaries of CYR107 and two miles inside that restricted military zone itself. The aircraft was inside there for approximately 40 seconds and inside the separation boundaries for about three minutes. Further, both grievors acknowledged that the incident would not have occurred if they had been aware that CYR107 was hot to 10,000 ft.

In the case of Mr. Schroeter, when he took over the Arrival Low position, he knew he could not see the OIDS properly from his sitting position but he failed to take steps to work within that limitation by standing from time to time to look at the OIDS or, by asking Mr. Dooling to keep an eye on it for him.

As to Mr. Dooling, he was the Supervisor in charge at the time the incident occurred. He had been fully briefed on the NOTAM and had read it earlier in the shift. As the Supervisor he had an added responsibility to know when CYR107 was active and insure that others were also aware of its status. Mr. Dooling conceded at the time he gave Mr. Schroeter the transfer briefing in Arrival Low he did not tell him CYR107 was active because he "forgot". As well, he failed to check the NOTAM or the OIDS.

Turning to the potential mitigating factors which the association urged contributed to the operating irregularity, Mr. Gibson argued that while those factors increased the volume and complexity of the traffic and made it more difficult for Controllers to perform their jobs, they are trained and expected to deal with such circumstances. That is especially so when the volume and complexity of traffic increases. Controllers are expected to adhere strictly to procedures, pay attention and use proper phraseology – the three "P's". Those mitigating factors are not sufficient reason to relieve the grievors of their responsibilities by suggesting the incident occurred as a result of a series of misadventures.

As to the argument of the association that the discipline was inconsistent with the practice under the previous Transport Canada regime, he observed that NAV Canada has made many changes from ways the Federal Government used to conduct business. He urged that the meetings held in early July, 1998 by Mr. Johannson with various Controllers brought to their attention that NAV Canada would be instituting a new disciplinary approach. They would no longer be following the old Transport Canada practices and Controllers were told they would be "held accountable" if an operating irregularity occurred and it was determined they had not followed the three P's.

In support of his argument counsel for the employer cited the following authorities: *Kmet and Kelowna Flightcraft Air Charter Ltd.* (1997) C.L.A.D. 283 (Chertkow); *NAV Canada (Kelly Grievance)* (August 10, 1992) (Thistle) (unreported); *Whittley and Treasury Board (Transport*

Canada) (1987) C.P.S.S.R.B. 31 (Young); *NAV Canada (Senyck Grievance)* (May 12, 1999) (Brown) (unreported); *Wardair Canada Inc*. (1985) 19 L.A.C. (3d) 99 (Chertkow); *Wire Rope Industries Ltd.* (1983) 13 L.A.C. (3d) 261 (Hope); *Board of School Trustees, School District No. 68 (Nanaimo)* (1996) 60 L.A.C. (4th) 129 (Kelleher); *BC Transit* (1993) 33 L.A.C. (4th) 49 (Ready); *Transcona-Springfield School Division No. 12* (1995) M.G.A.D. No. 41 (Teskey); *Oshawa General Hospital* (1976) 12 L.A.C. (2d) 182 (O'Shea); *British Columbia Ferry Corporation* (1993) 37 L.A.C. (4th) 332 (Korbin); *City of Brampton* (1978) 19 L.A.C. (2d) 237 (Shime); *Green and Treasury Board (Transport Canada)* (1998) C.P.S.S.R.B. No. 23 (PSSRB); *Slater Steel Industries Ltd.* (1975) 8 L.A.C. (2d) 135 (Shime); *Canadian Pacific Limited* (1989) C.R.O.A. No. 1941 (M. Picher); *Petrosul International Ltd.* (January 6, 1989) (Chertkow) (unreported); *Toronto Transit Commission* (1985) 22 L.A.C. (3d) 271 (Black) and *Spears and Treasury Board (Transport Canada)* (1987) C.P.S.S.R.B.C No. 53 (PSSRB).

IV

I now turn to my decision in this dispute.

I agree with Mr. Gibson that the principles enunciated in the *Wm. Scott* case are applicable to this dispute. The first thing I must determine is whether or not the employees here have given just and reasonable cause for some form of discipline.

It is well settled law that acts of negligence or carelessness by employees are proper subjects for a disciplinary response by an employer. At the very least, in this case, the grievors have conceded, albeit inadvertently, carelessness on their part in failing to be aware that CYR107 was active to 10,000 ft. at the time the incident occurred.

Mr. Barnacle argued that in the air traffic control environment "human error", where there is no recklessness or gross negligence, ought not to be the subject of a disciplinary response by the employer. With respect, that view has not gained acceptance in current labour jurisprudence. In *Wardair, supra*, I made the following observations at page 105;

> The company had the right to impose discipline for a negligent breach of the safety procedures in the Beatty case and it has the same right in the case before me. While it is true that it could have adopted a non-disciplinary approach, that does not preclude the company from determining that a disciplinary response is appropriate in similar circumstances.

There was discussion between counsel and some evidence during these proceedings about talks between the parties concerning a non-punitive approach to "operational irregularities" situations involving Controllers. By way of stipulated facts it was agreed that NAV Canada has established a Human Factors Committee and has invited the association to participate but the association was unable to provide a representative and the Committee has proceeded in its absence. On or about June of 1999 the association advised the employer that it was ready to participate in the Committee. Kathy Fox, who is Director of Air Traffic Services for the employer met with Bob Thurgur, the Vice President – Technical of the association, and he received a draft document for discussion purposes. As well, the Committee would be talking further about these issues.

However, nothing from those stipulated facts establishes that the employer has agreed, in cases of operational irregularities, to resile from its right to discipline Controllers for acts of carelessness or negligence.

So too, the evidence of what the Department of Transport might or might not have done in the past in that regard is not binding upon NAV Canada. It is a new private sector employer operating the air traffic control system in Canada.

Therefore, on the first question posed in *Wm. Scott*, I have concluded that Messrs. Schroeter and Dooling have committed an employment offence worthy of discipline. In the case of Mr. Schroeter, he failed to make himself aware that CYR107 was active to 10,000 ft. and was negligent when he turned CDR1369 left into the restricted military airspace. As for Mr. Dooling, he was negligent in his duty when he failed to properly brief Mr. Schroeter, who relieved him at the Arrival Low position, as to the active status of CYR107.

Having come to the above conclusion, it is then necessary to examine the second question in *Wm. Scott* and that is whether the three day suspensions given to each of the grievors was an excessive or

inappropriate response in all the circumstances of the case. For the reasons set forth below I have concluded the response by the employer was, indeed, excessive in light of all the circumstances of this case.

In coming to that conclusion it is appropriate to quote from the *Wm. Scott* decision which sets out the parameters that an adjudicator ought to consider in a case of this kind.

While Chairman Weiler in *Wm. Scott* discussed this issue in the context of a discharge case, his findings are just as applicable in cases of lesser discipline, in my view. In determining whether the penalty imposed by the employer was excessive or inappropriate he adopted the findings in *Steel Equipment Co. Ltd.* (1964) 14 L.A.C. 356 at pages 40-41. They are

> 1. The previous good record of the grievor.
>
> 2. The long service of the grievor.
>
> 3. Whether or not the offence was an isolated incident in the employment history of the grievor.
>
> 4. Provocation.
>
> 5. Whether the offence was committed on the spur of the moment as a result of a momentary aberration, due to strong emotional impulses, or whether the offence was premeditated.
>
> 6. Whether the penalty imposed has created a special economic hardship for the grievor in the light of his particular circumstances.
>
> 7. Evidence that the company rules of conduct, either unwritten or posted, have not been uniformly enforced, thus constituting a form of discrimination.
>
> 8. Circumstances negativing intent, e.g. likelihood that the grievor misunderstood the nature or intent of an order given to him, and as a result disobeyed it.
>
> 9. The seriousness of the offence in terms of company policy and company obligations.
>
> 10. Any other circumstances which the board should properly take into consideration, e.g., (a) failure of the grievor to apologize and settle the

> matter after being given an opportunity to do so; (b) where a grievor was discharged for improper driving of company equipment and the company, for the first time, issued rules governing the conduct of drivers after the discharge, this was held to be a mitigating circumstances; (c) failure of the company to permit the grievor to explain or deny the alleged offence.
>
> The board does not wish it to be understood that the above catalogue of circumstances which it believes the board should take into consideration in determining whether disciplinary action taken by the company should be mitigated and varied, is either exhaustive or conclusive. Every case must be determined on its own merits and every case is different, bringing to light in its evidence differing considerations which a board of arbitration must consider.

As well, at pages 5 and 6 in the *Wm. Scott* decision, the learned arbitrator outlined the factors that ought to be considered as to the gravity of the alleged employment offence when measured against the discipline imposed. At pages 5 and 6 he asked the following questions;

> (i) How serious is the immediate offence of the employee which precipitated the discharge (for example, the contrast between theft and absenteeism)?
>
> (ii) Was the employee's conduct premeditated, or repetitive; or instead, was it a momentary and emotional aberration, perhaps provoked by someone else (for example, in a fight between two employees)?
>
> (iii) Does the employee have a record of long service with the employer in which he proved an able worker and enjoyed a relatively free disciplinary history?
>
> (iv) Has the employer attempted earlier and more moderate forms of corrective discipline of this employee which did not prove successful in solving the problem (for example, of persistent lateness or absenteeism)?
>
> (v) Is the discharge of this individual employee in accord with the consistent policies of the employer or does it appear to single out this person for arbitrary and harsh treatment (an issue which seems to arise particularly in cases of discipline for wildcat strikes)?

> The point of that over-all inquiry is that arbitrators no longer assume that certain conduct taken in the abstract, even quite serious employee offences, are automatically legal cause for discharge. (That attitude may be seen in such recent cases as *Phillips Cables* (1974), 6 L.A.C. (2d) 35 (falsification of payment records); *Toronto East General Hospital* (1975), 9 L.A.C. (2d) 311 (theft); *Galco Food Products* (1974), 7 L.A.C. (2d) 350 (assault on a supervisor).) Instead, it is the statutory responsibility of the arbitrator, having found just cause for some employer action, to probe beneath the surface of the immediate events and reach a broad judgment about whether this employee, especially one with a significant investment of service with that employer, should actually lose his job for the offence in question.

The rationale, in my judgment, of the *Wm. Scott* decision is that the penalty imposed by the employer must be measured against not only the seriousness of the employment offence but it must look to the intent of the employee at the time the alleged offence occurred and *all* the circumstances surrounding the incident itself ought to be canvassed by the adjudicator. As Chairman Weiler so distinctly put it – "the point of that overall inquiry is that arbitrators no longer assume that certain conduct taken in the abstract, even quite serious employee offences, are automatically legal cause for discharge". I would substitute "discharge" for a "severe penalty". In the context of the employment relationship here, a three day suspension can be construed as a severe penalty.

Taken in the abstract and given the high safety standards in which Controllers must perform their duties one cannot automatically assume that any breach of those legitimate and high safety standards automatically constitutes an employment offence worthy of severe discipline. There are degrees of negligence or carelessness and there are degrees of potential consequences which must be taken into account.

In this case, as found by the Fact Finding Board there was "no risk of collision". That finding, in my view, was correct. Notwithstanding the NOTAM stated CYR107 was active to 10,000 ft., weather conditions had deteriorated to cloud cover at 1,500 ft. to 2,000 ft. Military aircraft operate in CYR107 VFR only. No aircraft operating in CYR107 could have or would have operated to 3,000 ft., the altitude at which CDR1369 intruded into that restricted airspace.

The evidence revealed significant mitigating factors which contributed, in my view, to the errors committed by the grievors and in particular, Mr. Schroeter's turning the aircraft into the restricted military airspace. Those factors have been canvassed extensively earlier in this Award and in the argument of counsel. Mr. Gibson urged that previous decisions between these parties; *Green and Treasury Board (supra)*, *NAV Canada (Senyck)* and *NAV Canada (Kelly), supra*, stand for the proposition that alleged "mitigating" factors should not nullify discipline or reduce it.

With respect, I disagree. The impact of all the circumstances, both avoidable and unavoidable, contributed to the operational irregularity. Messrs. Schroeter and Dooling were the last link in a chain of events which contributed to the extent that the incident would not have occurred, in my judgment, had any one or more of them not been present. Had the Terminal Coordinator not allowed two aircraft 30 minutes into the system prior to their approved metered times, had air traffic flow management, after there was a runway change from 26 to 08, not continued to flow aircraft for runway 26, had not the ILS for runway 08 right been inoperative, had not the DME for runway 08 left not been unserviceable, had not weather conditions deteriorated so rapidly immediately before the incident then there would have been no need for Mr. Schroeter to extend the downwind leg of arriving aircraft out 25 miles. Simply put, had those factors not occurred and more importantly, had the OIDS screen been placed in such a position in front of the Arrival Low Controller (as was done subsequently by the employer) in all likelihood Mr. Schroeter and/or Mr. Dooling, in spite of the highly stressed Pace 7 situation, they encountered, would have been reminded of the NOTAM information on the OIDS.

When an employer demands the highest of standards from its employees in sensitive safety situations as is the case here, it too owes a duty to give employees working in that environment the best of resources. Allowing the OIDS screen to be unviewable from an Arrival Low sitting position and allowing that situation to continue for some period of time was a significant contributing factor to the incident in question. Given all of the stressful circumstances in which the grievors operated at the date and time in question and given their was no risk of collision and therefore, no potential for a serious incident which would have placed aircraft or persons in jeopardy, I have concluded the response by the employer was excessive and inappropriate in all the circumstances of this case.

Therefore, it is necessary to examine the third question in *Wm. Scott* and that is what penalty ought to be substituted for the three day suspensions given by the employer in this case?

I have carefully considered the numerous cases cited by both counsel on the matter of quantum of penalty. Suffice it to say that each case must turn on its own facts and circumstances. While those cases are helpful in showing how other adjudicators have dealt with quantum of penalty in other factual circumstances, they really are of not much assistance to me in the particular facts of this case.

After carefully considering all the circumstances surrounding the incident in question and the carelessness of the grievors in failing to make themselves aware of the active status of CYR107 and considering that neither grievor has any written disciplinary record and given that the error was not premeditated but a spur-of-the-moment mistake in the most trying of circumstances, I have concluded the three day suspensions ought to be reduced to written warnings. As well, the grievors shall be recompensed forthwith for their three days loss of pay and benefits. It is so awarded.

DATED at Kamloops, British Columbia, this 30th day of November, A.D., 1999.

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MERVIN I. CHERTKOW
Arbitrator