TEAMSTERS CANADA RAIL CONFERENCE

CONFÉRENCE FERROVIAIRE DE TEAMSTERS CANADA

Douglas Finnson
President
Président

Roland Hackl
Vice-President
Vice-Président

1710-130 Rue Albert Street
Ottawa, ON - K1P 5G4
Tél: (613) 235-1828
Fax: (613) 235-1069
www.teamstersrail.ca

Christopher Lowe
Secretary Treasurer
Secrétaire-Trésorier

Don Ashley
National Legislative Director
Directeur législatif national

October 1, 2018

Chief Medical Examiner
Province of Manitoba
210 – 1 Wesley Avenue
Winnipeg, MB R3C 4C6

Dear Sir:

RE: Request for Coroner's Inquest – Hudson Bay Railway Incident September 15, 2018

As you are aware, a tragic incident occurred on September 15, 2018, south of Thompson and near Ponton, MB.

A Hudson Bay Railway (HBR) train, operated by two Teamsters Canada Rail Conference (TCRC) members, at approximately 1530 CDT, encountered a track failure resulting in the derailment of the leading locomotive, followed by the other locomotives in the consist and several rail cars.

The Conductor, aged 38, and Locomotive Engineer, aged 59, survived the initial crash. They were pinned beneath hundreds of tons of wreckage. The train was carrying liquefied petroleum gas (LPG), which was stable. Diesel fuel leaked from the locomotives as a result of the crash.

The short story is that the Conductor died on the scene shortly after 0100 on September 16. The Locomotive Engineer was cut free from the locomotive shortly after and eventually taken to Winnipeg in critical condition. He has life altering injuries.

Since the events of September 15-16, the facts and circumstances have evolved. The following summary is gleaned from first hand, contemporaneous reports from those involved.

The wreckage of the train was discovered entirely by chance by a helicopter crew coming to pick up a prospector. This was two hours after the derailment. No one, outside of the trapped and injured crew members, knew that anything untoward had occurred until a fluke observation by the helicopter crew. No one was coming to help them or even aware that they needed help.

The helicopter picked up the prospecting crew and returned to the wreck site, using incredible skill to set down on a sandbar approximately 50 meters away. The prospector, his assistant, and one member of the flight crew climbed through the bush and wreckage to see if anyone was there. The prospector heard the shouts of the injured crew members and observed a hand sticking out of the window. He climbed down to the crushed locomotive and found the two men, trapped, injured, but alive. The others climbed on top of the wreckage, trying to find higher ground and cell service. Somewhere around 1730 – two hours after the crash – the outside world became aware of the critically injured people in need of help.

At approximately 1830, while the prospector, his assistant and one of the flight crew remained with the injured men, offering them comfort, compassion and hope, the pilot headed to Ponton to pick up two RCMP officers and bring them back to the site. The RCMP arrived at the wreck site around 1845. The helicopter returned to Ponton at around 1850 in order to bring medical aid back to the injured crew members.

At around 2000, the pilot went back to the wreck site to pick up the prospector, his assistant and the other flight crew member. Paramedics, despite being in Ponton, where not allowed to attend the wreck and administer emergency treatment to the injured crew, apparently due to concerns about diesel fuel leakage.

Upon return to Ponton, the crew sought blankets, hot packs, water and medicine to bring back to make the injured crew members more comfortable. They were not permitted to take any medicine or the paramedics to the scene. The helicopter crew delivered the care package and assured the injured crew members that help was on the way.

Thompson firefighters, with rescue equipment, arrived some time later. Their efforts were amazing. They were, however, limited by their equipment which is designed to extricate people trapped in a two ton automobile, not a two hundred ton locomotive.

The Conductor, the autopsy report revealed, bled to death. Paramedics were never allowed to attend to him. The Engineer was cut loose and first saw paramedic treatment more than nine hours after help was called.

Neither family was notified that there had been an incident, let alone that their loved ones were injured for at least nine hours after the first 911 call was made.

It is unclear why paramedics were not allowed to attend the wreck site or how that decision was made, or by whom. These two men both survived the initial crash. The injuries sustained by the conductor were entirely survivable, assuming reasonable medical care. None was forthcoming.

It is our view that all processes, if in fact any exist, failed. No one knew these people needed help; they were only discovered by chance. The paramedics were not permitted to attend the scene. The firefighters, though valiant, simply did not have the equipment to deal with the hundreds of tons of steel trapping these men in the destroyed cab of the locomotive.

The TCRC strongly suggests that the foregoing facts alone warrant a Coroner's Inquest into these tragic events. But there is more. Initial media reports from the TSB suggest that beaver activity may have led to the failure of the box culvert, which also has been referred to as a bridge, causing the derailment.

We have been advised that the former owners of HBR eliminated the beaver control program some three years ago. These programs, which exist at both class one freight carriers (CN and CP) are designed to ensure that there are not significant buildups of water caused by beaver dams in the backcountry. The purpose is to proactively prevent the type of sudden washout that has been suggested to have been a causal factor in this instance.

There are dozens of similar structures across the HBR system, all potentially at risk.

The new owners of HBR have undertaken an investigation into this incident, which is admirable. The TCRC believes that the multiple systemic factors which might have contributed to the incident and its tragic consequences are far beyond the responsibility and scope of the HBR. We have advised the ownership group that we are seeking a Coroner's Inquest into this event and asked the ownership group to join us in that request.

As we understand your mandate, an inquest may be ordered by your office if it serves the public interest. We believe the facts speak for themselves. A train handling dangerous commodities derailed, apparently

due to a track structure failure. No one knew of this event for at least two hours and it was only then discovered by chance. Two workers were seriously injured and trapped in the wreckage.

The Conductor, who made it through the initial crash, suffered serious but survivable injuries, had he received appropriate and timely medical attention.

If, in fact, there has been no beaver control as has been suggested, there is a significant risk that similar events could occur.

It is not the TCRC's desire to inflame this tragic situation. The people living in the communities we serve need to know trains are being safely conducted through their towns and villages. Railroaders – the members we represent – need to have a fundamental faith in the integrity of the rail system. They need to know that they can depend on the track actually being there. The families of these workers need to know that, too.

A colleague of mine once said "there are no papercuts on the railway." I have often quoted that phrase. The work that railroaders due is not simple; there are incredibly long hours and it is a dangerous profession. Our members, their families and the communities they serve need to know that when something goes wrong, people will know and help will be on the way.

The Conductor died as a broken bone bled out. No one knew when the incident happened. No paramedics were allowed to attend the site. The rescuers, despite their best efforts, did not have the equipment to cut these men out of the wreck efficiently.

Our members at the HBR, and across this country, are incredibly grateful and thankful for all the efforts of the prospecting crew, the helicopter crew, the RCMP, the firefighters and the rail employees that assisted in trying to rescue our brothers.

We truly believe that improved processes may have either prevented this incident or, at the very least, ensured that critical medical attention reached these two workers, easing their suffering and perhaps making it possible for a 38 year old man to still be with us.

The TCRC urges you, as Chief Medical Examiner, to exercise your discretion and order an inquiry into these tragic events.

Please do not hesitate to contact the undersigned if you wish to discuss this matter, or require further information or clarification. Thank you for your attention to this matter.

Yours, Respectfully,

Roland Hackl
Vice President - TCRC

cc : Hon. P. Hajdu, Federal Minister of Labour
Hon. M. Garneau, Federal Minister of Transport
R. Donegan, General Chairman, CTY
KC James, General Chairman, LE
W. Geiler, PLBM
K. Affleck, AGT
TCRC Executive Board