

**Statement of  
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**CANADIAN  
PACIFIC**

**Before the U.S. House of Representatives  
Committee on Transportation and Infrastructure  
Hearing on “The Impact of Railroad Injury, Accident and  
Discipline Policies on the Safety of America’s Railroads”**

**October 25, 2007**

**Canadian Pacific  
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Gulf Canada Square  
Calgary, Alberta  
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On behalf of Canadian Pacific, thank you for the opportunity to provide this Committee with information about CP's approach to safety.

Canadian Pacific Railway (CP), founded in 1881, is the sixth-largest Class I railroad in North America. It provides rail and intermodal freight transportation over a 13,300-mile network in Canada and the U.S., serving the principle business centers in the U.S. Midwest and Northeast as well as Canada.

CP's rail assets consist of the Canadian railway division, and its U.S. rail assets operated by two wholly-owned indirect subsidiaries, Soo Line Railroad Company ("SooLine") and Delaware and Hudson Railway Company, Inc. ("D&H"). On October 4, CP completed the transaction to acquire Dakota, Minnesota & Eastern Railroad Corporation and its subsidiaries ("DM&E") which will expand CP's network by approximately 2,500 miles and increase its access to U.S. Midwest markets including agri-products, coal and ethanol. Approval of that transaction is pending before the Surface Transportation Board ("STB").

CP has earned a solid reputation as being a good, cooperative neighbor. "Community" is a part of our core values and is considered the responsibility of every CP employee. CP works with local communities to jointly address concerns and areas of common interest.

### **Executing Our Vision**

CP's corporate vision is to be "*the safest, most fluid railway in North America.*" The safety culture at CP is an integral part of Execution Excellence and we are achieving results. The safety and health of Canadian Pacific employees and the safety of our operations is of paramount importance to everyone who works for this company. A decade ago, CP re-aligned its management team and in the process created a consistent, visible focus on safety that has achieved extraordinary results. From 1996 to year-to-date 2007, CP train accidents and personal injuries fell by 61% and 72% respectively. Furthermore, in seven of the ten years from 1997 to 2006, CP achieved the best system-wide train accident rate among the North American Class I railways. In 2006, the CP train accident rate was 1.54 accidents per million train miles. This was well below the U.S. rail industry rate of 3.6.

CP's safety success is a testament to union/management commitment and involvement in hundreds of safety, health, training and business process activities. We have been building a safety-conscious culture where safety is built into our business processes. It is not a "bolt-on" activity or afterthought – it is how we do business. We have consistently approached safety management using the seven key principles listed. All of them are important factors in our safety success. Our employees recognize these efforts. On employee insights surveys conducted by an external consultant every two years, safety gets high marks; 70% of our employees agree/strongly agree with the statement "I feel that workplace safety receives appropriate attention here." There has been a significant

improvement in this metric over the last few years and we want to continue to improve these results.

## Safety

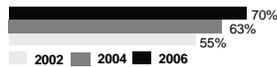
## Executing Our Vision<sup>1</sup>

### Our Approach

- Safety integral to business processes
- Priorities based on risk
- Involvement from all levels
- Free-flowing communications
- Multiple layers of defense
- Committed leadership
- Continuous improvement

### What Our Employees Say\*

- I feel that workplace safety receives appropriate attention here

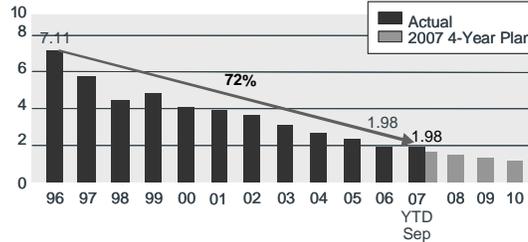


\* Hewitt Survey

### 1. To be the safest most fluid railway in North America

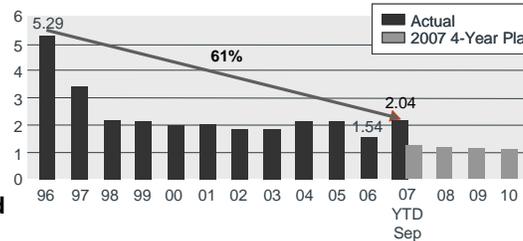
### FRA Personal Injuries - CP

(Per 200,000 Hours Worked)



### FRA Train Accidents - CP

(Per Million Train Miles)



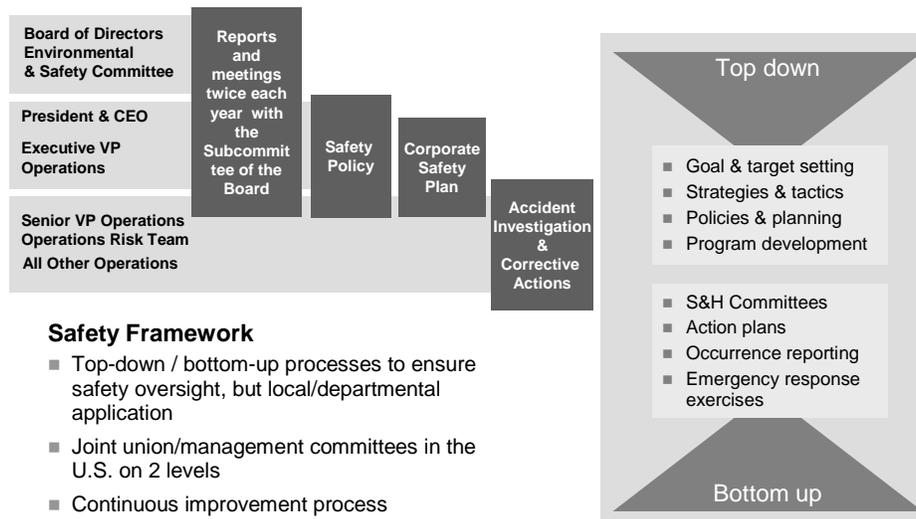
## Safety Framework

How did we get here and how can we ensure continuous improvement going forward? Since 1996, CP has consistently used a framework for workplace and operational safety that involves all levels of employees and management. This framework is founded on the belief that if CP can engage everyone in its workplace, at all levels, we will achieve continuous improvement in all aspects of safety, whether they are regulated or not.

The top-down safety focus starts at the Environmental and Safety Committee of the Board of Directors. Top-down activities include goal and target setting, developing the strategies and tactics, creating the policies, plans and oversight activities and developing the programs and tools needed to effectively integrate safety into day-to-day operations.

The bottom-up action planning directly engages over 1,000 employees who are members of about 100 work-place Health and Safety committees with outreach from these committees to all employees. These committees each produce an annual safety plan with activities targeted at local needs and concerns. They are also responsible for monitoring and auditing the effectiveness of the planned activities. These local plans are one layer of safety plans. CP integrates several layers of safety plans each year, including Service Area Plans, with the Corporate and Work Place Plans.

## Safety Management Oversight



**Corporate Social Responsibility Report on [www.cpr.ca](http://www.cpr.ca)**

Part of the annual safety framework cycle includes processes to monitor the effectiveness of the plans, including incident trend analysis. Plans and activities are adjusted as needed to continuously improve the processes and initiatives.

In addition to the work place committees, CP has senior union and management staff on Safety Committees. In the United States, there are Safety Advisory Boards for the major functional teams with participation from Union General Chairmen and senior managers. In Canada there are two layers providing senior union/management focus; Policy Committees for the major functional teams and a Master Committee. This committee structure and the processes we have built into safety management oversight, ensures a consistent approach with a constant focus on improving all aspects of safety.

The Safety Framework has been institutionalized at CP and will continue to set the platform for ongoing continuous improvement .

CP has also published a Corporate Social Responsibility Report for several years. The current version can be accessed on-line at [www.cpr.ca](http://www.cpr.ca)

## Safely Operating a Railway

Turning now to train operating safety, I want to discuss some of what it takes to operate a railway safely. There are four major elements – track, equipment, train operations and the outdoor environment – with a fifth element - the human factor - overlaying all of the basic elements. It has been said that railroading is an outdoor sport – we operate in all types of weather through all types of terrain and it greatly influences our approach to managing safety. Most of our effort goes into preventing accidents. In the distant past, the primary prevention defenses were manual - things such as planning, inspection and maintenance.

### Safely Operating a Railway

Proactive Elements				Post Accident
Human Factors				
Training & qualifications Communication Medical Fitness for Duty		Fatigue management Error trapping strategies Supervision & Peer observations		Superior Train Accident Investigation Process and Multi-cause analysis & corrective Actions (ISROP)
Track	Equipment	Train Operations	Environment	
Technology				
<ul style="list-style-type: none"> <li>▪ Rail flaw detection</li> <li>▪ Geometry and gauge</li> <li>▪ Vision technology               <ul style="list-style-type: none"> <li>• Joint bars</li> <li>• Ties</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ WILDs</li> <li>▪ Bearing detect.               <ul style="list-style-type: none"> <li>▪ Acoustic</li> <li>▪ Hot Boxes</li> </ul> </li> <li>▪ Truck performance</li> <li>▪ Vision &amp; laser technology for wheels/axles</li> </ul>	<ul style="list-style-type: none"> <li>▪ Signal systems</li> <li>▪ Control systems</li> <li>▪ ATCS</li> <li>▪ Digital cameras</li> </ul>	<ul style="list-style-type: none"> <li>▪ Slide detectors</li> <li>▪ Ground radar</li> <li>▪ Wind detectors</li> <li>▪ Weather Watch</li> </ul>	
Maintenance, Inspection, Practices, Planning & Regulations				
<ul style="list-style-type: none"> <li>▪ Joint mtce.</li> <li>▪ Rail grinding</li> <li>▪ Manual insp. and repair</li> <li>▪ Track renewal programs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Safety insp.</li> <li>▪ Repair</li> <li>▪ Design standards</li> </ul>	<ul style="list-style-type: none"> <li>▪ Marshalling standards</li> <li>▪ Visual inspections</li> <li>▪ Brake tests</li> <li>▪ Documentation</li> <li>▪ Rules &amp; proc.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Winter plan</li> <li>▪ Response and recovery</li> </ul>	

These activities continue to form the fundamental base of our pro-active prevention processes. They include things like track inspection, maintenance and renewal, equipment inspection and repair, train brake testing, and operating rules and practices. In the past few decades, technology started to play an increasingly important role with the wide spread introduction of signaling systems, computer control systems and the first generation of way-side detectors. Technology now plays a much more significant role in our prevention efforts. In fact, we are on the cusp of a revolution in new technology that will do a much better job than humans ever could of inspecting track and equipment.

When a train accident occurs, CP has a very structured approach to determining cause and corrective actions. CP has a small team of professionals with expertise in track, equipment, track-train dynamics (including computer simulation) and failure analysis. Since this team is small, we have trained about 1,500 CP managers in train accident reconstruction and cause-finding methods. Policies, procedures and reference material

has been developed to assist the organization, and the team is available to assist in determining cause when required. They regularly provide analysis of failed components, computer simulations and advise to assist the organization.

There is also an internal requirement for certain train accidents and serious personal injuries to be reviewed by the Health Safety Security and Environment Committee (HSSE), both for cause and corrective actions. The HSSE is comprised of senior Operations staff. It is chaired by the Senior Vice President of Operations and meets weekly.

But what has really enabled CP to be the North American leader in operations safety is our focus on the human factor. All humans make mistakes – many mistakes every day, from forgetting to do something, misplacing something, misunderstanding an instruction or getting distracted. We have systematically tried to understand how and where human error has played a role in accidents and tried to improve those underlying elements that led to an error or a series of errors causing an accident. To assist in this effort, we have a world-class set of investigation tools, called Investigation of Safety Related Occurrence Protocol (ISROP) that encourages understanding of the multiple causes of human error accidents and promotes corrective actions that address all aspects of causality, particularly at the interfaces between people and processes.

### **Human Error and Safety Culture**

Accidents in the railway industry will happen. Some are simply out of railway companies' hands, the result of unavoidable or unforeseeable situations such as an avalanche or a mudslide. Many accidents, however, are the result of human error and are rooted in a plethora of causes. Fatigue, inattention, absent or vague communication, poor judgment, deliberate rule violations, technical or operational errors, inadequate training, actions based on assumptions, complacency, and lack of teamwork are just a few of the human causes that can lead to accidents.

The culture of North American railroads is typically described as militaristic. In this culture, rules are created, people are trained to follow the rules and when a rule is broken, punishment is required to ensure the person who broke the rule won't do it again. Simultaneously, the punishment is supposed to send a message to other persons about the consequences of breaking rules.

For the past decade, CP has been slowly moving away from this militaristic model. We have been introducing an understanding of the "human factor" into our safety processes – how and why people make mistakes and what systemic changes can be made to avoid or trap errors. This has made us much more conscious of where processes may be vulnerable or where multiple layers of defenses may be lacking..

This is a journey; the progress we have made is still fragile. There are wide disparities within CP on acceptance and use of this approach and the various "tools" that have been introduced. And there is much more work to do. But generally, we are trying to move

from a culture that blames<sup>1</sup> the individual who ultimately makes the final error in the chain of accident causation, to one where we ask system-based questions such as: What defenses failed? How did they fail? How can the system be made more resistant?

### **CP's Human Factors Journey**

Dr. James Reason<sup>2</sup> introduced the world to several key concepts about system error, including;

- Latent conditions - The system defenses built by management all have holes in them. These are dynamic holes – they get larger or smaller as the environment changes. These holes often go unrecognized until there is an accident.
- Active Error – These are the errors that breach the system defenses and ultimately, if all the holes in the system line up, result in accidents.

In meetings in 2001 and again in 2005, Dr. Reason reinforced some other key messages with senior CP managers including these principles:

- People are people and making mistakes is part of being human;
- The remedies are mostly in the hands of the system “builders” not the employees who make mistakes;
- We need to create a system that doesn't require violations to get the job done; and
- It is easier to change practices than it is to change values and beliefs, but changing practices will eventually lead to culture change.

CP has used these constructs to help frame our approach to understanding human factors and human error management.

The operating environment of a railway is dynamic, not static. Situations change from hour to hour and the humans executing their daily tasks need to recognize those changes, create a new work plan, recognize the new hazards, communicate to each other and execute the new plan. This is done smoothly and without negative consequences most of the time. Our efforts, described below, have been targeted at improving an already good record and providing ways to continue to strengthen the defenses in our processes.

Changes introduced include elements such as improved instructional material, train accident cause-finding tools; human factor investigation protocol and corrective action guidelines; peer-based job observations; error trapping strategies; on-the-job coaching and mentoring and fatigue management initiatives.

There has always been recognition that people played a key role in safely operating a railway – they needed to be trained and qualified; they needed to have ongoing skills upgrading; they needed to meet fitness for duty requirements; they needed to be supervised to ensure ongoing compliance with the rules. What we have been trying to

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<sup>1</sup> According to Reason, the blame game is about blame, shame, retrain, discipline and write another procedure.

<sup>2</sup> James Reason. Managing the Risk of Organization Accidents 1997

change is how we react to the errors that cause accidents and to identify and change elements of the processes that create the conditions that allow errors to become accidents.

## **Human Error Investigation**

The internal investigation of various CP accidents in the late 1990's led to the development of a more comprehensive and human-factors oriented accident investigation methodology. In 2002, CP introduced the first version of the Investigation of Safety Related Occurrences Protocol (ISROP) to our Canadian operations. This protocol was updated and implemented system-wide in 2005. At this point in time, it's use is mandatory for certain accidents, and optional in all others.

ISROP is a set of tools designed to investigate all aspects of the work system, determine multiple causes of an occurrence and determine appropriate and effective corrective actions. While there are several tools within the protocol, four are of particular importance:

- The first is an aid for the investigator to help determine what kind of error occurred. This is a key determination. Knowing the error type helps guide the corrective actions. Furthermore, most types of errors should not result in employee sanctions.
- The second is an events mapping process that links the various decisions made that led to the accident into a structured picture of what happened and how the various decision points relate to each other.
- The third is a structured approach to collect data using the SHELL model. This approach helps to organize and preserve the information into five categories – the Software such as the policies, the Hardware including all the equipment and materials, the Environment and its impact if any, the Live-wear (the people) both immediately and peripherally involved. The chance of overlooking or omitting key information is reduced.
- The fourth is a guideline for corrective actions. More effective corrective actions will result from understanding the type of error made and the types of latent defects in the system.

ISROP has improved the quality of both our investigations and our corrective actions. Clearly, as we get better at using the tools, we will continue to improve the quality of systemic corrective actions. The impact of ISROP within the Mechanical department at three locations in Canada is currently being evaluated by the Federal Railroad Administration. A final report is expected in 2008.

## **Corrective Actions**

Here are examples of systemic corrective actions that have been made in the past few years. These were designed to trap future errors and were built based both on the type of error made and the type of latent condition identified during investigations.

## *Communication*

A high percentage of human error train accidents and injury caused by train contact include an element of misunderstanding between members of a crew<sup>3</sup>; one person assumes the other knows the sequence of tasks; communication about location of a critical control point is misunderstood; a critical piece of information is missing; a step in the process is inadvertently skipped over and so on. CP has implemented a number of initiatives to lessen the potential for communication error . These include:

*Special vests for new employees.* Most CP employees wear high visibility vests on the job. In 2005, we introduced a different colored vest for new train crew employees and a vest with special markings for new track workers. These vests are ongoing reminders for other members of the work team to pay extra attention while communicating and executing the task at hand

*Job briefings.* There is a formal requirement at the start of every shift for employees to have a job briefing that includes not only the work program but key safety elements and potential hazards. For some crafts these briefings are written and signed and for others it is verbal. The process also requires people working together to stop and re-do a briefing as conditions or the task changes. While job briefings have been a long-standing requirement, they have become much more formalized in the past 5-6 years.

*Crew Resource Management training.* Introduced in 2000, this is soft-skills training for new train crews to promote working together, professional behavior and how to problem solve in a crisis.

*Specific communication protocols:*

*Voice communication of switch position.* This requirement was introduced in 2002 and ensures a crew member on the ground and the member in the cab of a locomotive communicate switch position while at the switch, and thus lessens the opportunity for leaving a switch in the wrong position.

*Communicating 3-point protection.* This requirement ensures the crew member in the cab and the one on the ground have positively communicated to each other before the crew member on the ground is placed in a position of potential harm. This ensures both crew members understand what the other is about to do.

### *Understanding the right way to perform a task*

Another frequent source of error is lack of understanding of a task, process or rule which results in misapplying a rule or using the wrong rule. These misunderstandings can be created during training, by written and verbal instructional material or through long-standing poor work practices. Our efforts to improve understanding include:

*Improving instructional material.* CP has made efforts to improve the quality of our instructional material, using writing techniques such as targeting a grade 6 education level, using actions oriented verbs rather than passive, using bullet points rather than paragraphs and “chunking” information. Examples include our General Operating Instructions and the Red Book for track maintenance.

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<sup>3</sup> The definition of “crew” in this context is all the people involved in the communication chain, irrespective of their craft.

*On-the-job coaching.* Formal classroom training needs to be supplemented by on-the-job training. CP has created processes to train the “coaches” who are peers and to track the coaching activity to help ensure new hires are better prepared for the workplace.

*Peer-to-peer audits.* CP’s Health and Safety Committees have implemented two peer oversight programs where unionized members of committees audit compliance with operating rules. ORCA looks at radio communication and SOFA looks at switching activity. Data collected is confidential and trends are monitored to help determine where to direct safety efforts.

*The “training train” for supervisors.* Two years ago, operations supervisors received hands-on training in key procedures to ensure they understood the rules and the right way for employees to perform tasks, including the ergonomics.

*Proficiency testing.* Proficiency testing is a time-honored operation’s supervisor oversight program that has been enhanced in recent years with additional safety (rather than rules) focus and better management oversight in terms of using failure data to better target opportunities for improvement.

*Safety Rules and Safe Work Procedures Manuals.* In 2003 CP implemented four craft-specific Safety Rules and Safe Work Procedures Manuals. These rule books are a fraction of the size of the earlier manuals and were written in simple, easy to understand language, using pictures and diagrams where appropriate. They were written by large teams of unionized employees and supervisors, both from Canada and the U.S., and vetted by hundreds of employees prior to implementation.

### *Work Place Cues*

A third error-trapping strategy is to provide key information in the work place to trigger a reminder to an employee of a critical control point, event or procedure. Initiatives have included:

*Paper documents* Paper documents such as track maps in Timetables to ensure employees unfamiliar with a territory know where the critical control points are,  
*Way-side signs* Way-side signage has always been used to remind crews to – for example – where to start to blow the whistle for a crossing. We have expanded their use to include some critical points such as the start of a mountain grade, at which point, special operating instructions apply;

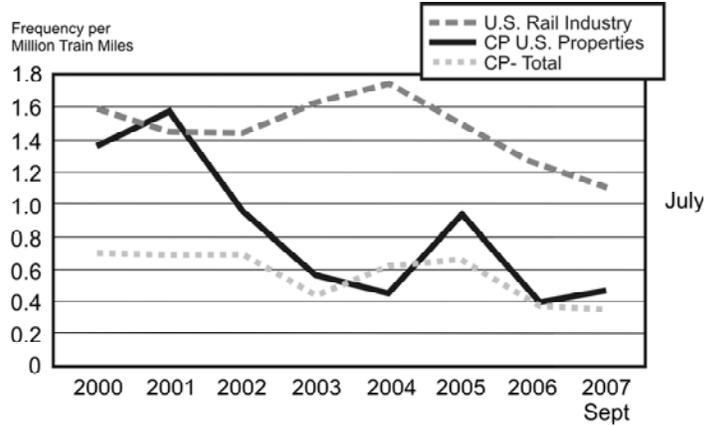
*Computer systems* We have changed a computer system to enhance rail traffic control’s identification of a situation where a train is likely causing broken rails; and

*TGBO* We now issue instructions to train crews in the order in which the crew will encounter restrictions on their trip.

## **Safety Results**

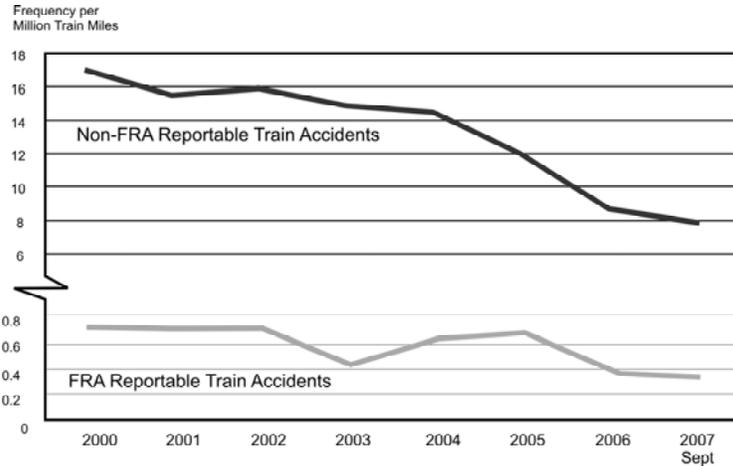
Over the period from 2000 to year-to-date 2007, CP reduced the frequency of operator caused accidents from 0.7 accidents per million train miles to 0.39, while the U.S. rail industry only began to see a reduction in 2005, after the issue became a focus for improvement by FRA

## Train Accidents Caused by Crew Error



In addition to the 44% drop in rate for our FRA-reportable accidents, the non-FRA reportable accidents have also declined 53%. This metric is one we follow closely. In safety parlance, these accidents form the base of the accident pyramid, and to reduce the larger reportable accidents, you have to reduce the frequency of the smaller occurrences.

## CPR Train Accidents Caused by Crew Error



But managing the “Human Factor” is a much more all encompassing process. In addition to elements already mentioned, it includes better employee selection processes, improved training and qualification processes, and better processes to manage fitness for duty including medical standards and managing fatigue.

## **Fatigue Management**

CP’s fatigue management efforts started in 1994 with a ground-breaking North American study of fatigue, called Canalert<sup>4</sup>. This was the first major scientific effort to study crew fatigue in North America<sup>5</sup>, and it precipitated much industry activity. The period from about 1995 – 2002 saw the launch of many projects on many railroads, some successful and some not. In this time period, in addition to crew fatigue, CP also conducted projects for Maintenance of Way and Signals & Communication employees. By 2002, the pace of industry activity started to slow partly because we had no way of systematically measuring the effect on fatigue of the various programs and projects that were tried. The development of an overall fatigue hazard management framework was the brain-child of Dr. Drew Dawson<sup>6</sup>, working with the Union Pacific, and has been subjected to a scientific peer-review process.

The framework has five levels – ensuring we provide adequate sleep opportunity; ensuring employees obtain adequate sleep; identifying and treating fatigue-related behaviors including sleep disorder conditions; identifying and trapping fatigue-related errors and finally, using accident investigation techniques to identify further corrective actions.

In late 2006, CP decided to adopt the UP/Dawson hazard-management framework. We are just beginning to use the software tools that we purchased and we will involve the unions at the appropriate time. As we gain experience with the FAID® software, its use will be expanded to the other parts of our operations – in the North East U.S. and in Canada.

CP views fatigue management as another defense strategy to minimize and trap human error. The emphasis here is on the word “manage”. Fatigue is part of the human condition. It can never be entirely eliminated. But, we believe that tired people can operate error-free under the right conditions – where they are operating as a highly trained team, with good communication protocols and other procedures to “trap” error conditions.

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<sup>4</sup> This was a joint union/management project involving the Brotherhood of Locomotive Engineers, CP, CN and VIA Rail.

<sup>5</sup> Unbeknownst to us at the time, there was a similar effort underway in Australia.

<sup>6</sup> Dr Drew Dawson - University of South Australia and the Centre for Sleep Research

## **Managing Performance for Non-Union and Union Employees**

Turning now to a discussion on the role of managing unacceptable behavior or performance, CP has a clear policy and processes to deal with circumstances where we believe a change is warranted. The Positive Behavior and Performance Development Policy (PB&PDP), is designed to identify and change unacceptable performance and/or behavior; to recognize good performance and to acknowledge an employee's satisfactory achievement of change, development or growth targets. It's focus is on coaching and improving performance -- that is, to help employees be successful.

Where informal coaching fails to achieve the desired changes, formal coaching may be used. This step is intended to clarify expectations and/or confirm performance expectations and may be a documented discussion accompanied by a written Positive Action Plan (PAP) developed jointly by the supervisor and the employee. The PAP outlines the expectations for change in the area of job performance or behavior requiring improvement and the specific steps the employee must take to meet the required performance. It also includes dates for review of goals. An employee who demonstrates success and consistently maintains the required behavior or level of job performance for 24 months, is removed from the automatic progression to the formal discipline process under the Collective Bargaining Agreement should s/he be involved in another incident.

### **Formal Discipline Pursuant to Investigatory Process Required by Labor Contract**

If formal coaching (which may include a PAP) fails to improve the behaviors or technical job performance issues, the next step is formal investigation/ discipline under the applicable Collective Bargaining Agreement. If the transcript of the Collective Bargaining Agreement Investigation demonstrates an employee's responsibility for an incident and a supervisor determines discipline is appropriate, there is a progression of discipline as follows: first incident – 5 calendar day suspension; second incident within 24 months – 10 day calendar suspension; third and final incident warranting formal discipline within 24 months - dismissal from service.

For very serious performance or behavior issues, a supervisor may choose to use the formal discipline process without going through the informal and formal coaching progression. For major offenses, immediate dismissal may be warranted depending upon the gravity of the situation and the specific circumstances. Immediate dismissal could result if an employee is responsible for insubordination, theft, violation of the Drug and Alcohol Policy, gross negligence or unsafe or dangerous conduct on duty.

By the time an employee enters the formal discipline process, there have already been extensive efforts to clarify expectations, provide additional resources or training in the informal process over an extended period of time. Thus, an employee who has not demonstrated a change in unacceptable behavior or performance may move through the formal discipline process quite quickly.

## **Creating a “Just” Reporting culture**

A discipline-free system or a system free of accountability does not work. Individual consequences are necessary to deal with egregious behaviors and outcomes. CP demonstrated this with a project in 1999 in a study carried out in Red Deer and Edmonton in Alberta, Canada. We conducted a special review of every incident that occurred over a six month time-frame to assist our understanding of how to approach human error investigation. To improve reporting, discipline was ‘waived’ for the six month period. There were a few employee – about 4 or 5 – who became “repeat” offenders since there were no adverse consequences.

What we need to create is a balance between a certain amount of discipline and an environment where employees freely report incidents without fear of unreasonable adverse consequences. This is what is known as a “just” reporting culture – based on the concept of justice, where discipline is meted out swiftly when warranted, but most accidents and injuries do not result in punishment. CP is actively pursuing the “just” reporting concept in two ways.

The first, is the FRA-supported Confidential Close Call Reporting System (C3RS). The United Transportation Union, the Brotherhood of Locomotive Engineers – Teamsters and CP management have signed an Implementing Memorandum of Understanding and requested a waiver from certain parts of 49 CFR Part 240, to implement C3RS on CP territory from the outskirts of Chicago, Il to just east of St Paul Mn. We will be the second FRA-supported C3RS Pilot site and hope to have the processes in place to start C3RS reporting by March 2008. We very much appreciate the efforts the FRA has made to advance and support this program and equally, are pleased with the contributions made by our Labor colleagues. CP is keenly aware of the potential to improve safety through better understanding of small events and accident pre-cursors.

In addition to participating in C3RS, CP began an internal dialogue at senior levels of the Operating Department in the fall of 2006, about the future role of formal discipline and how to change our discipline practices. We have sent senior staff from Operations, Safety, Human Resources and Labor Relations to educational seminars on how to create a “just” reporting culture. In early October 2007, we also introduced the topic to the top 125 Operating and Safety officers at our semi-annual Safety Conference, with the help of an external speaker.

We don’t have all the answers yet, but we are looking.

## **Accident/Incident Reporting**

As required by FRA, CP makes available the policy sections of our Internal Control Plan (ICP) to all employees. The ICP contains CP's policy and procedures for reporting personal injuries, train accidents and serious rule violations. It also articulates whistle blower protection and consequences, for both managers and employees, of interfering with reporting procedures. CP has an expectation that occurrences will be reported on the same day they occur, and will be recorded in our information system within two business days. We meet the two day target about 85% of the time. We also, from time-to-time, remind employees and managers of the requirements to report. For example, in the annual Safety meetings in early 2007, a presentation jointly developed by managers and union leaders on employee injury reporting, was delivered to all Engineering Services personnel.

## **Final Words on Safety Culture**

To quote James Reason one more time, culture is "how we do business around here". The manifestation of a safety culture is shared beliefs and values. But what really shapes changes in beliefs and values, are the day-to-day practices that employees encounter as they go about their work. CP has been striving to create a more people-centric approach to safety, where occurrences result less often in blame and more often in recognizing improvements required to the whole 'system'. This is a long journey. Changing culture takes a long time, but I believe we are focused in the right direction.