

IN THE MATTER OF ARBITRATION BETWEEN

METROPOLITAN COUNCIL)	
	“Employer”) Discipline
)	
AND)	BMS Case No. 12-PA-0596
)	
ATU LOCAL NO. 1005)	
	“Union”)

NAME OF ARBITRATOR: John J. Flagler

DATE AND PLACE OF HEARING: April 19 and May 2, 2012; St. Paul, MN

DATE OF RECEIPT OF POST-HEARING BRIEFS: May 4, 2012

APPEARANCES

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THE ISSUE

Whether the discipline issued to the Grievant was “just and merited” pursuant to Article 5, Section 1, of the Collective Bargaining Agreement, and, if not, what is the proper remedy?

BACKGROUND

The Grievant is a bus operator at South Garage. He is represented by the Amalgamated Transit Union (“ATU”), bargaining representative for the majority of Metro Transit’s first-line employees. On September 14, 2011, the Grievant was involved in an accident, which occurred at the traffic roundabout located at 66th Street and Portland Avenue in south Minneapolis. After a full investigation, Metro Transit management, pursuant to its operating policy for safety violations, issued him a written Final Record of Warning. He grieved the discipline and after two formal grievance hearings upholding the discipline, ATU moved the matter to arbitration.

The Grievant began working for Metro Transit in March, 2010. He was given Metro Transit’s Operating Policy and Operator Rule Book and Guide, which both outline Metro Transit management’s expectations of its operators. The Operating Policy provides for a progressive discipline process. With respect to accidents, an employee receives a verbal warning after a first “responsible” accident; a written warning referred to as a “Record of Warning” after a second “responsible” accident; a “Final Record of Warning” after a third responsible accident; and finally, a fourth “responsible” accident, an employee may be terminated. Additionally, the policy penalizes only those accidents which occur within a rolling three-year period. Accidents occurring outside of the three year period may not be used by management to determine discipline. In this case, the Grievant had incurred two previous responsible accidents within three rolling calendar years and was issued a Final Record of Warning for the accident at issue in this case.

An accident would not have occurred “but for” the operator’s failure to prevent it, and he could have done so – the operator will be held “responsible.” “Responsible accident” as used within the Operating Policy equates with “preventable.” This is a higher standard than comparative negligence in tort law. The determination is not whether another party could be partly to blame but rather, employing the Smith System’s Five Safety Keys: Aim High in Steering, Get the Big Picture, Keep Your Eyes Moving, Leave Yourself an Out, and Make Sure They See You, could the operator have prevented the accident?

As part of his training as an operator, the Grievant was taught the Five Safety Keys. He also received yearly remedial training entitled “Right to Know.” In addition to this training, he received remedial training because he was involved in two responsible accidents on the same day in November 2010. Further, after the Grievant returned from a medical leave in September 2011, he received route training specific to his assigned routes – at least two of these routes included a roundabout. This training occurred less than two weeks before the accident at issue in this case.

POSITION OF THE COMPANY

The Company charges that at approximately 6:24 p.m. on September 14, 2011, the Grievant ignored seven traffic signs (directional and pavement) requiring the use of the left lane when continuing on to East 66th Street from southbound Portland Avenue and drove into a white truck that was in the left lane utilized by vehicles legally proceeding straight or continuing in the roundabout. Both vehicles sustained damage.

Article 5, Section 1 of the parties Collective Bargaining Agreement states:

Metro Transit reserves to itself, and this Agreement shall not be construed as in any way interfering with or limiting, its right to discipline its employees, but Metro Transit agrees that such discipline shall be just and merited.

“Just and merited” is the equivalent of “just cause.” And though there are variations on what this definition means in the employment context, arbitrators generally apply the well-established “seven tests of just cause,” which are stated as follows:

1. Was the rule under which the Employee was discharged reasonably related to the safe and efficient conduct of the business;
2. Was the rule clearly expressed and effectively promulgated;
3. Did the Employer conduct a fair investigation into the facts;
4. Do the facts establish the guilt of the Employee;
5. Does the penalty of discharge fit the proven offense;
6. Has the Employee been afforded even-handed disciplinary treatment; and
7. Has the Employer either condoned such behavior in the past or otherwise entrapped the Employee into believing such conduct was acceptable?

In re Enterprise Wire & Enterprise Independent Union, 46 LA 359 (arbitrator Carroll Daughtery, 1966).

The main determination to be made in this case is whether the Grievant could have prevented the accident. As stated above, Metro Transit imposes discipline for accidents in which the operator had the opportunity to avoid the accident employing the Smith System Five Safety Keys, but failed to do so. Comparative fault is not a consideration. This policy by Metro Transit has been deemed reasonable in the arbitration setting:

The Union would interpret “responsible accident” by using Minnesota’s comparative negligence law. In other words, an employee could not be charged with a “responsible accident” unless he or she caused 51% or more of the total negligence leading to the accident.

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The Employer’s concept of “responsible accident” is much broader. They equate “responsible” with “preventable.” Although “responsible accident” is undefined in Employer’s policy, their witness stated that any accident that was “preventable” by using the five safety keys is a “responsible accident.” In other words, if the Grievant’s use of the five safety keys would have prevented the collision, she can be charged with a “responsible accident.” This would be true even if her negligence were only a small portion of the total causing the accident.

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I find the Employer’s interpretation far more persuasive, particularly in the Minnesota Statutes, Section 604.01.

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The public demands and the Employer expects the highest level of professionalism from bus operators. A “but for” test encourages constant cognizance of the driver’s extensive safety training. If an accident would not have occurred “but for” a violation of a Safety Key, they will be held accountable. In the interest of public safety, bus drivers must be ever vigilant of the accident risks that surround them. The five Safety Keys are designed to do just that. Awareness of the “big picture,” “keeping eyes moving,” “always leaving an out,” and “making sure they see you” are all common sense accident prevention techniques.

On the other hand, strict application of the comparative negligence law would allow a driver who is 49% negligent to escape disciplinary consequences. That is an unacceptable standard for a public carrier. (ATU and Metro Transit Case #10-PA-0412, Arbitrator Richard Beens).

The Grievant had been counseled on the Policy after being held “responsible” and disciplined for two previous accidents (both occurring on the same day in November of 2010 and involving him hitting a fixed object). He received a verbal warning for the first accident and a written Record of Warning for the second.

Regarding the third *Daugherty* test, upon learning of the September 13, 2011, accident, management conducted a full investigation. A safety conference was held with Safety Specialist and former CDL certified instructor Mark Kitzerow, in which the Grievant admitted fault. Kitzerow met with the Grievant, viewed a view of the accident, reviewed the accident reports and scene photos, and determined that he could have prevented the accident. He found that the Grievant failed to employ the first of the Five Safety Keys – Aim High Steering – because he was not observant of everything around him – his “zone of awareness.” Kitzerow sent his findings to higher management, who determined that the Grievant would receive a Final Record of Warning pursuant to the Operating Policy.

Smith Garage Manager, Frank Stumpf, after reviewing the evidence presented at the first step grievance hearing, upheld the discipline. One of his considerations was that the Grievant had been involved in three accidents within a relatively short period of total Metro Transit driving time. Due to a medical leave, the Grievant had only driven for Metro Transit for a total of five months and two weeks when the September 14, 2011, accident occurred. Further, Stumpf watched the video of the accident and, as a former Metro Transit instructor, believed that the Grievant failed to follow numerous traffic and directional signs requiring proper lane usage upon approach and within the roundabout. He also learned that the Grievant had received training on this particular route with a Metro Transit Instructor (which included a drive through the 66th and Portland roundabout) just two weeks prior to the accident. Additionally, the Grievant received remedial Safety Keys training in November 2010 after his prior two accidents.

Stumpf also considered that the Grievant’s version of events changed from his initial discussion with Safety Specialist, Mark Kitzerow. Initially, the Grievant admitted fault and stated that he knew he was required to be in the left lane but because he saw, what he perceived to be a customer waiting at the entrance of the roundabout on Portland Avenue, he mistakenly pulled over to the far right lane but then made no attempt to return to the proper left lane as

provided by the traffic laws. When the Grievant grieved his discipline, he stated that the reason he was in the far right lane was because he had not been properly trained by Metro Transit on how to navigate a roundabout and MN DOT allows oversized vehicles such as buses to straddle traffic lanes. He also stated that he believed Metro Transit buses were exempt from following designated traffic signs in roundabouts, which he had not stated to Kitzerow. There are no posted signs indicating buses are exempt at this intersection, nor were Stumpf or Kitzerow aware of any exemption for Metro Transit buses in roundabouts. Further, the Operator Rule Book and Guide specifically states “[A]ll Employees operating buses or other agency vehicles will be held responsible for obeying the traffic laws and rules of the state and municipalities serving Metro Transit.”

Assistant Director of Field Operations, Brian Funk, testified that he took these same things into consideration when he upheld the discipline after the second step grievance hearing. He also specifically considered the Union’s argument that MN DOT allows oversize vehicles to straddle lanes. He determined it did not apply in this situation, however, because upon reviewing the video, it was clear that the Grievant made no attempt to straddle the lane he utilized.”¹

As for the fourth *Daugherty* test, there is no dispute that the accident, did in fact, occur. The determination is whether the Grievant had used the Five Safety Keys, he could have prevented the accident.

In determining whether the penalty fits the offense in this case, one must consider that upon approaching the roundabout, the Grievant ignored posted traffic signs. He failed to yield to oncoming vehicles in the roundabout and attempted to continue on to East 66th from the right lane, in contravention of the posted signs.

All of Metro Transit’s witnesses testified that safety is its highest priority – safety of its customers and its bus operators. The Grievant’s penalty, a Final Record of Warning is not egregious. He was held responsible for his third accident within three years. Given that Metro Transit is a public carrier, this cannot be deemed unreasonable. In 18 months, the first two accidents will drop off of the Grievant’s record for disciplinary consideration.

As to the sixth *Daugherty* test, there has been no allegation that the Grievant was singled out for discriminatory treatment.

Finally, there is no evidence that Metro Transit condones this type of behavior. After his first two accidents, he was disciplined accordingly, the operating policy was reiterated and he was given remedial training. There can be no claim by the Union that the Grievant believed his current conduct was acceptable.

POSITION OF THE UNION

¹ It should be noted that under cross-examination, ATU’s Mark Lawson conceded that it appeared that the Grievant made no effort to straddle the lanes in the roundabout and “straddling lanes” was not at issue in this case.

The Grievant had just returned from a six month medical leave when he was assigned Route 111. Upon his return he learned five new routes over a two to three day period. Prior to his leave, he had been driving a route that included the Portland Avenue and 66th Street roundabout. That route, however, did not require him to turn from Portland onto 66th Street. That earlier route only required that he maintain a northerly direction of travel through the roundabout.

On September 14, 2011, the Grievant was traveling south on Portland in the right lane. (Mark Lawson, ATU Recording Secretary and Metro Bus Driver for 12 years and the Grievant testified that drivers are trained to drive in the right lane whenever possible.) There were two lanes of traffic flowing south and two lanes of traffic flowing north. Just before the Portland and 66th Street roundabout was a bus stop. Having just been trained on five (5) routes he was not entirely sure that the passenger waiting at the bus stop on the far right (west side) of Portland Avenue was not his to pick up. To err on the side of caution, he pulled over into the bus lane. When the passenger signaled that he did not wish to be picked up, the Grievant signaled left and maneuvered out of the bus lane and back into the right lane of southbound traffic.

His next stop was the south (right) side of West 66th Street, which was just outside of the roundabout. He deemed it unsafe to maneuver the bus into the left lane as he moved through the roundabout, only to have to promptly change back into the right lane in order to stop at his next bus stop. Even had he been able to get into the left lane after pulling into the bus stop and before entering the roundabout, he believed it was not safe to maneuver back into the right lane in order to stop at the 66th Street bus stop. As he navigated the roundabout, the Grievant testified that he believed the most prudent thing to do was to leave his left blinker on and carefully proceed east on 66th Street from his position in the right lane traveling southbound on Portland. As he began to proceed east on West 66th Street, a vehicle that was traveling south on Portland in the left lane of traffic collided with his bus. There were no injuries and the property damage does not appear to have been significant.

The Grievant testified that at no time prior to the accident did Metro Transit provide him with training on how to navigate roundabouts. Frank Stumpf, Transportation Manager for the South Garage, admitted that he was not aware of any training provided drivers by Metro Transit with respect in navigating roundabouts. Mark Kitzerow, Safety Specialist, admitted there is no training provided drivers by Metro Transit with respect to navigating roundabouts. Indeed, while the Bus Operator's Rule Book & Guide covers turning at intersections (p. 9), backing up the bus (p. 10), freeway operation (p. 10), and other maneuvers, it does not address roundabouts. See Employer Exhibit 2. Nor did the training manual provided address roundabouts. The current version of the training manual devotes one page to roundabouts (Union Exhibit 5), offering vague "guidelines". This version of the training manual given to the Grievant provides no information whatsoever about roundabouts.

According to Metro Transit, the Grievant should have maneuvered into the left lane from the southbound Portland Avenue bus stop as soon as traffic cleared, and then changed lanes again as he circled the roundabout in order to stop at the 66th Street bus stop. Mark Lawson testified that it is simply not safe for bus drivers to navigate the roundabout as Metro Transit suggests. To leave the bus stop on the west side of Portland, maneuver into the left lane and then

maneuver back into the right lane in order to stop at the bus stop on the south side of 66th Street is a recipe for disaster, according to Lawson. For one thing, “[t]he curve of the circle causes the mirrors to be less effective and hide vehicles in blind spots.” For another, buses suffer tail swing – where the back end of the bus swings wide on the left and right turns. Even the Metro Transit Police Department officer noted that “[d]ue to the positions of the bus stops this seems to be a very difficult maneuver due to the way the bus stop, and the lanes in the roundabout are positioned.

According to Lawson, he and other drivers enter roundabouts from the right lane, because that is what Metro Transit trains drivers; i.e., to travel in the right lane whenever possible. Lawson testified that while navigating roundabouts in his bus, he would straddle both lanes – keeping other vehicles at bay – a concept he only became aware of when he happened to see a video on cable public access put out by the DMV concerning oversized vehicles and roundabouts.

After the September 14, 2011 accident, Lawson went on the Minnesota Department of Motor Vehicle’s (DMV) website and found a DMV brochure, which recommends oversized vehicles straddle both lanes while navigating roundabouts. During the grievance process, Lawson informed Metro Transit management that the DMV recommends oversized vehicles straddle both lanes while in roundabouts (see Employer Exhibit 20), and he urged Metro Transit to consider reversing the discipline given the utter lack of training it provides its bus drivers on navigating roundabouts. He and the Grievant also explained during the grievance process the reasonable and prudent rationale for traveling in the right lane of the roundabout on entering onto 66th Street. Even though Metro Transit policy permits discretion in discipline where there are mitigating factors (see Employer Exhibit 3), Metro Transit nevertheless refused to reconsider the foregoing facts.

Metro Transit contends that the Grievant could have prevented the accident; there is just cause for the discipline. Indeed, the accident could have been prevented. Had Metro Transit provided the Grievant with training on how to navigate the bus through the roundabout. Had the Grievant been told to straddle both lanes while proceeding through the roundabout, the accident could have been avoided. Had the driver to his left yielded to the Grievant large oversized vehicle as he navigated the roundabout, the accident could have been avoided.

Unfortunately, the Grievant received no training whatsoever on how to safely navigate 40 feet of bus through a roundabout. In spite of the fact that Metro Transit’s primary focus is safety of its bus drivers, passengers, and other motorists and pedestrians, it failed to provide driver training on safe navigation of roundabouts. Metro Transit concluded that the root cause of the accident was that the Grievant was in the wrong lane; however, the root cause of the accident was Metro Transit’s lack of training and the juxtaposition of the bus stop with the turnaround. The Grievant had no good options for navigating the roundabout on September 14, 2011. He only did what he had been trained to do; aim high, get the big picture, and anticipate where he was and where he needed to be. He did what he thought was the most reasonable and prudent under the circumstances and that was not to change lanes back and forth as he navigated the roundabout.

Moreover, the question for the Arbitrator is not whether the accident could have been prevented, but whether the discipline imposed was just and merited. That is what the parties' contract requires – that discipline be “just and merited.” According to Webster's Ninth New Collegiate Dictionary, that which is “just” has a basis in or confirming to a fact or reason; is reasonable; conforms to a standard of correctness; acts or is in conformity with what is normally upright or good; is what is merited or deserved as in punishment; and is what is fair. In this case the discipline was not just and merited because the Grievant operated his bus through the roundabout September 14, 2011 in a manner he deemed most prudent given the circumstances.

The concept of “[j]ust cause...embodies the idea that the employee is entitled to continued employment, provided he attends work regularly, obeys work rules, performs at some reasonable level of quality and quantity, and refrains from interfering with his employer's business by his activities on or off the job. An employee's failure to meet these obligations will justify discipline.” R. Abrams and D. Nolan, “Toward a Theory of ‘Just Cause’ in Employee Discipline cases,” 185 Duke L.J. 594 (June 1985).

With the exception of the two minor scrapes he suffered in November 2010 and the roundabout accident on September 14, 2011, the Grievant's record of employment has been exemplary. He accepted full responsibility for the November 2010 incidents, but Metro Transit, not the Grievant, should accept responsibility for the September 14, 2011 accident. While the Grievant does not face termination currently, if the September 14, 2011 accident remains “chargeable,” it in combination with the two minor scrapes he suffered on the same day a year before puts him in a precarious position. He will be at risk for termination if he receives a warning in customer service, with respect to an adherence code, or in the area of safety. See Employer Exhibit 3, Appendix C for adherence codes.

However, even after he explained why he did what he did, and after urging Metro Transit to consider the lack of training he was provided with respect to roundabout navigation as a mitigating factor, Metro Transit continued to ignore reason and maintained its original stance – that the discipline was just and merited. That it was not willing to consider its own culpability demonstrates that its investigation was neither fair nor objective.

Discipline should be imposed for rational purposes. One rational purpose is rehabilitation. Another is deterrence. If the object of the discipline is to teach the driver and to prevent the same or similar type of future occurrences, proper training is the appropriate response – not imposing discipline on a driver who exercised reasonable and prudent judgment under the circumstances.

DISCUSSION AND OPINION

This case sorely needs to be reduced its essentials. The Company charges that the Grievant moved into the left lane where he drove into the white Avalanche pickup truck. The Grievant claims that he entered the right hand lane of the roundabout after inadvertently attempting to pick up a passenger who was actually waiting for westbound bus. He then

remained in the right hand lane when the Avalanche was driven into the side of his bus while encroaching on his space.

An unfortunate omission in the record is any information from the driver of the Avalanche or from her passenger as to their perceptions of what transpired leading to the collision. Standard investigative procedures, of course, routinely seek to interview all parties involved in a motor accident. Thus, the lack of critical input from the driver and passenger of the Avalanche is conspicuous by its absence.

In the face of such omission, a determination as to what actually happened must be pieced together by the Company from testimony of those who did not actually witness the disputed event. These include an SSR District Supervisor Report (Company Exhibit 8), a Metro Transit Police Department Report (Company Exhibit 9) and a Safety Conference Summary (Company Exhibit 11). All three reports contain substantial factual errors including but not limited to the following:

- SSR Report states "...Pickup truck continued south bound on Portland in the inside lane and collided with the left side of the bus.

Correction: The videotape shows that the bus and the truck had both passed the southbound lanes down Portland and had reached the northbound lanes of Portland at time that the Avalanche veered into the side of the bus. It is wrong therefore to state the Avalanche "continued southbound on Portland when the video shows the collision happened after both vehicles had passed the southbound exit. (See front end camera showing point of accident well past the southbound lanes and at the northbound lanes egress.)

- Metro Transit Police Report states "... (Grievant) was supposed to turn to the right rather than stay in the roundabout...passenger front side of her white Avalanche came into contact with the [bus]..."

Correction: The collision took place at least twenty feet before the 66th Street eastbound exit – well short of where the Grievant was "supposed" to turn right, per the MT Police Report faulty conclusion. The videotape shows that the collision took place at 18:24:19 immediately before the bus reached the northbound lanes of Portland Avenue.

Occupying these lanes at that moment were a silver sedan and a maroon SUV which promptly entered the roundabout in front of the stopped bus. The statement in the garbled MT Police Report seems to suggest that by the bus not turning right but staying in the roundabout the Grievant cut off the Avalanche's right of way. This conclusion does not square with the facts.

The plain and certain facts show that the Grievant did not stay in the right hand lane instead of making a required right hand exit. Clearly, no right hand turn was available to him prior to the collision. The only lanes immediately ahead at the moment of impact were the one-way northbound Portland lanes.

- Safety Conference Report "...A collision between the bus and the truck could have been mitigated if the proper lane was used."

Comment: At the hearing the Company witnesses stressed that the departure from the left lane to pick up what the Grievant mistakenly thought was a passenger at a bus stop was an inadvertent error and not, per se, the cause of the collision. Yet the Safety Conference Report plainly concludes that the accident "could have been mitigated if the proper lane (presumably the left hand lane of the roundabout) had been used."

When this obvious contradiction was raised in cross examination, the Company response was that the appropriate driving maneuver for the Grievant to make from the right hand bus stop was to have waited there until the traffic had cleared and then to have crossed over to the left hand lane and back again to his right in time to make his exit to 66th Street bus stop coming up quickly to his eastbound route.

The Company's position asserting that the Grievant should have waited until the traffic cleared and then to maneuver back to the left hand lane ignores the fact that the accident happened during the rush hour. Indeed, this maneuver was more easily recommended than it was to be executed, i.e., more easily said than done.

The videotape shows that traffic had slowed and, in fact, had backed up in the left lane of the roundabout at the time. Further, due to his position at the bus stop, the angle the Grievant was forced to negotiate was so tight that he actually lifted his back wheel over a curb in getting back to the right hand lane of the roundabout. He would have needed to still cross to the inside lane against rush hour traffic only to promptly swing back to the outside lane for the 66th Street exit.

Under such traffic conditions, the Grievant made, as he testified, the safer decision to remain in the right hand lane through the short distance remaining to 66th Street eastbound. The video evidence plainly shows that contrary to the charge that he crossed over into the path of the Avalanche causing the collision, the Grievant remained well within the right hand lane.

At this point this review turns to the version of the collision set forth in the Company's brief where it states:

At approximately 6:24 on September 14, 2011 the grievant ignored seven traffic signs (directional and pavement) regulating the use of the left lane which continuing on the East 66th Street from southbound Portland Avenue and drove into a white truck that was in the left lane utilized by vehicles legally proceeding straight or continuing in the roundabout..." (Company Brief, p. 3)

Analysis and Findings

The scenario presented in the Company Brief repeats certain errors contained in the Reports cited and reviewed earlier. In the interest of correcting these errors and resolving other

contradictions between sworn testimony of Company witnesses and the videotape, I conducted a site visitation and a further study of the videotape in evidence.

It was particularly instructive as to what actually happened to cause the collision, to reconstruct all significant elements of the crash scene including key views from the videotape and relevant sightlines as seen and estimated during the site visitation. I initiated the videotape examination by placing the four camera views together on the computer simultaneously (only three provided useful information).

Each was exactly synchronized on the time registers and all were stopped at 18:24:19 (the precise moment of impact between the truck and the bus). This method of reconstructing the collision revealed the following dispositive facts, as shown in the visual recordation:

The white truck encroached on the right hand lane already occupied by the bus and drove into the bus at a point a few feet behind the driver's platform. It cannot be correctly said that the Grievant "ignored" traffic signals requiring him to use the left lane of the turnaround. Instead it is correct to state that he mistakenly chose to move into the off lane to make what he perceived to be a passenger at a bus stop on his Route No. 111. The passenger it appears was waiting instead for a southbound rather than eastbound bus.

It is important to note at this point that the Company never charged that the Grievant's inadvertent mistake of driving to the right side-situated southbound bus stop was the dispositive cause of the collision in the roundabout. Instead, the Employer argues in its Brief that the Grievant "...drove into a white truck that was in the left lane utilized by vehicles driving straight or continuing in the roundabout."

The videotapes produced by the Company clearly establishes that the charge that the Grievant "drove into a white truck that was in the left lane..." is flat wrong. What the videotape clearly shows is that the white truck (Avalanche) drove forward in the left hand lane past the midpoint of the Grievant's bus and turned into the bus.

Of considerable significance, the videotapes taken from the front to back angle shows the Avalanche with its right side light signal blinking – indicating the driver's attempt to enter the right hand lane already occupied by the bus. (See the sequence time marked from 18:24:11 through 18:24:17). There can remain no doubt that the bus remained in the right hand lane throughout the time the Avalanche first appears in view at 18:24:11 through to the time of impact at 18:24:19.

The key observation proving that the Avalanche ran into the bus in the right hand lane (rather than the bus running into the Avalanche in the left lane as charged by the Company) appears framed in the camera view out the passenger entrance/exit door. At time of the impact, the view out the passenger door plainly shows the curb on the roundabout separation island between the southbound and northbound lanes of Portland Avenue.

This critical view out the passenger door shows the curbing no more than a couple of feet from the right side of the bus, permitting no other than the dispositive, exculpatory conclusion

that the collision could only have resulted from the encroachment by the Avalanche into the right hand lane of the turnaround which was already occupied by the bus.

Despite the foregoing findings of fact which completely exonerate the Grievant of the stated cause of the collision, i.e., that he drove into the truck while supposedly merging into the left hand lane of the roundabout, it might be useful to address some ancillary charges mentioned in the Company Brief, chief of which argues that the Grievant could have prevented the accident by adhering to the Smith System's Five Safety Keys.

The charge that the Grievant failed to use these five basic tenets lacks specificity and therefore stands unproven. In particular, the Company fails to show how any or all of these steps could have enabled the Grievant to escape the sudden swerve of the Avalanche into the upper quadrant of the bus.

Clearly, the Grievant had no immediately open exit lane available to him in the mere seconds before the Avalanche struck. Slamming on the brakes is certainly not an option due to the lack of time or space to make room for the truck to move ahead of the bus into the right hand lane.

No action involving any of these other tenets could have had any positive effect on escaping the truck's sudden swerve into the already occupied lane – no "Aiming High in Steering," nor "Getting the Big Picture," no "Constant Moving of the Eyes," nor was any "Out" available. Finally, one is hard pressed to explain how the Grievant could have made anymore sure the driver of the Avalanche could see the bus than was presented by its sheer bulk, highly visible in the right hand lane.

In sum, the Company's position on the Safety Keys essentially assumes that the Grievant would have entered the roundabout in the left hand lane – if only he had not erred by moving off his assigned route to pick up the bus stop passenger headed for a different destination. The operant fact is that the Grievant did commit this error, a mistake that nullifies any argument that he "should" have followed the Safety Keys (which simply do not in any sense refer to the fact of an inadvertent mistake).

Once the mistake was made, the issue becomes whether or not the Company provided the Grievant with the proper and necessary training to correctly re-enter the roundabout. The short answer is that the Company provided no training whatsoever on how the Grievant was allegedly supposed to re-enter the left lane of the roundabout and promptly maneuver back to the right lane for an early exit to 66th Street east for an upcoming bus stop.

Certainly, the inadvertent mistake of perceiving the passenger at the bus stop as waiting for a No. 111 cannot be considered a proximate cause of the collision. In the lexicon of the law of causation, this error which led the Grievant off the normal approach to the roundabout is called a remote or mediate cause. In the law of causation, a remote cause rarely takes on the force of immediacy necessary for an action to be accounted blameworthy as is the case for proximate, i.e., superseding causes.²

² For discussion of the law of causation see Black's Law Dictionary, 5th ed., West Publishing, St. Paul, MN (1979).

In the context of the instant fact situation, an example of null causation would be the assignment of the Grievant to Route No. 111 “but for” which he would not have been involved in the collision. The proximate or superseding cause, by contrast, was exclusively the incursion into the right hand lane of the roundabout by the driver of the Avalanche. In the absence of any explanatory information from this driver, no conclusion can be easily inferred as to the reason why she drove into the side of the bus from the left hand lane as the Grievant travelled well within the right hand lane – again, this latter fact is clear from the close proximity of the curbstone as seen from the passenger side doorway.

This discussion ought not end without comment on the dispute over the training provided the Grievant on how to handle roundabouts. Both parties’ arguments miss the point by contending over training to enter and exit and which lane should be used while traversing this traffic improvement feature – these contentions fail to deal with the real issue which can be stated as follows: What training was provided the Grievant on how to negotiate his way back through the roundabout to the 66th Street exit after he had mistakenly left the prescribed entrance lane to make what he thought was a passenger for his route?

The hearing record contains testimony on how he should have waited until traffic cleared and then re-entered the roundabout in its left hand lane. None of the testimony, however, suggested that the Company ever addressed the real life situation, together with its heavy traffic complications, that the Grievant confronted as he sought to return to his assigned route. Neither was any training provided him, based on the assumption he would enter the roundabout via the left lane, of any perceptible value in guiding him after he inadvertently crossed over to the right from this assigned approach.

These latter observations are not meant to fault the Company for not training for a contingency not likely to recur, but merely to dispel any notion that the Grievant should have known how to recover from his inadvertent error because he was trained on how to handle such contingency.

In sum, the Grievant made a judgment call to remain in the right hand lane as the safer route through the roundabout to his exit on 66th Street east. For reasons unexplained by dint of the conspicuous absence of information from the driver of the white truck, she veered into the bus as it approached Portland Avenue Northbound. It certainly cannot be correctly asserted, moreover, that the bus cut off her right of way – the Grievant clearly had the right of way by the sheer bulk of the bus moving steadily in the right hand lane. It is fanciful to conjecture that the driver of the white truck was less than completely at fault for driving into the side of the bus under the circumstances. This fact, and this unexplained fact alone states as the prima causa of the collision, without which no collision would have occurred.

DECISION

Based on the foregoing Analysis and Findings, the Grievant did not commit a preventable error as charged by the Company.

The grievance is, therefore, sustained and the remedy requested is awarded, i.e., the warning referring to the accident of September 14, 2011 shall be vacated.

June 11, 2012
DATE

John J. Flagler, Arbitrator