Noteworthy Decision Summary

Decision: WCAT-2008-02573 **Decision Date:** August 29, 2008
Panel: Teresa White, Warren Hoole, Guy Riecken

Section 115 of the Workers Compensation Act - Section 3.3 of the Occupational Health and Safety Regulation – Occupational Health and Safety Program - Administrative penalty - Claims cost levy

This decision is noteworthy as it provides an analysis of the administrative penalty and claims cost levy provisions of the *Workers Compensation Act* (Act) and *Occupational Health and Safety Regulation* (Regulation) and, in particular, it reviews the criteria to be considered in determining quantum when imposing a penalty or levy.

On January 10, 2003, four workers died in a barge and two others were seriously injured. The Workers' Compensation Board, operating as WorkSafeBC (Board), issued two Inspection Reports. The first Inspection Report contained two orders. The first order described a contravention of section 115 of the *Workers Compensation Act*. The second described a contravention of section 3.3 of the *Occupational Health and Safety Regulation*, relating to failure to initiate and maintain an occupational health and safety program. The Review Division of the Board confirmed both orders (*Review Reference #30104*).

The second Inspection Report imposed an administrative penalty of $20,111 for violation of section 3.1(2) of the Regulation and section 115(1)(a)(i) of the Act. The Board also imposed a claims cost levy of $110,541.55 pursuant to section 73 of the Act, as the deaths of two of the workers and serious injury to one worker were due substantially to the failure of the employer to adopt reasonable means for the prevention of injuries or deaths, and their failure to comply with the Regulation. The Review Division varied the second order regarding the claims cost levy in *Review Reference #R0056789*.

The panel confirmed the decision in *Review Reference #30104* finding that the employer failed to ensure the health and safety of its workers in contravention of section 115(1)(a)(i) of the Act. The panel concluded that:

1. The employer did not conduct a risk assessment in a workplace in which a need to rescue or evacuate workers might arise, as required by section 4.13(1) of the Regulation.

2. The employer did not develop and implement written rescue and evacuation procedures as required with respect to:

   a) work in confined spaces or where there is a risk of entrapment, as required by section 4.13(3)(b) of the Regulation; or

   b) work over water, as required by section 4.13(3)(e) of the Regulation.

3. The employer failed to comply with the confined space requirements as set out in Part 9 of the Regulation. Specific violations of Part 9 relating to the accident were set out as follows:

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a) The employer did not identify the void spaces within the barge as required by section 9.2(a) of the Regulation and no determination was made as to whether any such space would require entry by a worker, either in scheduled work activities or as a result of foreseeable system failures or other emergencies, as required by section 9.2(b) of the Regulation.

b) The employer did not ensure that each point of access to the void spaces was secured against entry or identified by a sign or other effective means to indicate the nature of the hazard and the prohibition of entry, and that workers were instructed not to enter, as required by section 9.3 of the Regulation.

c) The employer did not prepare and implement a written confined space entry program before a worker was permitted to enter a confined space, as required by section 9.5 of the Regulation. Rescue of a worker or workers from a confined space required compliance with section 9.5 of the Regulation.

4. Work was being conducted in two shop locations, the storage yard and on a number of vessels. Workers were isolated from one another and communication between them was severely restricted. The employer failed to develop or implement a written procedure for checking the well-being of a worker assigned to work alone or in isolation under conditions which presented a risk of disabling injury, as required by section 4.21(1) of the Regulation. Section 4.21(1) of the Regulation requires such a written procedure when workers might not be able to secure assistance in the event of injury or other misfortune.

5. The employer did not ensure that its workers were made aware of all known or reasonably foreseeable health or safety hazards to which they were likely to be exposed by their work, as required by section 115(2)(b)(i) of the Act.

6. The employer did not provide to its workers the information, instruction, training and supervision necessary to ensure the health and safety of those workers in carrying out their work, as required by section 115(2)(e) of the Act.

7. The employer did not have an occupational health and safety program as required by section 3.3 of the Regulation.

The panel varied the decision in *Review Reference #R0056789* finding:

1. An administrative penalty under section 196(1) of the Act was warranted.

2. The quantum of the administrative penalty in the amount of $20,111 was confirmed.

3. The employer was properly subject to claims cost levies in relation to three of the workers.

With regard to the quantum of the claims cost levy the panel noted that the *Prevention Manual*, policy item #D24-73-1, addresses the imposition of a claims cost levy. The board of directors of the Board amended the policy effective July 1, 2008 and the new policy applied to this appeal. The panel considered a number of factors including the nature of the violation, the nature of the potential hazard created, the employer's history, and the degree of actual risk created by the violation in determining the appropriate quantum of the levy. The panel concluded that the amount of each claims cost levy is to be calculated using 75% of the cost of compensation paid

to each worker, or his dependant(s), up to the statutory maximum set out in section 73(1) of the Act at the time of the accident.

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Guy Riecken, Vice Chair

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I. INTRODUCTION

(1) On January 10, 2003, four workers died tragically in a barge, and two others were seriously injured. One of the employer's workers was overcome by a lack of oxygen in a confined watertight void space. Five other workers, including a firefighter employed by the municipality where the accident occurred, entered the space, to attempt rescue, and they too were overcome. All four fatalities were determined to be due to the oxygen-deficient atmosphere in the void space.

(2) Workers' Compensation Appeal Tribunal (WCAT) decisions are written without personal identifiers. It can be challenging to describe events involving a number of individuals in a readable manner. In this case, there are four deceased workers and two injured workers. There are also a number of witnesses who were questioned during the investigation. We have identified the deceased and injured workers as follows:

- DR was the manager, shop and steel work, for the employer. He died in the accident.
- KR was a labourer and crane operator for the employer. He died in the accident.
- CM was a labourer for the employer. He was injured in the accident.
- SI was a welder/fitter for the employer. He died in the accident.
- KP was the manager, mechanical department for the employer. He died in the accident.
- DP was the firefighter injured in the accident.

(3) There are also a number of other workers who have given evidence, and they are identified using initials.

(4) A number of agencies investigated the accident: the Workers' Compensation Board, operating as WorkSafeBC (Board), British Columbia Coroners Service (Coroners Service), the Transportation Safety Board of Canada (TSB), and Transport Canada Marine Safety. However, on January 13, 2003 the Transportation Safety Board advised the Board that it was entering the accident in its system, "but, because the vessel was alongside [the dock] for maintenance and the personnel involved were essentially shore workers the TSB does not intend to conduct a more thorough investigation."

(5) The Board issued two Inspection Reports. The first Inspection Report 2005030370003 (IR #2005-003), dated January 18, 2005, contained two orders. The first order described a contravention of section 115 of the *Workers Compensation Act* (Act). The second described a contravention of section 3.3 of the *Occupational Health and Safety Regulation* (Regulation), relating to failure to initiate and maintain an occupational health and safety program. The Review Division of the Board confirmed both orders (*Review Reference #30101*).

(6) The second Inspection Report 2005030370095 (IR #2005-095), dated June 30, 2005, imposed an administrative penalty of $20,111 for violation of section 3.1(2) of the Regulation and section 115(1)(a)(i) of the Act. The Board also imposed a claims cost levy pursuant to section 73 of the Act, as the deaths of two of the workers (SI and KR) and serious injury to one worker (CM) were due substantially to the failure of the employer to adopt reasonable means for the prevention of injuries or deaths, and failure to comply with the Regulation. The claims cost levy was in the amount of $110,541.55. The Review Division varied the second order (claims cost levy) by removing the claims cost levy with respect to SI and including the claims costs relating to KP (*Review Reference #R0056789*). The review officer confirmed the remainder of the Inspection Report.

(7) The employer appealed both Review Division decisions to WCAT under section 239(1) of the Act.

(8) There are two appeals involved in this decision. We refer throughout this decision to the "appeal," or the "appeals," either of which encompasses one or the other, or both, as the case may be.

II. JURISDICTION

(9) In considering an appeal, WCAT may consider all questions of fact, law, and discretion arising in the appeal, but is not bound by legal precedent (sections 250(1) and 254 of the Act), including previous WCAT or Appeal Division decisions. However, a WCAT panel may consider and rely on previous decisions based on their persuasive value.

(10) WCAT must make its decision based on the merits and justice of the case, but in so doing must apply a published policy of the board of directors of the Board that is applicable (section 250(2) of the Act).

III. ISSUE(S)

(11) The following issues arise:

1. Did the employer violate the Act and the Regulation?

2. If so, is an administrative penalty warranted in this case?

3. If so, what is the appropriate quantum for any such administrative penalty?

4. Did the Board properly decide to impose a claims cost levy?

5. If so, what is the appropriate quantum of the claims cost levy?

IV. PRELIMINARY MATTERS

A. Parties

(12) On January 10, 2003, the appellant employer was engaged in the repair and maintenance of vessels and related equipment.

(13) Since the accident, the employer has ceased operating and is no longer registered with the Board. A successor continues to operate a similar business. The Board has decided not to collect the administrative penalty and claims cost levy from the employer because of the corporate changes.

(14) This appeal was filed on behalf of the employer in operation at the time of the accident. The employer is represented by legal counsel. All correspondence from counsel refers to that employer. Consequently, we have proceeded on the basis that the employer at the time of the accident is the proper appellant.

(15) The successor to the appellant was notified of this appeal and invited to participate. No response was received.

(16) There are 15 respondents in this appeal. Nine are participating. They are family members of the deceased workers. Some are represented.

B. Constitutional Question and Procedural History

(17) The Board's Accident Investigation Report (AIR) states that at the time of the accident, work operations on the barge were within the jurisdiction of the Board.

(18) The provincial legislation creating the Board and conferring its jurisdiction is the Act. The Board administers the Regulation which imposes occupational health and safety obligations and responsibilities that must be met by all workplaces under the inspection jurisdiction of the Board.

(19) On February 13, 2007, the employer served a "Notice of Constitutional Question" pursuant to section 8(2) of the *Constitutional Question Act,* RSBC 1996, c. 68, on the Attorney General of British Columbia (Attorney General). The employer asserted for the first time in these proceedings that its operation fell within federal jurisdiction relating to navigation and shipping.

(20) The Notice of Constitutional Question set out the issues to be argued as follows:

> (a) whether the Workers' Compensation Appeal Tribunal has jurisdiction to determine the constitutional validity of the orders identified above under sections 91 and 92 of *The Constitution Act, 1867*, 30 & 31 Victoria, c. 3;
>
> (b) whether the orders identified above fall under section 91(1) (navigation and shipping) or 92(13) (property and civil rights) of *The Constitution Act*, 1867;
>
> (c) whether [the employer] was in breach of the applicable provisions of the [Regulation] or *WCA*; and
>
> (d) whether the Administrative Penalty and Claims Cost Recovery were reasonable and appropriate under the applicable law and policy.
>
> [all quotes reproduced as written except as indicated]

(21) The Attorney General participated in the submission process. Both the Attorney General and the employer took the position that WCAT does not have the jurisdiction to address the constitutional question. In addition, the Attorney General submitted that the employer could proceed to have the constitutional issues determined in court.

(22) We agreed. In a preliminary decision dated July 31, 2007, we found that section 44 of the *Administrative Tribunals Act* deprives WCAT of the authority to determine the constitutional validity of the Board's administrative penalty and claims cost levy, and in particular whether the employer's operations were properly under federal jurisdiction, pursuant to section 91(10) (Navigation and Shipping), or provincial jurisdiction pursuant to section 92(13) (Property and Civil Rights in the Province), of the *Constitution Act, 1867*.

C. Procedural Issues

1. Quash and stay

(23) We included a section in our preliminary decision entitled "next steps" and invited submissions from the parties as to how to proceed. The employer submits that WCAT should stay this appeal, and "vacate" the Review Division decision on the basis of WCAT's inability to address the constitutional issue.

(24) In this regard, the employer's main argument is that the inability of WCAT to address constitutional questions means WCAT cannot determine the scope of its jurisdiction

which, in the result, deprives the employer of its appeal rights. The employer says it should not be up to it to pursue a constitutional remedy in court.

(25) We have considered this quandary and have determined to proceed to decide the merits of the employer's appeal. The employer never raised the constitutional argument before the Review Division. Consequently, we have before us two Review Division decisions that are on their face within the constitutional jurisdiction of the Board. Nothing we do deprives the employer of its constitutional remedy. The employer is free to attack the Review Division decision directly in court on the constitutional grounds regardless of whether WCAT has or does not have constitutional jurisdiction.

(26) WCAT does not have any statutory authority to stay an appeal in these circumstances. Furthermore, even if we were inclined to do so (and we are not), WCAT cannot "vacate" the Review Division decision simply because WCAT lacks the jurisdiction to decide the constitutional question. If WCAT were required to stay an appeal and/or quash a Review Division decision in these circumstances, a party need only raise a constitutional question in order to succeed on the appeal. This would be an absurd result.

2. Delay

(27) As part of its submissions about the "stay" issue, the employer has said that it reserved its right to advance an argument related to delay. From this, we infer it may be of the view that WCAT has delayed the resolution of this appeal such that the employer is entitled to a remedy. In that regard, we provide a short summary of the proceedings to date.

(28) The Review Division decisions are dated September 12, 2006. The notice of appeal was received on October 10, 2006.

(29) The Act requires that information regarding appeals of this nature be posted in the workplace. Confirmation that this had occurred was received from the employer on January 3, 2007. WCAT notified potential respondents and invited participation. This process was completed by approximately the end of February 2007.

(30) On February 13, 2007, the employer served the Notice of Constitutional Question. This brought into play the submission process, including submissions from the Attorney General. On July 3, 2007, WCAT wrote to the employer enclosing submissions received from the Attorney General. The employer was invited to make a final response and was given a deadline of July 17, 2007. Nothing further was received.

(31) On July 31, 2007, we issued our decision on the preliminary matter of jurisdiction to decide the "constitutional question."

(32) On August 16, 2007, WCAT received a letter from the employer with respect to vacating the Review Division decision and staying this appeal. We have outlined our response to that above.

(33) On August 17, 2007, WCAT wrote to the employer stating that constitutional questions aside, the merits of the appeals continued to be before WCAT. Further submissions with respect to how the merits should proceed were invited.

(34) On September 5, 2007, the employer wrote to WCAT again, stating that WCAT had not properly delineated the merits of the employer's appeals and how this was independent of the fundamental question of the application of the Act and the Regulation. The employer submitted that if WCAT addressed the merits of the appeal, "[t]he wielding of such powers without jurisdiction flies in the face of the rule of law."

(35) WCAT disclosed the submissions from the employer to the respondents. Two submissions were received, on September 26 and October 1, 2007. These were disclosed to the employer and a reply submission invited. A response was received on October 19, 2007. The employer reiterated its position that it was impossible to move to any other issues in the matter before WCAT.

(36) On November 22, 2007, WCAT wrote to the employer again asking it to state in writing whether it intended to pursue the appeal on the merits. On December 6, 2007, the employer wrote to WCAT stating "most emphatically" that it was not abandoning its appeal.

(37) WCAT wrote to the employer again on December 14, 2007. With regard to what constituted the "merits" of the appeal, WCAT reminded the employer that the merits included the grounds for appeal that the employer set out in its notice of appeal. The employer was directed to file written submissions by January 14, 2008 and informed that the appeal would proceed by way of written submissions.

(38) On January 31, 2008, the employer wrote to WCAT enclosing copies of an affidavit sworn by a legal secretary and a petition for judicial review. The employer said it was its view that the petition should be heard before any further representation was made.

(39) In light of the above, and in the absence of any clear submission from the employer that WCAT should offer a remedy because of delay, we make no finding about delay, other than to summarize what has occurred.

3. Summary

(40) This appeal arises from a tragic event in which four workers died and two were seriously injured. The respondents and their representatives include family members of

the deceased workers and the injured workers. Even if we had the jurisdiction to do so, in these circumstances we would not consider it proper to "stay" the appeal.

(41) Having given the matter due consideration, we have decided to proceed to adjudicate the merits of the appeal, based on the grounds put forward by the employer in the notice of appeal. Unfortunately, the employer has not fleshed out the arguments; but we have the submissions before the Review Division and have listened to the oral submissions at the Review Division oral hearing.

(42) We recognize that the constitutional question has not been resolved, and that if the employer succeeds, WCAT will then be found to have proceeded on the merits without jurisdiction. However, given the employer's emphatic position that it is not abandoning the appeal, and its apparent refusal to proceed to have the constitutional question resolved by a court of competent jurisdiction, in conjunction with its submissions about "delay," we have decided to proceed on the merits of the appeal. The employer's remedy in regard to the constitutional question lies in the courts.

D. Method of Appeal

(43) The employer requested an oral hearing but did not provide any reasons why one was necessary. We have reviewed the criteria in item #8.90 of the WCAT *Manual of Rules of Practice and Procedure*, and the events underlying this appeal. We have concluded that this appeal should proceed based on a read and review of the evidence and submissions on file.

(44) In reaching this conclusion, we note that there is extensive documentation on the file. In addition, an oral hearing was held at the Review Division. During that oral hearing, no witnesses were called. Rather, submissions were made by counsel for the employer and some of the respondents. The only evidence tendered was in the form of a statutory declaration, which is available to us.

(45) Normally, on an appeal considered on a read and review basis the panel considers submissions from the parties, material in the file, and any new documentary evidence. We have requested submissions from the employer several times. Each time, the employer has indicated it cannot provide submissions because it does not know what WCAT considers the "merits." We advised counsel that the merits included those identified by the employer in its "Schedule to WCAT Notice of Appeal." These included:

(a) the investigation proceeded despite a reasonable apprehension of bias;

(b) the Review Division proceeded in a procedurally improper manner;

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(c) the Board incorrectly concluded that the employer violated the *Workers Compensation Act* and/or the *Occupational Health & Safety Regulations*;

(d) the Administrative Penalty and Claims Cost Levy are inappropriate in fact and law and/or a misinterpretation of Board Policy;

(e) the Board proceeded on a mistaken interpretation of its own policies;

(f) the Review Division altered the Claims Cost Levy in respect of [KP] although the Claims Cost Levy with respect to [KP] was not part of the review; and

(g) In the alternative, the Administrative Penalty and Claims Cost Levy are excessive.

(46) In addition to identifying these issues as related to the merits of this appeal, we have reviewed the audio recording and considered the oral submissions made to the Review Division at its oral hearing.

(47) In the absence of any submissions or new evidence from the employer, we have considered the appeal on the basis of the material in the claim file including the submissions and evidence that were before the Review Division. We therefore find that an oral hearing is neither necessary nor appropriate and a fair hearing can be conducted by read and review.

V. BACKGROUND AND EVIDENCE

A. The Accident

(48) The accident underlying this appeal took place on January 10, 2003.

(49) The Board's AIR, which is publicly available on the Board's website, includes an extensive factual recitation of the events surrounding the incident, including the rescue and recovery. The parties are familiar with it. We will not repeat that chronology here, except as necessary to explain our decision.

(50) The barge involved in the accident is constructed of steel. It has fourteen watertight compartments (void spaces) below deck. Workers accessed the barge by way of a steep ramp (at an approximate 45-degree angle to the side of the barge at the time of the accident, because of the effect of the tide).

(51) On the day in question, the barge was being repaired. Repairs were made to boarding ladders, handrails, patches on the cargo side wall, navigation lights, and broken studs on the flanges of void space entry hatches. The employer's accident investigation report, completed by the employer's manager of fleet maintenance, a naval architect (KA), states that the day before the accident, she had discussed the work to be done with DR, the manager of shop and steel work for the employer (and one of the deceased). They looked at "freeboard readings." The readings indicated that there was no reason to think there was any significant water in the voids, and as there was only one day to do work on the barge, it was decided that all jobs would be performed externally.

(52) The location of the entry hatches outboard of the side walls made them susceptible to damage. When the barge was loaded, the entry hatches, covers, and hull sections can be damaged if other vessels strike the side of the barge near the entry hatch locations. When entry hatch cover studs are broken, repairing them requires removal of the entry hatch covers, rendering the void spaces open. The presence of a ladder-like structure immediately beneath the entry hatch would facilitate worker entry. Furthermore, assessment of the barge's integrity can be done by direct observation of whether visible light entered the void space. Such direct observation requires entry into the void space.

(53) There are extended periods (months) during which the entry hatch covers remain closed. As a result, oxygen-deficient atmospheres can develop in the void spaces due to consumption of ambient oxygen by naturally occurring chemical reactions such as oxidation (rusting).

(54) The only way of accessing the #2 starboard void space (the accident location) was through an entry hatch with an opening that measured 18 inches by 14 inches. The size of the entry hatch was too small for rescuers to enter wearing self-contained breathing apparatus. According to the accident investigation conducted by the fire department involved, the depth of the void space was 5.94 metres, or 19.5 feet. Photographs of the accident scene show that access to the entry hatch was difficult. It was not simply a hole in a deck. It was located on the outer edge of the barge and footing/access was limited.

(55) Inside the void space was a "ladder-like structure" that led to the bottom of the space. This consisted of alternating steps and rungs. According to the AIR, the ladder-like structure did not comply with Part 13 of the Regulation. The closed steps were said to limit hand-hold grasp potential. It was considered possible that this structure may have contributed to workers falling into the void space and could have complicated the rescue.

(56) One of the firefighters at the rescue, who went into the void space, described the ladder-like structure as follows:

> It was like almost like ah rebar pipe that comes out maybe 2 or 3 inches and then 6 or 8 inches wide, and then it would hook around like that. The only thing that I didn't, and there was about 2 of them and then you'd step on a piece of ah angle iron was about the 3rd rung. 2 more pieces of rebar an then angle iron. So every, I ah didn't have a problem climbing up and down the ladder. It was, except for the one part where the angle iron comes out and up and I used that as a handhold. And then may-be the 2nd piece of angle iron it was the opposite way so I went to grab it and there was nothing to grab onto and my hands slipped off. And I was holding on with the other hand. That could have been a hazard for your, as a hand hold.[1]

(57) On the morning in question, the entry hatch cover on the #2 starboard void space was opened, and broken studs were removed from the entry hatch flanges. This involved grinding off the damaged studs and replacing them with new studs, and a Neoprene rubber gasket. The employer's accident investigation report says that the cover over the #2 starboard void space was difficult to open because of a vacuum condition in the void space.

(58) DR was the manager, shop and steel work for the employer. He was last seen by a co-worker, BY (a welder), standing on the ladder-like structure below the entry hatch cover in the #2 starboard void space. BY was interviewed during the accident investigation. It is apparent that there was some degree of language barrier, but BY clearly stated that he saw DR standing in the entry hatch, approximately half-way in.[2] DR was at waist height. This was at approximately 9:30 to 9:45 a.m.

(59) The employer's accident investigation report says that DR went down the ladder, stopped halfway and closely inspected BY's work.

(60) BY's evidence was that DR inspected his welding work while standing in the entry hatch. He then gave BY instructions as to where replacement studs could be found.

(61) The evidence from other workers suggests that DR was essentially in charge of the repair work. There has been speculation throughout the proceedings underlying this appeal regarding why DR entered the confined space. Based on BY's evidence we find that DR likely entered the space to inspect BY's work.

1 Witness statement of TC dated January 17, 2003, p. 3.
2 Witness statements of AS and BY, February 4, 2003, p. 48.

(62) BY and another worker interviewed said that they had previously observed DR using the "sniffer" (air-testing device) before going into a hole, and that DR was safety conscious.[3]

(63) BY returned to work, wearing his welding helmet. He was grinding the #3 starboard void space entry hatch flange for approximately 10 minutes. At 10 a.m. BY rapped on the hull of the barge, signalling coffee time. He left for coffee, uncertain of DR's whereabouts.[4]

(64) BY gave evidence to the investigating officer that while he was working on the hatch for the #3 void space, he was also standing up to his waist in the entry hatch.[5]

(65) Another worker, BB, who was present during the interview of BY explained:

> Just…to clarify something. The reason we go down the one rung and sat on the edge. It's a lot safer because it's a real tumble hole edge so we usually sat here with your feet on the rung and he sat on the lip and you could work away. It was the safest point to be in.[6]

(66) While in the coffee room, another worker asked where DR was. BY said he had last seen DR standing in the entry hatch. SI, a labourer/crane operator, said he would go to the barge and check. At 10:20 a.m. SI made a short cell phone call to the office requesting that emergency services be called. Also at 10:20 a.m., coffee time ended.

(67) The office worker who had received the phone call asked where SI was, and stated that wherever he was, something was wrong. KR, a welder/fitter, and CM, a labourer, immediately left for the barge.

(68) BY saw CM enter the #2 starboard void space. The AIR states that it is likely that SI and KR had already entered the space.

(69) Another worker (KR2, the crane operator) gave evidence to the Board investigators that he went in the hole, "just the top rung," held his breath and looked down. He saw his co-workers "all piled up on top of each other."[7]

(70) Events proceeded with calls to emergency services, and other workers arriving at the accident site. KP, despite repeated objections by others, removed his jacket and descended into the void space. One of the workers at the site said that KP said he

[3] Witness statements of AS and BY, February 4, 2003, p. 18, p. 20.
[4] Witness statement of BY, January 10, 2003, p. 29.
[5] Witness statement of BY (with BB present), November 13, 2003, p. 3, p. 7.
[6] Witness statement of BJ, November 13, 2003, comment by BB, p. 8.
[7] Witness statement of KR2, February 3, 2003, p. 3.

could hold his breath, so he would go inside. KR2, who was at the site, said that he heard KP say, "ah shit I'm getting dizzy."[8] KR2 believes KP made it to the bottom of the hole.

(71) When firefighters arrived, one of the firefighters also descended into the void space. The entry hatch was too small for the firefighter to fit through while wearing his self-contained breathing apparatus. He had to hand it to another person, and descend into the hole before it was passed down to him. Witnesses say they heard a crash and realized the firefighter had fallen into the void space.

(72) Rescue attempts were very difficult due to the size of the entry hatch, and difficult access to the site. A fan was set up to blow air into the void space, but its use was ultimately abandoned because it limited access by rescue personnel. Firefighters using breathing apparatus and fall protection ultimately entered the void space. The firefighter, DP, was the first person pulled out of the void space, manually. He was hospitalized with serious injuries but survived.

(73) SI was then pulled out, followed by CM, then KP, DR, and KR. A mobile crane was used to assist in pulling the workers out.

(74) All of the deceased workers died because of the oxygen-deficient atmosphere in the void space. While some sustained injuries, autopsy reports indicate they were not the cause of death.

(75) DR sustained rib fractures, injuries said to be consistent with a fall from elevation. He died because of anoxia.

(76) SI was hospitalized. He succumbed to anoxic encephalopathy on January 17, 2003.

(77) KR sustained injuries consistent with a fall. He also died because of anoxia.

(78) KP did not sustain any physical injuries and died as the result of anoxia.

(79) CM suffered lower back, upper left leg, head, face, and right shoulder injuries. His statement was that he reached the bottom of the void space, but fell from the ladder-like structure while trying to exit after he had become dizzy.

(80) DP, the injured firefighter, suffered a closed head injury with mild hypoxic encephalopathy, multiple rib fractures, and a left pneumothorax.

[8] Witness statement of KR2, February 4, 2004, p. 4.

B. Workers' Evidence

(81) Several of the workers interviewed during the accident investigation gave evidence about their training in safety, and in particular, confined spaces.

(82) CM said that he routinely went into confined spaces. He said he "really wasn't trained" in regard to confined spaces. There was always a fan but no one "ever expressed why." He said that he tested the air before entry "just once in all the times I went down."[9]

(83) When questioned further about the sniffer, CM said that a few days before the accident, DR had showed him how to use the sniffer. He had some idea that "something like 21" was a safe level of oxygen.[10]

(84) CM said he never had ropes or a harness when going into a confined space.

(85) The same month but before the accident, CM had entered a void space with DR. Before entering, DR used the sniffer. As far as CM knew, the sniffer was not tested before use. It gave a reading, as far as he remembered, of 19. He was told by DR to stick together and to say so if he felt lightheaded. Both DR and CM went into the void space. CM said he "stuck by" DR and "they were loading so it was kinda scary."[11] DR went into two other void spaces. Before doing so DR told CM to keep talking and if DR did not answer back CM should use DR's cell phone to call "911" for help. They were not wearing any harnesses. There was no one standing by and no rescue plan.[12]

(86) CM told the investigators that at the time of the accident, he looked into the hatch. As he could not see anything, he went into the void space and saw two workers lying at the bottom. He "noticed it was hard to breathe so I tried to get out. I couldn't make it."[13]

(87) KR2 was asked whether there was any talk about confined space procedures. He said they had "a book and a tester and everything."[14] This worker knew about procedures involving confined space entry permits, although there were none for several years before the accident. He said that they did not wear harnesses when in the spaces because there was nothing to hook onto. He said he went into the void spaces two to three times per month. He said that nobody had ever gone over rescue techniques with him.

[9] Witness statement of CM, May 13, 2003, p. 4.
[10] Witness statement of CM, May 13, 2003, p. 6.
[11] Witness statement of CM, May 13, 2003, p. 9.
[12] Witness statement of CM, May 13, 2003, pp. 8-12.
[13] Witness statement of CM, January 24, 2003, p. 3.
[14] Witness statement of KR2, January 10, 2003, p. 6.

(88) Another employee gave evidence that in his experience, it was common practice in the industry to "pop" a hatch open, and leave it open for a day or two and then enter the void space.

(89) Another worker, TS, said that they frequently went into confined spaces, but always had good ventilation. They had never had any problems. The worker said:

> …we have lots of ventilation. We never we never have problems here, never. And we are the same like family we help each other, we love each other, we play each other, we joke each other. It's the same like family. And that's sad it's over now.[15]

(90) A worker gave evidence that everyone knew how to use the sniffer."[16] Another worker said that there was no calibration gas on-site.[17]

(91) Another worker, BB, was asked about testing of air in void spaces. He said:

> They were all there at the same time and they all knew–they were all working in the same job. They'd say that tank is safe or whatever or this that and the next thing. I'd have preferred a bit of system and safety. We don't have enough eh guys to have one guy in particular doing all the testing. And all the all the all the paperwork on it like you know.
>
> We'd have ideas and they saran wrapped over a hole and put a label on the tanks. Ok for hot work ok for this and that this is all after the fact like.[18]

(92) BB said that he had spoken with DR before the accident about a confined space accident that had recently happened in the Interior of the province, when a worker fell into a wine tank. He said:

> …--funny things that happened. And he normally normally I I'd give him a good worker and as far as I know he was a safe worker because we talked and talked time and time again about tanks and accidents and stuff like that. And especially when that thing happened up at Okanagan with that guy falling in the –I said that just shows you what can happen like in a small wine tank that things only eight feet high for crying out loud.[19]

[15] Witness statement of TS, January 10, 2003, p. 8.
[16] Witness statement of TS, February 4, 2003, p. 43.
[17] Witness statement of JV, January 31, 2003, p. 4.
[18] Witness statement of BB, January 31, 2003, p. 13.
[19] Witness Statement of BB, January 31, 2003, p. 19.

(93) Another worker said there were not a lot of safety meetings/crew talks. They would have some but he always wanted to have meetings. The crew was small and could vary at times. They never got into any kind of "rhythmic kind of program."[20]

(94) Another worker, DS, said, when asked whether there were health and safety meetings:

> Not per se it was more information it was never like a scheduled meeting. But there were numerous decisions about ah procedures and um and we all you know expressed concerns ah that we would have. Like ah some of the -- I recall recently one of the tanks that we had to go into–the ladder was sort of I wouldn't even call it a ladder it was more like a bunch of toothpicks. It was just so rotted with rust–but that was before anybody had to go in.[21]

(95) The same worker stated that he stood behind the company one hundred percent; they had been great to him, and "as far as I'm concerned ah it's up to every individual to take care of his own ass…."[22]

(96) Another of the firefighters said that the ladder-like structure in the #2 starboard void space was irregular, in that it was not consistent in rungs at some point on the way down. There was a sheet metal connection shelf or something similar on the way down that made it irregular. You did not hit every rung consistently, and had to change your handhold on the way down.[23]

C. Employer's Evidence

(97) The employer provided copies of confined space entry permits dated between February 22, 1999 and September 2000. Nine of twenty-nine involved confined space entry on the barge involved in the incident. The permits contain details of the work involved and the required precautions. The precautions listed relate primarily to cutting holes in the deck, and installing fans, in addition to testing air quality. There are no confined space entry permits after September 2000. However, it is apparent that work continued to be done in and around confined spaces. Notably, each permit specifies that a worker would be standing outside of the tank opening.

(98) When asked why the testing and recording stopped, a management employee of the employer said there was too much going on, more equipment, and "guys going off that way, guys going off this way, like off site I mean –."[24]

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[20] Witness Statement of GW, January 31, 2003, p. 18.
[21] Witness Statement of DS, January 31, 2003, p. 9.
[22] Witness Statement of DS, January 31, 2003, p. 10.
[23] Witness statement of DP2, January 17, 2003, p. 6.
[24] Witness statement of PH, November 12, 2003, p. 29.

(99) The employer's accident investigation report, completed by KA, the employer's manager of fleet maintenance (a naval architect), lists the following as unsafe conditions, acts, or procedures which contributed to the incident:

- Workers entered the void without instruction (i.e. no scheduled work).
- Confined space entry precautions were not followed.
- Air quality was not tested – air quality equipment was not utilized despite being available and workers being familiar with its operation.
- Vent fans were not readily available.
- Proper egress was not made.
- Rescue equipment was not readily available.
- Openings in the deck were not marked properly to indicate danger – do not enter.

(100) Recommended corrective actions, according to the employer's accident investigation report were:

- Re-examine confined space entry procedures.
- Continual awareness training of employees of dangers of confined space entry.
- Better identification of dangerous areas.
- Improve co-ordination and communication with local emergency front-line personnel.
- Work with agencies to make them aware of the industry-specific difficulties and challenges that ordinary training does not examine.

D. Details of Alleged Non-Compliance

(101) The Inspection Report (IR#2005-003) dated January 18, 2005 particularizes the employer's non-compliance as follows:

> 1.) The employer did not conduct a risk assessment in a workplace in which a need to rescue or evacuate workers might arise, as required by section 4.13(1) of the Regulation.
>
> 2.) The employer did not develop and implement written rescue and evacuation procedures as required with respect to:
>
> a.) work in confined spaces or where there is a risk of entrapment, as required by section 4.13(3) (b) of the Regulation; or
> b.) work over water, as required by sections 4.13(3)(e) of the Regulation.
>
> 3.) The employer failed to comply with the confined spaces requirements as set out in Part 9 of the Regulation. Specific violations of Part 9 relating to the incident on 2003 January 10 are set out as follows:

a.) The employer did not identify the void spaces within the [barge] (the "Void Spaces") as required by section 9.2(a) of the Regulation and no determination was made as to whether any such space would require entry by a worker, either in scheduled work activities or as a result of foreseeable system failures or other emergencies, as required by section 9.2(b) of the Regulation;
b.) The employer did not ensure that each point of access to the Void Spaces was secured against entry or identified by a sign or other effective means to indicate the nature of the hazard and the prohibition of entry, and that workers were instructed not to enter, as required by section 9.3 of the Regulation.
c.) The employer did not prepare and implement a written confined space entry program before a worker was permitted to enter a confined space, as required by section 9.5 of the Regulation. Rescue of a worker or workers from a confined space requires compliance with section 9.5 of the Regulation.

4.) Work was being conducted in two shop locations, the storage yard and on a number of vessels. Workers were isolated from one another and communication between them was severely restricted. The employer failed to develop or implement a written procedure for checking the well-being of a worker assigned to work alone or in isolation under conditions which presented a risk of disabling injury, as required by section 4.21(1) of the Regulation. Section 4.21(1) of the Regulation requires such a written procedure when workers might not be able to secure assistance in the event of injury or other misfortune.

5.) The employer did not ensure that its workers were made aware of all known or reasonably foreseeable health or safety hazards to which they were likely to be exposed by their work, as required by section 115(2) (b) (i) of the Act.

6.) The employer did not provide to its workers the information, instruction, training and supervision necessary to ensure the health and safety of those workers in carrying out their work, as required by section 115(2) (e) of the Act.

The above demonstrates that the employer failed to ensure the health and safety of its workers in contravention of section 115(1) (a) (i) of the [Act].

(102) The Inspection Report also detailed violations relating to the occupational health and safety program, and the employer's failure to maintain it adequately. This included a lack of regular inspections, lack of written instructions, failure to maintain current records, and a lack of instruction and supervision.

E. Recommendation for Sanction

(103) The recommendation for administrative penalty (recommendation for sanction, or RFS) was completed by a Board officer on January 18, 2005. The summary of the reasons for the recommendation states:

> [The employer] failed to ensure the health and safety of its workers in its disregard of the requirements for confined space entry, including rescue procedures, and requirements for working alone or in isolation which exposed workers to a high risk of serious injury or death. [The employer] failed to provide its workers with the necessary information, instruction, training and supervision to ensure those workers' health and safety. [The employer] failed to adequately maintain an Occupational Health and Safety Program.

(104) The RFS structures the officer's considerations based on a number of questions, which are drawn from the applicable policies.

(105) The RFS summarizes the employer's compliance history in the context of considering whether the employer was found in violation of the same section of Part 3 of the Act or the Regulation on more than one occasion. The employer had been cited on previous occasions for violations of the regulatory requirements for confined space entry, in October 1991, January 1992, and September 1998. After the September 1998 inspection, there were nine permits, dated between February 26, 1999 and September 17, 1999, documenting confined space entry into void spaces on the barge. Maintenance records indicate some work activities that involved confined space entry were conducted after September 18, 2000 but there were no written confined space entry records.

(106) An example was the work done in late November 2001 (this is the confined space entry by DR and CM described above), following heavy weather damage, which would have required confined space entry. There were no records relating to risk assessment, confined space entry, air tests, or considerations for rescue.

(107) Despite the orders in 1995 and 1998 requiring the development and implementation of an occupational health and safety program, such a program that satisfied regulatory requirements was not developed or implemented by the employer by January 2003.

(108) The employer was given an opportunity to make submissions regarding the recommendation for an administrative penalty. The response was received by the Board on May 20, 2005. We reviewed those submissions.

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(109) The decision regarding the administrative penalty is contained in the Inspection Report dated June 30, 2005 (IR #2005-095).

F. Employer's Submissions

1. Evidence of John MacKenzie, naval architect

(110) The employer tendered an affidavit by John MacKenzie, a naval architect. Mr. MacKenzie stated that he was a consultant to ship owners and shipyards on barge repair and repair techniques. Mr. MacKenzie was tendered as an expert in such matters. Mr. MacKenzie was asked to assume that no work was planned inside the confined space on the day in question.

(111) Mr. MacKenzie said that he personally knew DR, who was a skilled shipyard worker, well aware of the dangers of confined spaces. He also considered KP a skilled worker who knew of the dangers of confined spaces.

(112) Mr. MacKenzie said that repairing studs is work that can only be done on the deck and there was no need to enter the void space. Such entry would not be anticipated by management. In his experience, no watch personnel or rescue procedures are put in place when the work is stud replacement. Thus, the failure of the employer to put such procedures in place was not below the standard of a reasonably prudent shipyard and was not the cause of the accident.

(113) We observe that Mr. MacKenzie's understanding that repairing studs is done on deck with no need to enter the void space is inconsistent with the workers' evidence that they sat (or stood) with part of their bodies inside the void space when working on the hatches.

(114) Mr. MacKenzie said that usually, a bar is placed over the void space entryway to indicate that no one should enter. However, a bar could not be used because it would have hindered the work. Because DR appears to have intentionally entered the void space, a bar would not have made any difference.

(115) Mr. MacKenzie said he had observed deceased workers DR and KP instructing other workers on the hazards of confined spaces. He said that the employer's procedures were consistent with good shipyard practice regarding confined spaces.

2. Submissions

(116) As we explained above, the employer has refused to make any substantive submissions regarding the merits of its appeals in this proceeding, because, as the employer stated, it does not know what WCAT means by the use of the term "merits."

(117) We also explained above that we consider the only appropriate avenue for WCAT is to adjudicate the merits of these appeals, leaving aside the constitutional question which must be resolved elsewhere.

(118) Accordingly, we have relied upon the notice of appeal, and the employer's submission to the Review Division, including oral submissions at the Review Division oral hearing.

(119) The employer raised the potential conflict of interest said to arise because the Board investigated possible causes and contributing factors of accidents for which potential failures of the Board itself may be involved. There had been criticism of the Board (essentially for failing to take sufficient steps to ensure the employer was in compliance).

(120) Before the Review Division, the employer submitted that the Board's investigation proceeded despite a reasonable apprehension of bias. The employer said the Board was an active participant in the view of the public and the families. The Board pointed out the lack of procedure in the past, but did not follow up. The Board changed its attitude after the accident. The employer submitted that there are very few penalties imposed after inspections but they are common after an accident. The employer said the Board must have had procedures it could have passed on. The employer asked, "Where were they for 5 years?"

(121) The employer submitted that the very people who do inspections and have the background knowledge dropped the ball, and then were expected to do an impartial inspection.

(122) The employer also objected to the Board's publishing the AIR and publicly announcing the proposed penalty and its amount before the employer had an opportunity to make submissions. The employer suggested the Board may have had a hidden agenda, and that the decision to impose an administrative penalty had already been made, before the employer had a chance to make submissions.

(123) The employer also raised issues relating to factual errors, and objected to the Board's reference to a number of companies (the group of companies to which the employer belongs) related to the employer in considering financial impact.

(124) The employer submitted before the Review Division that it was improper for the review officer to have invited a submission from the Board's Prevention Division. This was tantamount to an appeal court judge asking the judge of first instance what that judge thought, and then hearing what he or she thought. Accordingly, the review officer hearing legal arguments and submissions by a Board officer is a serious procedural flaw.

(125) The employer submitted that the Board incorrectly concluded that it (the employer) violated the Act and/or the Regulation, as follows (summarized in point form):

- There were fundamental errors in the investigation.
- The Board failed to appreciate the practice of shipyards in the region.
- The Board officer went to "great lengths to exclude and ignore the evidence."
- Mr. MacKenzie is a well known and respected naval architect and a leading expert on barge repair. The investigating officer gave no weight to this.
- The procedures underway that morning were standard procedures.
- No confined space entry was contemplated or necessary.
- The employer's operation was not a rogue operation.
- The Board officer was selective in going through the evidence.
- DR's entry was totally unexpected. The investigating officer ignored what flowed from that. Therefore one would not expect normal procedures for confined space to be in place.
- DR was safety conscious and warned BY about confined spaces.
- Standard practice was not to enter without instructions from management. This was a small shop. Everyone interacted daily.
- It was adequate to have that system. Whether this lines up point by point with the Act and the Board is in question but the employer's system is relevant to whether the shipyard was acting in a grossly negligent manner with disregard to safety.
- What was going on was not a risky unsupervised activity.
- The shipyard frequently did confined space work and there had never been a serious incident. Their practices may not have aligned with Board expectations but they worked.
- The investigating officer said the hatch was unmarked and unsupervised. This could not be further from the truth. DR, the supervisor, was standing on the site. He had actual knowledge of the status of the space. This was overlooked by the Board officer as it did not fit with what the Board officer wanted to do.

- A barrier over the space makes no sense. The area was actively supervised. Counsel submitted, "to expect [DR] to put a barrier on top of himself as he went down makes no sense whatsoever."

- The Board's references to lack of training was based on ideology not evidence.

- The air-testing equipment had been demonstrated to everyone.

- Regarding working alone, within a few minutes someone noticed DR's absence and a search was conducted. If a procedure had been in place one would not expect it to work better than that.

- There was no watchman as there was no confined space work expected.

- Regarding training in rescue, if there had been a rescue team, DR would have been the head of the team because he was the most knowledgeable about confined spaces.

(126) Regarding the claims cost levy, counsel for the employer submitted that causation is a key element in section 73, and the fact that the very person who would have led a rescue was the person who went into the confined space is an important fact, that would be important to a judge. There was no causative connection because it is not known why DR went in.

(127) Counsel asked why rescuers consistently override personal safety and established protocols, and take risks. He said that over 60% of confined space fatalities are would-be rescuers. He submitted there is something at work here other than a lack of rescue plans or procedures. Counsel submitted that KP received a direct order not to enter but did. This was a complete override of everything he knew about confined space safety. No one would expect shipyard workers to have anything close to the training of firefighters yet the firefighter short-circuited his training.

(128) Counsel submitted that claims cost levies are rare. They strip away the insurance protection, and therefore should be used sparingly and only where the situation is clear-cut. The claims cost levy undermines the historic trade off. Even a "poor" Board officer could find some deficiency in every workplace. Counsel submitted that it was a principle of statutory interpretation that a statute that takes away rights should be given strict construction. What is stripped away in this case is insurance coverage. There must be more than a mere violation, ideological application, or lack of compliance.

(129) Counsel submitted that the amount of the claims cost levy was excessive. The amount of the administrative penalty and the claims cost levy suggest this was the worse possible behaviour, and it was not.

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G. The Review Division Decision

(130) The review officer identified the issues arising from the two requests for review as follows:

1. Did the employer contravene section 115(1)(a)(i) of the *Act* and section 3.1(2) of the *Occupational Health and Safety Regulations* (the "Regulation")?

2. If so, was it appropriate to impose an administrative penalty and/or a claims cost levy in this case?

3. If so, did the Board impose appropriate amounts?

1. Preliminary issues

(131) Before deciding those issues, the review officer addressed some preliminary issues raised by the employer's representative.

(132) The employer raised a preliminary objection to the participation of the family members of the deceased and injured workers at the oral hearing in the Review Division. The employer argued that the family members did not have standing under section 96.3(3) of the Act as they would not be directly affected by the Board's order. The review officer concluded that it was reasonable to give a liberal interpretation to the words "directly affected" in section 96.3(3), since it referred to family members, even though the majority of orders under Part 3 of the Act would have no financial impact on the family members of deceased workers. She allowed the participation of family members of deceased workers in the reviews.

(133) The employer's representative also objected to the participation of the Board's Compliance Section in the review, particularly to the fact that it was given an opportunity to respond to the employer's submissions. The review officer rejected the employer's argument on this issue. The review officer noted that under item B3.10 of the Review Division *Manual of Practices and Procedures* the review officer determines what information should be obtained, and how, when and from whom. This item also notes that it is common in assessment and prevention reviews for the review officer to request the Board officer to respond to a party's written submissions and attend an oral hearing. This was in the context of review proceedings which the review officer described as inquisitorial rather than adversarial.

2. Bias

(134) In the Review Division proceedings, the employer's representative also objected to the procedures followed by the Board that resulted in the orders in question. He submitted

that the administrative penalty and claims costs levies should be cancelled because the investigative procedures were flawed by individual and institutional bias. The review officer found no evidence to support the allegation of individual bias on the part of the Board officer. The investigation by the officer had been extensive and thorough. In addition to the Board investigation, independent investigations undertaken by other agencies (including the Coroners Service) and by the employer itself reached similar conclusions as those set out in the Board officer's AIR.

(135) With respect to institutional bias, the review officer found that having the Board carry out inspection and investigative functions, as well as making decisions with respect to the imposition of administrative penalties and levies, did not demonstrate bias. She noted that this is supported by legal authority, including the decision of the Supreme Court of Canada in *Ocean Port Hotel Ltd. v. British Columbia (General Manager, Liquor Control and Licensing Branch*), [2001] 2 S.C.R. 781, 2001 SCC 52 (CanLII).

(136) Specifically, the review officer noted the comments by Chief Justice McLachlin in *Ocean Port*, that the overlapping of investigative, prosecutorial, and adjudicative functions in a single agency is frequently necessary for a tribunal to effectively perform its intended role.

(137) In addition, absent constitutional constraints, it is always open to the legislature to authorize an overlapping of functions that would otherwise contravene the rule against bias. The review officer noted that policy item #D2-111-1 of the *Prevention Manual* recognizes that the president/chief executive officer of the Board has the authority to assign the powers and responsibilities described in Part 3 of the Act to divisions, departments, categories of officers and individual officers of the Board. The president's assignment currently in force gives any officer of the Board the authority to levy an administrative penalty under section 196 or impose levies under section 73.

3. Contravention of section 115(1)(a)(i) of the Act

(138) The review officer then turned to the issue of whether the employer had contravened section 115(1)(a)(i) of the Act as described in order #1 in the Inspection Report (IR #2005-003). Section 115(1)(a)(i) is a general requirement that an employer must ensure the health and safety of all workers working for that employer. In order #1 of IR #2005-003 the Board officer found the employer was in violation of numerous provisions of the Regulation and the Act relating to risk assessments, written rescue and evacuation procedures, confined space procedures, working alone procedures, hazard assessment, and the training, supervision and instruction of workers. The Board officer found that these examples of non-compliance demonstrated that the employer failed to ensure the health and safety of its workers in contravention of section 115(1)(a)(i) of the Act.

(139) The review officer accepted the employer's evidence that some information, supervision and coaching regarding health and safety matters was provided to the workers in the course of their work. However, she noted that during the oral hearing the employer's representative on at least three occasions acknowledged that the employer's practices may not meet the Board's criteria, but argued that the employer's was not a "rogue operation" since it did not involve behaviour that was a marked departure from normal shipyard standards and practices.

(140) The review officer concluded that following industry standards or practices cannot be used as a defence to either a violation or an administrative penalty if those industry standards or practices are themselves deficient. She found that although there was some evidence of mentoring or training, the whole of the evidence overwhelmingly revealed a lack of appropriate training, instruction and setting out of processes and procedures. For example, she noted that in his statement of November 12, 2003, the operations manager said that he knew air testing was not carried out when confined space work was undertaken. He also confirmed that there was no confined space rescue plan in place.

(141) The review officer acknowledged the employer's affidavit evidence from the naval architect about health and safety procedures in the employer's operations, but also noted the employer's accident investigation report addendum completed by the employer's manager of fleet maintenance (also a naval architect) which acknowledged a number of health and safety deficiencies in the employer's operation. Having regard to the acknowledged deficiencies and noting the lack of a defined rescue plan and regular training, the review officer concluded that the employer fell short of ensuring a safe workplace.

4. Contravention of section 3.2(2) of the Regulation

(142) The review officer next addressed the issue of whether the employer had contravened section 3.2(2) of the Regulation. This section requires an employer to maintain an occupational health and safety program. The review officer again noted the deficiencies in its occupational health and safety program acknowledged by the employer in its accident investigation report. She concluded that the whole of the evidence established a contravention of section 3.2(2) of the Regulation.

(143) Given her findings with respect to the employer's contravention of section 115(1)(a)(i) of the Act and section 3.1(2) of the Regulation, the review officer denied the employer's request for review of IR #2005-003.

5. Whether an administrative penalty should be imposed

(144) The review officer then considered whether an administrative penalty should have been imposed under section 196(1) of the Act, which provides that:

> 196 (1) The Board may, by order, impose an administrative penalty on an employer under this section if it considers that
>
> (a) the employer has failed to take sufficient precautions for the prevention of work related injuries or illnesses,
>
> (b) the employer has not complied with this Part, the regulations or an applicable order, or
>
> (c) the employer's workplace or working conditions are not safe.

(145) The administrative penalty was imposed by the Board in the June 30, 2005 Inspection Report (referred to as IR 2005-095).

(146) The review officer referred to policy item #D12-196-1 of the *Prevention Manual*, which provides that the Board will consider imposing an administrative penalty where one or more of a number of criteria are met, including whether the violation of the Act or the Regulation resulted in a high risk of serious injury, illness or death. In the RFS the Board officer had concluded that the employer's failure to comply with sections 3 and 9 of the Regulation as described in order #1 of IR #2005-003 had resulted in a high risk of serious injury, serious illness or death. The officer concluded specifically that the employer's failure to identify and prohibit entry into confined spaces and the lack of a rescue plan had exposed workers to a high risk of serious injury or death.

(147) The review officer noted that the employer's representative did not provide submissions on the issue of whether the specified violations resulted in a high risk of serious injury or death. Given that the employer's work includes confined space entry work on a regular basis, and that the investigation leading to the orders arose from an accident in which four workers died and two others were seriously injured, the review officer concluded that the violations resulted in a high risk of serious injury or death. She also noted that the officer had identified evidence that showed that the other criteria under policy item #D12-196-1 were met, but in light of her finding regarding the high risk nature of the violation, it was not necessary to review those criteria. The finding that the violation was high risk was sufficient to support a conclusion that the Board officer was correct to consider imposing an administrative penalty.

(148) The review officer next considered whether the employer had exercised due diligence to prevent the violations of the Act and the Regulation. Section 196(3) of the Act provides that the Board must not impose an administrative penalty if the employer exercised due diligence to prevent the circumstances described in section 196(1). "Due diligence" is described in policy item #D12-196-10. It states that persons may establish the exercise of due diligence by showing, on a balance of probabilities, that they took all reasonable care. This involves a consideration of what a reasonable person would have done in the circumstances. The review officer acknowledged the employer's

evidence and submissions that its procedures were consistent with industry standards. She concluded, however, that the employer did not do everything that was reasonably practicable to maintain an occupational health and safety program and to ensure the safety of its workers. Again, the review officer noted that the employer's accident investigation report identified necessary corrective actions to ensure worker safety, including the following which were not evident in the employer's health and safety program: regular inspections, the identification of hazardous conditions, the availability of formal training and practice, written instructions, a rescue plan and training drills. The review officer concluded that the employer had not exercised due diligence to prevent work-related injuries, and that the Board "had the right" to impose an administrative penalty.

(149) The review officer considered the other factors set out in policy item #D12-196-1, including whether an administrative penalty was warranted to motivate the employer and other employers in the province to comply. She noted that the employer appears to have become complacent about the need for formal training and the implementation of an occupational health and safety program. She considered the employer's submissions to show a reliance on ad hoc mentoring and supervision, and adherence to industry standards, and that the employer believed these to be sufficient. She also noted the employer's non-compliance with prior orders, the significance of the violations, the employer's apparent belief that it had not neglected its responsibilities, and the employer's suggestion that the Board should take responsibility for the violations. This last point related in part to the employer's submission with respect to the fact that there was no indication that the Board followed up to ensure compliance after issuing orders in 1998 that the employer had violated the Regulation. The review officer found that, although the employer had taken some steps to comply after 1998, the need for motivation was demonstrated by the limited corrective actions that were taken. She concluded that an administrative penalty was appropriate to emphasize to this and to other employers the importance of complying with the Act and the Regulation and ensuring health and safety in the workplace.

6. Penalty amount

(150) The review officer turned to policy item #D12-196-6, which deals with penalty amounts. This policy provides that category A penalties (the larger of two possible basic penalty amounts) are imposed where the violation was high risk or resulted from the employer's wilful or reckless disregard for compliance with the Act or the Regulation. She was not persuaded that the employer wilfully and recklessly disregarded the Act or the Regulation. Since she found, however, that the violations created a high risk of serious injury or death, a category A penalty was supported.

(151) The review officer also agreed with the Board's decision to increase the basic category A penalty amount by 30%. She noted the variation factors set out in policy item #D12-196-6, and concluded that the circumstances of the case were sufficiently

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exceptional to justify departing from the basic penalty amount. In particular, she cited the following factors as supporting the upward variation: the significant degree of risk to which the worker's were exposed as a result of the employer's violations; the fact that the employer had taken little action to overcome deficiencies identified in previous orders; the fact that the employer was aware of the dangers that resulted from noncompliance; and, the lack of persuasive evidence upon which to vary the Board's decision to increase the basic penalty amount by 30%. The review officer confirmed the penalty amount imposed by the Board.

7. Claims cost levy

(152) In addressing the claims cost levy, the review officer observed that section 73(1) of the Act gives the Board a broad discretion to levy and collect from the employer all or part of the claims costs where an employer's violation was a substantial cause of death, injury or disablement by occupational disease. The review officer considered the following criteria for the imposition of a claims cost levy set out in policy item #D24-73-1:

- Whether the grounds for an administrative penalty under policy item #D12-196-1 been met; and

- Whether a serious injury, disablement due to occupational disease, or a death, resulted from a violation of the Regulation.

(153) In light of her findings with respect to the employer's violation of section 115(1)(a)(i) of the Act by way of noncompliance with a number of requirements of the Regulation, as well the violation of section 3.1(2) of the Regulation, the review officer found that the first of the two criteria was satisfied.

(154) In addressing the second criterion, the review officer acknowledged the employer's submission that DR's entry into the confined space was unplanned. The employer's representative had argued that because no confined space work was planned that day, no procedures for confined space work would be planned, or be expected to be in place. The review officer noted, however, that the Act and Regulation require that numerous procedures be in place irrespective of whether the associated work is planned. Specifically, the requirements outlined in sections 9.2 to 9.5 of the Regulation must be met, but were not in this case.

(155) With regard to the link between the employer's violations and the injuries and deaths, the review officer referred to a number of research articles relied on by the case officer to show that a lack of worker training substantially led to death and injury.[25]

[25] Jan Manwaring and Carol Conroy, *Occupational Confined Space-Related Fatalities*: Journal of Safety Research, Vol. 21(4) (1990); *Worker Deaths in Confined Spaces DHHS* (NIOSH) Publication No. 94-103 January 1994; *Criteria for a Recommended Standard: Working in Confined Spaces* DHEW (NIOSH) Publication No. 80-106 (September 1979); *NIOSH Alert: Request for Assistance in Preventing Occupational Fatalities in Confined*

(156) The review officer acknowledged the argument by the employer's representative that by the Board's own analysis 60% of all people lost to confined space incidents are rescuers. She noted that this statistic is discussed in an article about a barge incident in 1993 that is "eerily similar" to the incident in this case.[26] The review officer noted that the author of the article (Bob Salo, a rescue instructor with 27 years of fire department experience) reviewed a 1993 event and found that the workers were inadequately trained in the potential dangers of confined spaces where rusting was visible. He also noted that the workers in that case did not have a rescue plan. In his view, the lack of training, or inadequate training, puts employees at great risk, and having a "little training" in confined space rescues often gets the individuals involved in more trouble.

(157) The review officer also found that there was ample evidence that training benefits emergency first responders, especially through simulated rescue operations. Research also confirms the effectiveness of frequent emergency training in saving lives.[27] She noted the evidence of the Board officer that there was a lack of training, including the following:

- Written entry procedures were not available to workers.
- When interviewed, workers were unable to demonstrate a complete understanding of confined space entry requirements, including rescue procedures.
- There was an absence of adequate written materials.
- There was no rescue plan for barge void space entry.
- There was no written evidence of rescue procedure training or practice drills.
- There was a failure to develop a confined space entry program.

(158) The review officer found that there was an overwhelming body of knowledge that supports a conclusion that hazard awareness, rescue training, and regular training drills would result in a more reasoned and measured rescue response. She found that in this case such procedures were not in place. She was satisfied that the evidence

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Spaces DHHS (NIOSH) Publication No. 86-110 (January 1986); *NIOSH In-house FACE (Fatality Assessment and Control Evaluation) Report* 2003-07, February 12, 2004.

[26] Bob Salo, *The Great Escape*, Occupational Health and Safety Canada vol.13 (5): 50-56(September 1997).

[27] Randal Beaton and Clare Johnson, *Instrument Development and Evaluation of Domestic Preparedness Training for First Responders,* Prehospital and Disaster Medicine 2002 July 01;17(3): 119-125; Michael R. Roop, *Confined Spaces – Rewriting the Rules of Rescue*, Occupational Health and Safety, Vol. 68, No. 2 (Feb. 1999) pp. 32-39; Alexander Cohen, *A Multidimensional Evaluation of Fire Fighter training for Hazardous Materials Response*: First Results from the IAFF Program, American Journal of Industrial Medicine 34:331-341 (1998). Public Health Reports, Vol. 110, No. 6, pp. 701-702; *Injury Prevention and Control*, 6th World Conference, Les Presses de l'Universite de Montréal, Montreal, Quebec, Canada, May 12-15 2002. Journal of Applied Behavior Analysis, 1981 Fall; 14(3):249-60.

supported a conclusion, on a balance of probabilities, that the employer's violations were a substantial cause of death and injury.

(159) In reaching this conclusion, and in addressing arguments from the employer about the workers (including one of the firefighters) who went into the confined space in spite of training and experience, the review officer referred to a recent paper (which she referred to as the "stress article"), which discussed the need for a better understanding of individual judgment and decision-making while under stress.[28] The review officer accepted that stress may have played a factor in individual judgment and decision-making, but noted that other than one firefighter, the fire department team members worked together quickly to implement their developed rescue plan.

(160) The review officer next addressed the issue of whether the case was a suitable one in which to exercise the discretion to impose a claims cost levy. She acknowledged the argument of the employer's representative that the charging of claims costs is to be used in exceptional circumstances only, as evidenced by the very limited number of such levies ordered by the Board historically. The employer also argued that because of the extraordinary nature of section 73(1) of the Act, the failure to comply must be something more than an ordinary violation. In addition, the employer submitted that the imposition of claims cost levies at the maximum level is inconsistent with the principles of section 73.

(161) The review officer noted that the issue of whether an administrative penalty and a claims cost levy should be mutually exclusive had been considered in a number of decisions of the former Appeal Division of the Board, including *Appeal Division Decision #2002-1769/1770*, which the review officer found persuasive. In that decision the panel noted that section 196(9) (now section 196(7)) of the Act expressly prohibits the Board from bringing a prosecution against an employer where an administrative penalty has been imposed for the same violation. The Appeal Division panel noted that there was no such provision in the Act which expressly prohibited the Board from imposing an administrative penalty under section 196, and a claims cost levy under section 73, in connection with the same event.

(162) In responding to the employer's argument that, because section 73 takes away protection normally provided to employers under the "historic compromise" that resulted in the no-fault compensation scheme, a claims cost levy should only be imposed in the most egregious cases, the review officer referred to another Appeal Division decision, *Appeal Division Decision #98-1950*, reported at 15(2) W.C.R. 265. In that decision the panel concluded that section 73 of the Act, by contemplating the charging of claims costs to an employer where death, injury, or disablement was due substantially to the failure of an employer to comply with the Regulation was not limited to egregious situations.

[28] K.M. Kowalski-Trakofler, C. Vaught, and T. Scharf, *Judgment and decision making under stress: an overview for emergency managers*, International Journal of Emergency Management, 2003 January 01; Vol. 1(3): 278-289.

(163) The review officer concluded that the circumstances in this case support the imposition of a claims cost levy. She referred to *Appeal Division Decision #2002-2582* which had reached the same conclusion in similar circumstances. In that case the panel concluded that the employer's failure to ensure worker competency, failure to properly train workers, and failure to ensure the worker knew the appropriate emergency response, amounted to a substantial cause of the accident that resulted in the worker's fatal injuries.

8. Which claims should attract a claims cost levy?

(164) The review officer went on to consider which of the claims should attract a claims cost levy. The Board officer concluded that the deaths of SI and KR, and the serious injury to CM, were due substantially to the employer's violations. The review officer noted that CM was a labourer who had only been with the employer for one year and eight months, and that he was the first responder when it was suspected that DR was in trouble. His role as the first responder likely resulted in an onerous responsibility and desire to take immediate action in the absence of any concrete information. Although the review officer accepted that more thorough training on the risks of confined space work and on appropriate procedures both for confined space entry and rescues, together with practice drills, would have made it less likely that SI would have entered the confined space, the review officer was not convinced that SI's death was substantially due to the employer's violations.

(165) The review officer noted that KR entered the confined space approximately three minutes after SI, followed shortly thereafter by CM. They had knowledge that two persons had entered the space and were in trouble. The review officer referred to information in the stress article that because extremely hazardous situations create some degree of stress in every worker present, training simulations should be used to replicate a true state of emergency. This was consistent with information in other studies discussed by the review officer. With a better understanding of the associated dangers, a rescue plan and regular training and practice of rescue procedure, JR and CM would have been deterred from entering the space. She concluded that KR's death and CM's injuries were substantially due to the employer's non-compliance.

(166) The review officer found that the same reasoning applied to the death of KP. With his years of experience and supervisory role, KP would likely have been a member of the rescue team if a rescue plan had existed. The lack of such a plan resulted in KP (and two other workers) simply running toward the hatch. The review officer found that KP's death was substantially due to the employer's non-compliance.

(167) The review officer agreed with the case officer that the limited available evidence did not support a claims cost levy with respect to DR's death. The employer's violation may have contributed to his death, but the review officer was unable to reach a conclusion, on a balance of probabilities, that DR's death was substantially due to those violations.

9. Levy amount

(168) The review officer found nothing in the relevant *Prevention Manual* policies (#D12-196-2, 3, and 4; #D12-196-8, #D12-196-10 and 11; and, #D16-223-1) which supported the employer's argument that imposition of the maximum amount is inconsistent with the principles of section 73. Nor did the review officer agree with the employer's representative that a levy at the maximum amount implies that the Board can think of no more egregious behaviour than "the causative failure." Rather, the items identified in policy item #D24-73-1 suggest that the factors important in the quantification of the levy are those same factors that determine whether a penalty should be assessed, namely: due diligence, prior violations, and the circumstances that prompted the issuance of the orders, including the fact that there was a high risk violation. The review officer reiterated the previous findings with respect to the employer's history of non-compliance, insufficient efforts to comply with previous orders, lack of due diligence to ensure ongoing compliance and the high risk nature of work undertaken by the employer on a regular basis. The review officer found that the root cause of the tragic event in this case was substantially due to the employer's failure to establish and maintain an adequate program of compliance with the Act and the Regulation, and she was not persuaded by the employer's arguments to vary the levy from the statutory maximum imposed by the Board.

(169) The review officer denied the employer's review of the Board's June 30, 2005 decision in IR #2005-095 with respect to the imposition of the administrative penalty and the claims cost levy.

10. Conclusion

(170) The review officer confirmed orders #1 and #2 in the Board's January 18, 2005 decision in IR #2005-003 (which had identified the employer's violations), and varied the Board's order of June 30, 2005 in IR #2005-095 (which imposed the penalty and claims cost levy) by excluding the costs attributable to SI's death and including a levy in the maximum amount for the costs attributable to KP's death.

VI. FINDINGS AND REASONS

(171) As we have already noted, the employer has not provided substantive submissions or new evidence to WCAT. We therefore referred to the earlier submissions and the notice of appeal.

A. Preliminary Issues

1. Review Division procedure

(172) At item (b) of the schedule to the employer's notice of appeal, the employer states as a ground of appeal that the Review Division proceeded in a procedurally improper manner. However, the employer has not particularized which Review Division procedures were improper, nor provided submissions to WCAT on this issue. For the following reasons we find that that we lack jurisdiction to address the employer's appeal with respect to the procedures followed by the review officer in conducting the review.

(173) Section 239(2)(a) of the Act provides that "a decision in a prescribed class of decisions respecting the conduct of a review" may not be appealed to WCAT.

(174) Section 4 of the *Workers Compensation Act Appeal Regulation,* B.C. Reg. 321/2002, states that for the purposes of section 239(2)(a) of the Act, the following are classes of decisions that may not be appealed to WCAT:

> …
>
> (b) decisions made under section …96.4(2)….

(175) Section 96.4(2) of the Act in turn provides that:

> (2) Subject to any Board practices and procedures for the conduct of a review, a review officer may conduct a review as the officer considers appropriate to the nature and circumstances of the decision or order being reviewed.

(176) Consequently, because decisions by the review officer with respect to procedures followed in the conduct of the review come within the prescribed class of decisions that cannot be appealed to WCAT, we lack jurisdiction to address the employer's appeal on this issue.

2. WCAT procedure

(177) Given that the employer objected to the participation of family members of the deceased and injured workers before the Review Division, we address the same objection as though it were made to WCAT, although as noted above the employer has declined to provide submissions.

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(178) Section 241(3) of the Act provides that for the purposes of section 239, any of the following persons who are directly affected by a decision of the review officer in respect of a matter referred to in section 96.2(1)(c)[29] may appeal that decision:

(a) a worker;
(b) an employer within the meaning of Part 3;
(c) an owner as defined in section 106;
(d) a supplier as defined in section 106;
(e) a union as defined in section 106;
(f) a member of a deceased worker's family.

(179) Most of the respondents are family members of the deceased workers (or their representatives). We notified the successor employer of this appeal, but no response was received.

(180) We are satisfied that all of the respondents were properly notified and invited to participate.

3. Bias

(181) In its submissions to the Review Division, the employer alleged that the Board's investigation and decision-making were carried out in an unfair manner. The employer's brief submissions to WCAT appear to repeat this argument.

(182) In the absence of reasoned argument from the employer to WCAT, we have considered the employer's submissions on this issue to the Review Division, where the employer stated that it is a breach of natural justice for the investigative and adjudicative function to occur within the same body.

(183) The breach of natural justice is said to arise from the appearance of bias inherent in a situation where the same body regulates, investigates, and adjudicates an issue.

(184) The employer says that the appearance of bias is all the stronger because the Board disclosed its accident investigation, which recommended a penalty, prior to making the decision to levy an administrative penalty on the employer.

(185) The employer's argument on this issue cannot succeed for two reasons.

(186) First, common law principles of natural justice cannot overcome clear statutory authority that empowers a single administrative body to both investigate and adjudicate an issue: *Ocean Port Hotel Ltd. v. British Columbia (General Manager, Liquor Control and Licensing Branch)*, *supra*.

[29] A Board order, a refusal to make a Board order, a variation of a Board order or a cancellation of a Board order respecting an occupational health or safety matter under Part 3 of the Act.

(187) It is therefore our view that an administrative body such as the Board may both investigate and adjudicate matters of occupational health and safety as long as these overlapping functions are authorized by statute.

(188) In this case, section 111(2)(b) of the Act explicitly authorizes the Board to investigate matters related to occupational health and safety. Section 187(1) explicitly authorizes the Board to make orders in relation to occupational health and safety matters. Section 196(1) of the Act explicitly authorizes the Board to levy administrative penalties on an employer in relation to occupational health and safety contraventions. In addition, section 73 of the Act authorizes the Board to impose claims cost levies.

(189) In light of these explicit statutory provisions, we are of the view that the legislature has expressly authorized the Board to both investigate and adjudicate the administrative penalties and claims cost levies in question. Consequently, we do not consider that the Board's overlapping functions constitute a valid ground of complaint for the employer.

(190) Even if we are wrong in the above conclusion, the second reason that the employer's argument cannot succeed is our view that any alleged breach of natural justice in the proceeding below has been cured through the appeal process.

(191) The proposition that appellate proceedings may "cure" a procedural defect in subordinate proceedings is not controversial. In this regard, we adopt the following statement from Brown and Evans in *Judicial Review of Administrative Action in Canada*, at page 3-43:

> A breach of the duty of fairness may be "cured" by an appeal that takes the form of a *de novo* hearing before another administrative body, at least where the appellant is not required to bear a burden of proof that is more onerous than it bore at first instance, where the second decision-maker is free from any reasonable apprehension of bias, and where the hearing is otherwise conducted fairly.

(192) Because WCAT is an independent administrative tribunal with the power to hear new evidence and the discretion to make further inquiries in the course of a rehearing, we are not bound by the decision or findings below and may take a fresh look at all of the evidence and arguments as well as new evidence and arguments that may be raised. We are free to substitute our own findings for those of the Board and the Review Division based on our assessment of the evidence and come to a fresh decision accordingly. Consequently, we find that consideration of the employer's appeal by WCAT has the effect of curing any potential breach of natural justice that the employer alleged may have occurred below.

(193) Having disposed of these preliminary issues, we now turn to the substance of the appeal.

B. Did the Employer Violate the Act and the Regulation?

(194) It is well understood, and the accident underlying this appeal starkly demonstrates, that confined spaces are very dangerous places.

(195) The National Institute for Occupational Safety and Heath (NIOSH) is part of the U.S. Department of Health, Education, and Welfare. In December 1979 NIOSH published a document entitled "Criteria for a Recommended Standard…Working in Confined Spaces." This document was before the Review Division, and is footnoted in the Review Division decision under appeal. On page 19, NIOSH states:

> The hazards encountered and associated with entering and working in confined spaces are capable of causing bodily injury, illness, and death to the worker. Accidents occur among workers because of failure to recognize that a confined space is a potential hazard. It should therefore be considered that the most unfavourable situation exists in every case and that the danger of explosion, poisoning, and asphyxiation will be present at the onset of entry.

(196) The above statement eloquently provides the reasons why it is imperative that an employer who operates in or around confined spaces have an effective safety program relating to entering and working in confined spaces.

(197) The same NIOSH article states, at page 21, in the context of discussing "Reasons for Entering Confined Spaces":

> One of the most difficult entries to control is that of unauthorized entry, especially when there are a large number of workers and trades involved, such as welders, painters, electricians, and safety monitors.
>
> A final and most important reason for entry would be emergency rescue. This, and all other reasons for entry, must be well planned before initial entry is made and the hazards must be thoroughly reviewed. The standby person and all rescue personnel should be aware of the structural design of the space, emergency exit procedures, and life support systems required.

(198) In assessing whether the employer violated the Act and the Regulation, we note that the Board made one order on a single regulatory breach (section 3.1(2) of the Regulation) and one order based on failure to comply with section 115(1)(a)(i) of the Act, as exemplified by several breaches of the Regulation. We will address each order and the allegations underlying it in turn.

1. Section 3.1(2) of the Regulation: Occupational Health and Safety Program

(199) The allegations are:

- The employer did not conduct regular inspections of the premises, equipment, work methods, and work practices at appropriate intervals for the purpose of ensuring that hazardous conditions are identified and prompt action taken to correct them, as required in section 3.3(b) of the Regulation.

- The employer did not make appropriate written instructions available for all workers to supplement the Regulation as required by section 3.3(c) of the Regulation. While the employer did provide some information, specific direction regarding lockout, fall protection, access and egress, operation and maintenance of cranes, and confined space entry, were not included.

- The employer did not maintain current records and statistics with respect to health and safety activities. The last health and safety meeting had been in September 1999. There were no records of workplace inspections. The calibration documents for the air-testing monitor and confined space records were incomplete. (We observe that the confined space records were more than "incomplete" for the approximately three-year period before the accident. There were no confined space records, although confined space work was being conducted.)

- The employer did not make adequate provision for the instruction and supervision of workers in the safe performance of their work as required by section 3.3(g).

- The employer did not maintain an occupational health and safety program as required by section 3.1(2) of the Regulation. The employer had been ordered to do so in September 1998.

(200) Section 3.1 of the Regulation requires an occupational health and safety program as outlined in section 3.3. Section 3.1, at the time of the accident, provided as follows:

> **3.1 When required**
>
> (1) An occupational health and safety program as outlined in section 3.3 must be initiated and maintained by each employer having
> (a) a work force of 20 or more workers, in an industry classified as "A" or "B" hazard in Part 33 (Occupational First Aid), or
> (b) a work force of 50 or more workers in an industry classified as "C" hazard in Part 33.

(2) Despite subsection (1) an occupational health and safety program may be required in any workplace when, in the opinion of an officer, such a program is necessary.

(201) Section 3.3 of the Regulation stated:

3.3 Contents of program

The occupational health and safety program must be designed to prevent injuries and occupational diseases, and without limiting the generality of the foregoing, the program must include

(a) a statement of the employer's aims and the responsibilities of the employer, supervisors and workers,
(b) provision for the regular inspection of premises, equipment, work methods and work practices, at appropriate intervals, to ensure that prompt action is undertaken to correct any hazardous conditions found,
(c) appropriate written instructions, available for reference by all workers, to supplement this Occupational Health and Safety Regulation,
(d) provision for holding periodic management meetings for the purpose of reviewing health and safety activities and incident trends, and for the determination of necessary courses of action,
(e) provision for the prompt investigation of incidents to determine the action necessary to prevent their recurrence,
(f) the maintenance of records and statistics, including reports of inspections and incident investigations, with provision for making this information available to the joint committee or worker health and safety representative, as applicable and, upon request, to an officer, the union representing the workers at the workplace or, if there is no union, the workers at the workplace, and
(g) provision by the employer for the instruction and supervision of workers in the safe performance of their work.

(202) Section 3.1(2) of the Regulation, at the time of the accident, stated that despite section 3.1(1), an occupational health and safety program may be required in any workplace when, in the opinion of an officer, such a program is necessary.

(203) Current guidelines published by the Board discuss how a Board officer will exercise the discretion found in section 3.1(2). They state:

A prevention officer who encounters a situation where all of the following conditions are present should consider requiring the employer to initiate and maintain an OHS program pursuant to section 3.1(2) of the *Regulation*:

- The employer has a workforce of less than 20 workers
- Those workers are exposed to high risks
- An OHS program is essential to the health and safety of workers.

(204) These "guidelines" are not binding policy, and we recognize they were not in place at the time of the accident. However, the guidelines are illustrative of the types of considerations an officer might take into account in exercising the discretion. In this case, the workers were exposed to high risks, and a program was clearly essential to health and safety.

(205) The employer made submissions suggesting that because a relatively small number of workers were involved, and the workers took care of each other and were "like family," the occupational health and safety program was adequate for the circumstances. The less experienced workers relied on the more experienced workers, who provided informal training and modeled safe work practices.

(206) In 1998, a Board officer exercised discretion under section 3.2 of the Regulation when he ordered the employer to maintain an occupational health and safety program in 1998. There is nothing in the record to show the employer appealed that order. The employer has not argued that the order mischaracterized the employer's obligations to comply with section 3.3 of the Regulation. The employer took steps to comply with the order, although the effort was not sustained.

(207) In any event, while the number of employees may suggest that section 3.3 of the Regulation need not apply, the nature of the work in and around confined spaces and the inherent high risks involved as described by experts in the literature cited above, more than justify an exception requiring a formal occupational health and safety program to be maintained by this employer.

(208) We find that section 3.3 of the Regulation applies to the employer.

(209) We further find that the employer failed to comply with the Board's 1998 order. They were in continued non-compliance at the time of the accident. Although the workers may have had informal discussions about occupational health and safety issues, it is evident that there was no program in place.

(210) We will now consider whether the employer met the requirements of the Regulation regarding occupational health and safety programs.

(211) The work site had a number of hazards, including confined spaces. Furthermore, the workers were required to work over water, and in conditions that required fall protection. From their statements, it is apparent that most workers were generally unaware of the hazards and how to effectively avoid accidents despite the fact that some had a rudimentary appreciation that there was some sort of risk.

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(212) For example, both DR and CM went into the void space. DR told CM to stick together and to say so if he felt lightheaded. CM said he stuck by DR and "they were loading so it was kinda scary." DR went into two other void spaces. Before doing so DR told CM to keep talking and if DR did not answer back, CM should use DR's cell phone to call "911" for help. They were not wearing any harnesses. There was no one standing by and no rescue plan.

(213) Before entering, DR used the sniffer. As far as CM knew, the sniffer was not tested before use. It gave a reading, as far as he remembered, of 19. We note that CM had also said that a few days before the accident, DR had showed him how to use the sniffer. He had some idea that "something like 21" was a safe level of oxygen. It is apparent that CM did not know the safe level of oxygen. He did not know whether a level of 19 was safe or not.

(214) It is apparent that at the time, CM did not acquire any appreciation of the risk or danger involved despite being in the presence of DR, and it is further unclear whether DR actually or fully understood the nature of the hazard.

(215) Based on this evidence we find that the employer's program clearly had not achieved the goals required by the Regulation and was therefore no real substitute for what was required by the Board under the Regulation.

(216) Even if it is considered in the alternative that section 3.2 and not section 3.3 applies, we do not consider that the "informal discussions" met the requirements of the program ordered to be maintained, nor did the discussions constitute a "less formal" program as provided for in section 3.2 of the Regulation.

(217) Thus, even if the officer incorrectly exercised the discretion found in section 3.1(2), we find section 3.2 of the Regulation would nonetheless apply. It stated:

> **3.2 Small operations**
>
> In any operation where the work force is less than that referred to in section 3.1(1) [20 or more] the employer must
> (a) initiate and maintain a less formal program based on regular monthly meetings with workers for discussion of health and safety matters,
> (b) ensure that meetings are directed to matters concerning the correction of unsafe conditions and practices and maintenance of cooperative interest in the health and safety of the work force, and
> (c) maintain a record of the meetings and the matters discussed.

(218) The Regulation requires the employer to, at least, have an occupational health and safety program, which includes monthly meetings and keeping a record of the meetings. The meetings must be to discuss matters concerning the correction of

unsafe conditions and practices and the maintenance of cooperative interest in the health and safety of the workforce. The evidence does not establish that there were regular monthly meetings for discussion of health and safety matters, and there is no record of such meetings.

(219) Therefore, we find that the employer violated section 3.3(b), (c), and (g) of the Regulation. Furthermore, we find that the failure to maintain an occupational health and safety program violated section 3.1(2) and section 3.2 of the Regulation.

2. Section 115(1)(a)(i) of the Act: General duties of employers

(220) Section 115 of the Act provides:

> **General duties of employers**
>
> 115 (1) Every employer must
>
> (a) ensure the health and safety of
> (i) all workers working for that employer, and
>
> (ii) any other workers present at a workplace at which that employer's work is being carried out, and
>
> (b) comply with this Part, the regulations and any applicable orders.
>
> (2) Without limiting subsection (1), an employer must
>
> (a) remedy any workplace conditions that are hazardous to the health or safety of the employer's workers,
>
> (b) ensure that the employer's workers
>
> (i) are made aware of all known or reasonably foreseeable health or safety hazards to which they are likely to be exposed by their work,
>
> (ii) comply with this Part, the regulations and any applicable orders, and
>
> (iii) are made aware of their rights and duties under this Part and the regulations,
>
> (c) establish occupational health and safety policies and programs in accordance with the regulations,

(d) provide and maintain in good condition protective equipment, devices and clothing as required by regulation and ensure that these are used by the employer's workers,

(e) provide to the employer's workers the information, instruction, training and supervision necessary to ensure the health and safety of those workers in carrying out their work and to ensure the health and safety of other workers at the workplace,

(f) make a copy of this Act and the regulations readily available for review by the employer's workers and, at each workplace where workers of the employer are regularly employed, post and keep posted a notice advising where the copy is available for review,

(g) consult and cooperate with the joint committees and worker health and safety representatives for workplaces of the employer, and

(h) cooperate with the Board, officers of the Board and any other person carrying out a duty under this Part or the regulations.

(221) The order under section 115(1)(a)(i) is based on a number of breaches of the Regulation and the Act. Each is addressed in turn.

a. Obligations relating to risk assessment/evacuation

(222) The allegation is that the employer did not conduct a risk assessment in a workplace in which a need to rescue or evacuate workers might arise, as required by section 4.13(1) of the Regulation. Additionally, the employer did not develop and implement written rescue and evacuation procedures as required in relation to confined spaces, risk of entrapment and work over water.

(223) Provisions in the Regulation regarding risk assessment include:

4.13 Risk assessment

(1) The employer must conduct a risk assessment in any workplace in which a need to rescue or evacuate workers may arise,
(2) If the risk assessment required by subsection (1) shows a need for evacuation or rescue, appropriate written procedures must be developed and implemented, and a worker assigned to coordinate their implementation.
(3) Written rescue and evacuation procedures are required for but not limited to
    (a) work at high angles,

(b) work in confined spaces or where there is a risk of entrapment,
(c) work with hazardous substances,
(d) underground work,
(e) work on or over water, and
(f) workplaces where there are persons who require physical assistance to be moved.

(224) The evidence does not show that the employer conducted any type of risk assessment, other than occasional informal discussions.

(225) The evidence supports a conclusion that the employer failed to conduct a required risk assessment in relation to (a) the dangers inherent in working around open entry hatches leading to void spaces, (b) the need to rescue or evacuate from confined space work should an accident occur, and (e) work on or over water and how that might complicate work or rescue efforts.

(226) The employer raised a number of points relating to the small size of the workplace, the close relationship between the workers, and the fact that no work was said to be planned in the confined space.

(227) We find that it is not sufficient for the employer to state that no work was planned for the interior of confined space. A risk assessment would include an appreciation of how the hatch work was to be performed, including the fact that workers were standing in or sitting on the edges of the entry hatch in order to perform work, as described by BY and BB. BB said, "[t]he reason we go down the one rung and sat on the edge. It's a lot safer because it's a real tumble hole edge so we usually sat here with your feet on the rung and he sat on the lip and you could work away. It was the safest point to be in." This shows there was a perception among the workers that standing waist-deep in the entry hatch was "safe." As events showed, this was not a safe work procedure. A risk assessment would have revealed the unsafe level of knowledge and practice among the workers.

(228) In addition, there is little evidence of a risk assessment relating to the need to evacuate or rescue workers. That is not surprising in view of the fact that there was no appreciation or assessment of the risk involved in the manner the work was carried out. Further, the lack of a risk assessment relating to the need to evacuate or rescue workers is obvious on the evidence. The events surrounding the accident reveal no overall risk assessment or plan regarding rescue other than calling "911." The failure to develop a plan is demonstrated by the difficulties locating and using rescue equipment, and the entry into the confined space by five other workers of the employer in an attempt to effect a rescue. There simply was no rescue or evacuation plan.

(229) Moreover, there was also no "risk assessment" other than reliance on the more experienced workers. We do not consider that the more experienced workers, such as

DR, using the uncalibrated sniffer before entry into a confined space (which was not a consistent practice, in any event), is evidence of a risk assessment.

(230) The evidence relating to the previous entry into a confined space by the more experienced DR and another more inexperienced worker CM (who was subsequently injured in the accident) demonstrates an inadequate appreciation of the risks. It underscores the need for the employer to have done a risk assessment. The two workers went into the confined space, together, and the only evacuation plan appears to have been "call 911" as demonstrated by DR giving his cell phone to the other worker, telling him to keep talking, and to call 911 if he did not respond. This was clearly a high risk activity and there were no confined space entry precautions except using the sniffer, there was no evacuation plan, and there was no one looking out for the two workers. Had an incident occurred, the two may well have been in the space for a lengthy period, with no one aware. We do not rely on the previous confined space activity, but rather note it is illustrative of the lack of awareness and training the workers had.

(231) While the accident underlying this appeal involved a confined space, the rescue attempts were complicated by the fact that the barge was on the water. The ramp over which the rescuers accessed the barge was steeply sloped. There were difficulties determining how the recovered/rescued workers would be removed from the barge and transported to hospital. This illustrates the necessity of a risk assessment in advance to take into account and assess the complicating circumstances of work over water.

(232) The employer submitted that the investigating officer agreed that training everyone in rescue is probably more dangerous than not training them, because the training would expose them to danger. He pointed out that the size of the shipyard and number of people employed is not great. He also submitted that had there been a rescue team DR would have been the head of the team, because he was most knowledgeable on confined spaces.

(233) While DR may have been assumed by the employer to be the most knowledgeable, we find that the evidence suggests he did not fully appreciate the risks and thus was not knowledgeable enough. The evidence of the previous entry into a void with CM and the circumstances of DR's death in this accident tend to bear that out. That any training that flowed from the risk assessment may expose workers to some risks is not a basis upon which to avoid a risk assessment, or the development of a rescue or evacuation plan. Training would take place in a controlled environment with all precautions in place. Neither is the fact that DR was considered the workplace expert on confined space entry, and would probably "lead" a rescue a factor militating against a risk assessment and training. It seems obvious to us that a rescue plan would take into account the possibility that any one of the workers may need rescue or evacuation, including DR, and would not rely solely on DR as leader. Indeed, in this case it was DR who was the first fatality in the void. Further, after appropriate training, CM and other

workers would have better appreciated the need for a systemic approach to rescue as opposed to plunging into the void space in desperation.

(234) It is not sufficient for the employer to say that it was unique in having a small number of employees, or to say it matters little that it did not have an evacuation or rescue plan because DR would have been the leader, and he was the first person overcome in the confined space. The employer's submission simply underscores the necessity of a comprehensive risk assessment and plan.

(235) That the workers had a "close relationship" also does not replace a proper risk assessment and plan. Relying on a close relationship rather than specific assessments and instructions does not satisfy the Act and the Regulation. It is necessary that the employer turn its mind to the risks in the workplace and to written rescue and evacuation procedures without assuming the workers' close relationship means they somehow knew what to do.

(236) Therefore, we conclude that the employer violated sections 4.13(1), 4.13(3)(b) and 4.13(3)(e) of the Regulation.

b. Confined space

(237) The next allegation of non-compliance relates to confined spaces requirements found in Part 9 of the Regulation.

(238) There is extensive provision in the Regulation relating to confined spaces. Part 9 of the Regulation addresses confined spaces. At the time of the accident, the provisions included:

> **9.1 Definitions**
>
> In this Part
>
> "*confined space*" means an area, other than an underground working, that
> (a) is enclosed or partially enclosed,
> (b) is not designed or intended for continuous human occupancy,
> (c) has limited or restricted means for entry or exit that may complicate the provision of first aid, evacuation, rescue or other emergency response service, and
> (d) is large enough and so configured that a worker could enter to perform assigned work;
>
> …

9.2 Initial determination

The employer must
(a) ensure that each confined space in the workplace is identified, and
(b) determine whether any such space will require entry by a worker, either in scheduled work activities or as a result of foreseeable system failures or other emergencies.

9.3 Prohibited entry

If a confined space exists at a workplace but no worker entry is required, the employer must ensure that each point of access to the confined space is secured against entry or identified by a sign or other effective means which indicates the nature of the hazard and the prohibition of entry, and that workers are instructed not to enter.

…

9.5 Confined space entry program

Before a worker is required or permitted to enter a confined space, the employer must prepare and implement a written confined space entry program which includes
(a) an assignment of responsibilities,
(b) a list of each confined space or group of similar spaces and a hazard assessment of those spaces, and
(c) written safe work procedures for entry into and work in the confined space, that address, where applicable
    (i) identification and entry permits,
    (ii) lockout and isolation,
    (iii) verification and testing,
    (iv) cleaning, purging, venting or inerting,
    (v) ventilation,
    (vi) standby persons,
    (vii) rescue,
    (viii) lifelines, harnesses and lifting equipment,
    (ix) personal protective equipment and other precautions, and
    (x) coordination of work activities.

(239) It is alleged that the employer did not identify the void spaces in the barge as required by section 9.2(a). No proper determination was made as to whether any such space would require entry by a worker, either in scheduled work activities or as a result of foreseeable system failures or other emergencies, as required by section 9.2(b).

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(240) The employer submitted that there was no need for a confined space entry procedure in this case because there was no work scheduled in a confined space. The employer further relies on a submission that it is not known why DR entered the space. These arguments cannot succeed.

(241) The evidence shows that DR was in the space, albeit only up to his waist. He was observed by another employee to have entered the void space. The purpose was to view the work at deck level. Additionally, the welder, BY, said that he stood inside the hatch of another void space. While DR may not have *planned*, ahead of time, to inspect the work in that manner, the very nature of the work on the hatch made entry likely. Another worker, BB, explained that sitting on the lip of the entry hatch with one's feet on the rungs below was the "safest" way to do the work.

(242) We find it more likely than not that DR lost his footing on the ladder-like structure, and fell into the void space. He suffered injuries consistent with a fall. Furthermore, the evidence establishes that DR's habit was to use the sniffer if work or an inspection was planned actually inside the space. It seems most likely that his further descent into the void was by accident.

(243) Notwithstanding the accidental nature of DR's full entry into the #2 starboard void space, we find that the employer did know, or should have known, that some degree of confined space entry would take place that day. The evidence establishes that it was common for workers to stand in and/or sit on the entry hatches while working on the flanges. Indeed, it appears this was the only convenient position from which to carry out and inspect the work. The employer knew that flange work was going on, so it knew that workers would likely enter the confined space.

(244) Thus, we find that at the very least, partial entry into the confined space was likely on the day in question. We appreciate that the entry was not planned for actually working inside the confined space, but in view of the manner work was being done, accidental full entry was foreseeable. For the purposes of addressing safety concerns and the requirements of the Regulation, we find no material distinction between working down inside the space, and entering the space with part of one's body. Therefore, the employer's argument that no confined space work was planned for that day is of little assistance in this appeal.

(245) Even if the entry into the space was involuntary, the very presence of an open hatch over a confined space brings into play section 9.2 of the Regulation. Someone could fall into the space. Or drop something and voluntarily enter the space unaware of the danger. Or, as appears to have happened here, partially enter the space, and by way of an accident, fall in.

(246) This situation falls squarely within the category of either an entry because of scheduled work activities, an entry due to reasonably foreseeable accidental circumstances, or a

"system failure." The employer failed to identify the confined space and to determine whether any such space requires entry by a worker, either in scheduled work activities or because of a foreseeable accident or other emergencies. Any of these circumstances might necessitate entry of others as rescuers.

(247) We have concluded that the employer violated section 9.2(a) and (b) of the Regulation.

(248) In addition, we find that the employer breached section 9.3 of the Regulation. The employer did not ensure that each point of access to the void spaces was secured against entry or identified by a sign or other effective means to indicate the nature of the hazard and the prohibition of entry, and that workers were instructed not to enter.

(249) At the Review Division oral hearing, the employer submitted that it would have been absurd for DR to have descended into the confined space and then placed a barrier or cover over his head. We agree it would have been absurd. However, the employer's submission is based on a fundamental misunderstanding of the confined space regulations. There was no suggestion by anyone that DR should have placed a barrier over his head, nor is there any requirement in those regulations that he do so. Rather, the Regulation required that there should have been a barrier to prevent DR from entering the confined space in the first place. The employer's argument on this point has no merit.

(250) We now turn to section 9.5 of the Regulation. The Investigation Report alleges that the employer did not prepare and implement a written confined space entry program before a worker was permitted to enter a confined space, as required by section 9.5 of the Regulation.

(251) The employer had a written confined space entry program but it was based on outdated regulations. It appears to have been developed in response to the inspection activity in the late 1990s. At that time, it appears the employer was taking steps to improve its occupational health and safety program. Unfortunately, the employer also appears to have stopped its efforts to comply.

(252) Furthermore, the confined space entry program was clearly not being followed on the day of the accident. It was not being followed during the previous confined space entry by CM and DR several weeks earlier.

(253) We consider this to establish that the employer did not comply with section 9.5 of the Regulation.

(254) For its part, the employer argued that the written confined space entry procedures in place were sufficient to discharge its obligations under the Act and the Regulation. We disagree.

(255) The confined space entry procedures to which the employer refers are an exact copy of the since repealed *Industrial Health and Safety Regulations* B.C. Reg. No. 585/77, effective January 1, 1978 (former Regulation). The Regulation in its current form was effective August 1, 1999.

(256) Even a cursory comparison of the former Regulation with the Regulation current at the time of the accident reveals there are now considerably greater employer obligations regarding confined space issues.

(257) For example, section 9.3 of the Regulation requires an employer to identify all confined spaces at a workplace and ensure that each point of access to that confined space is secured against entry or identified by a sign or other effective means indicating the nature of the hazard and the prohibition against entry.

(258) This requirement reflects a substantive difference between an employer's confined space entry obligations under the former Regulation and its obligations under the current Regulation.

(259) We also note that the particular difference in section 9.3 is directly material to the events at issue in this appeal because, had the employer satisfied this section, we are of the view that there would have been a real possibility of avoiding the deaths of four workers.

(260) Although the employer's written procedures might have met occupational health and safety standards from the past, such is insufficient to demonstrate that the employer's written procedures were enough to discharge its obligations under the Act and the current Regulation at the time of the accident.

(261) Consequently, we conclude that the employer's written confined space entry procedures were inadequate to meet the requirements of the Act and the current Regulation.

c. Working in isolation

(262) The next allegation is that work was being conducted in two shop locations, the storage yard, and on a number of vessels. Workers were isolated from one another and communication between them was severely restricted. The employer failed to develop or implement a written procedure for checking on the well-being of a worker assigned to work alone or in isolation in conditions which presented a risk of disabling injury, as required by section 4.21 of the Regulation.

(263) Section 4.21 of the Regulation stated:

4.21 Procedures

(1) The employer must develop and implement a written procedure for checking the well-being of a worker assigned to work alone or in isolation under conditions which present a risk of disabling injury, if the worker might not be able to secure assistance in the event of injury or other misfortune.
(2) The procedure for checking a worker's well-being must include the time interval between checks and the procedure to follow in case the worker cannot be contacted, including provisions for emergency rescue.
(3) A person must be designated to establish contact with the worker at predetermined intervals and the results must be recorded by the person.
(4) In addition to checks at regular intervals, a check at the end of the work shift must be done.
(5) The procedure for checking a worker's well-being, including time intervals between the checks, must be developed in consultation with the joint committee or the worker health and safety representative, as applicable.
(6) Time intervals for checking a worker's well-being must be developed in consultation with the worker assigned to work alone or in isolation.

Note: High risk activities require shorter time intervals between checks. The preferred method for checking is visual or two-way voice contact, but where such a system is not practicable, a one-way system which allows the worker to call or signal for help and which will send a call for help if the worker does not reset the device after a predetermined interval is acceptable.

(264) There is no dispute that workers were working in several different locations and communication between them was restricted. This is illustrated by the fact that DR was last seen standing in the entry hatch by the welder BY, who then went to obtain replacement studs and to another location to continue working. It is also illustrated by the fact that no one noticed DR was missing until sometime into the coffee break. DR was unable to secure assistance. There was no provision for emergency rescue. Furthermore, DR was engaged in a high risk activity.

(265) The employer submitted that this was a technical failing only. It submitted that someone noticed DR's absence and a search was conducted within a very few minutes. The employer submitted that even if a procedure was in place, one would not expect it to work any better than what actually happened. The employer said that as there was no confined space work planned, there was no watchman.

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(266) This does not relieve the employer from its obligation to comply with the Regulation. Section 4.21 is not a discretionary provision dependent on whether or not the employer believes a rescue plan would be useful or have any practical purpose. Section 4.21 places an obligation on the employer to develop a rescue plan. The employer did not do this.

(267) Even if section 4.21 was discretionary, it was merely fortuitous that other workers noticed DR was missing at coffee break. Had it not been coffee time when he fell into the void space, it is likely DR would not have been found for a much longer period of time. We do not agree this was a "technical failing" only.

(268) We conclude that the employer violated section 4.21 of the Regulation.

d. Information, instruction, training and supervision

(269) The allegation here is that the employer did not comply with section 115(2)(e) of the Act. Section 115(2)(e) states that the employer must provide to the employer's workers the information, instruction, training and supervision necessary to ensure the health and safety of those workers in carrying out their work and to ensure the health and safety of other workers at the workplace.

(270) The only training related to confined spaces around the time of the accident was that the workers (and it is not clear if that means all of the workers on-site on the day of the accident) had been trained in the use of the "sniffer." This training apparently took place some years before the accident. Even then it appears at least some were not clear as to what the sniffer readings signified in terms of a safe or unsafe environment. For example, CM said that "something like 21" is a safe level of oxygen. This evidence demonstrates an absence of adequate information, instruction, and training necessary to ensure these workers' health and safety.

(271) The employer submitted that training was provided because DR was very safety aware and informally trained other workers in regard to confined spaces. We disagree.

(272) Without in any way intending to be critical of DR, it is apparent that he was not an expert nor adequately trained in confined spaces himself. This is evident from the previous incident with CM, in which DR and CM both entered a confined space. DR suggested to CM that if he felt lightheaded he should say so. DR went further into the confined space himself, with the only precaution and/or rescue plan being CM speaking to him, and if there was no response, calling "911."

(273) Had either or both DR or CM been injured, or overcome by atmospheric conditions, no one may have known in time to rescue them. This is all the more troubling because, in any event, there was no rescue plan in place. While no accident occurred, this incident clearly illustrates a lack of knowledge and/or training about confined space safety.

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(274) Further, DR entered the confined space on the day of the accident, without following proper procedures and in particular, was in the space while working in isolation, without a rescue plan.

(275) Any informal training provided by DR appears to have been limited to warning workers that confined spaces can be dangerous. DR's confined space entry procedures appear to have been limited to testing the air before entry, and if necessary ventilating the space. The requirements in the Regulation go much further. It follows that we are not satisfied that DR himself was adequately trained. It need hardly be said that he was therefore not in a position to pass on, informally or otherwise, proper training for other workers.

(276) The evidence strongly supports a conclusion that the employer did not provide its workers with the information, instruction, training, and supervision necessary to ensure the health and safety of those workers in carrying out their work as required by section 115(2)(e) of the Act, and we so find.

C. Is an Administrative Penalty Warranted in this Case?

(277) Having determined that the breaches of the Regulation and the Act are substantiated, we turn now to considering whether an administrative penalty was warranted.

(278) Section 196 states that the Board may, by order, impose an administrative penalty on an employer if the Board considers that the employer has not complied with Part 3 of the Act or the Regulation. The Board exercises its discretion under section 196 based on considerations found in the *Prevention Manual*.

(279) *Prevention Manual* policy item #D12-196-1 states, in part:

> The Board will consider imposing an administrative penalty when:
>
> - an employer is found to have committed a violation resulting in high risk of serious injury, serious illness or death;
> - an employer is found in violation of the same section of Part 3 or the regulations on more than one occasion. This includes where, though a different section is cited, the violation is essentially the same;
> - an employer is found in violation of different sections of Part 3 or the regulations on more than one occasion, where the number of violations indicates a general lack of commitment to compliance;
> - an employer has failed to comply with a previous order within a reasonable time;

- an employer knowingly or with reckless disregard violates one or more sections of Part 3 or the regulations. Reckless disregard includes where a violation results from ignorance of the Act or regulations due to a refusal to read them or take other steps to find out an employer's obligations; or
- the Board considers that the circumstances may warrant an administrative penalty.

(280) Policy item #D12-196-2 sets out violations that are assumed to be high risk in the absence of evidence showing the contrary. The list includes permitting workers to be exposed to situations or conditions that are immediately dangerous to life or health.

(281) We note that in order for the Board to consider imposing an administrative penalty, only one of the criteria in policy item #D12-196-1 need be satisfied. For the sake of completeness, we have addressed all six of the criteria.

1. Was the employer found to have committed a violation resulting in high risk of serious injury, serious illness, or death?

(282) The Board found that the employer's failure did result in a high risk of serious injury, illness, or death. In particular, the failure to identify and prohibit entry into a confined space and the lack of a rescue plan exposed the worker's to high risk. Four workers were killed and two injured. The employer is required to comply with confined space regulatory requirements whenever a confined space exits, regardless of whether work is planned in the confined space. There were no procedures to direct workers to an appropriate rescue response.

(283) The Board pointed out that the violation was high risk because the oxygen-deficient atmosphere was a "high hazard atmosphere," as defined in section 9.1 of the Regulation. It was an atmosphere that may expose a worker to risk of death, incapacitation, injury, acute illness or otherwise impair the ability of the worker to escape unaided from a confined space, in the event of a failure of the ventilation system or respirator.

(284) There was air-testing equipment available, but it was not used before workers entered the space.

(285) In addition, although workers typically worked in confined spaces and over water, there was no written procedure for checking on workers, or for rescue and evacuation. This exposed the workers to a high risk of serious injury or death.

(286) We agree. The employer's violation of the Act and the Regulation exposed the workers to a high risk of serious injury or death.

(287) The employer made a number of submissions suggesting that there was no violation that exposed the workers to a high risk of injury or death. We are not persuaded by any of the submissions that the violation was not "high risk."

(288) For example, the employer submitted that what was going on was not a risky unsupervised activity because DR was a supervisor and he was at the entry hatch. It need only be noted that previously DR suggested that CM call "911" if DR did not respond, while both of them were in a confined space with no rescue plan in place. That DR was supervising did not remove the obviously high risk nature of any activities taking place in a confined space.

(289) The employer submitted it frequently did confined space work, and had not had a previous accident. The employer said it had a perfectly acceptable and safe program that was in accordance with industry practice. The employer said that its program may not have aligned with the Regulation but "it did work." The workers knew the space had not been ventilated, and had "actual knowledge" of the status of the space. This, the employer submitted, was overlooked by the investigating officer because it did not fit what the officer wanted to do.

(290) We do not consider the fact that there had not been a similar accident to demonstrate that the employer's confined space program worked. It may well have averted accidents in the past by virtue of using the sniffer; or it may have been sheer luck. But it clearly did not avert the very serious accident, leading to four fatalities and two serious injuries on this occasion. Even in the absence of an accident, we would be satisfied that the violations in question exposed the workers to a high risk of serious injury or death.

(291) The employer also pointed to the evidence of Mr. MacKenzie that the employer's practices were in accordance with normal practices in the industry and were not high risk. That the practices were "industry standard" does not remove their high risk nature. Confined spaces are inherently very dangerous. The atmosphere in the #2 starboard void space was oxygen deficient. The employer breached the Act and Regulations relating to protecting workers from this oxygen-deficient atmosphere. This breach clearly exposed the workers to a high risk of injury and death.

(292) We find that the employer committed a violation resulting in high risk of serious injury, serious illness, or death.

2. Was the employer found in violation of the same section of Part 3 of the Act or the Regulation on more than one occasion?

(293) The employer had a history of previous citations for violations of the regulatory requirements for confined space entry, in October 1991, January 1992, and September 1998. As was noted above, after the September 1998 inspection there were nine

permits, dated between February 26, 1999 and September 17, 1999, documenting confined space entry into void spaces on the barge. There were also permits relating to another barge. Maintenance records indicate some work activities that involved confined space entry were conducted after September 18, 2000 but there were no written confined space entry records.

(294) We find that the employer had been found in violation of the same regulation (or its predecessor, which addressed confined spaces) before. Thus, the employer violated those regulations on more than one occasion.

3. Was the employer found in violation of different sections of Part 3 of the Act or the Regulation on more than one occasion, where the number of violations indicates a general lack of commitment to compliance?

(295) Orders were written in 1995 and 1996 for violations of the regulations relating to first aid equipment, and in 1996 and 1998 relating to crane operation and maintenance. Requirements for confined spaces were brought to the employer's attention by a compliance order in October 1991. Even if the employer's subsequent efforts satisfied the former Regulation, the employer did not take steps to ensure ongoing compliance. Further, it appears that although the confined space entry program was on paper, it was actually implemented and complied with for only a brief period.

(296) A confined space entry program which satisfied regulatory requirements had not been developed or implemented by the employer by January 20, 2003, despite prior orders from the Board on this topic. This indicates a general lack of commitment to compliance.

(297) In addition, overall occupational health and safety program requirements were brought to the employer's attention by a compliance order on January 12, 1995, but a program had not been developed or implemented by January 20, 2003.

(298) The employer submitted that the Board should have assisted it more. The simple response to this argument is that it is the employer's responsibility to comply with the Act and the Regulation.

(299) In any event, the Board did provide the employer with assistance. For example, officers met with the employer and reviewed confined space entry programs and gave the employer a generic occupational health and safety program that the employer indicated it would "adapt." A satisfactory program that complied with the Act and the Regulation was never developed.

(300) We conclude that the employer's violations indicate a general lack of commitment to compliance.

4. Has the employer failed to comply with a previous order within a reasonable time?

(301) We answer this question yes. The employer failed to comply with the citations in 1991, 1992, and 1998 for regulatory violations related to confined space entry.

(302) We recognize that the employer provided the Board with a document relating to a confined space entry program, but it is apparent that the employer and workers were not following even the less stringent requirements in the document.

(303) Five years after the last order relating to confined spaces, the employer still did not have a program in place that complied with the Act and the Regulation. We have no difficulty concluding that five years is outside a "reasonable time" for the purposes of the policy.

(304) The employer failed to comply with the previous order within a reasonable time.

5. Has the employer knowingly or with reckless disregard violated one or more sections of Part 3 of the Act or the Regulation?

(305) Reckless disregard includes a violation resulting from ignorance of the Act or Regulation due to a refusal to read them or take other steps to find out an employer's obligations.

(306) We have already noted that the employer's occupational health and safety program in relation to confined spaces was based on the former Regulation. The employer's failure to inform itself of the new regulatory requirements, which had been in place for more than four years, leads us to infer that the employer refused or otherwise failed to take steps to find out its occupational health and safety obligations were in relation to confined spaces.

(307) In addition, we are satisfied that the employer had prior knowledge of confined space requirements because of the previous orders. Barge maintenance and consequential entry into confined spaces was a routine part of the work activity of this employer. Given its business, the employer also had knowledge that confined space entry work was hazardous. DR, for example, was a member of management and he was aware of the dangers of confined spaces to some extent. KP was also a manager and was aware of confined space danger. The employer did not take steps to find out what its obligations were under the Act and Regulation.

(308) Given the employer's knowledge in this regard, its failure to take any steps to inform itself of its obligations under the Act and the Regulation amounted to reckless disregard.

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6. Do the circumstances warrant an administrative penalty?

(309) We find that the circumstances warrant an administrative penalty. Despite the well-known hazards of confined space entry, and the frequency of confined space work at the work site, a confined space entry program had not been developed by the employer. Confined space entry in this case occurred without pre-entry air testing, mechanical ventilation, a standby person, or a rescue plan. Access to the void spaces was not restricted or controlled when entry hatch covers were removed. There was no written procedure for checking individuals working alone or in isolation under conditions that presented a risk of disabling injury. Based on work records, there was no evidence that a hazard assessment was conducted.

(310) The employer's occupational health and safety program did not fulfill regulatory requirements.

D. Should an Administrative Penalty be Imposed?

(311) Policy item #D12-196-1 in the *Prevention Manual* provides that if violations or other circumstances requiring consideration of a penalty have occurred, a number of additional factors will also be considered in deciding whether to actually impose the administrative penalty. We will consider them in turn.

1. Did the employer have an effective, overall program for complying with the Act and the Regulation?

(312) Based on the employer's response to the September 1998 inspections, the Board considered that action was taken by the employer on health and safety issues only subsequent to an inspection visit. The employer's compliance history and the documents produced by the employer confirm the Board's view.

(313) It is true that in response to the September 1998 inspections, the employer made an initial attempt to develop a health and safety program based on generic materials available through the Board, but the job was not completed or implemented.

(314) There was no evidence of regular inspections, and no documentation to show that the air-testing instrument was calibrated, and indeed the instrument was not functioning properly in relation to oxygen sensing. This was despite the manufacturer's recommendation that there be a test before each use and a full instrument calibration monthly.

(315) The Board noted that the employer's mobile crane had last been inspected in September 1998, and this type of crane requires an annual inspection.

(316) All of this evidence weighs in favour of a conclusion that the employer did not have an effective overall program for complying with the Act and the Regulation.

(317) On the other hand, the evidence shows that the workers did discuss safety issues on an informal basis. We accept that DR warned other workers of the dangers inherent in confined space entry. However, there had not been a safety meeting for some time before the accident. We find that this sort of informal program, particularly in a hazardous workplace, falls short of being an effective, overall program for complying with the Act and the Regulation.

(318) In our view this supports imposing an administrative penalty.

2. Has the employer exercised due diligence to prevent the failure, non-compliance or conditions to which the penalty relates?

(319) *Prevention Manual* policy item #D12-196-10 states:

> The Board will consider that the employer exercised due diligence if the evidence shows on a balance of probabilities that the employer took all reasonable care. This involves consideration of what a reasonable person would have done in the circumstances. Due diligence will be found if the employer reasonably believed in a mistaken set of facts which, if true, would render the act or omission innocent, or if the employer took all reasonable steps to avoid the particular event.

(320) The Board's investigation established that although the workers, and in particular DR, were somewhat familiar with the hazards of confined spaces, the employer had not taken all reasonable steps to control the hazards, train the workers or put a plan in place to oversee work in or around a confined space, or effect an orderly and safe rescue should circumstances require. In our view, the events leading up to and after the accident establish a lack of steps to control the hazards. There had been some efforts after the previous inspections, but the evidence shows that workers were allowed to quickly revert to their previous unsafe practices.

(321) The employer tendered the evidence of a marine architect who said that the employer was following industry practice. The employer also submitted that the procedures in place were demonstrated to be safe because of a lack of previous serious incidents. We considered whether this is what a reasonable person (employer) would have done in the circumstances. We also considered whether this shows that the employer reasonably believed in a mistaken set of facts which, if true, would render the act or omission innocent, or if the employer took all reasonable steps to avoid the particular event.

(322) We do not consider that the evidence of industry practice, even if correct, means that the employer did what a reasonable person would do under the circumstances, or that the employer reasonably believed in a mistaken set of facts.

(323) The dangers of confined spaces are well known in the industry and were known to the employer, as the employer had previously been cited for failure to comply with the Act and the Regulation, specifically in relation to confined spaces.

(324) Although there had been no previous serious incident, the lack of an overall program set the stage for the accident that did occur. Most of the workers were unable to demonstrate a complete understanding of confined space entry, despite the frequency of such entry. The employer did not have a confined space entry program that complied with the Regulation, even substantially.

(325) Safety orientation for new workers involved little in the way of substantive education in confined space entry. Rather, inexperienced workers relied on more experienced workers, who were not required to be and, as it turns out, were not sufficiently trained in confined space safety.

(326) There was no confined space rescue plan. In a previous incident, two workers entered a confined space with no precautions other than an air test, no watch person, and no emergency rescue plan other than one of the workers in the confined space calling 911. This demonstrates the lack of reasonable steps to control a known hazard.

(327) The employer pointed out that a trained firefighter also entered the space, suggesting that proper training would not have prevented the accident. In this sense, the employer suggests that there was no point in training workers regarding confined spaces. Thus, the employer appears to be suggesting that due diligence did not require that the workers be properly trained regarding confined spaces.

(328) We accept that the circumstances would have created a high level of stress, anxiety, and a desire to "do something." In this sense, we agree that even a complete program might not have averted the tragedy that occurred.

(329) Indeed, the firefighter's entry into the confined space, despite his training, illustrates the importance of a comprehensive training program. The firefighter was faced with a situation where the employer had no confined space entry program in operation and a serious, life-threatening accident in circumstances where there was, essentially, no rescue plan, inadequate equipment, and panicked workers. But this does not mean an employer can simply ignore the necessity of training. We point out that the literature cited by the review officer acknowledges that proper training can overcome what can clearly be an almost overwhelming desire to help in a very stressful situation. Rather than illustrating the futility of a proper employer program, the firefighter's precipitous entry illustrates the importance of one.

(330) We conclude that the employer did not exercise due diligence. Even if the employer was following industry standard practice, that practice was unsafe. We find that following such practice is not due diligence in the circumstances.

(331) In our view this supports imposing an administrative penalty.

3. Did the violations or other circumstances result from the independent actions of workers who had been properly instructed, trained, and supervised?

(332) The employer submitted that no confined space work was planned, and therefore there was no need for precautions such as supervision on the day in question. As we have discussed above, we disagree. DR was observed standing waist deep in the confined space to perform his inspection of the work and the reason for his entry is apparent. BY also said he had entered another entry hatch that day to perform his work. Another employee said it was common practice to sit in the hatch as they believed it was the "safest."

(333) The entry was not the independent action of workers who were properly instructed, supervised, and trained. That DR worked in a supervisory capacity and was at the confined space entry point is not, in our view, evidence of proper instruction, supervision, and training. DR himself entered the confined space in circumstances that fell short both of regulatory compliance and of what a prudent well-trained worker might have done, and, in the result, became the first casualty.

(334) As was noted by the Board, the confined spaces on the barges were not identified to workers. There was no written evidence of an inventory of confined spaces and hazard assessment being conducted. The workers were unable to demonstrate a complete understanding of confined space entry requirements. Combined with the absence of written materials, this confirmed that the workers lacked adequate training. They were not acting independently in the face of adequate comprehensive training.

(335) The employer's assumption that a worker's past experience with confined spaces translated into knowledge and qualifications to address the hazards of confined spaces was clearly incorrect. We find that workers, and in particular the supervisors, were not sufficiently knowledgeable about confined space hazards and how to avoid the tragic accident that occurred. In the absence of proper or explicit training, we cannot conclude that the worker's actions were the independent actions of well-trained and knowledgeable workers.

(336) In our view, this supports imposing an administrative penalty.

4. Did the potential for serious injury or illness, the number of people who might have been at risk, and the likelihood of injury or illness occurring, support imposing an administrative penalty?

(337) As observed by the Board, there is potential for serious injury or even death when a worker enters an untested and unassessed confined space. The accident demonstrates beyond question that the atmosphere inside the void space was immediately dangerous to life or health. Four workers died and two were injured. The fact that four other workers entered the void space sequentially demonstrates the degree of risk and numbers at risk due to the shortfall in adequate training and the absence of a work hazard plan.

(338) In our view, this supports imposing an administrative penalty.

5. Did the compliance history of the employer (the nature, number, and frequency of violations, and the occurrence of repeat violations) support imposing an administrative penalty?

(339) We consider the employer's compliance history, particularly its failure to comply with prior orders relating to confined spaces, supports the imposition of an administrative penalty. The evidence establishes that orders had been issued previously but the employer did not develop or implement a system to ensure continuing compliance.

(340) In our view, this supports imposing an administrative penalty.

6. Did the extent to which the employer was aware, or should have been aware, of the hazard or that the Act or the Regulation were being violated support imposing an administrative penalty?

(341) We agree that given the nature of the employer's activity, the employer was or should have been aware of the hazards associated with entry into confined spaces. The employer knew that it was required to comply with the Act and the Regulation but failed to do so.

(342) This factor also supports an administrative penalty.

7. Did the need to provide an incentive for the employer to comply support imposing an administrative penalty?

(343) We observe that the employer is no longer registered with the Board. Thus, there can be no "incentive to comply."

8. Would an alternate method of enforcing the Regulation be more effective?

(344) We note that previous enforcement methods had not been effective. Previous orders have been issued and while the employer took steps in the immediate aftermath to attempt compliance, there was a marked lack of follow-up and continued compliance. We agree that the nature of the hazard, along with significant violations of the Act and the Regulation, plus the worker fatalities, support an administrative penalty of a quantum which would be significant to the employer and other employers and impress upon them the need for constant vigilance and regulatory compliance.

9. Are there other relevant circumstances to note?

(345) The employer submitted that it should not be penalized because rescuers in situations involving confined spaces consistently override personal safety and established protocols, and take risks. Over 60% of confined space fatalities are would-be rescuers.

(346) The employer essentially argues that it was the victim of unfortunate circumstances and that the reason for the accident was something other than the employer's failure to comply with the Act and the Regulation. The employer said that it should not be fined in these circumstances.

(347) We have addressed this argument previously. The fact that confined space accidents happen and that rescuers consistently override personal safety simply underlines the importance of a proper confined space entry program, something the employer did not have. Therefore, we do not consider the nature of confined space accidents and rescuers' reactions to them is a circumstance weighing against an administrative penalty.

(348) The employer also submitted that it was treated differently than others. The employer pointed to a hazard alert on the Board's website (incident 03-11) in which a welder entered a hollow barge, and became unconscious. Four would-be rescuers went into the space and became unconscious. They were rescued using ropes, and the four rescuers survived. The welder did not. This is a similar reaction of the first people on the scene as occurred here.

(349) We do not know if the employer involved in incident 03-11 was subject to an administrative penalty. In any event, each circumstance is different and the Board must consider the relevant facts and weigh the evidence based on the individual circumstances.

(350) A relevant circumstance that weighs in favour of an administrative penalty is that confined space entry is a common work activity in the employer's industry, and that confined space hazards are encountered in a multitude of other industries. An administrative penalty was needed to motivate not just the employer, but also other

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employers. It serves to encourage the employers in a dangerous industry to be vigilant in health and safety matters.

(351) We find that such a penalty accords with the purposes of Part 3 of the Act (Occupational Health and Safety):

> 107 (1) The purpose of this Part [Part 3] is to benefit all citizens of British Columbia by promoting occupational health and safety and protecting workers and other persons present at workplaces from work related risks to their health and safety.
>
> (2) Without limiting subsection (1), the specific purposes of this Part are
>
> (a) to promote a culture of commitment on the part of employers and workers to a high standard of occupational health and safety,
>
> (b) to prevent work related accidents, injuries and illnesses,
>
> (c) to encourage the education of employers, workers and others regarding occupational health and safety,
>
> (d) to ensure an occupational environment that provides for the health and safety of workers and others,
>
> (e) to ensure that employers, workers and others who are in a position to affect the occupational health and safety of workers share that responsibility to the extent of each party's authority and ability to do so,
>
> (f) to foster cooperative and consultative relationships between employers, workers and others regarding occupational health and safety, and to promote worker participation in occupational health and safety programs and occupational health and safety processes, and
>
> (g) to minimize the social and economic costs of work related accidents, injuries and illnesses, in order to enhance the quality of life for British Columbians and the competitiveness of British Columbia in the Canadian and world economies.

(352) Weighing all of the above factors, we therefore conclude that the Board properly decided to impose an administrative penalty.

E. What is the Appropriate Quantum?

(353) The Board based the administrative penalty on the employer's 2002 payroll of $632,000, resulting in a category A penalty of $15,470. This was increased by the maximum of 30% to $20,111 following consideration of the factors set out in *Prevention Manual* policy item #D12-196-6.

(354) Policy item #D12-196-6 states that a category A penalty is appropriate in several circumstances, including where the violation in question results in a high risk of serious injury or death. We have already found that the employer's violations did so. It follows that a category A penalty is appropriate. The employer has not objected to, and we see no error in the calculation of, a category A penalty based on the employer's payroll.

(355) We will now consider the factors found in policy for varying a penalty.

(356) Policy item #D12-196-6 states the following regarding variation factors:

> **c) Variation factors**
>
> In each individual case, the "basic amount" of the penalty may be varied by up to 30%, having regard to the circumstances, including the following factors:
> (a) nature of the violation;
> (b) nature of the hazard created by the violation;
> (c) degree of actual risk created by the violation;
> (d) whether the employer knew about the situation giving rise to the violation;
> (e) the extent of the measures undertaken by the employer to comply;
> (f) the extent to which the behaviour of other workplace parties has contributed to the violation;
> (g) employer history;
> (h) whether the financial impact of the penalty would be unduly harsh in view of the employer's size; and
> (i) any other factors relevant to the particular workplace.

(357) The review officer concluded that the circumstances of the case were sufficiently exceptional to justify departing from the basic penalty amount. She noted that the degree of risk to which the workers were exposed was significant, and the employer had previous notice of the violations yet took little action to overcome the deficiencies, which were extensive. The review officer was satisfied that the employer was aware of the dangers that resulted from non-compliance.

(358) We agree that the administrative penalty was appropriately varied upwards by 30%. The violations were very serious and created significant risk to workers. The hazards

related to confined spaces, which can be, as here, immediately dangerous to life. The employer knew that confined space entry was common, and knew that compliance with the Act and the Regulation was required, but did not take adequate measures to comply. The behaviour of other workplace parties was not a factor (we do not consider the actions of properly trained or supervised workers to be a consideration here).

(359) The administrative penalty is relatively small, because of the employer's payroll. Given the size of the employer's operation and the nature of its business, we do not consider the financial penalty would be unduly harsh.

(360) We consider the penalty amount was appropriately applied based on category A, with a 30% variance upwards.

(361) We confirm the quantum of the administrative penalty.

F. Claims Cost Levy

1. Statutory and policy background

(362) Section 73 of the Act authorizes the Board to charge claims costs to the employer in certain circumstances. The maximum amount the Board may levy is adjusted annually in accordance with the Consumer Price Index under section 25 of the Act.

(363) British Columbia has had a statutory provision to charge claims costs in a particular case directly to the employer since 1922 (*Workmen's Compensation (Amendment) Act*, 1922 S.B.C., Chap 86, s. 11).

(364) Section 73(1) of the Act stated, at the time of the accident:

> (1) If
>
> (a) an injury, death or disablement from occupational disease in respect of which compensation is payable occurs to a worker, and
>
> (b) the Board considers that this was due substantially to
>
> (i) the gross negligence of an employer,
>
> (ii) the failure of an employer to adopt reasonable means for the prevention of injuries, deaths or occupational diseases, or
>
> (iii) the failure of an employer to comply with the orders or directions of the Board, or with the regulations made under Part 3 of this Act,

> the Board may levy and collect from that employer as a contribution to the accident fund all or part of the amount of the compensation payable in respect of the injury, death or occupational disease, to a maximum of $42,434.15.
>
> [footnote referencing effective date of amount omitted]

(365) The *Prevention Manual*, policy item #D24-73-1 addresses the imposition of a claims cost levy. The board of directors of the Board amended the policy effective July 1, 2008. The amended policy applies to all decisions, including appellate decisions, to charge claims costs after the effective date. We are satisfied the new policy applies to this appeal, although the previous decisions were made under the old policy.

(366) The policy states:

> This section may be applied if:
>
> - the grounds for an administrative penalty under Item D12-196-1 are met; and
> - a serious injury or disablement from occupational disease, or a death, results from a violation of the regulations.
>
> The Board has a discretion as to the amount charged under section 73(1) up to the maximum amount. A decision to charge claim costs may include the cost of future amounts of compensation that may be incurred after the decision if those future costs result from matters currently under consideration by the Worker and Employer Services Division, the Review Division or the Workers' Compensation Appeal Tribunal.
>
> Where appropriate, the Board will apply the policies and practices set out in the following Items to the charging of claims costs under section 73(1):
>
> - D12-196-1, -2, -3, -4;
> - D12-196-8;
> - D12-196-10, -11; and
> - D16-223-1.

(367) Section 73 is found in a different part of the Act than the administrative penalty provisions. It is found in Division 5 (Procedure and Miscellaneous) of Part 1 (Compensation to Workers and Dependants). Section 73 states that the Board may "levy and collect," as a "contribution to the accident fund," an amount up to the maximum.

(368) As mentioned earlier, policy item #D24-73-1 was amended. The amendments apply to all decisions, including appellate decisions, to charge claims costs on and after July 1, 2008 (Resolution of the Board of Directors No. 2008/05/28-04).

(369) We invited the employer to make submissions in relation to the amendment of policy item #D24-73-1. The employer responded by way of submission dated July 29, 2008. The employer says that WCAT should not apply the new policy.

(370) The thrust of the employer's argument falls into two areas. First, the employer states that the board of directors of the Board failed to follow aspects of the section 251 process. The employer's argument on this point relies on the mistaken assumption that the new policy item resulted from the section 251 process. It did not. This argument therefore has no merit.

(371) The employer's second argument is set out in paragraph six of his letter and states:

> Rather than applying the new policy, WCAT is bound, it is submitted, to conduct the appeal in light of the determination by the Board of Directors that the former policy as applied was patently unreasonable (Section (251(8)). The new policy – to the extent it purports to apply to past facts and a past determination – is, it is submitted, both arbitrary and contrary to the rule of law, and hence "patently unreasonable". As a result, WCAT should either refuse to apply the new policy in this instance, or refer the temporal aspects of the new policy back to the Board in accordance with Section 251(1).

(372) We do not agree that the new policy, including its "temporal aspects" is patently unreasonable. On the contrary, the new policy recognizes a discretion under section 73 that the former policy may not have explicitly recognized. That discretion does, if anything, assist the employer. The old policy required the imposition of the entire cost of a claim, subject to the maximum, whereas the new policy allows for a lesser amount of the claims costs to be considered when imposing a levy.

(373) In addition, we note generally that any presumption against retroactivity is normally limited to circumstances where the retroactive instrument takes away rights or entitlements, or is otherwise prejudicial. Indeed, this is reflected in the employer's own quote from Sullivan's text *Statutory Interpretation*:

> [Retroactivity] is also unfair insofar as it inflicts loss or hardship on persons in ways that could not have been anticipated.

(374) Simply put, we consider that the new policy assists the employer. We therefore see no reason not to apply that policy, including its temporal aspects in the circumstances of

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this appeal. It follows that we decline to refer the new policy to the chair of WCAT pursuant to section 251 of the Act, and we will apply the new policy in this appeal.

2. Double jeopardy

(375) That the Act allows the imposition of both an administrative penalty and a claims cost levy raises the question of potential double jeopardy. In the absence of any specific argument from the employer on this point, we do not propose to discuss this issue at length. In our view, it is sufficient to state that we conclude that the general principle against double jeopardy does not preclude the Board from exercising its discretion under section 73 to charge a claims cost levy notwithstanding the fact that it has also levied an administrative penalty against the employer in respect of the same events. We note two grounds in support of this conclusion.

(376) First, as pointed out at paragraph 91 of *Appeal Division Decision #00-1160*, dated July 31, 2000, section 73 involves somewhat different purposes than the administrative penalty provisions set out in Part 3 of the Act. As already noted, we are not bound to follow Appeal Division decisions; however, we agree with and adopt this reasoning to the extent that the decision suggests double jeopardy does not apply where there are separate purposes or objectives to a penalty under Part 3 of the Act and to a claims cost levy under section 73.

(377) We agree that the purposes of section 73 include a dimension of encouraging compliance. In this sense it is true that section 73 serves a similar function as an administrative penalty under section 196. However, we consider that section 73 also includes the additional purpose of providing the Board with a discretionary tool to ensure a greater degree of fairness amongst employers with respect to assessment costs.

(378) In this regard, we note the reference in section 73 to a claims cost levy being a "contribution to the accident fund." Section 73 levies are not described as penalties or fines. The accident fund is contributed to by all employers in order to fund the compensation system in the province.

(379) By requiring an additional payment into the accident fund, section 73 suggests that, at least in the circumstances listed within that provision, the costs of certain injuries may fall outside the reasonable scope of the risk intended to be covered by the collective responsibility of employers under the workers' compensation scheme in the province. It is unfair to require all employers to share the costs associated with an employer's conduct which, by breaching section 73, has increased the risks of the workplace where that increased risk materializes in an injury, death or disablement from occupational disease. In our view, it is this inequity that section 73 is intended, in part, to redress.

(380) Section 73 therefore offers the Board a discretionary method of providing a greater degree of fairness between employers within the same class and more generally to all employers in the province. Consequently, we are satisfied that section 73 involves a somewhat different purpose from the provisions in the Act relating to the imposition of administrative penalties.

(381) For this reason, we are satisfied that it does not offend the principle of double jeopardy to impose both a claims cost levy under section 73 and an administrative penalty under section 196 on the employer in the circumstances of this appeal.

(382) The second reason in support of our conclusion that the principle of double jeopardy does not assist the employer in its appeal can be found in the reasoning of a previous WCAT panel in *WCAT Decision #WCAT-2007-03400*, dated October 30, 2007:

> Although the author of the *Core Services Review Report* recommended the legislature delete the claim costs levy provision in section 73 of the Act, the legislature did not follow that recommendation. Despite making significant amendments to the Act in March 2003, the legislature maintained both the claim costs levy and administrative penalty provisions of the Act. I agree with the Board's submission that this speaks to the legislature's intention that the Board have remedies available to concurrently impose a claim costs levy under section 73 of the Act and an administrative penalty under section 196 of the Act against an employer, albeit the same unsafe conduct of the employer may underlie the Board's decisions to impose the levy and the penalty. Even though the same act of the employer may ground both the penalty and the levy, I am satisfied that the legislative intent was to give the Board the discretion to impose both the penalty and the levy concurrently against an employer. See *R. v. Prince*, 33 D.L.R. (4th) 724 (SCC). I note that legislators may override the common law principle against "double jeopardy". See *R. v.* Kienapple and *R. v. Prince*, cited above, as well as Appeal Division *Decision #2002-0636/0637* (March 12, 2002) and WCAT *Decision #2003-03517-AD* (November 13, 2003). Thus, even if sections 73(1) and 196(1) of the Act could be construed as imposing double penalties against an employer to address the same safety problem, I would find that the common law principle against "double jeopardy" did not apply in this case.

(383) We agree with and adopt the reasoning of the previous panel. The common law principle against double jeopardy does not apply.

3. Is a claims cost levy appropriate in each case?

(384) Section 73 requires that the deaths and injuries from the accident be substantially due to the gross negligence of the employer, the failure of the employer to adopt reasonable

means for the prevention of injuries, deaths or occupational diseases, or the failure of the employer to comply with the orders or directions of the Board, or with the regulations made under Part 3 of the Act. The employer submitted that a claims cost levy should only be used in exceptional circumstances, and that it can be inferred from the imposition of a claims cost levy that the facts are the worst possible facts that can be contemplated.

(385) The employer also submitted that there must be more than a mere violation, ideological application of the rules, or lack of compliance. We do not agree that what occurred here was a "mere violation" or was based on ideology. There was a lack of compliance with the Act and the Regulation, which was substantially the cause of four deaths and one serious injury of the employer's workers.

(386) The review officer noted that the Board investigates only a small proportion of claims by way of an accident investigation, as was done in this case. This means that in most cases the information necessary to assess causation, as required by section 73, does not become available through the investigation. (We observe that this would also impact the frequency of penalty action after a serious accident, which is more likely to attract a comprehensive examination.)

(387) The employer also submitted that a claims cost levy undermines the historic compromise that underlies the workers' compensation system. It is akin to stripping away insurance coverage, something that is done in very limited circumstances. The employer submitted that even a "poor" Board officer could find a deficiency in every workplace.

(388) We acknowledge the employer's submission that section 73 could be perceived as stripping away insurance protection offered by the Act. It also may well be the case that some deficiency, however minor, could be found in almost every workplace. However, it is not every deficiency in a workplace that attracts a claims cost levy. Furthermore, there are instances of what could broadly be termed "misconduct" in which insurance coverage can be "stripped away."

(389) For example, it is common knowledge that most "all risk" home owner insurance policies do not cover a number of "risks," such as water damage caused by pipes freezing if the homeowner is away for more than four consecutive days, unless the homeowner has someone checking the property daily. (See *Lind v. Canadian Northern Shield Insurance Company*, 2001 BCCA 229.)

(390) In any event, the no-fault protection offered under the Act is not absolute. There are instances in which a worker may have his or her "insurance" coverage under the Act negatively affected. For example, section 5(3) of the Act states that where an injury is attributable solely to the serious and wilful misconduct of the worker, compensation is not payable unless the injury results in death or serious or permanent disablement.

(391) Section 5(3) could be seen, from a worker's perspective, as analogous to section 73 in that it removes the "no fault" aspects of the compensation system. In addition, section 33 of the Act limits the maximum amount of income loss recoverable by workers.

(392) We also note that the extent to which an employer's insurance protection is removed by section 73 is limited to the statutory maximum amount. We take notice that claims costs, particularly in severe injury or fatal claims with dependants, can greatly exceed the statutory limit in section 73. Indeed, in this case KP's claims costs were $667,669.93. Consequently, we do not accept the employer's argument that its insurance coverage is "stripped" and we do not agree with the employer's argument that section 73 undermines the historic compromise.

(393) On the contrary, as already discussed, section 73 fosters fairness between employers to the extent that employers collectively should not be required to subsidize the full costs of claims due to a single employer's actions falling within the scope of section 73. We therefore disagree that section 73 is an exceptional provision that should be resorted to only in extreme circumstances, as suggested by the employer.

(394) The Act contemplates a claims cost levy where the injury was due to the failure of an employer to adopt reasonable means for the prevention of injuries, deaths, or occupational diseases, or the failure of an employer to comply with the orders or directions of the Board, or with the regulations made under Part 3 of the Act. We see nothing in the Act as a whole or section 73 in particular, to suggest that it is limited to extreme or egregious circumstances.

(395) The employer also argues that it had not had a previous confined space accident, indicating their approach was working. The employer submitted that the accident might not have been prevented, even if there were a confined space entry program that was in compliance. We disagree with this argument because the employer effectively implies that, overall, regulation relating to confined spaces and the adoption of a program is pointless.

(396) We recognize that the situation the workers found themselves in was extremely stressful and that their judgment was likely impaired by the stress of the situation. The evidence, which we accept, was that this was a small and close-knit workforce. Some of the workers said they felt like family. In such a circumstance, the pressure to take immediate action must be immense. This is made clear by the articles referred to by the review officer.

(397) However, this pressure to take immediate action does not mean that the employer's non-compliance was less than a substantial cause of the accident. Rather, the lack of training and supervision, as well as the lack of well-established rules and plans relating to confined spaces meant that when they encountered the extremely stressful situation,

workers had nothing to fall back on. They had no plan and no equipment prepared. It is apparent based on our review of the whole of the file, that there was, essentially, no emergency plan whatsoever, despite the hazardous nature of the work. As was pointed out by Mr. Salo,[30] having a little training in confined space rescue often gets the individuals involved in even more trouble, many times resulting in multiple fatalities. The lack of training, or inadequate training, puts workers at great risk. This applies both to those who work in confined spaces and to those who attempt (or are responsible for) rescue.

(398) We consider that had the employer complied with the Regulation and the Act, and had a confined space program, it is unlikely that DR would have found himself at the bottom of the void, without anyone there to help. DR was not properly trained on the date of the accident. He entered the confined space without testing the air, and without precautions in place in case he slipped or somehow fell further into the void space. Even if DR voluntarily decided to go to the bottom of the void space, for unknown reasons, such an entry indicates that he was inadequately trained. Furthermore, even if he accidentally fell head first into the space while looking in for something, (which we consider unlikely given the small hatch), this again illustrates the absence of a proper confined space program.

(399) There were inadequate mechanisms in place to check on the safety of individuals working in isolation. There were inadequate mechanisms in place to monitor the safety of a worker who had entered a confined space. Although there was a fan and a crane at the work site, there was no coordinated or properly developed confined space rescue plan. In the absence of such a plan, workers did not know what to do. Furthermore, they were not properly trained in confined space rescue, despite the frequent confined space work done by the employer.

(400) It cannot be known for certain that a confined space program in compliance with the Act and the Regulation would have completely prevented the accident. We recognize that the firefighter was trained and despite his training, he entered the space to try and rescue the trapped workers. But, as set out above, we consider that his entry occurred in part because of the very stressful environment created by an almost complete lack of training and planning on the part of the employer.

(401) We reviewed the various articles on confined spaces and rescue. We agree with the review officer that a better understanding of the associated dangers, a rescue plan, and regular training and practice would have deterred workers from entering the space. However, we consider this applies to all of the employer's workers who died or were injured. That DR stood in the hatch to inspect the welder's work, without any precautions, was substantially due to the employer's non-compliance. Similarly, the other four workers of the employer entered the space without any precautions

[30] *Ibid*, note #26.

substantially because there was no coordinated plan, they were not trained, and they did not know what else to do. We therefore do not agree with the employer's argument that a compliant confined space program would have been futile.

(402) In a similar vein, the employer says that DR's absence was noted quickly and that even a compliant safety program would not have succeeded in indentifying DR's absence more quickly. We disagree. It was only fortuitous that DR's absence was noted because his entry into the space occurred immediately before the coffee break. In any event, by the time the workers noticed DR's absence from the coffee break, it was already too late.

(403) Finally, the employer argues, and we accept, that workers were generally aware of the dangers of confined spaces. DR and KP in particular were experienced, and knew that void spaces could be dangerous. The employer seems to submit that this degree of knowledge amounted to evidence of the employer adopting reasonable means for the prevention of occupational injuries or deaths.

(404) We do not accept this argument. Although some workers demonstrated some knowledge of confined spaces, that knowledge translated into little more than using an uncalibrated sniffer. The entry by DR and CM some weeks before the accident illustrates the employer's failure to adopt reasonable means for the prevention of occupational injuries or deaths.

(405) The employer's failures in this regard apply to all of the workers that were injured or killed on January 10, 2003. Unlike the review officer, we see no reason to distinguish between the circumstances of any of these deaths or injuries. We say this because, although different stressors acted on each individual, and each worker responded differently, the common denominator was the lack of a proper plan, training, and supervision.

(406) Weighing all of the above, we find that all the deaths and injuries were substantially due to the failure of the employer to adopt reasonable means for the prevention of injuries and deaths of these workers. These injuries and deaths were also substantially due to the failure of the employer to comply with the orders or directions of the Board, and with the regulations made under Part 3 of the Act and the Regulation. Absent the jurisdictional defect we identify below, we would levy a claims cost in respect of all the deaths and injuries.

(407) The Board's decision to impose a claims cost levy underlies this appeal. In that decision, the Board concluded that a claims cost levy was appropriate in relation to the injured worker CM, and the deceased workers SI and KR. The Board did not make any decision imposing a claims cost levy in relation to DR and KP. There was no request for review by the employer or any other party under section 96.2(1)(b) of the Act with respect to DR or KP. Nor did any of the respondents make a submission that a claims

cost levy should be imposed with respect to the deaths of DR and KP at the Review Division or WCAT. In these circumstances, we find the Review Division did not have jurisdiction under section 96.2(1)(b) with respect to KP.

(408) It follows that we have decided to vary the Review Division decision by removing the claims cost levy respecting KP. The same reasoning applies in respect of DR.

(409) With respect to SI, we have decided to vary the review officer's decision and reinstate the claims cost levy. SI's claims costs were originally included in the Board's decision, and the employer had an opportunity to make submissions on that question. The review officer decided to remove the levy. We considered inviting the employer to provide specific submissions in relation to SI. However, we concluded that there was no new issue arising because it was fundamental to the overall decision and was clearly within the scope of the appeal. We note again that the employer was asked several times to provide substantive submissions on the merits of its appeal to WCAT; however, it did not do so. Consequently, we are satisfied that it was not necessary to seek a specific submission from the employer in relation to SI.

(410) We conclude as follows. The Review Division decision is varied to the extent that KP's claims costs are removed and SI's are reinstated.

4. Quantum of claims cost levies

This brings us to the quantum of the levies.

(411) As mentioned above, because of the common underlying cause of all the deaths and injuries in the circumstances of this appeal, we do not intend to discuss the quantum of the claims cost levy for each individual worker. In our view, the same considerations apply to the quantum of all the levies.

(412) Policy item #D24-73-1 of the *Prevention Manual* applies to the charging of claims costs, but does not provide guidance with regard to how to determine the quantum of the levy.

(413) In light of the lack of policy guidance, determining the amount of a claims cost levy is a discretionary matter. How then should the discretion regarding the amount of the claims cost levy be exercised?

(414) For guidance, we turn to the principles related to the exercise of discretion in an administrative law context. Discretion was discussed in *Roncarelli v. Duplessis*, [1959] S.C.R. 121, in which Rand, J. said at page 140 that "there is always a perspective within which a statute is intended to operate." The exercise of discretion "is to be based upon a weighing of the considerations pertinent to the object of the [statute's] administration."

(415) There is further discussion by the Supreme Court of Canada in *C.U.P.E. v. Ontario (Minister of Labour)*, [2003] 1 S.C.R. 539. The issue related to the appointment of retired judges as interest arbitrators in a health care collective bargaining dispute. The relevant legislation conferred a broad discretion to the minister to appoint, "a person who is, in the opinion of the Minister, qualified to act." The Court said, at paragraph 94 (per Binnie, J., writing for the majority):

> In this case, the "perspective within which a statute is intended to operate" is that of a legislative measure that seeks to achieve industrial peace by substituting compulsory arbitration for the right to strike or lockout. The "perspective" is another way of describing the policy and objects of the statute.

(416) The Court referred to a decision of the House of Lords, in *Padfield v. Minister of Agriculture, Fisheries and Food*, [1968] A.C. 997, at page 1030:

> …if the Minister, by reason of his having misconstrued the Act or for any other reason, so uses his discretion as to thwart or run counter to the policy and objects of the Act, then our law would be very defective if persons aggrieved were not entitled to the protection of the court.

(417) Finally, we have also considered Sara Blake's analysis of the exercise of discretion by administrative decision-makers in chapter 3 of *Administrative Law in Canada, 4th Edition*.

(418) From the above, we conclude that one of the most important factors in the exercise of discretion is considering the purpose of the Act generally and the discretionary provision specifically.

(419) We have already discussed the purposes underlying the Act and section 73. We have considered, in the broad sense, that one of the fundamental purposes of the Act as it relates to section 73 is the prevention of injury, death, or disablement in the workplace. Another purpose is to promote a degree of fairness between employers in the administration of the collective liability scheme.

(420) In furtherance of these objects, the Board has set out guidance for the exercise of the section 73 discretion in policy item #D24-73-1 of the *Prevention Manual*. This policy item incorporates by reference various other policies, which relate to administrative penalties.

(421) Although an administrative penalty is different from a claims cost levy, the factors are helpful in determining the quantum of a claims cost levy, in particular whether to include all or part of the compensation payable in the levy, subject to the statutory maximum.

(422) From the policies referred to in policy item #D24-73-1, we take the following principles as relevant to the quantum of a claims cost levy:

- The nature of the violation is set out in policy item #D12-196-2, which requires consideration of the whether a violation involved a high risk of serious injury, serious illness, or death. In this case, the violations involved a high risk of serious injury, particularly in relation to the confined space regulations. This factor weighs in favour of a higher claims cost levy.

- Policy item #D12-196-1 requires consideration of the nature of the potential hazard created. This is a similar consideration to the one above. The policy discusses the potential seriousness of the injury or illness that might have occurred, the number of people who might have been at risk, and the likelihood of the injury or illness occurring. When considered in the context of this case, this factor weighs in favour of a larger levy.

- Policy item #D12-196-1 also speaks of employer history, referring to an employer who is found in violation of the same section of Part 3 or the Regulation on more than one occasion, or who has failed to comply with an order within a reasonable time. It refers to violations where the number of violations indicates a general lack of commitment to compliance. Again, these factors weigh in favour of a larger levy. The employer had a history of non-compliance, and that history related in large part to the confined space regulations. This factor also supports a larger levy.

- Policy item #D12-196-2 refers to the degree of actual risk created by the violation. This is also a factor related to those above. In this case, a number of deaths and serious injuries occurred. This factor supports a larger levy.

- Policy item #D12-196-1 refers to whether the employer knowingly or with reckless disregard violated Part 3 or the Regulation. Reckless disregard includes where a violation results from ignorance of the Act or the Regulation due to a refusal to read them or take other steps to find out an employer's obligations. In this case, the employer knew about the confined space and other regulations, having had the benefit of previous intervention by the Prevention Division. The employer knew or should have known of the new Regulation and continued to rely on a confined space program based on the former Regulation. Even then, the employer did not follow its own, out-of-date confined space program. Finally, the employer was aware of the hazards associated with confined spaces but did not take adequate steps to ameliorate them, to the degree possible. This factor weighs in favour of a larger levy.

- Policy item #D12-196-1 refers to whether the employer knew about the violation. This relates to the extent to which an employer was aware or should have been aware of the hazard or that the Act and the Regulation were being violated. This

employer was aware of the hazard, and knew that it was necessary to have a proper confined space program. This consideration is somewhat similar to the previous factor and to the extent that it is of significance it similarly supports a larger levy.

- The same policy also refers to the extent of the measures taken by the employer to comply. This includes whether the employer has an effective, overall program for complying with the Act and the Regulation, and whether the employer has otherwise exercised due diligence. We have already found that the employer did not have an effective, overall program for complying and did not exercise due diligence. Adhering in a general way to "industry standards" is not sufficient and does not demonstrate due diligence. The evidence does not show, on the balance of probabilities, that the employer took all reasonable care nor did what a reasonable person would do in the circumstances. The employer obtained the air-testing "sniffer" and workers used it but there was no other precaution, no calibration of the tester, no rescue plan, and poor practices such as two workers entering a confined space with no lookout and no rescue plan other than phoning 911. This factor supports a larger levy.

- Policy item #D12-196-1 also involves consideration of the extent to which the behaviour of workers who have been properly instructed, trained, and supervised contributed to the violation. The policy refers to the independent actions of workers. In this case, we have already found that the workers were not properly, instructed, trained, and supervised. Therefore, this factor does not mitigate the employer's responsibility under section 73 for the deaths and injuries that occurred on January 10, 2003.

- Finally, policy item #D12-196-1 refers to additional factors, and other relevant circumstances. Such factors could include the size of the employer and steps taken to address the regulatory breaches in question. The employer took steps to improve its confined space entry program. However, neither the employer nor its successor has provided evidence of improvements made after the accident. Accordingly, the steps taken by the employer after the accident support, at most, only a modest decrease in the claims cost levy. In addition, the employer's relatively small size in conjunction with the large claims costs also weigh to some extent against a full levy.

(423) In addition to the guidance set out in policy item #D24-73-1, we also considered prior decisions of WCAT and the Appeal Division. Of particular note, we agree with the concept of a "sliding scale" discussed in *Appeal Division Decision #2002-0662*.

(424) In that decision, the appeal commissioner viewed the three different grounds for a claims cost levy under section 73(1)(b) as creating a "sliding scale," with gross negligence requiring a higher level of claims cost levy than circumstances that might be viewed as a "simple" breach of the Regulation. The appeal commissioner said that gross negligence may merit a higher claims cost levy than circumstances lacking gross

negligence, but the Board is not restricted to that analysis and can consider other relevant factors.

(425) We note that *Appeal Division Decision #2002-0662* was written prior to the new version of policy item #D24-73-1. We also note that the Appeal Division was not at the time required by the Act to apply published policy, unlike WCAT. However, we do not consider that policy item #D24-73-1 precludes the use of the sliding scale concept. At least in the circumstances of this appeal, we consider that the sliding scale concept is consistent with the purposes of section 73 and with published policy, providing it is not the only consideration.

(426) The concept of the sliding scale would support inclusion of all or most of the costs of compensation in the event of gross negligence.

(427) We have considered whether the employer's failures could be characterized as "gross negligence." This phrase is not defined in the Act or in published policy. *Black's Law Dictionary (Abridged Fifth Edition)*, defines gross negligence as the intentional failure to perform a manifest duty in reckless disregard of the consequences as affecting the life or property of another.

(428) We do not find that the employer intentionally failed to perform a manifest duty in reckless disregard of the consequences of this failure. Although the employer fell far short of proper compliance with the Act and the Regulation, and although this failure was a substantial cause of the deaths and injuries, there is insufficient evidence to establish the degree of intention required for a finding of gross negligence in this case.

(429) The absence of gross negligence tends to support a conclusion that the claims cost levy should reflect less than the full costs of the compensation payable. However, we have found that the employer failed to adopt reasonable means for the prevention of injuries or deaths. The employer also failed to comply with orders of the Board and with the Regulation. The sliding scale analysis therefore suggests the imposition of a levy reflecting a substantial portion of the claims costs at issue in this appeal.

(430) We agree with the review officer that the actual cost of the claim is not a consideration (except in regard to the statutory maximum). The cost of compensation is impacted by an individual worker's circumstances. For example, when there is a fatal claim, the cost of compensation is larger for workers with dependants.

(431) Given all the circumstances described above, and taking into account the factors described in policy item #D24-73-1, including the small size of the employer and its post-accident efforts to comply, and the "sliding scale" analysis, we find that a claims cost levy equivalent to 75% of the claims costs in each case (up to the statutory maximum at the time of the accident) is appropriate.

5. Conclusion regarding claims cost levies

(432) We allow the employer's appeal, in part, regarding the imposition of claims cost levies. We vary the Review Division decision by imposing a claims cost levy on the employer in relation to SI's death and taking out the claims cost levy respecting KP.

(433) We allow the employer's appeal with respect to the quantum of the levies, in part, by varying the Review Division decision so that 75% of the compensation payable in each case, up to the statutory maximum, will constitute the levy payable.

VII. CONCLUSION

A. Review Reference #30104

(434) The decision in *Review Reference #30104* is confirmed. The employer failed to ensure the health and safety of its workers in contravention of section 115(1)(a)(i) of the Act.

(435) We have concluded:

4. The employer did not conduct a risk assessment in a workplace in which a need to rescue or evacuate workers might arise, as required by section 4.13(1) of the Regulation.

5. The employer did not develop and implement written rescue and evacuation procedures as required with respect to:

   a) work in confined spaces or where there is a risk of entrapment, as required by section 4.13(3)(b) of the Regulation; or

   b) work over water, as required by section 4.13(3)(e) of the Regulation.

6. The employer failed to comply with the confined space requirements as set out in Part 9 of the Regulation. Specific violations of Part 9 relating to the accident on January 10, 2003 are set out as follows:

   a) The employer did not identify the void spaces within the barge as required by section 9.2(a) of the Regulation and no determination was made as to whether any such space would require entry by a worker, either in scheduled work activities or as a result of foreseeable system failures or other emergencies, as required by section 9.2(b) of the Regulation.

   b) The employer did not ensure that each point of access to the void spaces was secured against entry or identified by a sign or other effective means to

indicate the nature of the hazard and the prohibition of entry, and that workers were instructed not to enter, as required by section 9.3 of the Regulation.

c) The employer did not prepare and implement a written confined space entry program before a worker was permitted to enter a confined space, as required by section 9.5 of the Regulation. Rescue of a worker or workers from a confined space required compliance with section 9.5 of the Regulation.

8. Work was being conducted in two shop locations, the storage yard and on a number of vessels. Workers were isolated from one another and communication between them was severely restricted. The employer failed to develop or implement a written procedure for checking the well-being of a worker assigned to work alone or in isolation under conditions which presented a risk of disabling injury, as required by section 4.21(1) of the Regulation. Section 4.21(1) of the Regulation requires such a written procedure when workers might not be able to secure assistance in the event of injury or other misfortune.

9. The employer did not ensure that its workers were made aware of all known or reasonably foreseeable health or safety hazards to which they were likely to be exposed by their work, as required by section 115(2)(b)(i) of the Act.

10. The employer did not provide to its workers the information, instruction, training and supervision necessary to ensure the health and safety of those workers in carrying out their work, as required by section 115(2)(e) of the Act.

11. The employer did not have an occupational health and safety program as required by section 3.3 of the Regulation.

B. Review Reference #R0056789

(436) The decision in *Review Reference #R0056789* is varied and we make the following findings:

4. An administrative penalty under section 196(1) of the Act is warranted in this case.

5. We confirm the quantum of the administrative penalty in the amount of $20,111.

6. The employer is properly subject to claims cost levies in relation to KR, CM, and SI.

7. The amount of each claims cost levy is to be calculated using 75% of the cost of compensation paid to each worker, or his dependant(s), up to the statutory maximum set out in section 73(1) of the Act at the time of the accident.

(437) There was no request for reimbursement of expenses and we make no order in this regard.

Teresa White
Vice Chair

Warren Hoole
Vice Chair

Guy Riecken
Vice Chair

TW/WH/GR/gl

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