Citation:

Date:
Docket: 7850
Registry: Golden

IN THE PROVINCIAL COURT OF BRITISH COLUMBIA

REGINA

V.

CANADIAN PACIFIC RAILWAY COMPANY
AND TONY SILVA

REASONS FOR JUDGEMENT

OF THE

HONOURABLE JUDGE CARLGREN

Counsel for Crown	Bruce Fairley
Counsel for accused, Canadian Pacific Railway Company	Alan Blair and Christine Kowbel
Counsel for the accused, Tony Silva	Leo McGrady, Q.C.
Date and Place of Hearing	May 18, 2002 Golden, BC
Date of Judgment	June 20, 2002

Brief Synopsis

[1] Shawn Ormshaw died beneath a piece of equipment on which he was working. This was at the Canadian Pacific Railway yards in Golden, British Columbia on June 22, 2000. Nearly a year later, charges were laid under the Canada Labour Code against a crane operator, a mid-level supervisor, and the Railway. Those charges are set out in their entirety in Appendix A. Count 5 has been stayed by the Crown.

[2] A traction motor sits within the wheel assembly of an Ohio crane. It is very heavy, weighing more than a ton. Estimates actually go as high in the evidence as 5000 pounds. It is secured against dropping by a single bolt, referred to as a suspension bolt or anchor bolt. When that bolt is removed, the motor is free to swing downward, likely damaging the gear mechanism to which the other side is attached. That is to say, it will pivot. Shawn was beneath the motor and apparently completely unscrewed the bolt. The motor struck him in the head, and killed him. In very general terms, the Crown finds particular fault here with the nature of the instructions Shawn was given, and the lack of a fail-safe procedure. I am also advised that the accused crane operator, Tony Silva, is lower on the command structure than anyone previously charged in any of the reported decisions on

occupational safety charges under the Labour Code or related provincial legislation.

[3] It is also clear that these charges are “strict liability” offences, meaning that once the Crown has proven beyond reasonable doubt that the prohibited acts have taken place, it is for the defence to establish, on a balance of probabilities, the exercise of due diligence to prevent their occurrence.

What is at Issue

[4] None of the “details'-identity, place, jurisdiction-are at issue. That leaves the argument to turn on whether the Crown has established the particulars alleged in the counts, and whether the defence of due diligence has been made out. Those particulars require that the evidence answer:

> Count 1: was Shawn properly trained and supervised; and were proper safety measures in place?
>
> Count 2: was Shawn made aware that the motor would fall if the anchor bolt were completely removed?
>
> Count 3: was changing the motor “maintenance”, were there written instructions on maintenance, and does “'first set

out" mean before equipment is used, or before each time it is used?

Count 4: was Shawn "qualified" to perform the job?

Count 6: was Shawn properly cautioned, and was he given sufficient instruction to allow him to perform the job safely?

Count 7: was Shawn properly informed of the risk of the motor falling, and was sufficient care taken to ensure that it did not?

Count 8: as in count 7.

The Witnesses

[5] The court is aware of the emotional distress and personal grief caused both Mr. Silva and Mr. Carroll. It is obvious that the latter has a way to go in dealing with his own reactions to this tragedy, and I wish him well. Mr. Silva, I am told, has returned to work only briefly and has suffered from stress virtually since the accident. For both, the number of times these proceedings have forced them to re-live the circumstances is unfortunate in the extreme. One can only hope

that each is able to obtain the counselling and assistance required to carry on in good health.

[6] That said, I do not intend to deal at length with the evidence of each witness. I intend, rather, to state the facts as I have found them and to make fairly general remarks about that process. Hopefully, the evidence which has been preferred, where that is necessary, will be clear from that process.

What Happened

[7] Ray Pittman operated an Ohio crane, which is a large crane that travels under its own power along the railway. The boom and house of the crane sit atop a wheel assembly at either end, consisting of wheels, support structure and axles, and brakes. There is also a traction motor. That motor is mounted so that it sits low on the structure of the wheel assembly, and attached at one end to the gearing mechanism. At the other, as mentioned, it is held in place by a single bolt. That bolt is large, being about 1.25 inches in diameter and about 16 inches long. It has its head nearest the railbed, and the threaded end above and secured by a crown nut. That nut is the shape of a crown, with indentations from its top about half way to its bottom. Those indentations are to permit a

cotter pin to be placed through the nut and the bolt, thus preventing the nut from wiggling itself loose. This crown nut is in an awkward spot on the top side of the wheel assembly, making it difficult to place a wrench on it. This in turn makes it necessary that the bolt be loosened or removed from the bottom. At the bottom, there is a plate mounted beneath the head of the bolt, which is apparently there to prevent the bolt falling out if for some reason the nut did come off. In order to remove the bolt, it is necessary to first remove this catch plate, then turn the bolt very slightly so that the cotter pin can be removed. Once that is accomplished, the bolt may be unscrewed. In this instance, the tool chosen for that task was a 1” drive ratchet with a deep socket attached. It is nearly two feet long, and would require the user to be on their back, with one hand holding the socket in place on the bolt head, and the other manipulating the ratchet. It is possible to do this so that the person's body extends away from the bolt and motor, with the head nearest it. The hand holding the socket is extended horizontally from the head, and raised somewhat in the position necessary to hold it in place. The evidence before me, both verbally and by demonstration, indicates that it is possible to do this so that one's head is about a foot away from the motor, and away from the direction it would swing if released completely. The exact clearance

would, of course, depend on the size, strength and agility of the person holding it and the height of the track at the work location. This is, of course, not a product liability case, but it seems a strange design, and one wonders why it would not have been possible to have the end of the bolt which is to be merely held at the bottom, and the end to be turned at the top. In any event, the position taken beneath a wheel assembly which is in the field rather than over a pit in the shop allows the ratchet user only about one-eighth to one-quarter turn per movement of the ratchet. On this occasion, Corey Carroll was given the job of holding the nut with a pipe wrench, and Shawn went below the wheel assembly to turn the bolt head. I will deal later with how this came to be. It is clear that Shawn continued undoing the bolt until it no longer held, and that by that time he had moved so that his head was now beneath the motor-in its downward path once the bolt no longer held it. At this stage, there was no blocking beneath the wheel assembly to prevent the motor “falling”, nor was the motor suspended in any way.

The Alleged Failure

(8] The Crown position is essentially that Shawn was not “qualified” to perform this task, because he had not been adequately trained and informed to appreciate the perils he

faced; that there was a lack of supervision and monitoring; that there was a lack of effective communication both of the job to be done and the inherent risks; and that there were reasonable safety precautions which were not taken. Much of the information should normally be communicated, according to the company's policies, at a job or safety briefing. Each work day is supposed to start with such a briefing, which is to ensure that every employee is made aware of their job for the day, and how it fits into the larger scheme of things if there are related jobs that day, made aware of any risks or safety issues arising in these jobs, and then re-advised as the nature of the work changes. This briefing is entrusted to a supervisor, but is set up as an inter-active procedure where the employee is supposed to understand his assignment and ask questions to resolve any issues. The Crown is here arguing that the briefings which took place on this day were wholly inadequate; and where the information provided might have been adequate, there was no effort to ensure that it was understood.

Supervision

[9] There were a number of persons present during the day who were supervisors. Mr. LeGresley, who was originally charged in count 5, was the senior supervisor present during the day. He

was not called as a witness, even after the charge was stayed. His assistant was a Mr. Suhan, who was called. Mr. Pittman was the operator of the crane which had need of motor removal. Normally, he would supervise operation of his crane, and maintenance on it. Additionally, Mr. Silva was the operator of a similar crane, and ended by assuming some supervision. Ormshaw was a member of the crew of the disabled crane, and began work that day in Silva's crew because Pittman's crane was not operable. Silva's job for the day involved “distributing” materials along the track from Palliser to Golden. When this job complete4 early, and Pittman's motor had been determined to need removal, Silva indicated his willingness to get involved. He had, I am satisfied, a mechanical inclination and enjoyed performing this type of function. The evidence also indicates that he has experience of about 20 such motor “change-outs”, some done as an assistant mechanic and others as a crane operator. By virtue of the number he had done, he was considered to be knowledgeable and competent in this area. In any event, he involved himself and his crew in this operation. The first thing which needed doing was to remove the wheel assembly at issue from beneath the crane. A crew from a different department arrived, and the house and boom area of Pittman's crane were lifted to permit the wheel assembly to be pushed

and pulled from beneath. I'm satisfied that over-all control of this portion of the job was in the hands of the car department. The process was to lift one end, put it on blocks, and then remove the assembly. Next, the traction motor was to be removed. Mr. Silva's plan here was to loosen the anchor bolt; relax the turnbuckle keeping the brakes in contact with the wheels so that the body of the wheel assembly could be lifted clear; secure the traction motor by “slinging” it to a crane; undo the anchor bolt completely; and then lift the traction motor clear of the wheel assembly. He had originally planned that Terry Feuz, a mechanic sent to ensure the traction motor needed replacement, would use the crane mounted on his truck to assist. This changed when Feuz, working elsewhere, had not returned by the time Silva viewed the motor as being ready to be “slung”. So he changed his mind, and decided to use the Pittman crane, which was usable though no longer mobile. Until the point that Silva left to start the Pittman crane for this purpose, he was clearly supervising from the point the wheel assembly had been cleared by the car department crane. It is less clear from this moment, but I would specifically find that Silva having been in charge could only relieve himself of that responsibility with a direction to another that was clear to all affected by the change. This did not occur. Thus, I am satisfied that the

direct supervisor of Shawn, from the moment the wheel assembly was removed until his death, was Mr. Silva.

The Job Briefing

[10] There were a number of points where job briefings were required to comply with the company policy. That policy is, of course, not law. And the law does not require a job briefing, at least in the precise format and circumstances envisaged by the company here in its safety policy. There should, for example, have been a briefing at the point of removal of the wheel assembly from beneath the, deck of Pittman's crane. This was not apparently done. It may well have been the car department's responsibility to have done so, but Ms. Boyko, for example, who had been a member of Silva's crew for the day, would have to have been told by Silva that she was now responsible to the car department's supervisor. It is not clear that this occurred. Some of these jobs, however, entail little risk and that risk is readily apparent. She just pitched in. Once the wheel assembly was clear, Mr. Silva did have a job briefing. I have heard various versions of the content of that briefing. Both Ms. Boyko and Mr. Carroll were present. Their recollections are quite different. Boyko, who appeared to me to have been disinterested in most of what occurred earlier in the day, and whose job for the most part

did not require much of her, recalled having been told that the bolt needed to be “loosened”; to be loosened enough to provide “a little bit of give”. She thought there was something about needing to have the motor hooked up before it was removed. Mr. Carroll was not really sure who was supervising the removal. He did not remember the briefing Silva gave at the wheel assembly in any detail, but seems only to have discovered, then or following, that his role was to hold a wrench on the crown nut with Shawn turning the bolt from beneath. He says that “they”-and it is clear that this is speculative to the extent that it indicates Shawn's view-thought the bolt had to come all the way out, and that he does not recall any direction to just unscrew it a certain number of threads, or any mention that the bolt or motor might fall. In cross-examination, Mr. Carroll conceded that he did not remember the job briefing, or being told that the bolt had to come out, and agrees that the instruction might have been to loosen it. He feels he might not have been paying attention, as his mind was likely on the coming week-end, about which he and Shawn had quite a bit of discussion. Ray Pittman was also present for this briefing, a task for which he said he, as a crane operator himself, had received no detailed or formal training. There was mention of the weight of the motor, the fact it was held by only one bolt, the need to undo it “a

little”. The discussion went over this material 3 or 4 times. He also agreed with the suggestion in cross-examination that it was clear that the motor would go to the ground when the bolt was out, and that the bolt was the key element holding it all together. With the same reservations about his ability to speak for others, I accept Mr. Pittman's description of the basic contents of the job briefing. He also mentions that there were questions asked, which was how he came to the conclusion the others had understood. Lastly, Mr. Silva reconstructed the job briefing when cross-examined by the Crown. He said he regarded it as an opportunity to teach, and that he explained-and pointed out-the parts involved and the process. In particular, he says that he showed the anchor bolt and explained that the motor had to be hooked up before this was taken all the way out, or it would swing to the ground. As he describes the briefing, he added a good deal about the next parts of the job, and what they involved, and why those steps were to be taken. He saw the job as well-explained, and took the questions asked him as confirmation of their understanding. Although it is possible some of Mr. Silva's recall is reconstruction, and aimed at putting him in a better light, I generally accept what he has said. He was in a far better position to recall the full contents of his briefing even without the accident happening than were Carroll and

Boyko, and following the accident probably had far more reason to recall it than did Pittman. And his evidence as a whole strikes me as honest; I had no sense of a conscious effort to distort the truth. In addition, it largely accords with Pittman's recollection and is not inconsistent with Boyko’s. I would be astonished, given her demeanour and stated approach to the work, if she recalled much of the instructions, but she nonetheless does recall “loosen”' rather than “remove”.

The Accident

[11] Although Silva had initially intended to do the under-carriage work himself, he thought it would be educational if the others participated, and did not interfere with that. When it turned out that Pittman seemed reluctant to go beneath because of the clean white shirt he wore, he saw nothing wrong with Shawn taking his place. And, seeing that both Carroll and Shawn were properly in place, doing what they were supposed to, he then turned his attention to using the Ohio crane instead of the Feuz crane-I believe because he realized he could, and because Feuz had not yet returned. He left to start the crane. This had the effect of leaving the two youngsters, Carroll and Ormshaw, either unsupervised or supervised by Pittman. I should point out that there was no direction that this occurred—”Ray, you're in charge!”-and it likely would not

have changed the result, though it should have taken place. In any case, Pittman says that he checked the crown nut, saw that it had been about half-removed, and removed the pipe wrench from Carroll's hand, saying 'That's enough” loudly enough for both boys to have heard. Pittman was very soft-spoken in court, but I recognize court is not the work-place and would be reluctant to conclude he spoke as softly on the job-site. In any event, he was heard by Boyko and Silva, both of whom were at least as far away as Shawn. Carroll has no recollection of either the remark, or the wrench being removed. Pittman then says that he bent to begin slackening the brakes, a task for which he required Shawn's assistance from the inside of the wheel assembly. He did not note that Carroll had put the wrench back on the crown nut, or that Shawn had shifted his position, or more particularly that Shawn made the 20 to 40 ratcheting motions which would have been necessary, on his evidence, to fully remove the bolt. I suspect that his evidence of the number of threads remaining in the nut is probably part of the reason for this, and is inaccurate: if it were otherwise, his failure to hear or see what was occurring such a short distance away is inexplicable. In any event, it is at this stage-Silva at the crane, Boyko and Carroll above the wheel assembly and him at the side-that the motor falls on Shawn.

Lack of Safety Precautions

[12] The Crown's expert witness, Mr. Slanzi, says that this job should never have been performed without placing blocking beneath the traction motor assembly prior to working on the anchor, or suspension, bolt. It would also have been possible to place a sling around the motor at this early stage rather than waiting until the bolt was partly loosened to do so. Mr. Silva indicated his reasons for not placing this blocking: it would either be in the way of the sling when ready to place this, or in the way of removing' or loosening the anchor bolt itself. However, when the Crown pointed out that 4” by 4”“ blocking might have been used, instead of the railroad ties considered by Mr. Silva, he agreed. And if that size of blocking were used, there might not be interference with the removal of the suspension bolt or slinging the motor for removal. It appears, then, that Mr. Silva agrees that blocking in a smaller size, and even slinging to the crane, may both be possible prior to removal of the suspension bolt. With respect to the latter, I must say that, though it wasn't specifically dealt with in evidence, it would seem to me that suspension by crane prior to removal of the suspension bolt could require that some slack be left in the sling. Still, it would not need to be much.

The Statute Law

[13] I have set out all of the provisions of the Canada Labour Code, and the Occupational Health and Safety Regulations which apply to this case in Appendix B.

The Case Law

[14] These charges fall under the rubric of strict liability offences as described in the leading case on the subject, R. v. Sault Ste. Marie, [19781 2 S.C.R. 1299. That, of course, results in this simple statement of the relative burdens: “Thus while the prosecution must prove beyond reasonable doubt that the defendant committed the prohibited act, the defendant need only establish on the balance of probabilities his defence of reasonable care.” (headnote) . There is, in the last full paragraph of Mr. Justice Dickson's reasons, this statement: “Where an employer is charged in respect of an act committed by an employee acting in the course of employment, the question will be whether the act took place without the accused's direction or approval, thus negating wilful involvement of the accused, and whether the accused exercised all reasonable care by establishing a proper system to prevent commission of the offence and by taking reasonable steps to ensure the effective operation of the system. The availability of the defence to a corporation will depend on whether such

due diligence was taken by those who are the directing mind and will of the corporation, whose acts are therefore in law the acts of the corporation itself.” On the facts at issue in this case, it would seem to me the Crown could reasonably argue that the “system” needs to deal not only with an awareness of the necessity to consider and discuss safety issues in the job briefing, but to identify risks inherent in the work and establish safe procedures to be followed when such tasks arise.

“Maintenance” or “Repair”

[15] In counts 3 and 4, the Crown alleges that the manner of doing the work here violated the provisions of sections of applicable regulations. Both of the sub-sections referred to require that the work be either inspection, testing, or maintenance. Since the work here is clearly not inspection or testing, if it is not maintenance the Crown must fail on these counts. Every witness called by the Crown who was in a position to know has called the work “'repair”, including their expert, throughout his report. The ordinary dictionary definition of both terms distinguishes maintenance as a “keeping” and repair as a “restoring”'. I suppose that there are very minor “repairs' which would be seen by most as “maintenance”, but this is the general use of the term.

“Maintenance” is typically, for example, changing oil, lubricating, cleaning, checking electrical wiring, tightening. “Repair” is typically the replacement of parts which have worn or been lost with new. In this section of the regulation, the primary focus is on setting out the regular tasks which need to be done to keep equipment operating safely. Further on in the regulations there is a section dealing with “repairs”. Considering all of the above, I agree with the position of the defense that section 14.20 of the regulations, as relied on for these two counts, has no application to the task here. This work was a “repair”, and not “maintenance”. I should add that if this work were indeed maintenance, then I would also agree with the defense position that the regulation imposes a duty with respect to written instructions, the subject of count 3, which should have been performed some 20 years previous. I do not find language in the regulation which suggests a continuing offence, or continuing obligation. It would have been very simple to have said, “No work shall be done on or with equipment unless written instructions on inspection, testing and maintenance have been set out by the employer”.

The Crown's Expert

[16] The defense vehemently attacks the impartiality of the Crown's expert, Mr. Slanzi, along with questioning his expertise. It is their suggestion that I accord his evidence little weight for both reasons. The Crown, meanwhile, suggests that there is no evidence of the witness acting in a partial manner and nothing in his expert opinion to justify the comment. Much of the defense argument rests on the fact that Mr. Slanzi did not remain in the courtroom to hear the defence evidence. It is an argument based as well on what is suggested as a poor level of investigation by HRDC, the government body charged with enforcement of the Canada Labour Code. I should say that I do not find any indication of a lack of impartiality in Mr. Slanzi's involvement, or in failing to remain in attendance. Indeed, given the lack of detailed cross-examination on the particular evidence he gave of procedure, and the extent of cross based on his view of "mechanical background", I am sure that both he and the Crown were reasonably be of the view that there was nothing to be gained, and no further evidence to be required. In any event, only the Crown and not Mr. Slanzi should bear any burden from his failure to remain, if there were any to be borne.

[17] However, there are issues with respect to expertise and opinion. Mr. Slanzi is not a licensed mechanic, nor has he

been. His actual experience in doing the operation here, the change-out of a traction motor on this crane, is at best parallel to Mr. Silva's and may perhaps be less, given that much of his experience is on an older model and no one has detailed for me how that model may differ. And his hands-on experience is very dated. The majority of his service with the competing railroad appears to have been supervisory, and from his stated safety record, he managed a safe work environment for at least a good part of the time that he was a supervisor. I believe it appropriate to characterize the degree of expertise he possesses as being practical-he does this job the way he was shown, and it has been done safely each time he was involved in doing it. From the evidence, though, I believe the same could be said for Mr. Silva on the day before this incident. Mr. Slanzi has no engineering qualifications and relatively limited and dated experience on this crane. Persuasive expertise would be more likely to come from someone with a much more extensive background in either doing or supervising this particular job, or from someone highly trained in analyzing risk and devising methods of reducing it, if such a person exists. With respect to Mr. Slanzi’s opinion, I share the defense view that there does not appear to be reason or logic behind one theme of Mr. Slanzi's: that this job had to be supervised by someone with a mechanical

background. To choose Mr. Feuz, with such a background, as the person who should have supervised this operation in preference to Mr. Silva, who seems to have much the same background as Mr. Slanzi himself and to insist on training in general mechanics rather than training on the specific job, I can not accept. For example, assuming that the Ohio crane manufacturers consulted with all of the users of their equipment, and engineers and safety specialists, and prepared a detailed procedure which would be efficient and safe, it would seem that Mr. Silva's principles would still require that the job be supervised by a mechanic unfamiliar with the protocol in preference to an operator, without mechanical background, who was familiar with it. I do not accept this view point, and consider that it does place far too much emphasis on job-title and not nearly enough on experience. His is an opinion which seems to be formed in the “'this is the way we always did it' model.

(18] The other important issue which arises in Mr. Slanzi’s evidence is the need to have blocking placed beneath the traction motor before the suspension bolt was worked on. There was no cross-examination of Mr. Slanzi on his opinion that this should have been done, or the potential difficulties that placing blocking would have involved according to Mr. Silva.

I, like the Crown, believe this should have been put to Mr. Slanzi. However, I also agree with the defense that it was open to the Crown to seek to recall Mr. Slanzi. Given my overall view of the level of Mr. Slanzi's expertise, I doubt that I would have preferred his view but he may have convincing contrary experience to Silva's. As I have said, and without any criticism of Mr. Slanzi as a person, I view his expertise as being more of the "I did it this way, and it worked-just look at my record" type, than of someone who has such extensive experience or training that might justify the same view or who is so familiar with the way others do the job that he is able to draw on their experiences, both good and bad. I should say that it would seem to me to be a simple way to ensure that if someone loosened the bolt too far, or it was stripped or damaged, the motor would not swing down at all. But there could be hazards caused by having blocking in place, such as dislodging the blocking itself if not of sufficient size to bear the weight at the point of its application, or the effect that even a slight weight shift might have on the truck's position and consequent risk to persons involved in the procedure. And, as Mr. Slanzi wasn't asked, there might be difficulties posed by the placement of blocking for either access to the anchor bolt itself, or the proper placement of a sling to remove it. This is Mr. Silva's position, and I do not

feel qualified to assess the respective risks. I have heard that during a demonstration done after this incident, with blocking in place, the truck tipped. I know nothing of the detail of that operation, but mere mention is consistent with my view that I am dealing here with the evidence of two people only-Slanzi and Silva. As I view their level of training and practical experience on this job as approximately equal, I find it impossible to say that blocking as suggested offers the safety asserted by the Crown. I am surprised, however, that there does not exist a detailed change-out procedure as mentioned above, which should have considered the “belt and braces” approach to safety and might, for example, recommend the placement of a jack of some sort, or a particular type and placement of blocking, or even slinging from a crane as additional safety for the performance of this job. It does not appear to exist in either of the Canadian railroads, or even in the shops supervised by Mr. Slanzi. Whether the steps in such a protocol were standard or not, it would at least act as a checklist for those familiar with the process, and as a methodology for those who are not. I cannot say, however, that I find fault in either CPR or Silva in failing to do what has not apparently yet been done. I say the latter because I assume that Slanzi and the Crown would have attempted to find such a procedure if one existed and compare it to what was

done here-they should have in fairness. If it supported Slanzi's view, it would have greatly assisted the Crown, and if it did not, it would need to be weighed in the charge approval decision and the decision to proceed with charges. So, as mentioned, I assume it does not exist, at least to the knowledge of the Crown and those of the CPR who testified here.

[19] What this finding means to these charges is this: I do not find that the Crown has demonstrated beyond a reasonable doubt that proper safety measures were not in place for the simple reason that I do not find it demonstrated beyond a reasonable doubt what such measures would be. That has this result: counts 1, 7 and 8 have not been proven by the Crown.

Supervision Findings

[20] The position of the Crown is that Mr. Silva's supervision of Shawn Ormshaw was inadequate and that Shawn was improperly trained for his job. Much of that focus is on the job briefing. It is trite law to remind oneself that the Crown bears the burden of proof beyond a reasonable doubt in all cases. Here, there is a wide variance in the evidence of the witnesses for the Crown on the issue of supervision, and particularly as it relates to conducting a job briefing. I

prefer the evidence of Pittman and Silva himself as to the contents of the job briefing. In particular, I find that Silva made clear that the bolt was the sole support of the engine, that the engine was very heavy, and that the bolt should only be loosened. I see no reason why Boyko should remember the latter instruction if it were not given, and clearly. I also find that Silva showed Shawn the proper position to take up beneath the wheel assembly, and find that had Shawn remained in this position, he would not have been struck by the motor. Further, Pittman acknowledges having examined how far the nut had been loosened, removing the wrench from Carroll's hand, and saying 'that's enough” or words to that effect. Silva testifies to like effect. While I appreciate the difficulties faced by the Crown when all of the actual witnesses to the event are co-workers of an accused or employees of an accused, as here, it nonetheless is evidence offered by the Crown. To conclude that something less than testified to by all but Carroll is what was said, in the face of this body of evidence, would be to defy logic and common sense. And the case of Faryna v. Chorny, [1951] 4 WWR 171, a decision of the British Columbia Court of Appeal, is of little assistance. That case essentially provides that there is no gauging of the reliability of evidence solely on demeanour or lack of contradiction, but that instead a piece of evidence needs to

be viewed in the context of other evidence and “the probabilities affecting the case as a whole”. It is worth noting that is a civil case with a very different standard of proof: in this case I would be wrong as a judge to decide credibility by weighing probabilities. While I have no quarrel with the case, and much appreciate its colourful language and adept description of the problem of deciding where to place one's “belief”, there is really no general set of demonstrable facts here against which to weigh the evidence of, say, Pittman or Silva. Even in terms of probability, can it really be said that it is more likely the job briefing did not mention the inherent risks simply because it resulted in accident when paying heed to those risks would have avoided it? I would not accept that Shawn had any wish to die, but considering Carroll's evidence of the nature of their discussion it seems to me as likely that Shawn's attention was broken or otherwise directed as never engaged. I therefore find that Shawn and the others were properly told of the risks before engaging on the specific task of loosening the anchor bolt, and find that Mr. Silva, on leaving the immediate area of the truck, had no reason to believe that Shawn was in a position of danger or that the loosening was continuing. This is not to say that I find the job briefing without problems. Some of what I have to say will be found under the discussion

of due diligence, but for now I believe it sufficient to say that some tasks are really quite simple. I'm sure this briefing could have been better: Silva could have said, for example, “Ray, you help Corey put a wrench on the crown nut. After it has been loosened x number of turns, make sure the wrench is removed and there is no more loosening. Shawn, you get underneath, stay where I showed you until you are told to move again, do not get under the motor, and loosen only until Ray has told you to stop. That will be in x number of turns. Does everyone understand their part?” I also agree that CPR does not appear to have taken steps to ensure that each of its employees who would have to give a job briefing was in fact skilled at doing it. Nor does Silva's practice, concluding understanding from a lack of questions or a seeming grasp of a part of the process by the employee (here, by Shawn grabbing the right size wrench), necessarily indicate what the employee understands. For one, it would certainly be better if each were asked to repeat back what was expected of them. Secondly, very junior employees may simply not know enough about potential risk to even know what questions they might ask. in terms of count 1, though, as there is no vicarious liability on CPR for errors by its employees, and Silva appeared to be its most skilled employee at traction motor removal, I do not find the Crown has proven a lack of either proper supervision

or training. The task for Shawn was such a simple one that I am satisfied, given the job briefing I have found, he was properly trained. And Silva was a proper supervisor, and left matters at the truck in the hands of Pittman who should have been capable of supervising the remaining function, believed to be loosening of the brakes. These findings I believe are sufficient to dispose of counts 1 and 2 against the CPR and all counts against Silva.

Due Diligence

[21] Although there will not be, findings of guilt on the counts, I want to deal with due diligence. What this requires of the employee, such as Silva, is mirrored in the wording of the counts and the sections themselves: take all reasonable and necessary precautions. Why the elements of proof differ for the individual accused and the employer is explained by the submissions of counsel for Mr. Silva: the reasonableness standard is a part of the charge and not just raised in defense because of the more limited range of decision-making, relevant to the job, which such an employee has relative to the employer. Therefore, the actus to be proven against the ordinary employee deals with the concept of reasonableness, where the employer must raise “reasonable” in his defense. In either case, it is sufficient for acquittal if at the end of

the day the court finds that though the actus is proven, the accused had exercised due diligence, or put otherwise, taken all due care. In terms of the employer, such evidence will normally be in the form of description of a system designed to catch potential error and excise it. In terms of the employee, the evidence will focus on the specific occasion, but again deal with reasonable care. The test to be applied is well put in the case of R. v. Gonder, 62 C.C.C. (2d) 326. Then Chief Judge Stuart said, at page 5: “Reasonable care implies a scale of caring. The reasonableness of the care is inextricably related to the special circumstances of each case. A variable standard of care is necessary to ensure the requisite flexibility to raise or lower the requirements of care in accord with the special circumstances of each factual setting. The degree of care warranted in each case is principally governed by the following circumstances: (a) Gravity of potential harm. (b) Alternatives available to the accused. (c) Likelihood of harm. (d) Degree of knowledge or skill expected of the accused.” In this case, obviously the potential harm here was the death of a worker. What is not clear on the evidence, as already mentioned in part, is the alternatives and the likelihood of harm. I believe this is shortly dealt with for Mr. Silva: having assigned the simple task of loosening a bolt, and shown the proper and safe

position to be in, to a generally responsive and aware employee, and then left him having apparently completed this portion of his task and directly beside his usual “boss” who understood the consequences of continuing and had directed the loosening cease, is it reasonable for Mr. Silva to be expected to have done, or to do, more? Here, for Mr. Silva, I would find that harm was highly unlikely if his instructions were followed, and if the situation as it presented itself when he left the immediate area Shawn was working in had not inexplicably changed. I don't believe the question could be answered affirmatively without expecting a much more exacting standard than reasonableness of Mr. Silva. One must also keep in mind that whatever limitations might apply to Shawn as a result of his youthfulness and lack of experience also apply to Mr. Silva in the sense that he doesn't know what he doesn't know, either. His experience and training limit him, as all of us. And the evidence before me does little to assist on the issue of “likelihood” other than to say that apparently the methods used by Mr. Slanzi had not failed him, and up to the day of this incident Mr. Silva could say the same. As for the employer, its most experienced traction motor change-out person was on the job, and assisted by another crane operator. Other supervisory personnel were in close proximity. A system of job briefings, which were to include safety factors and

issues, had been put in place. Employees could attend safety committees, and Mr. Silva had. There was generalized safety training in place, and awareness that safety was an issue the company took seriously. There is a system in place which contains demerits for those who do not perform properly and financial incentives for those who do. I have more difficulty in finding this to measure up to what is expected of "reasonable" care. It seems to me that an employer has an over-riding obligation to determine the situations which might place its employees at risk, and then to take all reasonable care to eliminate those risks. That is not limited to putting the employees in charge of their own safety, which might put every employee at some time in the same position as Shawn was said to be here: incapable of asking the questions which might protect him because of the level of his own training and experience. It often falls to employees to complete a job using available resources-this is the lack of decision-making ability referred to in defence here by Mr. McGrady. And the "resource" which might be required to protect, as the complexity and risk of the task increase, may well require that experts be consulted to identify what risks specifically exist and how they might best be ameliorated. There are other areas for improvement. The first, I would suggest, is the number of plasticized cards and the amount of detail contained

on them which the supervisory employee is expected to carry and adhere to. The Crown refers to this as a top-down emphasis on safety, and I agree. Notwithstanding the existence of the safety committees and the worker's chance to make representations, this program as a whole looks to be driven more by theory than practice. It relies on the immediate supervisor to decide what safety factors apply, and to address them. While there is nothing wrong with this, and obviously all supervisors will have to continually make such assessments, I believe more solid information would likely be more helpful to employees than the abundance of cards here. For example, I find it surprising that a relatively common and complex task like this change-out procedure has not resulted in the creation of a step by step procedure, as already referred to. That could form part of the crane operator's manual and thus be available wherever and whenever it was needed. Given that many people are not good verbal learners, and find words convey less information than pictures, such a procedure could include a 'break-out” detailed drawing of the components, perhaps even showing the placement area for sling, or blocking if such is determined to be advisable. Obviously, this would entail the employer determining where the risks are greatest, and making a determined effort to find safer ways of doing those jobs. Writing down the procedure, and having it

readily available, would act as a checklist for the experienced to ensure nothing was forgotten and a training tool for the less-experienced. I also agree with the Crown that the job briefing and the company's view that it should be inclusive of safety are of little value unless there is some monitoring done of the ability of the supervisors, at every level, to give such an inclusive briefing. The daily briefing, attended irregularly by higher level supervisors, is probably not the best test of this, given the amount of very routine work which is likely performed. Also there seems to be quite a bit of 'making do” going on here. Mr. Silva was the supervisor because he was the nearest person with the most experience. He chose his helpers on this job because they were available, and the Pittman crane to do the eventual lifting because it was there and the Feuz crane was not. He would have used ties for blocking, and only considered them, because they were at hand. Perhaps this goes to the independence of the railroader, or to shortages of appropriate materials, or the pressures of the job, but it can lead to trouble which might not otherwise occur. That said, this company has gone to considerable lengths to promote safety and make it a primary consideration for all of its employees, management and otherwise. They are to be commended for that. Nonetheless, if the Crown had established its particulars regarding a straight-forward

charge of failing to ensure the safety of Shawn Ormshaw by failing to provide sufficient safeguards against accident, I would have difficulty concluding the corporation had established the requisite diligence in defence.

Appendix A-Charges

COUNT #1

On or about June 22, 2000, at the Town of Golden, British Columbia, **Canadian Pacific Railway Company / Compagnie De Chemin De Fer Canadien Pacifique**, a corporation under the Canada Business Corporations Act, R. S. C. 1974-75-76, c. 33, as amended, and an employer subject to Part II of the Canada Labour Code R. S. C. 1985 c. L-2, as amended, unlawfully failed to ensure that the safety and health at work of an employee, William Shawn Ormshaw, was protected, by allowing the said employee to perform work beneath a wheel assembly known as a truck, being a component of a mobile locomotive crane located at the Canadian Pacific Railway Yard at the Town of Golden, British Columbia, without proper super-vision and training, and without proper safety measures being in place, contrary to section 124 of the Canada Labour Code, Part II, the direct result of such contravention being the death of the said employee, thereby committing an offence contrary to section 148(4) of the Canada Labour Code.

COUNT #2

On or about June 22, 2000, at the Town of Golden, British Columbia, **Canadian Pacific Railway Company / Compagnie De Chemin De Fer Canadien Pacifique**, a corporation under the Canada Business Corporations Act, R. S. C. 1974-75-76, c. 33, as amended, an employer subject to Part II of the Canada Labour Code R. S., C. 1985 c. L-2, as amended, allowed an employee, William Shawn Ormshaw, to perform work beneath a wheel assembly known as a truck, being a component of a mobile locomotive crane located at the Canadian Pacific Railway Yard at the Town of Golden, British Columbia, a work place controlled by the employer, without ensuring that the said employee was made aware of every known or foreseeable hazard in the area where the employee was working, to wit: the hazard that the traction motor of the said truck was held in place by an anchor bolt, and that if the said anchor bolt was completely unscrewed the traction motor would fall from the truck assembly, contrary to section 125(s) of the Canada Labour Code, Part II, the direct result of such contravention being the death of the said employee, thereby committing an offence contrary to section 148(4) of the Canada Labour Code.

COUNT #3

On or about June 22, 2000, at the Town of Golden, British Columbia, **Canadian Pacific Railway Company / Compagnie De Chemin De Fer**

Canadien Pacifique, a corporation under the Canada Business Corporations Act, R. S. C. 1974-75-76, c. 33, as amended, an employer subject to Part II of the Canada Labour Code R. S. C. 1985 c. L-2, as amended, allowed an employee, William Shawn Ormshaw, to perform work beneath materials handling equipment, to wit, a wheel assembly known as a truck, being a component of a mobile locomotive crane located at the Canadian Pacific Railway Yard at the Town of Golden, British Columbia, a work place controlled by the employer, without having first set out in writing instructions regarding the mechanical maintenance of the materials handling equipment, contrary to section 125(q) of the Canada Labour Code Part II, and subsection 14.20(1) of the Canada Occupational Safety and Health Regulations, thereby committing an offence contrary to section 148(1) of the Canada Labour Code.

COUNT #4

On or about June 22, 2000, at the Town of Golden, British Columbia, **Canadian Pacific Railway Company / Compagnie De Chemin De Fer Canadien Pacifique**, a corporation under the Canada Business Corporations Act, R. S. C. 1974-75-76, c. 33, as amended, an employer subject to Part II of the Canada Labour Code R. S. C. 1985 c. L-2, as amended, allowed an employee, William Shawn Ormshaw, to perform work beneath materials handling equipment, to wit, a wheel assembly known as a truck, being a component of a mobile locomotive crane located at the Canadian Pacific Railway Yard at the Town of Golden, British Columbia, a work place controlled by the employer, without ensuring that the employee was a qualified person to perform the task, contrary to section 125(q) of the Canada Labour code, Part II and subsection 14.20(3) of the Canada Occupational Safety and Health Regulations, thereby committing an offence contrary to section 148(1) of the Canada Labour Code.

COUNT #5

On or about June 22, 2000, at the Town of Golden, British Columbia, **Rene LeGresley, also known as Rene Legresley**, Track Program Supervisor and employee of Canadian Pacific Railway Company / Compagnie De Chemin De Fer Canadien Pacifique, a corporation under the Canada Business Corporations Act, R. S. C. 1974-75-76, c. 33, as amended, failed to take all the reasonable and necessary precautions to ensure the safety and health of an employee under his supervision, namely William Shawn Ormshaw, by permitting the said employee to perform hazardous work beneath a wheel assembly known as a truck which is a component of a mobile locomotive crane located at the Canadian Pacific Railway Yard at Golden, British

Columbia, without taking reasonable steps to ensure that the hazardous work could be performed safely, contrary to section 126(1)(c) of the Canada Labour Code, Part II, thereby committing an offence contrary to section 148(1) of the Canada Labour Code.

COUNT #6

On or about June 22, 2000, at the Town of Golden, British Columbia, **Tony Silva**, Special Group Machine (Crane) Operator, employee of Canadian Pacific Railway Company / Compagnie De Chemin De Fer Canadien Pacifique, a corporation under the Canada Business Corporations Act, R. S.C. 1974-75-76, c. 33, as amended, failed to take all the reasonable and necessary precautions to ensure the safety and health of a fellow employee, namely William Shawn Ormshaw, by failing to caution or warn the said employee as to the hazards of working beneath a wheel assembly known as a truck which is a component of a mobile locomotive crane located at the Canadian Pacific Railway Yard at Golden, British Columbia, and by failing to ensure that the said employee could perform the hazardous work safely, contrary to section 126(1)(c) of the Canada Labour Code, Part II, the direct result of such contravention being the death of the said employee, thereby committing an offence contrary to section 148(4) of the Canada Labour Code.

COUNT #7

On or about June 22, 2000, at the Town of Golden, British Columbia, **Tony Silva**, Special Group Machine (Crane) Operator, employee of Canadian Pacific Railway Company / Compagnie De Chemin De Fer Canadien Pacifique, a corporation under the Canada Business Corporations Act, R. S.C. 1974-75-76, c. 33, as amended, failed to take all the reasonable and necessary precautions to ensure the safety and health of a fellow employee, namely William Shawn Ormshaw, by letting the employee perform hazardous work beneath a wheel assembly known as a truck which is a component of a mobile locomotive crane located at the Canadian Pacific Railway Yard at Golden, British Columbia, without identifying the said hazard to the employee, namely that the traction motor of the said truck was held in place by an anchor bolt, and that if the said anchor bolt was completely unscrewed the traction motor would fall from the truck assembly, and without taking reasonable and necessary steps to ensure that the said traction motor was secured against falling on the employee, contrary to section 126(1)(c) of the Canada Labour Code, Part II, the direct result of such contravention being the death of the said employee, thereby committing an offence contrary to section 148(4) of the Canada Labour Code.

COUNT #8

On or about June 22, 2000, at the Town of Golden, British Columbia, **Tony Silva**, Special Group Machine (Crane) Operator, employee of Canadian Pacific Railway Company / Compagnie De Chemin De Fer Canadien Pacifique, a corporation under the Canada Business Corporations Act, R. S. C. 1974-75-76, C. 33, as amended, failed to take all the reasonable and necessary precautions to ensure the safety and health of a fellow employee, namely William Shawn Ormshaw, by letting the employee perform hazardous work beneath a wheel assembly known as a truck which is a component of a mobile locomotive crane located at the Canadian Pacific Railway Yard at Golden, British Columbia, without identifying the said hazard to the employee, namely that the traction motor of the said truck was held in place by an anchor bolt, and that if the said anchor bolt was completely unscrewed the traction motor would fall from the truck assembly, and without taking reasonable and necessary steps to ensure that the said traction motor was secured against falling on the employee, contrary to section 126(1)(c) of the Canada Labour Code, Part II, thereby committing an offence contrary to section 148(1) of the Canada Labour Code.

Appendix B-Applicable Statute Law

CANADA LABOUR CODE, PART II

Section 124: Every employer shall ensure that the safety and health at work of every person employed by the employer is protected.

Section 125: Without restricting the generality of section 124, every employer shall, in respect of every work place controlled by the employer,

> (q) provide, in the prescribed manner, each employee with the information, instruction, training and supervision necessary to ensure the safety and health at work of that employee;
> (s) ensure that each employee is made aware of every known or foreseeable safety or health hazard in the area where that employee works.

Section 126(1): While at work, every employee shall

> (c) take all reasonable and necessary precautions to ensure the safety and health of the employee, the other employees and any person likely to be affected by the employee's acts or omissions.

Section 148(l): Subject to this section, every person who contravenes any provision of this Part is guilty of an offence and liable on summary conviction to a fine not exceeding fifteen thousand dollars.

Section 148(4): Every person who contravenes any provision of this Part the direct result of which is the death of or serious injury to an employee is guilty of an offence and liable on summary conviction to a fine not exceeding one hundred thousand dollars.

REGULATIONS RESPECTING OCCUPATIONAL SAFETY AND HEALTH MADE UNDER PART II OF THE CANADA LABOUR CODE

PART I

Section 1.2: In these Regulations,

“qualified person” means, in respect of a specified duty, a person who, because of his knowledge, training and experience, is qualified to perform that duty safely and properly.

Section 14.20(1): Before motorized or manual materials

handling equipment is used for the first time in a work place, the employer shall set out in writing instructions on the inspection, testing and maintenance of that materials handling equipment.

Section 14.20(2): Instructions referred to in subsection (1) shall specify the nature and frequency of inspections, testing and maintenance.

Section 14.20(3): The inspection, testing and maintenance referred to in subsection (1) shall be performed by a qualified person who

(a) complies with the instructions referred to in that subsection; and

(b) makes and signs a report of each inspection, test or maintenance work