Occupational Health and Safety Tribunal Canada

Tribunal de santé et sécurité au travail Canada

Ottawa, Canada K1A 0J2

Citation: Canadian National Railway Company v. Teamsters Canada Rail Conference, 2013 OHSTC 29

Date: 2013-10-15
Case No.: 2012-93
Rendered at: Ottawa

Between:

Canadian National Railway Company, Appellant

and

Teamsters Canada Rail Conference, Respondent

Matter:	Appeal under subsection 146(1) of the *Canada Labour Code* of a direction issued by a health and safety officer
Decision:	The direction is confirmed
Decision rendered by:	Mr. Pierre Hamel, Appeals Officer
Language of decision:	English
For the Appellant:	Mr. L. Michel Huart, Counsel, Langlois Kronström Desjardins, LLP
For the Respondent:	Mr. Ken Stuebing, Counsel, CaleyWray

Canada

REASONS

[1] These reasons concern an appeal brought before the Occupational Health and Safety Tribunal Canada (Tribunal) under subsection 146(1) of the *Canada Labour Code* ("the Code") by the Canadian National Railways Co. ("CN" or "the employer"), against a direction issued on December 7, 2012 by Health and Safety Officer (HSO) Mr. Todd Wallace. The appeal was filed with the Tribunal on December 21, 2012 by Mr. L. Michel Huart, counsel for the employer, and was accompanied by an application for a partial stay of the direction, to be effective until the disposition of the appeal on the merits. The partial stay was granted by the undersigned on January 10, 2013, with reasons set out in *Canadian National Railway* v. *Teamsters Canada Railways Conference*, 2013 OHSTC 5. The effect of the stay was to remove certain sentences from the direction which, the employer argued, exceeded the jurisdiction of the HSO's powers in the circumstances of this case and caused the employer prejudice. As a result, I ordered that the redacted version of the direction appended to my Reasons was to be used for the purpose of the Code pending the disposition of the appeal on its merits.

[2] On March 1, 2013, counsel for the employer advised the Tribunal that in his view, the appeals officer could dispense with having an oral hearing and requested that the appeal proceed by way of written submissions on the basis of the Tribunal's record, in light of the fact that the employer's main contention was a question of law. The employer contends that HSO Wallace exceeded his jurisdiction by drawing conclusions as to the cause of the accident resulting in a fatality, and stating them in his direction issued under subsection 145(1) of the Code. Counsel for the respondent, Teamsters Canada Rail Conference ("TCRC" or "the Union") objected to that proposal and indicated that, in his view, the testimony of HSO Wallace was necessary to the disposition of this case. I advised the parties that a hearing would be held and HSO Wallace eventually testified at the hearing held in Vancouver, British Columbia, on April 17, 2013.

[3] In light of my conclusion to dismiss the appeal and confirm the direction as originally issued by HSO Wallace for the reasons set out below, I am at liberty to quote the text of the direction issued on December 7, 2012 in its entirety. The direction reads as follows:

> **IN THE MATTER OF THE *CANADA LABOUR CODE***
> **PART II – OCCUPATIONAL HEALTH AND SFAETY**
>
> **DIRECTION TO THE EMPLOYER UNDER SUBSECTIOIN 145(1)**
>
> In response to a report of a fatal injury sustained by an employee of Canadian National Railway on November 28, 2012, Health and Safety Officer Keith Dagg and the undersigned Health and Safety Officer conducted an inspection of the workplace owned and operated by Canadian National Railway, being an employer subject to the *Canada Labour Code* Part II, at Mile 864.3 of Canadian National Railways' Fort Nelson subdivision, the said workplace commonly known as Gutah or Gutah Camp. This inspection was performed on November 29 and 30, 2012 and carried out in the presence of Canadian National Railway Officers Mr. Doug Ryhorchuk, Mr. Brian Kalin, Mr. Don Penney, Mr. Roger Worsfold, Ms. Carrie Mackay, Mr. Chris

Doerksen, Mr. Don Ennis and Employee Health and Safety Representative Mr. Joe Dineley.

The undersigned Health and Safety Officer is of the opinion that the following provisions of the *Canada Labour Code* Part II are being contravened.

Section 124 of the *Canada Labour Code* Part II

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

The use of non standard, non reflectorized signs and lack of clear instructions to the employees resulted in a derailment and an employee sustaining fatal injuries.

Paragraph 125(1)(*s*) of the *Canada labour Code* Part II

Every employer shall, in respect of every workplace controlled by the employer..ensure that each employee is made aware of every known or foreseeable health and safety hazard in the area where the employee works.

By utilizing signage that is of a non-standard nature which shares the identical characteristics of many other signs that are commonly seen throughout the railway on the former BCR, by failing to notify employees of the presence of non-standard signage and the failure to clearly make employees aware of multiple derails on this track, the employer has failed to ensure that employees are made aware of known hazards in the area where employees work and has resulted in an employee sustaining fatal injuries.

Therefore, you are HEREBY DIRECTED, pursuant to paragraph 145(1)(*a*) of the *Canada Labour Code*, Part II, to terminate the contraventions no later than January 4, 2013.

Further, you are HEREBY DIRECTED, pursuant to paragraph 145(1)(*b*) of the *Canada Labour Code* Part II, to take steps to ensure signs which advise employees of the presence of critical equipment are standardized and instructions for exceptional circumstances are provided with clarity to employees as well as any other steps the employer deems appropriate prior to January 4, 2013, to ensure the contraventions do not continue or reoccur.

Issued at New Westminster this 7th day of December 2012.

(signed)
Todd Wallace
Health and Safety Officer

[Underlining added]

[4] The underlined portions of the text were temporarily redacted as a result of the stay. It is those words that the employer wishes to have permanently removed from the direction by the present appeal.

The Issue

[5] The issue is whether HSO Wallace exceeded his jurisdiction under the scheme set out in Part II of the Code, by including his conclusions as to the cause of the accident in the body of his direction issued pursuant to subsection 145(1), and whether those words should be permanently redacted from the direction.

The Facts

[6] The facts that gave rise to the present proceedings can be summarized as follows. On November 28, 2012, HSO Todd Wallace, accompanied by HSO Keith Dagg, responded to the reporting by CN of a fatal accident that had occurred on that day. The accident occurred in the work place owned and operated by the employer located at Mile 864.3 of the Canadian National Railway Fort Nelson Subdivision, that work place being commonly known as Gutah or Gutah Camp. At approximately 17:10 (PDT), Mr. Bryan Giesbrecht, a Conductor employed by the CN, sustained a fatal injury when the tank car he was riding on derailed and rolled over him.

[7] HSO Wallace testified that he was acting pursuant to the Code, more precisely under subsection 141(4), which requires that "… a health and safety officer investigate every death of an employee that occurred in the work place or while the employee was working…". Upon being apprised of the accident, HSO Wallace immediately issued a direction to the employer not to disturb the scene of the accident, with exceptions related to retrieval of the victim, health, safety, protection of property and the environment. HSOs Wallace and Dagg took the first flight out of Vancouver International Airport to Fort St. John at 08:00 a.m. on November 29, 2012, and eventually arrived at the scene of the accident at approximately 20:15 that day. An initial scene assessment was performed that night, which provided some indications of the same conditions in effect on the night of the occurrence (the previous day), such as ambient lighting or lack thereof, temperature, sight lines and visibility with light snowfall taking place. The Coroner, Paramedics from the BC Ambulance Service and the RCMP along with CN personnel had arrived on the scene in the early morning of November 29, 2012. They had removed the deceased and transported the locomotive engineer and other persons from the camp back to Fort St. John. HSO Wallace testified that other than the removal of the deceased and the continued snowfall, the scene had remained completely intact and undisturbed.

[8] In the course of his investigation, HSO Wallace requested from the employer detailed information relating to the accident and to the employees on duty that day, on the condition of the equipment, various inspection records, logs, records of communication, pictures taken by CN personnel, sketches drawn by CN personnel, etc. In addition, HSO Wallace ordered the employer to conduct testing with a view to determining the reflective quality and clarity of the sign located at the affected derail. Those sets of instructions were contained in two directions (filed as Exhibits R-2 and R-3 at the hearing) issued by HSO Wallace on December 3, 2012. He required the employer to produce the information sought no later than December 17, 2012. HSO Wallace points out that the employer had thus far cooperated fully in the investigation and that the issuance of those

directions was in no way meant to address any failure from CN personnel in that regard. It should be noted that the communications, both oral and written, that HSO Wallace had with CN officials between the time he was notified of the accident and the issuance of his December 7, 2012 direction, clearly state that he was conducting an investigation pursuant to a report of a fatality, as mandated by subsection 141(4) of the Code.

[9] The investigation of the accident and inspection of the workplace and accident site carried on until November 30, 2012. At 09:40 a.m. on that day, HSO Wallace released the scene of the accident back to CN. HSO Wallace had numerous conversations and email exchanges with CN officials during the course of these two days and gathered a significant amount of information on the employees on duty that night, such as their length of service, the training they had received, as well as on the condition of the car involved in the accident. He interviewed the train engineer who was on duty on the day of the accident. He made a number of observations while on the site, took measurements, and gathered information to understand what had caused the accident and what deficiencies, if there were any, were to be remedied.

[10] HSO Wallace has over 20 years of experience in the railway industry. He was a conductor with BC Rail for approximately 13 years (1993-2006) and prior to that, worked as a locomotive engineer with the Canadian Pacific for 7 years (1985-1992). He received his designation as a Health and Safety Officer in 2006. He testified that, having been a conductor himself, he looked at his own experience and placed himself in the same position as the employee who had been fatally injured in his examination of the scene of the accident.

[11] HSO Wallace testified that he noticed the derail signs and immediately expressed concern about those signs not being standard signage used by CN and of poor reflective quality. It should be noted that sometime in 2004, CN acquired the rights of operation to the British Columbia Railway (BCR) from the Province of British Columbia, which included various assets including employees, railways cars, locomotives and responsibility for maintenance of track and related infrastructure. A derail is a mechanical device placed on a track that will derail railway cars or locomotives passing over it. He explained that the signage used to advise an employee of a derail, a rail lubricator, a mile post, a structure and a train length on much of the former BCR territory are identical except to the extent of what is written on them. They have white reflective background on both sides, with black writing. “Flanger” signs are of the same dimension, except that they are reflective on one side only. A “flanger” sign denotes the presence of an obstruction that a snow plow being pushed by a locomotive would impact with its blade, such as a switch or a roadway crossing. In this instance, HSO Wallace observed during his inspection of the accident site that the back of a flanger board was used for the derail sign and was not equipped with a reflectorized background.

[12] HSO Wallace, also observed the following facts when he conducted his investigation on November 29 and 30, 2012: there was approximately 670 feet of room in the siding (a side track running parallel to the main track) north of the service equipment; there were multiple derails on this siding, one being near the clear mark at the north end

of the siding, a second one located approximately 160 feet north of the service equipment and two additional derails located south of the service equipment at various points. He testified that CN's Time Table for the Fort Nelson Subdivision states that there is a derail situated 120 feet north and south of the service equipment. There is no reference to the existence of multiple derails on the track in question. HSO Wallace concluded that the instruction contained in the Time Table regarding the hazards at Gutah Camp lacked clarity insofar as it did not alert employees to the presence of an exceptional circumstance where two derails exist in relatively close proximity on a single track.

[13] Mr. Wallace identified a number of factors that, in his opinion, contributed to the accident. Those factors are summarized in the covering letter to his direction that HSO Wallace sent to Mr. John Orr, Chief Safety and Sustainability Officer on December 7, 2012, as follows:

> The employee fatally injured was not an ex British Columbia Railway (BCR) employee and that his total years of service, including training time was approximately one and one half years, having began his employment as a CNR employee on or about April 2011.
>
> Preliminary explanation for the derailment is that equipment was pushed over a derail.
>
> The sign used to indicate the presence of this specific derail was of a non-reflective type and in addition, was not the standard CNR design, shape or colour as illustrated and explained in CNR's General Operating Instructions (GOI). There is no reference found in any CNR Special Instruction indicating that signage used on the former BCR is not standard to CNR.

[14] HSO Wallace testified that, based on his examination of the scene, his conversations with CN personnel and on the information that he had in hand at the time of issuing his direction on December 7, 2012, he came to the conclusion that the fatal injury to Mr. Giesbrecht was the result of a tank car rolling over him after having derailed, i.e. having left the track unto the ground. The path of the tank car after it derailed caused its lead truck - the mobile platform on which one end of the tank is resting - to dig into the ground and come to rest at a severe angle, on the slope adjacent to the rail. The effect of the angled position at which the car stopped likely triggered a sloshing action of the tank, which caused it to launch off its trucks into the air and hop over the pin that maintains it in place on the trucks. The tank rolled over on the same side that the Conductor was riding on, and continued rolling until it reached the tree line.

[15] HSO Wallace concluded that the car was pushed over a derail because the Conductor was unaware of the presence of the derail. He was unaware of its presence due to his unfamiliarity with this specific portion of the territory, the lack of adequate signage to indicate the presence of this derail, and the lack of sufficiently clear information and instructions advising of what he considered as an exceptional condition (i.e. the presence of multiple derails). As HSO Wallace testified, even an experienced employee would not reasonably expect derails to be located where they are located at Gutah. HSO Wallace

explained at the hearing that he reconstructed the sequence of events largely based on the physical observations that he made while at the scene (resting place of the deceased employee, final location of the tank car, etc.) and measurements that he took while he was on site on November 29 and 30, 2012.

[16] HSO Wallace also acknowledged in his testimony that some of the information that he sought by the two directions he issued on December 3, 2012, was received later in December, i.e. after he had issued his December 7 direction. He testified however that to large extent, he either already had the information in hand on December 7, or the information that came later such as the "event recorder" of the locomotive, did not cause him to change the conclusions he had reached at that point as to the sequence of events and the cause of the accident resulting in the death of the employee.

[17] HSO Wallace further testified that he gave some thought to issuing a direction under subsection 145(2) of the Code, based on his conclusion that the inadequate signage and lack of clarity in the instruction contained in the Time Table for Gutah constituted a dangerous situation in the workplace that required immediate correction. Such a direction would have resulted in a stoppage of CN's activities in that workplace, until the problem was corrected. He chose to avoid that option given the good faith intentions of the employer to bring about adequate remedial measures rapidly and the high level of cooperation that was receiving from the employer's representatives. It should be noted also that the employer is stated to have complied with the "operative" parts of the direction and immediately undertook various actions to correct the contraventions identified by HSO Wallace, as reflected in his Investigation Report.

[18] HSO Wallace finished the preparation of his Investigation Report on or about December 28, 2012. HSO Wallace's investigation was the only one conducted in relation to the accident. It also came out of HSO Wallace's testimony that he is involved in the process that may eventually lead to a prosecution as a result of his investigation into that fatality.

Submissions of the Parties

[19] The parties' counsel were invited to present written submissions at the close of the hearing. The full text of the parties' submissions is part of the Tribunal's record and I will summarize the salient points of arguments presented by the parties.

For the Appellant

[20] Counsel for the appellant first presented an overview of the circumstances that brought HSO Wallace to the site of the accident that occurred on November 28, 2012. After reviewing the sequence of events, counsel invited the Appeals Officer to disregard any fact gathered after the issuance of the direction, i.e. after December 7, 2012, as being irrelevant. This includes the totality of the Investigation Report dated December 21, 2012, prepared by HSO Wallace. Counsel stresses the fact that HSO Wallace only provided a draft of that report to the Tribunal, and no other documentation purporting to be in

support of his direction. In counsel's view, this makes it clear that the HSO reached a conclusion on the cause of death hastily without having gathered all appropriate evidence and, in his view, the direction is therefore without adequate factual foundation.

[21] Counsel for the appellant reiterated the ground invoked to appeal the direction, namely that it was made in excess of jurisdiction and based on an error of law. Moreover, counsel added that the issue is not about the sufficiency of the information to support the conclusion reached by HSO Wallace, nor about the process that he followed. It is solely a question of legal interpretation and counsel submits that the standard of review of HSO Wallace's direction is correctness, i.e. that he had to be correct in his interpretation of the provisions of the Code pursuant to which he was acting, in particular those provisions which establish a distinction between an investigation and an inspection. According to the employer, HSO Wallace erred in that interpretation and was wrong in his belief that subsection 145(1) of the Code gave him the authority to determine the cause of death of an employee.

[22] Counsel stresses the difference between an inspection and an investigation: the inspection is a review of a situation and may include the gathering of information leading to the issuance of a direction; it is not concerned with the gathering of evidence for the purpose of sustaining a prosecution. An investigation refers to a collection of evidence that may be used in a Court of law for the purpose of obtaining a conviction, and involves a higher standard of procedural fairness. The direction itself states that HSO Wallace was conducting an inspection of the workplace, unlike two previous directions which he issued on December 3, 2012, which referred to him conducting an investigation. Yet, without authority, he draws a conclusion on the cause of the accident and the death of an employee in the context of what he himself referred to as an inspection. HSO Wallace thus confused the two legal concepts and used the information gathered in an investigation process impermissibly, for the purpose of an inspection and direction under subsection 145(1). HSO Wallace was acting pursuant subsection 145(1) as he himself states in his direction, and consequently was only authorized to state the contravention, direct that it be terminated and order appropriate corrective measures to prevent the hazardous occurrence from reoccurring, as contemplated in paragraphs 145(1)(*a*) and (*b*). Setting out his conclusions on the cause of death, counsel stresses, has serious and unfair implications for the employer, particularly in light of the evidence that HSO Wallace is also involved in a process that could lead to prosecution.

[23] Counsel for the appellant further submits that the purpose of Part II of the Code is to prevent workplace accidents and injuries, and their reoccurrence (Ronald M. Snyder, *The 2013 Annotated Canada Labour Code*, Toronto, Carswell (2013), at pages 832, 935-936; *CUPE, Air Canada Component* v. *Air Canada,* 2010 FC 103, paragraphs 15, 21 and 24). As to HSO Wallace having exceed his authority when issuing a direction that points to the cause of death of an employee when he is only empowered by subsection 145(1) to ensure that a contravention is addressed and an unsafe situation be corrected, counsel referred to the following authorities: *Aéroports de Montréal* (Appeals Officer Decision 95-012) at page 13; *Canadian Airlines International Ltd* (Appeals Officer Decision 95-022) at page 18. Counsel also submits that the powers of the HSO are limited to those

expressly listed in the Code (*Canadian National Railway Co.* v. *Brocklehurst (C.A.)*, [2001] 2 F.C. 141). Sections other than subsection 145(1) of the Code as well as other Acts deal with investigation of accidents for the purpose of obtaining a conviction or identifying the cause, such as police or coroner's investigations, inspection under the *Railways Safety Act*, or section 7 of the *Canadian Transportation Accident Investigation and Safety Board Act*, S.C. 1989, c. 3, ("the *CTAISB Act"*).

[24] Counsel for the appellant concludes by requesting that the reference to the cause of the accident resulting in the employee sustaining fatal injuries be permanently removed from the direction.

For the Respondent

[25] Counsel for the respondent submits that the HSO Wallace's direction, as originally worded, is well founded and within the powers and authority provided by the Code. Counsel points out that there is no question now, as there was no question then, that HSO Wallace was conducting an investigation of a workplace fatality that occurred on November 28, 2012 at Gutah Camp, pursuant to subsection 141(4) of the Code. The direction under appeal was released entirely in the context of the Hazardous Occurrence Investigation that he conducted under subsection 141(4) of the Code.

[26] Counsel for the respondent highlights the fact that HSO Wallace testified in a straightforward manner and that he applied his 20 years of experience in the railway industry in developing his understanding of the circumstances that led to the fatality. Counsel submits that those findings are correct and amply supported by his Investigation Report and his testimony at the hearing outlining how he reached the conclusions set out in the December 7, 2012 direction. He testified that it is his experience and practice as an HSO to tie findings of contraventions of the Code to an event, where there is one, in order to give context to the contravention. Counsel submits that in the present case, given the gravity and nature of the issue, HSO Wallace was correct in doing so.

[27] Counsel for the respondent further submits that there is nothing that prevents an HSO from making findings of causation in a direction issued, whether it is part of an investigation, inquiry or inspection. In light of the purpose of the Code set out in sections 122.1 and 122.2, the power to investigate a fatality must be given a broad and purposive interpretation. Linking a contravention to a specific event is in service of the very purpose of Part II of the Code, and it is neither improper nor unlawful in making this nexus explicit in the direction.

[28] Counsel then distinguishes the *Aéroports de Montréal* (95-012) case cited by the employer, on the basis that the HSO in that case appeared to place responsibility for the accident on an entity that was not even the employees' employer in that case. Moreover, section 10 of the *Workers Compensation Act* of British Columbia, R.S.B.C. 1996, chapter 492, provides for a statutory bar to potential civil actions that may arise from compensable workplace accidents, with the result that the concern expressed by the appeals officer in that decision is not present in the instant matter. In any event, counsel

submits that the Tribunal jurisprudence has evolved since that decision was rendered and refers to decisions rendered more recently that, in counsel's opinion, fall squarely on the issue under appeal in this case and should be viewed as determinative of the issue: *Royal Bank of Canada (Re),* 2012 OHSTC 5, and *Canada (Human Resources and Skills Development)* v. *Canada Employment and Immigration Union,* 2013 OHSTC 6.

[29] Counsel for the respondent concludes that the direction is both legally and factually correct and was well within HSO Wallace's discretion and legal authority to issue as worded, including his findings of result and causation, and should be confirmed.

Appellant's Reply

[30] Counsel for the appellant briefly reiterates his main points of argument, namely the distinction between investigation and inspection, and the legal significance of this distinction. He referred to section 16 of the *CTAISB Act* as an indication of Parliament's concern that investigations to determine the cause of an accident should be conducted with the utmost care and procedural safeguards followed by coroners, which were not provided in the present case. The direction was issued under subsection 145(1) in the context of an inspection, with no authority for the HSO to make findings of causation. In counsel's view, a contravention does not need context or a tie to events.

[31] Counsel also reiterates the fact that the direction was issued before HSO Wallace had a complete picture of the facts, and as a result was based on insufficient evidence to allow him to come to a finding of causation. Counsel refers to the *Royal Bank of Canada (Re),* and *Canada (Human Resources and Skills Development)* decisions which both point to the importance for any finding of causation to be to be based on "authoritative evidence". Counsel stresses the fact that the direction in the *Canada (Human Resources and Skills Development)* case clearly referred to an investigation, not to an inspection, contrary to the impugned direction in the present matter.

Analysis

[32] The issue raised in this appeal, as it is framed by counsel for the appellant, is whether HSO Wallace exceeded his powers under the Code when he expressed an opinion as to the cause of the accident that he was called upon to investigate on November 29 and 30, 2012. That accident resulted in the death of an employee of CN. The employer has pointed out on a number of occasions that it does not attack the "operative" parts of the December 7, 2012 direction seeking the correction of a contravention of section 124 and paragraph 125(1)(*s*) of the Code. The employer has indeed taken immediate steps to comply with the said direction, as confirmed in HSO Wallace's Investigation Report marked as D-9 and filed with the Tribunal. Accordingly, the employer made it clear in its Notice of Appeal, in its opening remarks at the hearing and in its written submissions, that its line of attack of the direction does not pertain to the validity of HSO Wallace's conclusions/opinions themselves, or on the sufficiency of the information to support his conclusion, or the correctness of the process followed by the HSO. Rather, the employer's case rests on the contention that there is no legal

authority for a health and safety officer to include his conclusions as to the cause of the fatal accident in a direction issued under subsection 145(1) of the Code in the context of his inspection of the workplace. As the employer puts it, the employer is invoking that HSO Wallace erred in law and an exceeded his jurisdiction in so doing and has articulated his submissions mainly on that ground.

[33] Although the employer has set out the issue in the manner described above, the employer nevertheless brings up on a number of occasions in its submissions the fact that the conclusions reached by HSO Wallace as to the cause of the accident were premature, were based on insufficient facts and missing evidence. In other words, the employer did question the sufficiency of the evidence on the basis of which HSO Wallace came to his conclusions. This explains why I have recounted the facts in some detail, as some findings of facts will be required on my part for the resolution of the appeal.

[34] The first question of fact that I must address in light of the employer's submissions is: under what authority was HSO Wallace acting when he presented himself at Gutah Camp to investigate the events of November 28, 2012? Mr. Wallace's testimony clearly establishes that he was responding to a notification of a fatality and conducting the mandatory investigation contemplated in subsection 141(4) of the Code. That section reads as follows:

> **141. (4)** A health and safety officer shall investigate every death of an employee that occurred in the work place or while the employee was working, or that was the result of an injury that occurred in the work place or while the employee was working.

[35] There is no question that he communicated that information to representatives of the employer, and expressly referred to that authority in the two directions he issued on December 3, 2012 (Exhibits R-2 and R-3). When he was asked the question on December 21, 2012 by Mr. John Nicoletti, Risk Management Officer (Mountain region) with the CN, HSO Wallace confirmed that it was under the authority of subsection 141(4) of the Code (Exhibit R-1). I therefore find that HSO Wallace conducted an investigation pursuant to subsection 141(4) of the Code and that was the *raison d'être* of HSO Wallace's presence at Gutah Camp on those dates.

[36] The employer then argues that while Mr. Wallace may have been conducting an investigation pursuant to subsection 141(4), his direction was issued pursuant to subsection 145(1), and makes reference to his having conducted an inspection of the workplace. The employer argues that there is a conceptual difference between those two terms and that a direction issued in the context of an inspection cannot include any reference, as was done in this case, to the cause of an accident or a fatality. Consequently, the employer contends that HSO Wallace had no legal authority under that section to link the stated contraventions to the cause of the accident.

[37] Both parties have referred to the purpose provisions of Part II of the Code in support of their respective, and opposite, positions. I will start at the same place and reiterate that the purpose and objective of Part II of the Code, as stated in section 122.1, is

to “prevent accidents and injury to health arising out of, linked with or occurring in the course of employment to which this Part applies”. Section 122.2 expands on that purpose as follows:

> **122.2** Preventive measures should consist first of the elimination of hazards, then the reduction of hazards and finally, the provision of personal protective equipment, clothing, devices or materials, all with the goal of ensuring the health and safety of employees.

[38] It seems to me that such a statement of legislative intention is completely concerned with causation, i.e. the determination and elimination of factors in the work place that may cause an accident or create a hazard that may result in illness, injury or death of employees. In order to prevent those situations from occurring, Parliament has prescribed a series of detailed obligations on employers and employees. It has also enacted a set of rights aimed at the protection of employees, such as the right to refuse to work in case of danger, the right to participate through health and safety committees or representatives, and more closely related to the direction at issue in this case, the right to be informed of every know or foreseeable health or safety hazard in the area where the employee works. Parliament has also prescribed an enforcement framework to ensure that parties comply with their obligations, namely through the interventions of health and safety officers designated by the Minister of Labour for such purpose.

[39] Section 141 sets out the powers of health and safety officers, as follows:

> 141. (1) Subject to section 143.2, a health and safety officer may, in carrying out the officer’s duties and at any reasonable time, enter any work place controlled by an employer and, in respect of any work place, may
> (a) conduct examinations, tests, inquiries, investigations and inspections or direct the employer to conduct them;
>
> (b) take or remove for analysis, samples of any material or substance or any biological, chemical or physical agent;
>
> (c) be accompanied or assisted by any person and bring any equipment that the officer deems necessary to carry out the officer’s duties;
>
> (d) take or remove, for testing, material or equipment if there is no reasonable alternative to doing so;
>
> (e) take photographs and make sketches;
>
> (f) direct the employer to ensure that any place or thing specified by the officer not be disturbed for a reasonable period pending an examination, test, inquiry, investigation or inspection in relation to the place or thing;
>
> (g) direct any person not to disturb any place or thing specified by the officer for a reasonable period pending an examination, test, inquiry, investigation or inspection in relation to the place or thing;

> (h) direct the employer to produce documents and information relating to the health and safety of the employer's employees or the safety of the work place and to permit the officer to examine and make copies of or take extracts from those documents and that information;
>
> (i) direct the employer or an employee to make or provide statements, in the form and manner that the officer may specify, respecting working conditions and material and equipment that affect the health or safety of employees;
>
> (j) direct the employer or an employee or a person designated by either of them to accompany the officer while the officer is in the work place; and
>
> (k) meet with any person in private or, at the request of the person, in the presence of the person's legal counsel or union representative.
>
> [Underlining added]

[40] I note that the legislator has used the words "examinations, tests, inquiries, investigations and inspections (…)" to describe the types of interventions or actions that a health and safety officer may engage in. Those words are not defined in the Code and are referred to generically in the list of powers of a health and safety officer. In my opinion, those words are used interchangeably and each relate to the nature or situational context within which a health and safety officer may be called upon to carry out their duties under Part II of the Code. The fact that different words are used is principally for semantic or contextual reasons, in my view. For example, the *Oxford English Dictionary* defines "*examination*" as a detailed inspection or study and would likely be used in relation with records, a device, data, etc.; "*inquiries*" is defined as "a close examination of a matter in a search for information" and makes sense when used in relation with persons or an event; "*investigation*" is defined as "formal or systematic examination or research, a formal inquiry". Likewise, "*inspection*" is defined as a careful examination or scrutiny of something. Semantically, one does not "inspect" an accident or a death or a particular situation, nor does one "investigate" a work place or a record (see for example the wording of subsection 141.1(1): "[…] shall conduct an inspection of the work place […]". I consider those words to be synonyms and meant to describe the various manners by which health and safety officers carry out their duties under Part II. Consequently, I find that the distinction drawn by counsel for the employer between "investigation" and "inspection" as placing restrictions on a health and safety officer's remedial powers, is without merit. Clearly, the evidence establishes that HSO Wallace was called upon to attend the site of the accident as a result of being notified of a fatality. This triggered the operation of subsection 141(4) of the Code and HSO Wallace's presence on the site was for the purpose of investigating the accident. In the conduct of his investigation, he made inquiries with CN personnel, conducted tests and measurements, examined documents and records and more generally, inspected the work place and the site of the accident.

[41] I turn now to subsection 145(1), which enables a health and safety officer to direct an employer to terminate a contravention to a provision of the Code. That section appears under the heading "Special Safety Measures". In addition to other powers given to health and safety officers in connection with their enforcement role in sections 141 to 144,

Parliament has granted them broad coercive powers to order compliance, should they find, as a result of their investigation, examination or inspection of the workplace, that a contravention occurred or that a danger exists in the workplace. This power to order compliance supports the very purpose of Part II, which is to prevent workplace injuries from occurring, or reoccurring, as the case may be. Subsections 145(1) and (2) place no restriction on the context that may allow a health and safety officer to exercise the powers they provide for. They are available to the health and safety officer as a means to order compliance, regardless of what brings the health and safety officer to the particular workplace. In other words, it may be during a routine inspection of a work place, in response to a refusal to work, or in the conduct of an investigation into an accident. The direction may be "proactive" or "reactive", i.e in reaction to an event that has occurred and caused the health and safety officer to attend the particular work place.

[42] Counsel for the appellant invites me to read section 145(1) in a way that it only allows the health and safety officer to cite a contravention and direct that corrective measures be taken. In his view, expressing conclusions on the cause of an accident in the context of a direction issued pursuant to subsection 145(1) is an excess of jurisdiction on the part of the health and safety officer, since that provision does not expressly authorize it.

[43] In my opinion, this is too narrow a reading of that section. Subsection 145(1) cannot be read in isolation from other provisions setting out the enforcement scheme and the purpose of Part II the Code: it is one of the tools Parliament places in the hands of health and safety officers to ensure that the protections to prevent accidents are in place at all times. Subsection 145(1) is broadly worded and leaves some measure of discretion to the health and safety officer in the formulation of his direction. As the Federal Court states in *CUPE, Air Canada Component* v. *Air Canada*, 2010 FC 103, at paragraph 21:

> [21] The purpose of Part II of the *Code* is to "prevent accidents and injury to health arising out of, linked with, or occurring in the course of employment (see subsection 122.1). As set out above, the *Code* empowers HSO's with extensive investigative powers, broad discretion with regard to determining the action, if any, to be taken, and provides them with wide remedial powers to address *Code* violations.
>
> [Underlining added]

[44] The question, in my view, should rather be put as follows: does anything in the statutory framework prevent the health and safety officer from linking a contravention to the occurrence of a particular event if he/she is satisfied that such causation is established? In circumstances such as the present case where the direction is issued after the occurrence of a fatal accident, the purpose of the direction is to prevent the re-occurrence of the event by taking remedial measures and ceasing the contravention that was identified as the cause - or a key contributing factor - of the accident. What would be the purpose of the mandatory investigation contemplated by subsection 141(4) of the Code if it is not to determine what caused the fatality and more precisely whether it is attributable to a hazardous situation in the work place that needs to be corrected? That

process clearly implies making a determination on the cause of the accident, i.e. whether there is a causal link between the fatality and a situation at the workplace, be it a "danger" or a contravention of the Code or its regulations. Once, in the opinion of the health and safety officer, such a causal relationship is established, he must report on the results of his investigation (subsection 141(6)), but he can also resort to the "toolbox" of powers that he enjoys under subsection 145(1) and (2) to direct the corrective measures that he deems appropriate in the circumstances. This is how I understand the manner in which the scheme set out in the Code is meant to operate.

[45] Seen in that light then, it only makes sense to link a remedial order to the particular hazard or situation which the HSO identified and led him to exercise his remedial powers. It is entirely consistent with the purpose and intent of Part II of the Code to do so, which is to prevent future accidents from happening. *A fortiori*, when a direction is issued in the context of the investigation of an accident resulting in a fatality, the prevention objective will indeed be better served when a causal link between the corrective measure and the cause of the accident, if such an equation can reasonably be established, is explicitly stated in the direction. Directions must be in writing and worded in a sufficiently clear manner that enables the employer and employees affected by it to understand what needs to be remedied and why.

[46] While there was no obligation on HSO Wallace to expressly refer to the link that he saw between the accident and the contravention (i.e. that employees be properly informed of every foreseeable hazard), I do not read section 145(1) as preventing him to do so. When there is no particular event or hazardous occurrence leading to the issuance of a direction, the health and safety officer will simply state the contravention and order correction. But where, as in this case, a health and safety officer is of the opinion that a contravention of the Code contributed to an accident that he is investigating and that needs to be corrected immediately, there is no legal or policy reason why his conclusion cannot be stated in the direction. Since every direction is to be forwarded to the Health and Safety Committee(s) or representatives, doing so is consistent with the preventive function of those committees to know of the particular context of the event related to the issuance of the direction, so that its members and employees generally are better informed of its significance and implications.

[47] The same comments apply to subsection 145(2) and the power to issue a direction in situations of danger: clearly, the purpose of that power is to correct a particular situation that constitutes a danger in the work place and that may cause, or may have already caused, harm or injury to the employees. There would be nothing improper in establishing a clear nexus between the corrective action and the dangerous situation observed, including the injury that it may have already caused. HSO Wallace testified that he considered issuing a direction under subsection 145(2) of the Code, based on his conclusion that the inadequate signage and lack of clear instructions about the presence of multiple derails, constituted a danger that required immediate correction. Such a direction would have resulted in a temporary stoppage of CN's activities in that workplace, which he chose to avoid given the good faith intentions of the employer to bring about adequate remedial measures rapidly. The employer argues that this illustrates the lack of

understanding by HSO Wallace of his powers under the Code. I am of a different view. In my opinion, HSO Wallace acted within the discretion conferred on him by section 145 of the Code in selecting the measure that appeared, in his judgement, the most appropriate in the circumstances.

[48] The employer placed significant emphasis on the fact that HSO Wallace mentioned in the preamble of his direction that he was conducting an inspection (rather than an investigation). In my view, this is of no material consequence. The use of the word "inspection" in the preamble of the direction is immaterial, in my view, to the nature of the powers that a health and safety officer is granted by section 145. As I stated earlier, subsection 145(1) does not make that distinction. Regardless of what brings a health and safety officer to the work place, whether it is in the context of an investigation of an event, be it an accident or a fatality pursuant to subsection 141(4), an inspection of a workplace, or an inquiry into any given event, the HSO is empowered to exercise the broad powers set out in section 145.

[49] The employer further justifies the importance of its distinction between "investigation into an accident" and "inspection of the workplace" on the basis that the former implies the application of greater procedural safeguards and fairness, for example the need for search warrants, protection against self-incrimination, right to legal counsel, etc. In my view, those rights do not depend on whether an investigation, as opposed to an inspection, is being conducted, but rather on the purpose of the health and safety officer's intervention. It may be that the rights and procedural safeguards that the employer enjoys are greater if the HSO is conducting an investigation or inspection for the purpose of gathering evidence to support a prosecution, rather than an investigation into an accident or inspection of a workplace that may result in a direction under section 145. However, those protections become relevant, in my view, only in relation to that eventual prosecution and would be matter for debate in that particular forum, not in the context of an appeal filed under section 146 of the Code.

[50] The employer also argued that the determination of the cause of an accident, in this instance a railway accident, is within the exclusive mandate of other entities, such as the police, the coroner, or inquiries and investigations under the *Railway Safety Act*, R.S.C. 1985, c. 32 (4th Supp.) and the *CTAISB Act*. In the latter case, counsel for the employer refers to section 7 of that *Act*, which states as follows:

> 7. (1) The object of the Board is to advance transportation safety by
>
> (a) conducting independent investigations, including, when necessary, public inquiries, into selected transportation occurrences in order to make findings as to their causes and contributing factors;
>
> (b) identifying safety deficiencies as evidenced by transportation occurrences;
>
> (c) making recommendations designed to eliminate or reduce any such safety deficiencies; and

> (d) reporting publicly on its investigations and on the findings in relation thereto.
>
> (2) In making its findings as to the causes and contributing factors of a transportation occurrence, it is not the function of the Board to assign fault or determine civil or criminal liability, but the Board shall not refrain from fully reporting on the causes and contributing factors merely because fault or liability might be inferred from the Board's findings.
>
> (3) No finding of the Board shall be construed as assigning fault or determining civil or criminal liability.
>
> (4) The findings of the Board are not binding on the parties to any legal, disciplinary or other proceedings.

[51] In my view, that provision does not necessarily establish an exclusive mandate to the Canadian Transportation Accident Investigation and Safety Board (CTAISB) to investigate accidents and determine their cause. It is useful to quote sections 14 and 15 of the *CTAISB Act* in that regards:

> **14.** (1) Notwithstanding any other Act of Parliament but subject to section 18, the Board may, and if so requested by the Governor in Council shall, investigate any transportation occurrence for the purpose of carrying out the object of the Board.
>
> (2) Subject to section 18, the Board may investigate a transportation occurrence where a department, the lieutenant governor in council of a province or the Commissioner of the Northwest Territories or Nunavut, or the Commissioner of Yukon with the consent of the Executive Council of that territory, requests the Board to investigate and undertakes to be liable to the Board for any reasonable costs incurred by the Board in the investigation.
>
> (3) Notwithstanding any other Act of Parliament,
>
> > (a) no department, other than the Department of National Defence, may commence an investigation into a transportation occurrence <u>for the purpose of making findings as to its causes and contributing factors if</u>
> >
> > > <u>(i) that transportation occurrence is being or has been investigated by the Board under this Act, or</u>
> > >
> > > <u>(ii) the department has been informed that that transportation occurrence is proposed to be investigated by the Board under this Act; and</u>
> >
> > (b) <u>where an investigation into a transportation occurrence is commenced by the Board under this Act after an investigation into that transportation occurrence has been commenced by a department, other than the Department of National Defence, the department shall forthwith discontinue its investigation, to the extent that it is an investigation for the purpose of making</u>

findings as to the causes and contributing factors of the transportation occurrence.

(4) Nothing in subsection (3)

(a) prevents a department from commencing an investigation into or continuing to investigate a transportation occurrence for any purpose other than that of making findings as to its causes and contributing factors, or from investigating any matter that is related to the transportation occurrence and that is not being investigated by the Board; or

(b) prevents the Royal Canadian Mounted Police from investigating the transportation occurrence for any purpose for which it is empowered to conduct investigations.

(5) For greater certainty, where the Board does not investigate a transportation occurrence, no department is prevented from investigating any aspect of the transportation occurrence that it is empowered to investigate.

15. (1) Where, at any time during an investigation into a transportation occurrence under this Act, a department other than the Department of National Defence investigates that transportation occurrence or undertakes remedial measures with respect to that transportation occurrence, the Board and the department shall take all reasonable measures to ensure that their activities with respect to that transportation occurrence are coordinated.

(2) Where conflicting interests arise between the Board and a department in co-ordinating their activities pursuant to subsection (1), the requirements and interests of the Board, subject to subsection (3) and any agreement entered into under section 17, take precedence and are paramount to the extent of the conflict.

(3) Nothing in subsection (2) gives the requirements and interests of the Board precedence over those of the Royal Canadian Mounted Police, or prevents a department from taking emergency remedial measures under any other Act of Parliament or any regulations made thereunder.

[Underlining added]

[52] The purpose of these provisions is to ensure that investigations of transportation accidents are conducted in an efficient manner by the Board, without overlap and duplication with other departmental entities (such as Transport Canada or HRSDC's Labour program) who may also have a statutory mandate to investigate the same accidents, albeit from a different perspective. To do so, subsections 14(3) and (4) establish paramountcy on investigations conducted by the CTAISB to determine the cause of accident, over other investigations. But, more to the point that I wish to make by referring to those provisions, they also imply that other entities, such as health and safety officers under the Code, may very well have a similar investigation mandate under other applicable legislation to look into the circumstances of an accident and determine its

cause, and such mandate could be exercised concurrently with that of the CTAISB, thus triggering the effect of the provisions quoted above.

[53] As I stated earlier, it seems to me that the obligation to investigate fatal accidents occurring in the workplace set out in 141(4) is designed to require health and safety officers to make a determination on what caused the fatality, and more precisely whether it is attributable to a hazardous situation in the work place that needs to be corrected. It clearly implies making a determination on the cause of the accident, i.e. whether there is a causal link between the fatality and a situation at the workplace, be it a "danger" or a contravention of the Code or its regulations. In my view, the two mandates coexist: the mandate under the *CTAISB Act* having a "public safety" focus (as set out in section 7 of the Act), the mandate under the *Canada Labour Code* having an employment focus. Had there been a CTAISB investigation, it may well be that the operation of section 14 of the *CTAISB Act* would have prevented HSO Wallace from expressing his conclusions on the cause of the accident and resulting fatality. The evidence presented at the hearing has established that no investigation under the *CTAISB Act* has or will be conducted regarding the November 28 accident. Therefore, none of these *CTAISB Act* provisions apply to our situation and I see no impediment in HSO Wallace conducting his investigation as mandated by subsection 141(4) of the Code, identifying the cause of the accident and possible contraventions to the Code, and as a result directing corrective measures that are consistent with his findings under the authority of subsection 145(1) of the Code.

[54] The employer cited *Gilmore* v. *Canadian National Railway*, ([1995] F.C.J. No. 1601; 104 F.T.R. 74) in support of the proposition that health and safety officers only enjoy the powers that are specifically assigned to them under the statute. In that case, the issue concerned the validity of a direction issued by an HSO, and confirmed by the appeals officer whose decision was the subject of the judicial review, that the employer cease taking reprisal measures against an employee, in contravention of the Code. The Court quashed the appeals officer's decision on the basis that the Code expressly provided a specific avenue of redress before the Canada Labour Relations Board (as it was then) for complaints raising alleged reprisals by the employer. At page 9, the Court states as follows:

> [7] Counsel for the applicant relied heavily on the wording of subsection 145(1) of Part II of the Code which reads:
>
> 145. (1) Where a safety officer is of the opinion that any provision of this Part is being contravened, the officer may direct the employer or employee concerned to terminate the contravention within such time as the officer may specify and the officer shall, if requested by the employer or employee concerned, confirm the direction in writing if the direction was given orally.
>
> [8] In my view, this subsection, which provides for oral directions, <u>can only relate to contraventions which the safety officer is otherwise authorized to conduct and about which he or she is empowered to make decisions under Part II of the Code.</u>

> [9] The roles of the Board and of the safety officer are separate and distinct. The only legislated exception is in respect of matters provided in subsection 129(5) where the Board may review a decision of the safety officer. Pursuant to section 134, the Board has exclusive jurisdiction to deal with contraventions of paragraph 147(a) of the Code (disciplinary measures). Nowhere in Part II of the Code is the safety officer given the remedial power to deal with disciplinary measures taken by the employer by reason of the employee's exercise of his or her rights under that Part. The record shows that the applicant herein made a complaint to the Board, but that it was judged by the Board to be out of time by reason of the provisions of subsection 133(2) of the Code. Subsection 145(1) does not provide the employee with an alternative recourse to a safety officer in such cases
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> [Underlining added]

[55] The Court found that the subject matter of the direction could not be investigated by an HSO because the statutory scheme created an exclusive redress mechanism before the CLRB. That decision can easily be distinguished from the present case, where the subject matter falls squarely within the jurisdiction of health and safety officers under subsection 141(4) and 145(1), and "about which the health and safety officer is empowered to make decisions under Part II of the Code".

[56] Likewise in *Canadian National Railway Co.* v. *Brocklehurst (C.A.)(supra)* cited by the employer, the Court found that Canadian Transportation Agency had no substantive jurisdiction (*rationae materiae*) over a particular subject matter (complaints about noise from railway yards), and consequently had no jurisdiction to issue compliance orders under its enabling statute. In the present case, HSO Wallace not only has jurisdiction but a statutory duty to act on the subject matter which resulted in the direction and accordingly, could resort to the wide corrective powers conferred by section 145 of the Code.

[57] Counsel for the employer also referred to the decisions rendered in *Canadian Airlines International Ltd* (Appeals Officer Decision 95-022) and *Aéroports de Montréal* (Appeals Officer Decision 95-012) in support of his contention that subsection 145(1) does not authorize a health and safety officer to draw conclusions as to the "cause of death" or the "cause of the accident". In those cases, the appeals officer expressed the view that the HSO is limited to making a finding of a contravention under 145(1), without "assigning responsibility for the accident". Interestingly enough, the appeals officer states as follows, at page 16 of his reasons in the *Canadian Airlines* case:

> […]
> I do not have to decide here who is responsible for the accident, but I must say that, in my opinion, the performing of the de-icing while the engines were running is not the cause per se of the accident. […]
>
> [Underlining added]

[58] The appeals officer himself seems to make the distinction, as he should, between referring to the cause of an accident in order to provide context to a direction, and assigning responsibility for the accident. I am in agreement that a health and safety officer is not authorized to make a finding of civil liability for the accident and include it in his direction. In my view, HSO Wallace is neither assigning responsibility nor making a finding of liability, in the legal sense, by referring in the text of his direction to what he views as the cause of the accident. While establishing a causal link between a contravention of the Code and the occurrence of an accident may be seen as implying a fault, it is clear that the actual assignment of responsibility, be it civil or criminal liability, with all its legal implications, is determined in other *fora* in the course of other judicial procedures. HSO Wallace's opinion is in no way binding on those other processes, which follow their own course. Those cases would proceed quite independently from the direction and would be based on material evidence presented before that Court, under the applicable standard of proof. In the final analysis, I do not agree that a reference, in the wording of a direction , to a contravention causing an accident will, in and of itself, "expose the employer to civil actions", as stated by the Appeals Officer in the *Aéroports de Montréal* case, no more no less than if no such reference is made.

[59] The appeals officer in *Canada (Human Resources and Skills Development)* v. *Canada Employment and Immigration Union (supra)*, expressed the following view on this point, with which I agree:

> [27] […] For the respondent these two provisions [subsection 141(4) of the Code and paragraph 15.5 of the COSH] combine to give an HSO authority to investigate a death in or related to an employee's workplace and the jurisdiction to make the findings included in the direction. With respect to these latter findings and particularly to the words that the appellant seeks to have removed, the respondent argues that they do not establish a level of liability and that the HSO "was merely stating the facts as she found them."
>
> [28] I have considered the parties' respective submissions on this matter and find that I am in agreement with the appellant's contention that an HSO is not authorized to make a finding of civil liability. However, I do not regard liability as synonymous with causation as the appellant appears to do in the passage quoted in paragraphs 8 and 26 above where it is submitted that "the HSO does not have authority to make findings of causation or liability either directly or indirectly." (My emphasis). I find that the respondent's counter argument in this respect has some merit.
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> [Underlining added]

[60] Having said all of the above, I am persuaded by the views expressed by the Appeals Officer in the two cases cited by the Respondent: *Royal Bank of Canada (Re)(supra)* and *Canada (Human Resources and Skills Development)* v. *Canada Employment and Immigration union*. In the first case, the Appeals Officer was called upon to review the circumstances of a direction issued by an HSO under subsection 145(1) in the course of an investigation under subsection 141(4) of the Code, much like the present case, albeit following a death from natural causes that occurred in a federally-regulated workplace.

At paragraph 16 of the decision, the appeals officer held that the direction was made in the context of a section 141(4) investigation, notwithstanding that subsection 141(4) was not expressly referenced in the direction. The appeals officer stated as follows:

> [16] […] The appellant makes no reference to subsection 141(4) in its submission but then neither is the subsection referenced in the text of the direction. However, the appellant was in possession of the HSO's report and related documents before making its submission and would be aware that his investigation of the death was undertaken pursuant to that subsection of the Code. RBC should not therefore be surprised that the Appeals Officer would give consideration to the wording of the subsection when considering this appeal. Certainly an HSO would need to become aware of a death in the workplace in order to fulfill the statutory obligation to investigate that death.
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> [Underlining added]

[61] While much of the discussion in that case pertained to whether a health and safety officer had jurisdiction under subsection 141(4) to investigate a death from natural causes, the following comments found at paragraph 27 support my own view of the scheme set out in the Code, and more specifically what I see as the purpose of subsection 141(4), as I have outlined earlier in these reasons:

> [27] The mandatory investigation by an HSO as provided for in the subsection is instructive. It is the HSO's entry to a set of circumstances that result in a death in the workplace. The scheme and purpose of the Code place a duty on the HSO to endeavour to determine the cause of death, to consider whether or not occupational health and safety concerns are involved and, if so, what remedial measures might be recommended. For example, the record shows that the HSO in this case enquired about signs of workplace stress. He found none but it was consistent with the Code's purpose that he should give consideration to such a possibility.
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> [Underlining added]

[62] The appeals officer also notes, at paragraph 29, that a health and safety officer's inquiry into the circumstances of the death of an employee may occur concurrently with other bodies that may investigate the same matter.

> [29] […] A health and safety officer is a specialist and an HSO's statutory mandate in the case of a death of an employee in the workplace or while working is separate from and autonomous of that of the medical personnel, the police and the Coroner whose mandates are determined by different legislation. Obviously, in a case such as the one at hand, an HSO would be well advised to take account of what these other authorities do and what they find. However, the HSO has expertise that the others do not necessarily possess; indeed the other authorities may need to tap that specialized expertise when acquitting their own functions and responsibilities.

[63] In addition, I find support for my interpretation of the legislative scheme in the reasoning expressed by the Appeals Officer in the second – and more recent – case cited

by the respondent, *Canada (Human Resources and Skills Development)* v. *Canada Employment and Immigration Union (supra)*. That case is in my view even more closely related to the issue raised by the present appeal, is persuasive and, in my opinion is determinative of the present appeal. In that case, the employer appealed a direction issued by a health and safety officer which included a finding that the hazardous activity "resulted in the fatality of an employee". As the employer is seeking in the present appeal, the employer in that case sought to have that last phrase removed from the text of the direction, on the basis that the health and safety officer exceeded the authority provided in subsection 145(1). At paragraph 25 of his decision, the Appeals Officer commented on the significance of context provided in the text of a direction, and the HSO's discretion to provide such context on the basis of findings that are "reliably available" to him or her:

[64]

> [25] In the light of this broader purpose of issuing directions I find it reasonable that a direction should contain context and that the HSO is left with reasonable discretion as to what should be included in that context. Taken to, its extreme which I do not believe was the respondent's intention, a bare order such as that pursuant to paragraph 145(2)(a) in the direction issued by HSO Parkin on March 28, 2012, simply requires the employer "to alter the activity that constitutes a danger immediately." The employer and those intimately involved in circumstances leading to the direction might find this sufficient to determine the necessary remedial follow up; although why leave room for misunderstanding? Others, including other employees of the employer with a less direct involvement but nevertheless with justified interest in the matter, might be left puzzled by the lack of specifics and the informational, educational and preventive purposes of the direction would be compromised. Background is needed to make sense of such an order and I am of the view that it should reasonably include in cases of this kind a description of the hazardous occurrence, its timing and location, such factual details as are reliably available to the HSO as to its cause and outcome and a narrative indication of the contraventions addressed by the direction.
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> [Underlining added]

[65] The Appeals Officer then rejected the position advanced by the employer that the health and safety officer did not have the authority to make findings of causation or liability and set them out in a direction, in the following terms at paragraphs 30 and 31:

> [30] […] In line with the rationale put forward in the Royal Bank decision, the HSO had authority to inquire into the cause of the death and into whether or not it was the result of a hazardous occurrence that occurred in the workplace or while the employee was working.
>
> [31] The purpose and intent of the Code frequently require the outcome of investigations to be reported and available for use under the Code's authority. Subsection 141(6) specifically requires an HSO to provide copies of any written report to the employer and the work place committee or health and safety representative within ten days of its completion. To restrict the inclusion of valid findings of cause and result in the content of a report made or a direction issued by an HSO would compromise their utility under the Code and negate the educational and

> preventive objectives implicit in the statute. Hazardous occurrences can happen, as in the present case, while quite routine duties are being performed. Recording their outcomes can alert employees to the potential for danger no matter how routine the tasks involved and promote vigilance and prevention. In short, I find that the legislative scheme of the Code provides the HSO with authority to make findings of cause and result of the hazardous occurrence investigated by her in late March 2012.
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> [Underlining added]

[66] It is also my view that this is the correct interpretation of the provisions empowering health and safety officers to issue directions under 145(1) and (2) of the Code.

[67] Having found that HSO Wallace did not err in law and did not exceed his jurisdiction in referring to the cause of the accident and its resulting effect in his December 7 direction, these conclusions should be dispositive of the present appeal. However, I have noted earlier in these reasons that although the employer had framed the issue in this case as being one of jurisdiction and legal interpretation, the employer nevertheless did put the justification of HSO Wallace's conclusions into question in its submissions. As a result and in all fairness, I feel that I must address the question of whether HSO Wallace's conclusions are justifiable.

[68] Counsel for the employer urges me to disregard all material that HSO Wallace forwarded to the Tribunal, other than the direction itself. According to counsel, HSO Wallace failed to provide the Tribunal with any information supporting the direction. The Investigation Report that was forwarded at the Tribunal's request should be disregarded because it is subsequent to the date of the direction and simply could not have formed the basis of the direction.

[69] I am of the view that the Investigation Report marked by Tribunal staff as D-9 is admissible and forms part of the evidence that I can properly and lawfully consider. A copy of the Investigation Report was forwarded to the parties in January 2013. The Investigation Report relates entirely to the fatal accident that occurred on November 28, 2012 at Gutah Camp, and as such is relevant to the direction under appeal, issued as it was on December 7, 2012, in relation to the same event. An appeal under section 146 of the Code is a *de novo* process, further to which the appeals officer must make a determination as to whether the direction should be confirmed, varied or rescinded (see: *Canadian Freightways Ltd* v. *Canada (Attorney General)*, 2003 FCT 291). In carrying out my duties, I can receive and accept any evidence and information on oath, affidavit or otherwise, whether or not admissible in a court of law (subsection 146.2(*c*) of the Code). I am also to give the parties an opportunity to present evidence and make submissions, and must consider the information relating to the matter (subsection 146.2(*h*). The primary consideration regarding the evidence is therefore its relevance to the question raised by the appeal, and its reliability (see: Ronald M. Snyder, *The 2013 Annotated*

Canada Labour Code, Toronto, Carswell (2013), at page 959; and *Hogue-Burzynski et al* v. *Via Rail Canada,* Appeals Officer Decision No. 06-015 (May 1, 2006).

[70] As I have already stated, the Investigation Report relates entirely to the accident of November 28, 2012. But more importantly, most of its content is based on observations made and information gathered by HSO Wallace before the issuance of the direction under appeal. The fact that HSO Wallace finalized his report a few weeks later does not mean that the December 7 direction has no evidentiary basis. HSO Wallace testified at the hearing and recounted his investigation of the scene of the accident, and the information that he gathered on that occasion. The fact that some of the information that is referred to in his Investigation Report was obtained after December 7, 2012 is of no consequence to the issue raised by the appeal. The evidence presented is that none of the information received after the date of issuance of his direction caused HSO Wallace to be of a different view regarding his conclusions on the cause of the accident.

[71] Having considered all the circumstances of this case, it is also my opinion that the observations, analysis and conclusions reached by HSO Wallace as to the sequence of events that caused the derailment and the tank car rolling over Conductor Giesbrecht, fatally injuring him, are well founded and have not been substantially challenged. No other hypothesis was advanced to explain the cause of the accident or the cause of Mr. Giesbrecht's death. HSO Wallace has the expertise, the experience and had ample information and evidence upon which to make his findings as to the cause and the result of the accident. Absent any facts that could cast doubt on the safety officer's competence or investigation, the appeals officer must be able to rely on the conclusions of that officer, who has specialized knowledge of the rules and practices in the sector he is investigating (see: *Pierre Brûlé et al.*, [1999] CIRB No. 2, paragraphs 19-21).

[72] HSO Wallace based his conclusions on his observations at the scene of the accident, on information he possessed at the time of issuing his direction, all of which he analyzed in light of his experience of more than 20 years of employment in the railway industry, including many years as a Conductor with BCR. Contrary to the employer's claim in its submissions that HSO Wallace felt obliged to act because there had been a fatality and "he felt a need to find fault", I am of the view that HSO Wallace's sole motivation was the employees' safety and the desire to prevent such a serious accident from reoccurring.

[73] On the basis of the evidence presented, HSO Wallace's conclusions appear to me to be well founded and reliably available to him. I see no basis upon which to vary the direction in that respect.

[74] In summary, I find that HSO Wallace did not exceed his jurisdiction when, on December 7, 2012, he issued the direction, as originally worded, in the circumstances described above. A proper and purposive interpretation of the remedial provisions pursuant to which HSO Wallace acted leads me to conclude that he had the authority and discretion to state in his direction that the contraventions of the Code (inadequate signage

and lack of clarity of information regarding known hazards) “resulted in a derailment and an employee sustaining fatal injuries”.

Decision

[75] For the reasons set out above, I hereby confirm the direction and dismiss the appeal.

[76] For greater certainty, the redacted version of the direction that resulted from my decision granting the stay on January 10, 2013, is no longer in effect as of the date of this decision.

[77] Furthermore, HSO Wallace had ordered the employer to cause a copy of the direction to be posted in *all locations where operating crews report for duty on the former BCR* for a period of forty five (45) calendar days or until the contravention noted is corrected, whichever is greater (underlining added), and give a copy to the Policy Committee and the Workplace Health and Safety Committee or the Health and Safety Representative. As a result of the stay, only the redacted version of the direction was posted and copied to the health and safety committee. I was not made aware of the state of compliance with the corrective measures ordered by HSO Wallace. At page 21 of his Investigation Report, HSO Wallace mentions that he has received on December 21, 2012 “written response detailing corrective actions to satisfy the direction of December 7, 2012”. Some of those measures would likely take some time to implement and may not be finalized at this time. I can only speculate as to whether the measures taken by the employer have, in actual fact, “corrected the contravention noted” as contemplated by HSO Wallace. In the circumstances, I have no ground upon which to vary that aspect of the direction and no authority to exempt the employer from its obligations under subsection 145(5) of the Code. Consequently, the original order to post the direction and provide copy to the Health and Safety Committees or representative, is by necessary implication, hereby revived and applies to the unredacted version of the direction, which I have attached to the present decision.

Pierre Hamel
Appeals Officer