Decision No: 97-013

PART II
OCCUPATIONAL SAFETY AND HEALTH

Review under section 146 of the Canada Labour Code, Part II
of a direction issued by a safety officer

Applicant:	Logistec Stevedoring Inc. Marine Terminal 22 Halifax, Nova Scotia Represented by: Brian G. Johnston McInnes, Cooper & Robertson Barristers & Solicitors, Halifax, Nova Scotia
Respondent:	David Nauss President, International Longshoreman's Union Local 269, Halifax, Nova Scotia
Mis en cause:	Peter Lim Safety Officer Marine Safety, Transport Canada
Before:	Doug Malanka Regional Safety Officer Human Resources Development Canada

On January 4, 1997, Mr. Brent Slaunwhite, a fork lift truck operator was unloading cargo from a ship called the M.V. Hoegh Drake. At approximately 0040 hours, he climbed from his forklift truck to adjust the forks on his machine to accept metal crates of rubber stacked on a cargo transporting device called a Head Board Flat (HBF). At that moment, another forklift truck operator, operating on the opposite side of the HBF, accidentally struck and caused two metal crates of rubber stacked on each other to topple from the HBF. The metal crates of rubber, each weighing approximately 2800 pounds, struck and injured Mr. Slaunwhite. He was transported to hospital by ambulance where it was learned that he had a broken neck. The accident left Mr. Slaunwhite permanently paralysed from the neck down.

The accident was investigated jointly by safety officer Peter Lim of Marine Safety, Transport Canada, and by safety officer Ron Thibault of Human Resources Development Canada. Following their investigation, safety officer Lim issued two directions to Logistec Stevedoring Inc.. They are attached to this Report as Appendices A and B. Logistec Stevedoring Inc. requested a review of the directions and a hearing was held on July 10, 1997.

Hearing:

At the beginning of the hearing Mr. Johnston and Mr. Nauss informed me that they would not be calling witnesses and did not wish to question safety officer Lim. They said that safety officer Lim's report is complete and that they did not have any questions for him. I accepted their proposal to proceed with summary statements.

Background:

Safety officer Lim's report entitled, "INVESTIGATION INTO HAZARDOUS OCCURRENCE WITH RESPECT TO DISCHARGING CARGO FROM THE M.V. HOEGH DRAKE ON 04 JANUARY 1997," forms part of the file connected with this case and will not be repeated here. Since neither party queried or challenged the contents of the report, I take safety officer Lim's account of events to be accurate and complete.

Employer Position

The employer's report prepared by Mr. Johnston forms part of the file and will not be repeated here. However, during his summary statement at the hearing, Mr. Johnston reiterated the significant parts of his report. Instead of dealing with them here, I will address them in my decision that follows.

Employee Position:

Mr. Nauss provided arguments relative to the directions. Instead of dealing with them here, I will also address them in my decision.

Decision:

Given that each of the two directions consists of three items, I will, for ease of reference to the reports by safety officer Lim and Mr. Johnston, deal with each direction and items in the same order as they appear in the safety officer's report.

Looking first at item #1 of the direction made pursuant to subsection 145.(1)**:**
Safety officer Lim wrote:

> The said safety officer is of the opinion that the following provisions of the Canada Labour Code, Part II are being contravened:
>
> 1. Paragraph 125.(c) of the Canada Labour Code, Part II and paragraph 15.5(c) of the Canada Occupational Safety and Health Regulations. Employer failed to report serious accident within
> 24 hours.

In his summation, Mr. Johnston acknowledged that paragraphs 15.5 (c) and (d)[1] of the Canada Occupational Safety and Health Regulations (COSHRs) requires the employer to report to a safety officer, within 24 hours after becoming aware of it, any accident that results in the loss by an employee of a body member or part thereof, in the complete loss of the usefulness of a body member or a part thereof, or in the permanent impairment of a body function of an employee.

However, he explained that Mr. Maher did not report the accident immediately to a safety officer because he did not believe that Mr. Slaunwhite's injury was serious. He said that, Mr. Maher's written statement concerning the accident is that Mr. Slaunwhite was conscious, breathing and able to move his head and arms.

As further proof of the reasonableness of Mr. Maher's assessment that this was not a serious injury, Mr. Johnston referred me to a statement that Mr. Maher allegedly took from Mr. Robert (Bob) Chaisson on January 9, 1997. According to the statement, Mr. Chaisson confirmed that the ambulance attendants had not immobilized Mr. Slaunwhite's neck before transporting him to the hospital. Mr. Johnston further noted that the initial police report did not mention paralysis.

Mr Johnson then argued that, although Mr. Maher had learned at 0300 hours on January 4, 1997, that Mr. Slaunwhite had a broken neck, he was not aware that there was paralysis as specified in 15.5(c) of the COSHRs. Mr. Johnston suggested that people who suffer broken necks often recover without paralysis. He affirmed that Mr. Maher only became aware that there was permanent paralysis a week later.

Mr. Johnston then pointed out that, technically, Logistec had informed a safety officer of the serious accident within the required 24 hour period. He reminded me that Mr. Nauss is an employee of Logistec, and that he had reported the accident to safety officer Lim some time before noon on January 4, 1997. He contended that further notification by Logistec would not have added any additional information.

In response, Mr. Nauss said that, following the accident, Mr. Slaunwhite had no movement except for his head, and that the men at the scene of the accident believed it to be a serious injury. He insisted that Logistec should have reported the accident after they learned that Mr. Slaunwhite had a broken neck. He added that, when he visited the hospital at approximately 10:00 hours on January 4, 1997, the day of the accident, he was told that Mr Slaunwhite had no movement from the neck down.

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[1] Paragraphs 15.5 (c) and (d) of Part 15 (Hazardous Occurrence Investigation , Recording and Reporting) of the COSHRS read as follows:

15.5 The employer shall report to a safety officer, by telephone or telex, the date, time, location and nature of any accident, occupational disease or other hazardous occurrence referred to in section 15.4 that had one of the following results, as soon as possible but not later than 24 hours after becoming aware of that result, namely,

…(*c*) the loss by an employee of a body member or a part thereof or the complete loss of the usefulness of a body member or a part thereof;
(*d*) the permanent impairment of a body function of an employee;…

Decision

I have several doubts related to Mr. Maher's belief that Mr. Slaunwhite's injury was not serious. First, when I look at Mr. Maher's actual statement of January 8, 1997, I see that he only detected some hand movement. This differs significantly from Mr. Johnston's characterization that Mr. Slaunwhite was conscious, breathing and able to move his head and arms following the accident. When I consider the actual words in Mr. Maher's statement, I get a picture of an accident victim who is in serious medical distress. Mr. Maher's exact words were:

> "I observed that he was conscious, his eyes were open but his eyelids were flickering. He conversed with his associates in tones too low for me to hear what was being said. I detected some hand movement by him at this time…"

Notwithstanding this, It is also unclear to me how Mr. Maher arrived at the conclusion that the injury was not serious. For example, Mr. Maher did not actually render first aid and assess Mr. Slaunwhite's injury. The wording in his statement shows that his conclusion was based solely on visual observations from some distance. For example, Mr. Maher wrote, "I observed that he (Mr. Slaunwhite) was conscious…and, "…I was looking, in particular, for sign of pulse and breathing." (Words underlined for emphasis.)

In addition, there is no evidence that Mr. Maher made an effort to interview the workers who actually attempted to render first aid to Mr. Slaunwhite. If he had he could have learned from Mr. Moore, as contained in his statement of February 6, 1997, that "There was yellow stuff and blood coming from his (Mr. Slaunwhite's) mouth, and that "After he (Mr. Slaunwhite) cleared his throat he said that he cannot pick himself up and cannot feel anything." He could also have learned from Mr. Richards that "…Brent was hurt badly and that he cannot feel anything." There is no evidence that Mr. Maher called or visited the hospital to confirm the situation even after he heard from Mr. Todd Slaunwhite that his brother Brent had a broken neck.

For the above reasons, Mr. Maher's conclusion that Mr. Slaunwhite's injury was not serious was not based on the facts that were readily available to him, and so was not reasonable.

Nor can I assign weight to Mr. Johnston's suggestion that the action of the ambulance attendants and the police demonstrate the reasonableness of Mr. Maher's belief. Mr. Todd Slaunwhite's statement on February 18, 1997, is that the ambulance attendants had stabilized Brent's neck with a makeshift collar during transport, and that there was a proper collar when he reached the hospital. While this disagrees with the statement Mr. Chaisson is alleged to have given to Mr. Maher on January 9, 1997, I note that the written statement is unsigned by Mr. Chaisson. So without having received corroboration at the hearing, Mr. Chaisson's statement is essentially hearsay.

In terms of the police report not mentioning paralysis, it is generally not the responsibility of investigating police officers to assess the extent of medical injury of an accident victim and to report their assessment to the employer. Instead, employers are responsible for informing themselves concerning the extent of injury through information available to them, and for complying with the Code and regulations where their subsequent action is required. Therefore, I fail to see how the actions of the police demonstrated the reasonableness of Mr. Maher's essentially uninformed belief, except as a self-serving afterthought.

I also reject Mr. Johnston's argument that Logistec had technically informed a safety officer of the serious accident within the required 24 hour period because Mr. Nauss had informed Marine Safety, Transport Canada of the accident at 08:30 hours on January 4, 1997. While this argument might appeal to hind-sighted logic, it does not accord with the very regulation that safety officer Lim alleges in his direction was contravened. Specifically, section 15.5 of the COSHRs states that the employer must report the occurrence to a safety officer. Mr. Maher did not inform a safety officer and that is sufficient to establish that there was a contravention of paragraph 15.5(c) of the COSHRs.

In response to Mr. Johnston's claim that the employer did not know Mr. Slaunwhite's accident resulted in a permanent paralysis until later, it is necessary to examine the wording in paragraph 15.5(c) and (d) of the COSHRs. Paragraph 15.5(c) refers to the complete loss of the usefulness of a body function or part thereof, while paragraph 15.5(d) refers to a permanent impairment of a body function of an employee. I suggest that, If Parliament had wished for paragraph 15.5(c) to include the word permanent, it would have done so. I am satisfied that it was possible for Mr. Maher to have learned the next morning that Mr. Slaunwhite was suffering paralysis. All that he had to do was to make inquires, and this was not done.

Finally, Mr. Johnston stated that Mr.Tom Hale provided safety officer Lim with a phone number for Mr. Maher and, if I understood his words, implied that it was safety officer Lim who may have failed to contact Mr. Maher. He suggested that it was probably better left that there was some disconnect between Mr. Lim and Mr. Maher.

In this regard, the only disconnect that I can see is that Mr. Maher failed to carry out his legislated duty.

For all of the above reasons and the reasons specified by the safety officer in his report, I agree with safety officer Lim that the employer was in contravention of paragraph 15.5(c) of the COSHRs.

However there is a technical error in the direction which I must correct. In his direction, safety officer Lim indicated that the employer failed to report a serious injury. Section 15.5 does not actually use the term "serious injury", but more precisely, refers to "an accident, occupational disease or other hazardous occurrence.," As a result,
I HEREBY VARY the direction as follows:

> The said safety officer is of the opinion that the following provisions of the Canada Labour Code, Part II are being contravened:
>
> 1. Paragraph 125.(c) of the Canada Labour Code, Part II and paragraph 15.5(c) of the Canada Occupational Safety and Health Regulations. Employer failed to report to a safety officer within 24 hours of becoming aware of an accident that resulted in the complete loss by an employee of the usefulness of a body member or part thereof.

Looking at item #2 of the direction made pursuant to subsection 145.(1): Safety officer Lim wrote:

> The said safety officer is of the opinion that the following provisions of the Canada Labour Code, Part II are being contravened:
>
> 2. Paragraph 127.(1) of the Canada Labour Code Part II.
> The employer disturbed the scene of a serious accident on January 4, 1997 at Pier 31.

Mr. Johnston noted in his argument that the term, "serious" is not defined in the Act or regulations. He contended, however, that one would expect some consistency with this reporting requirement and the reporting requirements in paragraph 15.5 of the COSHRs. He concluded that, since Mr. Slaunwhite's injuries were not fatal, and since the accident did not involve a disabling injury to two or more employees, then paragraph 15.5(c) remains.

Mr. Johnston acknowledged that Mr. Maher learned shortly after the accident that Mr. Slaunwhite had a broken neck, but pointed out that Mr. Maher was still not aware that there was a permanent paralysis.

For his part, Mr. Nauss said the fact that Logistec had not reported the accident, no-one was able to go to the scene and observe first hand what actually happened and the state of the equipment at the time of the accident. That, he said jeopardized any investigation to determine the exact cause of the accident.

Decision:

Mr. Johnston is correct to say that the term "serious" injury is not defined in the Part II or the COSHRs. However, concerning his argument that there must be consistency between the term serious and the reporting requirements in subsection 15.5, I would make the following observations.

First, a careful examination of the wording in paragraph 125.(c)[2] of the Canada Labour Code reveals that there is no mention of the term "serious injury." The paragraph instead refers the reader to prescribed standards.

When one looks at the prescribed regulations, which Mr. Johnston identifies as Part XV of the COSHRs, one also sees that there is no reference to "serious injuries." In fact many of the investigation, recording and reporting requirements in Part XV do not even require that there be an injury.

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[2] Paragraph 125.(c) reads:

125. Without restricting the generality of section 124, every employer shall, in respect of every work place controlled by the employer,…
(*c*) investigate, record and report in the manner and to the authorities as prescribed all accidents, occupational diseases and other hazardous occurrences known to the employer;

For example, in subsection 15.4(1)[3] of the COSHRs, the regulation requires the employer to investigate any accident, occupational disease or other hazardous occurrence affecting any employee in the workplace. Section 15.5 then requires the employer to report to a safety officer as soon as possible, but not later than 24 hours after becoming aware of the incident, any accident, occupational disease or other hazardous occurrence that has resulted in specified outcomes. For the outcomes specified in paragraphs 15.5(e) to (g)[4] there does not have to be an injury.

Similarly, section 15. 8(1)[5] requires employers to submit within 14 days a written report to a safety officer concerning an investigation carried out pursuant to subsection 15.4(1)(a), where the hazardous occurrence resulted in outcomes specified in paragraphs (a) to (d). For paragraphs (c) to (d) there does not have to be a serious injury for the provision to apply. As a result, one cannot look to Part XV for interpreting the term "seriously injured" found in subsection 127.(1).

In the absence of a definition for the term "serious injury", in section 127.(1), it is my view that employers must make their own judgement as to whether an injury is serious or not. In this regard, it is reasonable to expect that the employer's decision would be based on the information the employer has or that is available to him or her. This would include consideration of the events or circumstances that led up to the injury, the need for emergency assistance respecting the injury and the actual condition of the injured employee. The evidence shows that there was sufficient facts for Mr. Maher to realize that the injury was serious.

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[3] Subsection 15.4(1) reads:

15.4(1) Where an employer becomes aware of an accident, occupational disease or other hazardous occurrence affecting any of his employees in the course of employment, the employer shall, without delay,

(*a*) appoint a qualified person to carry out an investigation of the hazardous occurrence;
(*b*) notify the safety and health committee or the safety and health representative, if either exists, of the hazardous occurrence and of the name of the person appointed to investigate it; and
(c) take necessary measures to prevent a recurrence of the hazardous occurrence.

[4] Paragraphs 15.5(e) to (g) read:

15.5 The employer shall report to a safety officer, by telephone or telex, the date, time, location and nature of any accident, occupational disease or other hazardous occurrence referred to in section 15.4 that had one of the following results, as soon as possible but not later than 24 hours after becoming aware of that result, namely…

((*e*) an explosion;
(*f*) damage to a boiler or pressure vessel that results in fire or the rupture of the boiler or pressure vessel; or
(*g*)any damage to an elevating device that renders it unserviceable, or a free fall of an elevating device.

[5] Subsection 15.8(1) reads

15.8 (1)The employer shall make a report in writing, without delay, in the form set out in Schedule I to this Part setting out the information required by that form, including the results of the investigation referred to in paragraph 15.4(1)(*a*), where that investigation discloses that the hazardous occurrence resulted in any one of the following circumstances:

(*a*) a disabling injury to an employee;
(*b*) an electric shock, toxic atmosphere or oxygen deficient atmosphere that caused an employee to lose consciousness;
(*c*) the implementation of rescue, revival or other similar emergency procedures; or
(*d*) a fire or an explosion.

Finally, subsection 127.(1)[6] is unequivocal relative to not disturbing an accident site without the authority of a safety officer. Therefore, I place no weight on Mr. Johnston's statement that safety officer Lim had an opportunity but declined to visit the site after he learned about the accident before the unloading of the rubber was completed.

For all of the above reasons, **I HEREBY CONFIRM** this part of the Direction.

Looking at item #3 of the direction made pursuant to subsection 145.(1): Safety officer Lim wrote:

> The said safety officer is of the opinion that the following provisions of the Canada Labour Code, Part II are being contravened:
>
> 3. Paragraph 125(f) and paragraph 16.3(2) of the COSHR Part II.
> No first-aid attendant was available.

Mr Johnston argued that Messrs. Maher and Pace were holders, albeit it out of date, of first aid certificates, and that Mr. Maher did, in fact, render first aid at the time of the accident. He pointed out that nothing in the Code or Part XVI of the COSHRs requires the first aid certificate to be current.

Decision:

Paragraph 16.3(2)[7] requires that at least one of the employees must be a first aid attendant and there is no evidence that anyone including Messrs Maher or Pace were holders of valid holders of a basic first aid certificate or a standard first aid certificate.

I do not accept the argument that nothing in the Act or COSHRs specifies that the certificate be current. Such an interpretation is inconsistent with section 124, the purpose clause of Part II, or section 148.(6)[8] that permits a defence of due diligence for violations of the Code except for, amongst others, paragraph 125(f)[9].

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[6] Subsection 127 reads:

Subsection 127.(1), Subject to subsection(2), where an employee is killed or seriously injured in a work place, no person shall, unless authorized by a safety officer, remove or in any way interfere with or disturb any wreckage, article or thing related to the incident except to….
(underlining for emphasis)

[7] Subsection 16.3(2) reads:

16.3(2) At a work place at which 15 or more employees are working at any time, at least one of the employees shall be a first aid attendant.

[8] Subsection 148.(6) reads:

(6) On a prosecution of a person for a contravention of subsection (4) or
(*a*) paragraph 125(*q*), (*r*), (*s*), (*t*), (*u*), (*v*) or (*w*),
(*b*) paragraph 126(1)(*c*), (*d*), (*e*), (*f*), (*g*), (*h*) or (*i*),
(*c*) paragraph 147(*b*),
(*d*) subsection 125.2(1), 125.2(2), 127(1), 135(1), 136(1), 144(2), 144(2.1), 144(3), 144(4) or 155(1), or
(*e*) section 124, 125.1, 142. or 143,

it is a defence for the person to prove that the person exercised due care and diligence to avoid the contravention.

[9] Paragraph 125.(f) reads:

Moreover, nothing in the evidence indicates that either Mr. Maher or Mr. Pace actually rendered first aid to M. Slaunwhite. One can only wonder if the reason that they did not do so was because their training was out-of-date. Given the seriousness of the injury, I am surprised by Mr. Johnston's suggestion that an acceptable interpretation of the Code would be that first aid certificates need not be current.

For all of the reasons above and the reason specified by the safety officer in his report, **I HEREBY CONFIRM** this part of the direction

Looking at item #1 of the direction made pursuant to subsection 145.(2):
Safety officer Lim wrote:

> The said safety officer considers that the use or operation of the machine or thing constitutes a danger to an employee while at work:
>
> 1. Ice and snow was not properly removed from the Headboard Flat before using it to discharge bales of rubber.

Mr. Johnston argued that snow and ice had been cleared from the HBF before it was brought on ship, and that the HBF had been used for at least one or two lifts prior to the accident without repercussions. He said that while the Hatchtender, Mr. Joe Grandy noted that snow remained on the HBF when it first came on board ship, and called for salt, operations continued.

Mr. Johnston also pointed out that a re-enactment of the accident showed that a metal crate of rubber could be knocked from the HBF even though the HBF was cleaned. He said that the cause of the accident was Mr. Rose pushing the load into the HBF and Mr. Slaunwhite getting off the fork lift truck and standing with his back to the load.

Decision:

When I consider the evidence contained in the safety officer's report and the report of the employer, I understand that the following events of interest occurred prior to the accident.

First, the snow and ice on the HBF was not adequately cleared before the HBF was put into operation and there was a call for salt and sawdust. Secondly, Mr. John Henneberry, machine driver in the hold, reported to hatchtender Joe Grandy that he would refuse for safety to load the flats unless the HBF was cleaned. Later, when he tried to place a metal crate of rubber on the HBF, it began to slide out and he refused to load the pan. Mr. Raymond Harnish was reluctant to do so but did it anyway. It was shortly after this that events unfolded on the dock and Mr. Slaunwhite was injured.

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

f) provide such first-aid facilities and health services as are prescribed;

The failure to clear ice and snow from the HBF before using it to discharge bales of rubber was, at the very least, a contributing factor to the accident. In addition, it could be said that, if the employer had investigated the hazardous occurrence that took place on the ship, when the rubber bale followed the fork lift truck away from the HBF, corrective action could also have been taken at this point. In my view, if corrective action had been taken at each of these two events, the accident may have been avoided. I therefore reject Mr. Johnston's suggestion that the sole cause of the accident was Mr. Rose pushing the load into the HBF and Mr. Slaunwhite getting off the fork lift truck and standing with his back to the load.

For the above reasons and the reasons specified by the safety officer in his report I **HEREBY CONFIRM** this part of the safety officer's direction.

Looking at item #2 of the direction made pursuant to subsection 145.(2):

Safety officer Lim wrote:

> The said safety officer considers that the use or operation of the machine or thing constitutes a danger to an employee while at work:
>
> 2. Improper equipment (headboard flat) was used for discharging rubber bails.

Mr. Johnston explained to me that the HBF has been in operation since October, 1992. He noted that the ship's RO-BOT pan and the HBF pan are used extensively during loading and discharging operations at all ports from Asia to the U.S. and are considered a safe and efficient method of handling bulk rubber.

He referred me to minutes of the Logistec health and safety committee meetings held on November and December 1992, and on February 1993, where the dangers associated with this were discussed. He pointed out minutes of the December 1992 health and safety committee meeting show that the committee and Mr. P. MacConigal of Coast Guard Ships Safety had reviewed the discharging methods and equipment used and found them to be satisfactory. Of the changes that were made to the HBF since the accidents, he said only that one hopes that they will achieve an additional level of safety to the operation.

For his part Mr. Nauss said that the HBF had been used for a long time and he would not go so far as to say that it was an improper piece of equipment but would agree that it could have been safer. He agreed that the evidence gathered in the investigation of the accident supports the findings of Transport Canada.

Decision:

On the one hand, it is reassuring to see that the operation and use of the HBF was reviewed by the health and safety committee. It is not clear from the evidence submitted whether this was a proactive review of the equipment and operations or to review a specific concern of Transport Canada relative to the stability of the HBF pan or some other aspect.

With regard to the notion that the HBF operations were somehow approved by a Transport Canada safety officer when, on December 16, 1992, it is said that he reviewed the discharging methods and equipment used for discharging rubber, and found them satisfactory, I must make the following clarification. Nothing in the Code or the COSHRs authorizes a safety officer to approve any process, procedure or thing in the work place. When a safety officer sees or reviews something in the work place and does not take issue with it, the only conclusion the employer or employee(s) can draw is that, for that moment in time, the safety officer is of the opinion that, based on the information before them, there is no contravention of the Code or COSHRS, and there is no danger as defined by the Code.

For clarity, Part II of the Canada Labour Code places primary responsibility on the employer to ensure that the safety and health of employees is protected. Consequently, a safety officer review does not alter the employer's responsibility under the Code. Therefore, I grant no weight to the argument that a safety officer in 1992 found the process and equipment to be satisfactory. The employer should have understood this from his reading of the Code.

In the instant case, evidence shows that the design of the HBF, with its flat, open and narrow floor, and its lack of a non skid surface, in combination with the ice and snow on its surface, led to the hazardous occurrence Henneberry reported to Grandy when the metal crate slipped back with his fork lift truck and to the accident that injured Mr. Slaunwhite. The hazardous occurrence incident involving the HBF on the ship revealed to the employer that there was a problem with the HBF seemingly not previously appreciated. The incident was inseparably connected to the accident that resulted in the injury to Mr. Slaunwhite.

While Mr. Nauss said that he would not go so far as to say the HBF was an improper piece of equipment, he readily agreed that the modifications were necessary. The accident that injured Mr. Slaunwhite showed that the openness of the HBF pan was a contributing factor to the accident and the injury.

For these reasons and those of safety officer Lim, I agree the HBF, was an improper piece of equipment in respect of the metal crates of rubber and **I HEREBY CONFIRM** this part of his direction.

Looking at item #3 of the direction made pursuant to subsection 145.(2):

Safety officer Lim wrote:

> The said safety officer considers that the use or operation of the machine or thing constitutes a danger to an employee while at work:
>
> 3. Bales of rubber being discharged were not properly secured to pans.

Mr. Johnston referred me to a document signed by Mr. Maher that mentioned the visit by safety officers Lim and Thibault to an unloading operation that took place on January 27, 1997. The document states that the two safety officers observed the use of the ships RO-BOT pan and the HBF to discharge rubber bales. According to the document, safety officer Thibault purportedly

expressed reluctance regarding the absence of a perimeter type of securing on either pan. Mr. Johnston argued however that bales of rubber cannot be secured to the headboard before discharge because the cargo must be free to be moved off the headboard flat by the fork lift driver. Mr. Nauss agreed and said that in making the HBF more secure you could not put sides on it.

Decision:

I too have concerns with securing the rubber bales to the head board pans or installing some sort of perimeter guard on the RO-BOT pan or the HBF. The evidence shows that a contributing factor to Mr. Slaunwhite being injured was that he was off his fork lift truck when the crates of rubber toppled. As a result, it would seem to me that the potential hazards related to discharge operations would only be increased if workers were dismounting their forklift trucks to remove whatever device was used to secure the bails of rubber to the pans. Even if another employee was made responsible for removing the device, the potential for that person being injured exists.

In addition, I am satisfied that the modifications made to the HBF have increased the security of the load.

For these reasons I am not persuaded that securing the rubber bales to the pans would have the overall effect of increasing employee safety. Therefore, **I HEREBY RESCIND** that part of the safety officer's direction.

Decision rendered September 29, 1997.

Doug Malanka
Regional Safety Officer

APPENDIX A

IN THE MATTER OF THE CANADA LABOUR CODE
PART II - OCCUPATIONAL SAFETY AND HEALTH

DIRECTION TO THE EMPLOYER UNDER PARAGRAPH 145(2)(a)

On January 6th, 1997, the undersigned safety officer conducted an accident investigation in the work place operated by LOGISTEC CORPORATION, being an employer subject to the Canada Labour Code, Part II, at P.O. Box 264, Halifax, NS, the said work place being sometimes known as Pier 31.

The said safety officer considers that the use or operation of the machine or thing constitutes a danger to an employee while at work:

1. Ice and snow was not properly removed from the Headboard Flat before using it to discharge bails of rubber.

2. Improper equipment (headboard flat) was used for discharging rubber bails.

3. Bails of rubber being discharged were not properly secured to pans.

Therefore, you are HEREBY DIRECTED, pursuant to paragraph 145(2)(a) of the Canada Labour Code, Part II, to protect any person from danger immediately.

Issued at Halifax, Nova Scotia, this 20th day of January 1997.

Peter Lim
Safety Officer

To: LOGISTEC STEVEDORING
LOGISTEC CORPORATION
P.O. BOX 264
HALIFAX, N.S.
N3J 2N7

APPENDIX B

IN THE MATTER OF THE CANADA LABOUR CODE
PART II - OCCUPATIONAL SAFETY AND HEALTH

DIRECTION TO THE EMPLOYER UNDER SUBSECTION 145(1)

On January 6th, 1997, the undersigned safety officer conducted an inquiry in the work place operated by LOGISTEC CORPORATION, being an employer subject to the Canada Labour Code, Part II, at P.O. Box 264, Halifax, NS, the said work place being sometimes known as Pier 31.

The said safety officer is of the opinion that the following provisions of the Canada Labour Code, Part II are being contravened:

1. Paragraph 125(c) of the Canada Labour Code Part II and paragraph 15.5(c) of the Canada Occupational Safety and Health Regulations. Employer failed to report serious accident within 24 hours.

2. Paragraph 127(1) of the Canada Labour Code Part II. The employer disturbed the scene of a serious accident on January 4, 1997 at Pier 31.

3. Paragraph 125(f) of Part II and paragraph 16.3(2) of COSHR Part II. No first aid attendant was available.

Therefore, you are HEREBY DIRECTED pursuant to subsection 145(1) of the Canada Labour Code, Part II, to terminate the contraventions no later than January 31st 1997.

Issued at Halifax, Nova Scotia, this 20th day of January 1997.

Peter Lim
Safety Officer

To: LOGISTEC STEVEDORING
LOGISTEC CORPORATION
P.O. BOX 264
HALIFAX, N.S.
N3J 2N7

Decision: 97-013

SUMMARY OF REGIONAL SAFETY OFFICER DECISION

Applicant: Logistec Stevedoring Inc.
Marine Terminal 22
Halifax, Nova Scotia

Respondent: International Longshoreman's Union

KEY WORDS

Ship, headboard flat, ice, forklift truck, serious accident, paralysis, first aid attendant, basic first aid certificate, hazardous occurrence, notification, accident site preservation

PROVISIONS

Code: 124,125(c), (f), 127.(1), 145.(1) & (2), 148.(6), 148.(6).
COSHRS: 5.4(1),15.5, 15.8(1),16.3(2)

SUMMARY

On January 4, 1997, a fork lift truck operator was permanently paralysed when two metal crates of rubber toppled from the headboard flat he was unloading and struck him. At the time, he was adjusting the forks on his machine to accept the metal crates.

The accident was investigated jointly by safety officers from Marine Safety, Transport Canada, and Human Resources Development Canada. Following their investigation two directions were issued to Logistec Stevedoring Inc. The direction issued pursuant to section 145.(1) of the Code specified that Logistec was: (1) in contravention of Paragraph 125.(c) of the Code and paragraph 15.5(c) of the COSHRs in that the employer failed to report a serious accident within 24 hours; (2) in contravention of paragraph 127.(1) of the Code, in that the employer disturbed the scene of a serious accident; and, (3) in contravention of paragraph 125(f) of the Code and paragraph 16.3(2) of the COSHRs in that no first-aid attendant was available.

The direction issued pursuant to section 145.(2) of the Code specified that a danger to an employee while at work existed because: (1) ice and snow was not removed from the headboard before using it to discharge bails of rubber; (2) the headboard flat was improper equipment for discharging the rubber bales; and (3) the bails of rubber were not properly secured to the headboard.

Following his review of the direction issued pursuant to section 145.(1) of the Code, the Regional Safety Officer **VARIED** item 1 of the direction to replace the words, "serious accident" with the words, "the complete loss by an employee of the usefulness of a body member or part thereof."

The words, “serious injury” do not appear in the Regulation. The Regional Safety Officer **CONFIRMED** items 2 and 3 of the direction.

Following his review of the direction issued pursuant to section 145.(2) of the Code, the Regional Safety Officer **RESCINDED** item 3. The Regional Safety Officer was concerned that the safety risk could increase for employees who would have to install and remove the safety device used to secure the bales of rubber to the headboard when forklift truck operations were ongoing. The Regional Safety Officer **CONFIRMED** items 1 and 2 of the direction.