Canada Appeals Office on Occupational Health and Safety | Bureau d'appel canadien en santé et sécurité au travail

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Canada Labour Code
Part II
Occupational Health and Safety

Compagnie d'arrimage de Québec Ltée
employer

and

Canadian Union of Public Employees
trade union

Decision No. 2003-16
September 19, 2003

This case was decided by appeals officer Serge Cadieux on the basis of written arguments submitted by the parties.

Submissions

Mr. Denis Caron, Manager, Occupational Health and Safety, for the employer
Mr. Mario Dubé, Canadian Union of Public Employees, for the employees

Health and safety officer

Louis Rodrigue, Transport Canada, Marine Safety, Quebec Region

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[1] The following appeals against directions were brought pursuant to subsection 146(1) of the *Canada Labour Code*, Part II (the *Code*) by Mr. Denis Caron, Manager, Occupational Health and Safety, Compagnie d'arrimage de Québec Ltée (Compagnie d'arrimage). Mr. Caron notified the Canada Appeals Office on Occupational Health and Safety (the Appeals Office) that he was appealing against three directions that, in his opinion, were given by the health and safety officer at various times for various reasons.

[2] The three directions,[1] to which Mr. Caron refers are the following:

I. A verbal direction concerning possible danger given by the health and safety officer to the Compagnie d'arrimage on Tuesday, October 2, 2001.

II. A verbal direction, confirmed in writing on October 2, 2001, concerning a hazardous situation, issued pursuant to paragraphs 145(2)(*a*) and (*b*) of the *Code* (Appendix 1).

[1] Mr. Caron also mentioned an S.I.7 form, which is a document issued pursuant to the *Canada Shipping Act.* Since this document had not been issued pursuant to the Code, I was not qualified to hear an appeal concerning this document and will not deal with it in this decision.

III. A written direction, issued pursuant to paragraph 145(1) of the *Code*, dated November 7, 2001 (Appendix 2).

The health and safety officer's investigation

[1] The background and circumstances of this case are described by the health and safety officer in his INSPECTION REPORT ON THE INCIDENT INVOLVING A CRANE AND A HYDRAULIC SHOVEL THAT OCCURED ON BOARD M.V. *TORO* (hereto referred to as the Investigation Report).

[2] According to the investigation report, Mr. Rodrigue, together with a ship inspector from the Quebec City office, arrived at Section 107 of Quebec Harbour around 10:45 a.m. on Tuesday, October 2, 2001, to conduct the harbour control of M.V. *Toro*. Before going on board, the health and safety officer met Mr. Berthiaume, a Compagnie d'arrimage walking boss, who informed him about an accident that had happened around 7:10 p.m. the previous evening, October 1, 2001, when a grab bucket from crane #220-06, belonging to Armand Guay Inc., had smashed into the cabin of hydraulic shovel #232 operated by a Compagnie d'arrimage dockworker in the *Toro*'s hold. The shovel was so badly damaged that it had to be withdrawn from service.

[3] The health and safety officer told Mr. Berthiaume and Mr. Martin Gagné, the Compagnie d'arrimage superintendent, that no investigation had yet been launched into the accident. For their part, the company representatives told the health and safety officer that no steps had been taken in the meantime to prevent another accident from taking place. They were notified however that Mr. Caron was due to arrive around noon to start the investigation.

[4] The health and safety officer noticed that a new work team was on the job and that loading operations were taking place. He then confirmed with his office manager, Mr. André Desrochers, that the accident in question had not been reported. He also learnt from the ship's captain that he (the captain) was not aware that an accident had occurred the previous evening because he had not been notified about it.

[5] The health and safety officer informed his manager, Mr. Durocher, that, contrary to what section 14.3[2] of the *Marine Occupational Health and Safety Regulations* [hereto referred to as the Regulations], Part XIV (Hazardous Occurrence Investigation, Recording and Reporting), "… I was unable to find any indication that the employer had started an investigation without delay, as stipulated in section 14.3(*a*) or that steps had been taken to prevent the situation from recurring, as stipulated in section 14.3(*b*) (*sic*), i.e., 16 hours after the incident had occurred the previous evening around 7:10 p.m., and that a new work team was now on site."

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[2] **14.3** If an employer becomes aware of an accident, occupational disease or other hazardous occurrence affecting any of their employees in the course of their employment, the employer shall, without delay,

(*a*) appoint a qualified person to conduct 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 recurrence of the hazardous occurrence.

[6] On his manager's recommendation, the health and safety officer decided to stop work operations and begin an investigation. Around 11:30 a.m. the health and safety officer notified the ship captain and Mr. Gagné that operations had to be stopped, and this was done.

[7] The investigation began with Mr. Gagné obtaining the names of the people working on the 4 p.m. – to – midnight shift on October 1, 2001. The health and safety officer then arranged to look at the hydraulic shovel involved in the accident.

[8] Around 11:40 a.m., Mr. Caron arrived at the work place. The health and safety officer explained the situation to him and told him that he had begun an investigation. The health and safety officer said that unloading could recommence as soon as he was satisfied that there was no longer any risk. The health and safety officer says that Mr. Caron told him that, according to sections 14.3 or 14.4 of the Regulations, he had 24 hours to carry out an investigation.

[9] The investigation proceeded normally. Around 12:45 p.m., Mr. Caron asked permission to recommence unloading and continue the investigation later. The health and safety officer then shared certain concerns with Mr. Caron, namely:

> *"...that another accident could occur and injure a dockworker. That is why we wanted to continue the investigation to ensure that the worker in the hold would not be exposed to any danger. We also had the impression that there had not been any change in the way the vessel was being unloaded. We added that if the worker was taken out of the hold when the grab bucket was filling up in the hold, unloading could restart right away, since any possible danger would be eliminated if the worker was removed ..."*

[10] At Mr. Caron's request, a test was made in the presence of Mr. Caron, Mr. Priedite and the health and safety officer. Radio communication between the signaller and the crane operator was tested and judged to be effective by the health and safety officer. The health and safety officer therefore concluded that at that stage in the investigation, there was no longer any risk, since the dockworker was out of the hold when the grab bucket was filling up there. However, when the health and safety officer met Mr. Priedite, who was the unloading supervisor at the time of the incident, the latter informed him *"...that before the accident, he went for dinner at 7 p.m., intending to bring back radios for the signaller and the crane operator on his return from dinner."*

[11] The investigation was put off until 4 p.m. because the people involved in the incident would not available before that time. Around 3:30 p.m., the health and safety officer met Mr. Caron in the Compagnie d'arrimage offices. At that time, he handed Mr. Caron a written direction pursuant to subsection 145(2) of the *Code* (Appendix 1). In return, Mr. Caron handed the health and safety officer a description of an unloading procedure that would involve no dockworker being in a ship's hold when a crane was operating in the same hold. The work procedure, proposed by Mr. Caron as a temporary measure (i.e., for the duration of the health and safety officer's investigation) is reproduced below in its entirety and without any correction:

Proposed working procedure that is accepted by all the parties present:

1. The “baco”[3] operator will make one or more appropriate piles;
2. The “baco” will then be placed in a safe position;
3. The “baco” operator will then get out of his machine and place himself in a safe place;
4. The signaller on the deck will signal to the operator of the Guay crane on the wharf to let down and fill the bucket;
5. The Guay crane will operate the grab bucket until the time comes to make piles again;
6. The Guay crane bucket will be stopped and kept in a safe position at an appropriate place on the wharf until the “baco” has finished making piles;
7. The “baco” operator will notified to leave his safe location to come and operate his machine;
8. The “baco” operator will continue to make piles as required by the unloading operation;
9. After the “baco” operator has finished, the same procedure starts again, and so on.

[12] The investigation started again at 4 p.m. It continued the next day, October 3, 2002, when the health and safety officer questioned the signaller and the hydraulic shovel operator. The health and safety officer completed his investigation, emphasizing that the testimony from those involved in the incident of October 1, 2001, had brought out the following points:

- There is no set procedure for how the hydraulic shovel should move about. In practice, the hydraulic shovel operator leaves the machine, indicates to the signaller that he wants to go and work at the exact spot where the grab bucket is filling up, gets back into the cabin of the hydraulic shovel, without making sure that the crane operator is aware of the loading;
- The signaller does not wear special clothing to enhance his visibility;
- The signaller does not have a signaller’s lamp;
- The signaller’s position under the hatch panel and behind the hatch coaming greatly reduces the signaller’s visibility for the crane operator;
- The lighting on the ship blinds the crane operator;
- The incident happened at dusk at a time when the signaller was less visible because of his black clothing (hard hat, vest and trousers);
- The only means of communication between the signaller and the crane operator is visual. At the time of the incident, the tide was high and the signaller was not able to simultaneously watch both the hold and the crane operator. In order to be seen by the crane operator, the signaller had to go across some pipes and move approximately seven metres to reach the deck of the ship;
- The superintendent intended to bring back radios after dinner;

[3] Based on the photos submitted, it appears that the reference to the “baco” (read “back hoe”) refers to a hydraulic shovel of the kind that was involved in the accident.

- There was no three-way communication between the crane operator, the signaller and the hydraulic shovel operator;
- The direction the crane was facing restricted the crane operator's visibility, since the crane mast prevented the crane operator from seeing in advance where the signaller was located and what was taking place on the part of the ship that the grab bucket was going to pass over;
- In this particular case, it often happens that the grab bucket passes over the top of the hydraulic shovel (with an operator inside when the hydraulic shovel is working on the front part of the hold and the grab bucket is working in the rear part);
- It often happens also that the grab bucket works near the hydraulic shovel when the hold is full, until the hold is sufficiently empty to enable the hydraulic shovel to take refuge under the deck between the bulkhead and the hold opening;
- Just before the grab bucket smashed into the cabin of the hydraulic shovel, the crane operator noticed that the other crane operator was energetically signalling him to stop at the precise moment when the grab bucket was coming down very fast. The first crane operator applied the brakes to the descending line; this considerably reduced the grab bucket's speed of impact on the hydraulic shovel cabin and limited the incident to only physical damage;
- Neither the ship captain nor the ship crew were notified of the incident.

[13] In a letter dated October 15, 2001, Mr. Caron informed Mr. Rodrigue, that pursuant to section 14.4[4] of the Regulations, he was not obliged to report the accident that had happened; this is contrary to what the health and safety officer had said when on board the ship, since no criteria in this section were applicable to this situation.

[14] According to Mr. Caron, the health and safety officer suspended operations "<u>because we had not reported the material-damage incident as required by the *Canada Labour Code*</u>" (Mr. Caron's underlining). Mr. Caron appealed this verbal direction. He also appealed the direction of October 2, 2001, (see Appendix 1), which was not given at the work place. A copy of this direction, dated October 26, 2001, was delivered by registered mail to Mr. Normand Giroux, Compagnie d'arrimage's vice-president of operations.

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[4] 14.4 The employer shall report to a safety officer employed with the Marine Safety Branch of the Department of Transport the date, time, location and nature of any accident, occupational disease or other hazardous occurrence …that has one of the following results, as soon as possible but not later than 24 hours after becoming aware of that result:

(*a*) the death of an employee;
(*b*) a missing employee;
(*c*) a disabling injury to two or more employees;
(*d*) the loss of consciousness by an employee as a result of an electric shock, a toxic atmosphere or an oxygen-deficient atmosphere.

[15] On November 7, 2001, the health and safety officer responded to Mr. Caron's letter of October 15, 2001. In this letter, the health and safety officer pointed out that section 14.4 of the Regulations were not relevant to the case in point, but that section 14.3 of the same regulations was. According to the health and safety officer, the latter section does not grant any time lapse before an investigation begins and necessary measures are taken to prevent a recurrence of the hazardous situation. In his letter of November 7, 2001, that he sent to Mr. Caron, the health and safety officer specifically explained his thinking as follows:

> *Re your letter of October 15*
>
> In the context of the *Canada Labour Code*, my understanding is that, pursuant to section 14.4 of the *Marine Occupational Health and Safety Regulations*, you were not required to declare the incident that occurred at around 7:10 p.m. on the evening of October 1, 2001. The use of the SI-7 form No. LOR02-10-01-01 referring to the section of the *Shipping Casualties Reporting Regulations*, which were established pursuant to the *Canada Shipping Act*, was not the appropriate administrative tool under the circumstances. To some extent, these facts respond to your arguments concerning the first "direction" that you mention in the copy of the letter of October 23, addressed to the Appeals Office.
>
> At the same time, I notice that you do not mention section 14.3 of the same *Marine Occupational Health and Safety Regulations*, which oblige the employer to conduct an investigation without delay, notify the safety and health committee about such an investigation and take necessary steps to prevent a recurrence of the hazardous situation. It is for good reason that section 14.3 does not grant any delay, since the employer must remove the danger immediately; it was the employer's unequivocal responsibility (sic) to conduct such an investigation immediately and before work started up again. During my investigation the following day, on October 2, I ascertained that no corrective action had been taken and that the hazardous situation still existed. That was why I issued the direction, identified as the second direction in the copy dated October 23 that was addressed to the Appeals Office.
>
> I must point out that this direction was first given to you verbally and confirmed several hours later by a written direction that I prepared in the Champlain Harbour Station, the building right next to the work place in question. As soon as it was completed, I personally handed you the said direction at our scheduled meeting in the Arrimage Québec office. I was unable to give you the written direction sooner because part of the time I was on the phone with you and part of the time I was attending a practical demonstration at your request around 1:30 p.m. In my opinion, this procedure is consistent with the spirit of subsection 145(1.1) of the *Code*, namely that a verbal direction must be confirmed very quickly in writing.
>
> When I intervened on the ship, I was obliged to demand that the work be suspended so that I could complete the investigation that the employer should have conducted the evening before. As a result of this contravention of section 14.3 of the *Marine Occupational Health and Safety Regulations*, I gave the direction contained in appendix.
>
> You will agree, I am sure, that the working procedures and, in particular, the means of communication between the crane operator, the signaller and the operator working at the bottom of the hold, which were in effect when the incident occurred and until temporary corrective measures were taken following my investigation (see your letter that was received by fax at 3:27 p.m. on October 2), were indicative of a hazardous situation as defined in Part II of the *Canada Labour Code*…

[16] In the context of this letter, the health and safety officer gave Mr. Caron a direction (Appendix B) issued pursuant to subsection 145(1) of the *Code*. This direction stated that the employer was in violation of paragraph 125(1)(*c*) of the *Code* and section 14.3 of the Regulations because the employer had not taken measures to prevent recurrence of the hazardous situation that occurred around 7:10 p.m. on October 1, 2001. Mr. Caron appealed this direction as well.

Arguments for the employer

[17] Mr. Caron submitted to the appeals officer detailed reasons for the appeals against the three directions that were issued by the health and safety officer. These three directions are described above in paragraph 2. I will deal with each of these directions individually without repeating in detail the reasons that are an integral part of the file.

A verbal direction, without written confirmation, given by the health and safety officer to the Compagnie d'arrimage on Tuesday, October 2, 2001.

[18] Mr. Caron alleges that the health and safety officer, in the presence of several witnesses, gave a verbal direction to suspend the unloading of M.V. *Toro* because the employer had failed to report a material-damage incident (the accident) that had occurred the previous evening, i.e., October 1, 2001. The employer received no written confirmation of this verbal direction, as required by subsection 145.(1.1) of the *Code*. No mention of this fact was reported by the health and safety officer in his investigation report.

[19] Mr. Caron argues, by referring to testimony from certain individuals, that Mr. Rodrigue "puts more emphasis on the investigation that was not started and concerning which we only received a DIRECTION ON NOVEMBER 7 OR A MONTH AND A HALF LATER" (Mr. Caron's underlining). According to Mr. Caron, the health and safety officer acknowledges in this letter that Mr. Caron was not obliged to report the incident of October 1, 2001. In addition, Mr. Caron states that an investigation began the same evening when he telephoned the superintendent, Mr. Andy Priedite.[5] Mr. Caron states that he agreed with Mr. Priedite at that time on what steps to take to prevent another accident of this type from recurring.

A verbal direction concerning a hazardous situation, confirmed in writing on October 2, 2001, and issued pursuant to subsections 145(2)(*a*) et (*b*) of the *Code* (Appendix 1).

[20] Mr. Caron argues that the direction that is being appealed refers to a hazardous situation relating to work that had been performed the previous evening, as well as to work performed on the day itself, which, in his view, seemed to represent another hazardous situation. This written direction was reportedly received much later and was therefore not written at the work place. Furthermore, Mr. Caron mainly refers to the covering letter dated October 26, 2001, that accompanied the direction. This letter indicates that the direction of October 2, 2001, was issued

[5] According to Volume 1, which contains Mr. Caron's written arguments in relation to the appeal against this non-confirmed verbal direction, Mr. Caron received Mr. Priedite's testimony at 10:30 a.m. on Monday, November 12, 2001, in the absence of any witnesses and more than a month and eleven days after the incident in question.

in respect of the event that occurred the previous evening on October 1, 2001. On the other hand, according to Mr. Caron, Mr. Rodrigue never observed for himself the facts relating to the incident that occurred the previous evening on October 1, 2001, since he was not present when the incident occurred. With respect to the written direction of October 2, 2001, this was not written at the work place and therefore does not in accordance with subsection 145(1.1) of the *Code*.

A written direction, dated November 7, 2001, issued pursuant to subsection 145(1) of the *Code* (Appendix 2).

[21] Mr. Caron lists several administrative requirements that the health and safety officer failed to respect when he sent him this direction. Mr. Caron also notes that the health and safety officer, in his letter of November 7, 2001, erred when he stated that the employer was obliged to conduct an investigation without delay. Such a requirement does not appear in the wording of section 14.3 of the Regulations. In this regard, the only requirement for the employer in subsection 14.3(*a*) is to appoint a qualified person to conduct an investigation into the situation. This provision reads as follows:

> **14.3** If an employer becomes aware of an accident, occupational disease or other hazardous occurrence affecting any of their employees in the course of employment, the employer shall, without delay:
>
> (*a*) appoint a qualified person to conduct an investigation of the hazardous occurrence.
>
> However, Mr. Caron alleges that the employer appointed him precisely for this function, that Mr. Priedite had notified him of the accident and that after Mr. Priedite's phone call, he had begun the investigation and that they had jointly agreed on what action to take to prevent another such incident from recurring.

[22] Subsection 14.3(*c*) of the Regulations provides as follows:

> **14.3** If an employer becomes aware of an accident, occupational disease or other hazardous occurrence affecting any of their employees in the course of employment, the employer shall, without delay:
>
> (*c*) take necessary measures to prevent a recurrence of the hazardous occurrence.
>
> According to Mr. Caron, measures were taken the very evening of the incident after discussion with Mr. Priedite. Mr. Caron states that after this conversation, "…Mr. Priedite removed the hydraulic shovel (back hoe) and radios were handed out to the Armand Guay Inc. operator and our signaller." Also, although the health and safety officer's direction focused on the conditions prevailing the day of the incident, the conditions on October 2, 2001, were quite different from those on October 1, 2001. Mr. Caron thus concludes that the situation was completely different on October 2, 2001, and that the work method was appropriate for the situation.

[23] Mr. Caron argues that the direction received one month and one week later, should have been prepared at the work place, as required by subsection 145(1.1) of the *Code*. Also, the wording of the direction refers in a general and imprecise way to section 14.3 of the Regulations but does not specify the applicable paragraph: (*a*), (*b*) or (*c*). It seems that, in this particular case, the health and safety officer was referring to paragraph 14.3(*c*) of the Regulations. However, Mr. Rodrigue did not accurately describe what happened.

Arguments for the employees

[24] The written arguments for the employees were jointly presented by Mr. Stéphan Arsenault, CUPE (Canadian Union of Public Employees) President, and Mr. Mario Dubé, CUPE Director of Occupational Health and Safety, both of whom are members of Local 2614. The submission of Mr. Arsenault (read Mr. Arsenault and Mr. Dubé) takes the form of responses to the questions raised by Mr. Caron in the three volumes that were filed by Mr. Caron as the employer's submissions. However, it should be noted that the responses provided only relate to a letter from Mr. Caron dated September 13, 2002, that accompanied Volume 2 of the employer's submissions. The purpose of these documents was to serve as:

> A complementary response and supporting arguments relating to my request for review dated October 23, 2001. This response relates to receipt of a verbal direction on October 2, 2001, concerning the fact that there was a hazardous situation relating to work that had been performed the evening before, as well as to work that had been performed on the day itself, which seemed to represent another hazardous situation. We received the written direction much later; it had not been prepared at the work place.

[25] The Appeals Office placed several phone calls in vain to the offices of Mr. Arsenault and Mr. Dubé in order to obtain arguments on all the points raised by Mr. Caron in the three volumes of employer arguments. There has also been no response so far to a letter to the above effect, dated August 13, 2003, which was sent to Mr. Arsenault, with copy to Mr. Dubé.

[26] Mr. Arsenault's arguments deal with the validity of the occupational health and safety officer's investigation, as well as the fact that the written direction was issued in relation to a hazardous situation in a timely manner to the right person and in the right place, even though it was prepared away from the work place. Mr. Arsenault states that there was "…no means of communication other than a signaller who had no other way of communicating than making signs to the crane operator." Mr. Arsenault also went further by adding that "it should be noted that the crane operator did not see the signaller and thus could not see the signs the signaller was making."

[27] Mr. Arsenault rejects Mr. Caron's arguments concerning the relevance of identifying in the direction itself where the employees were located when the accident occurred. He supports the health and safety officer's decision stating that a real danger existed at the time of his investigation, insofar as the work was being performed in the same way as the evening before when an accident occurred under the same circumstances. He was therefore justified in ordering the work stoppage that he did.

[28] According to Mr. Arsenault, Mr. Caron asked for the direction to be revoked because Mr. Rodrigue had committed certain procedural errors; these errors did not concern absence of a hazardous situation, but only questions of time, place and the meaning of some parts of what Mr. Rodrigue had written. The health and safety officer was primarily concerned with protecting the health and safety of the workers and his direction should be confirmed.

Reasons for the Decision

[29] In this case, Mr. Caron impressed upon me that, for a multitude of mostly technical reasons, I should revoke the three directions that he allegedly received from the occupational health and safety officer. For his part, the health and safety officer claims to have only given two directions to Mr. Caron. The first of these concerns the existence of a hazardous situation at the time of his arrival at the unloading area of M.V. *Toro* on October 2, 2001, because the employees were working in the same conditions as the previous evening when a serious accident occurred. He also acknowledges stopping the work in order to protect the employees in the ship's hold. The occupational health and safety officer's second direction was issued much later because the health and safety officer had concluded, after analysing the facts, the employer was, in addition to the first direction, in contravention of the Regulations because it had not taken the necessary measures to prevent another accident from occurring. Moreover, Mr. Arsenault has confirmed on several occasions that the health and safety officer suspended operations on October 2, 2001, after determining that the work was being performed in the same way as the previous day when an incident took place that threatened the health and safety of the employees working in the ship's hold.

[30] Here is my summary analysis of this situation. The evidence in the file clearly establishes the following facts:

- That the health and safety officer did, in fact, go to the work place described above;
- That a serious accident involving an employee working in the *Toro*'s hold had occurred the previous evening;
- That he had determined on site that no measure was in place at the time of his investigation to prevent another accident from occurring and injuring an employee;
- That, in order to protect the safety of the employees, he stopped the work and later the same day issued a written direction to the employer pursuant to paragraphs 145(2)(*a*) and (*b*) of the *Code*, confirming that a hazardous situation persisted; and
- That several weeks later, he confirmed in a written direction pursuant to subsection 145(1) that the employer had not taken the necessary measures on October 2, 2001, to prevent another accident from recurring.

[31] From reading the file, it is clear that the health and safety officer committed certain technical errors during his investigation. However, I do not believe that these errors compromise his work and conclusions. In my opinion, a danger, as described in the *Code*, existed for the employees working in the ship's hold, when the health and safety officer arrived at the work place where the employees were unloading the *Toro* on October 2, 2001.

[32] In subsection 122(1) of the *Code*, danger is defined as follows:

« danger » Situation, tâche ou risque – existant ou éventuel – susceptible de causer des blessures à une personne qui y est exposée, ou de la rendre malade – même si ses effets sur l'intégrité physique ou la santé ne sont pas immédiats –, avant que, selon le cas, le risque soit écarté, the situation corrigée ou la tâche modifiée. Est notamment visée toute exposition à une substance dangereuse susceptible d'avoir des effets à long terme sur la santé ou le système reproducteur.

"danger" means any existing or potential hazard or condition or any current or future activity that could reasonably be expected to cause injury or illness to a person exposed to it before the hazard or condition can be corrected, or the activity altered, whether or not the injury or illness occurs immediately after the exposure to the hazard, condition or activity, and includes any exposure to a hazardous substance that is likely to result in a chronic illness, in disease or in damage to the reproductive system.

[33] I made a careful study of the concept of danger, as defined in the *Code* in several decisions, namely *Darren Welbourne v. Canadian Pacific Ltd.*, Decision No. 01-008, March 21, 2001, and, more recently, *Parks Canada v. Doug Martin and the Public Service Alliance of Canada*, Decision No. 02-009, May 23, 2002. This concept was also referred to by appeals officer Douglas Malanka in *Correctional Service of Canada – Drumheller Institution v. Larry De Wolfe*, Decision No. 02-005, May 9, 2002.

[34] On the basis of the principles established by these decisions, I am of the opinion that a danger, as provided for in the *Code*, did exist in this particular case, since the facts gathered by the health and safety officer show, with respect to the above definition of danger, that,

- a potential hazard, activity or condition would happen;
- that an employee would be exposed to this;
- that it could reasonably be expected that

this hazard, activity or condition would cause injury or illness;

the injury or illness would occur immediately after exposure to this hazard, activity or condition.

[35] When the health and safety officer arrived at the *Toro*, he acted rapidly and in the employees' interest by notifying the employer of the existence of a danger, stopping the work, and subsequently issuing a written direction to the employer concerning a hazardous situation. All these steps are in accordance with paragraph145(2)(*a*) of the *Code* which stipulates the procedure that a health and safety officer should follow when he detects danger. This provision reads as follows:

145. (2) If a health and safety officer consider that the use or operation of a machine or thing, a condition in a place, or the performance of an activity constitutes a danger to an employee while at work,

(*a*) the officer shall notify the employer of the danger and issues directions in writing to the employer directing the employer, immediately or within the period that the officer specifies, to take measures to

i) correct the hazard or condition or alter the activity that constitutes danger, or
ii) protect any person from the danger; and

(*b*) the officer may, if the officer considers that the danger or the hazard, condition or activity that constitutes the danger cannot otherwise be corrected, altered or protected against immediately, issue a direction in writing to the employer directing that the place, machine or thing, or activity in respect of which the direction is issued not be used, operated or performed, as the case may be, until the officer's directions are complied with, but nothing in this paragraph prevents the doing of anything necessary for the proper compliance with the direction.

[36] This provision dealing with the situation where a health and safety officer concludes that a danger exists, does not stipulate that the health and safety officer must provide a written direction while at the work place. The health and safety officer has explained that he could not immediately hand his direction to Mr. Caron because he was initially on the phone with him and then attended, at Mr. Caron's request, a practical exercise. As a result, the direction was provided verbally and then confirmed in writing several hours later.

[37] The explicit obligation to provide a written direction at the work place falls on the health and safety officer when the officer has previously given to the employer or employee concerned at the work place in question, a verbal direction for a contravention pursuant to subsection 145(1) of the *Code*. This provision reads as follows:

145 (1) A health and safety officer who is of the opinion that a provision of this Part is being contravened or has recently been contravened may direct the employer or employee concerned, or both, to

(*a*) terminate the contravention within the time that the officer may specify; and

(*b*) take steps as specified by the officer and within the time that the officer may specify, to ensure that the contravention does not continue or reoccur.

(1.1) A health and safety officer who has issued a direction orally shall provide a written version of it

(*a*) before the officer leaves the work place, if the officer was in the work place when the direction was issued (underlining mine); or

(*b*) as soon as possible by mail, facsimile or other electronic means, in any other case.

[38] Pursuant to paragraph 145(1.1)(*a*) of the *Code*, the health and safety officer is obliged to confirm any verbal direction in writing before leaving the work place. However, in the case that concerns us, the health and safety officer issued a direction concerning danger pursuant to subsection 145(2) of the *Code* and not a direction for a contravention pursuant to subsection 145(1) of the *Code*, as Mr. Caron argues. This distinction is important in this case.

[39] The officer determined that a danger existed. The health and safety officer's conclusion in this respect has been repeatedly stated and I accept it. At the same time, I am well aware that the fact that the officer allowed himself to make comments on the investigation that the employer should have conducted might have had the effect of confusing the employer. I am also well aware that the officer erred in claiming that the employer's investigation should have started

immediately. However, I set greater store by the health and safety officer's positive actions, especially when he was on board the ship. These actions were consistent with the direction concerning danger that he issued the same day.

[40] The officer determined that a danger existed. He also notified the employer, confirmed the existence of the danger in writing, as authorized by paragraph 145(2)(*b*) above, and stopped the work until the danger was removed. The health and safety officer was well aware of what he was doing in that respect because he was only authorized to stop work pursuant to that provision and no other. Also, the written direction issued pursuant to paragraphs 145(2)(*a*) and (*b*) confirm this. These facts can be verified and that is why I set great store by them.

[41] Mr. Priedite's testimony seems to contradict the health and safety officer's version, especially with respect to the measures that the officer allegedly took to prevent another accident from taking place. Mr. Priedite's testimony raises some questions in my mind, particularly in terms of the time lapse and other circumstances before it was obtained. In fact, this testimony was obtained solely by Mr. Caron one month after the health and safety officer's investigation had been completed. Mr. Priedite's testimony contains certain evident contradictions with the facts observed during the health and safety officer's investigation. On the other hand, for the following reasons, I assign less weight to this testimony than to the health and safety officer's investigation report:

[42] In my opinion, the employees were still exposed to the same condition, activity and hazard at the time of the health and safety officer's investigation that they were when the accident occurred the previous evening. At the time of the health and safety officer's investigation, Mr. Berthiaume and Mr. Gagné stated that nothing had been done to prevent recurrence of what had happened the previous day. Also, Mr. Caron and Mr. Priedite never notified the health and safety officer at the time of his investigation that measures had been taken to prevent another accident from taking place. I am therefore forced to conclude that even if Mr. Priedite had indicated his intention to *…bring back radios for the signaller and crane operator on his return from dinner…* , there is no evidence in the file indicating that he actually gave radios to the persons mentioned and that they were using them at the time of the health and safety officer's investigation.

[43] The question of whether or not the health and safety officer determined the facts relating to the incident on October 1, 2001, is of little importance. On the other hand, it is important that the officer was satisfied that the event took place and that the same conditions existed at the time of his investigation, especially with respect to the inadequate communication between the signaller and the crane operator. It was the facts that he determined on October 2, 2001, that led him to conclude that a danger existed and to stop the work. I think that the officer acted responsibly and in total compliance with the law.

[44] I am also of the opinion that, if quick action had not been taken by the employer or, as in this particular case, by the health and safety officer, it was very possible that one or more of the employees would have been injured while working in the same conditions as those of the previous evening, given that there was no adequate system of communication to protect them. The fact that none of them had been injured the evening before or at the time the health and

safety officer intervened is more due to luck than to any other factor. A serious accident occurred and nothing was done to prevent another one. A potential hazard existed and, as happened the previous evening, it was likely to cause injury to an employee before it could be removed.

[45] By virtue of the powers conferred upon me by section 146.1 of the *Code*, I am going to vary the direction concerning potential danger (Appendix 1). Both directions will be combined into a single direction since, in reality, the health and safety officer accomplished in two directions what should have been contained in only one. As a result, there is no *raison d'être* for the direction issued pursuant to subsection 145(1) of the *Code*. To make this change, I will take the following two steps:

1. I revoke the direction issued pursuant to subsection 145(1) of the *Code* by the health and safety officer on November 7, 2001, concerning a contravention of paragraph 125(1)(*c*) of the *Code* and section 14.3 of the *Marine Occupational Health and Safety Regulations*.

2. I vary the direction issued on October 2, 2001, pursuant to paragraphs 145(2)(*a*) and (*b*) of the *Code* for a hazardous situation by changing it as follows:

In the Matter of *Canada Labour Code* Part II – Occupational Health and Safety Direction Pursuant to Paragraphs 145(2)(*a*) and (*b*)

On October 2, 2001, the undersigned health and safety officer conducted an investigation into the unloading of M.V. *Toro* by a mobile grab-bucket crane at the work place operated by Compagnie d'Arrimage de Québec Ltée, an employer subject to Part II of the *Canada Labour Code* and located at 961 Champlain Blvd., POB 1502, Quebec City, QC G1K 7M6, the said location sometimes referred to as Section 107, Quebec Harbour.

The said health and safety officer considered that, following the accident that had occurred on October 1, 2001, through the use of Armand Guay mobile crane #220-06 by an operator who did not have adequate means of communication with the signaller because of the presence of workers in the vessel's hold, a danger existed for the workers in the hold at the time of my investigation for this same reason, due to the fact that the employer had not taken the necessary measures to prevent another accident from recurring.

In consequence, you are HEREBY ORDERED, pursuant to subsection 145(2)(*a*) of the *Canada Labour Code* Part II, to immediately take action to eliminate the danger. In addition, Notice of Danger No._____ must be posted on the Armand Guay mobile crane #220-06 in accordance with subsection 145(3) of Part II, until such time as the direction has been implemented.

In addition, you are HEREBY PROHIBITED, in accordance with paragraph 145(2)(*b*) of the *Canada Labour Code* Part II to continue unloading M.V. *Toro* until this direction has been implemented.

Issued in Quebec City on 2001-10-02.

Health and safety officer (signature) & Number: Louis Rodrigue
Direction provided to: Denis Caron, Occupational Health and Safety Manager

____
Serge Cadieux
Appeals Officer

Appendix I

Danger – Notice of Danger

In the Matter of *Canada Labour Code* Part II – Occupational Health and Safety

Direction Pursuant to Subsection 145(2)(*a*) and (*b*)

On October 2, 2001, the undersigned health and safety officer conducted an investigation into the unloading of M.V. *Toro* by a mobile grab-bucket crane at the work place operated by Compagnie d'Arrimage de Québec Ltée, an employer subject to Part II of the *Canada Labour Code* and located at 961 Champlain Blvd., POB 1502, Quebec City, QC G1K 7M6, the said location sometimes referred to as Section 107, Quebec Harbour.

The said health and safety officer considers that the use of the Armand Guay mobile crane #220-06 involves risks for the health and safety of employees when it is used by an operator who does not have adequate means of communication with the signaller because of the presence of workers in the vessel's hold. The employees in the hold should not be exposed to such danger.

In consequence, you are HEREBY ORDERED, pursuant to subsection 145(2)(*a*) of the *Canada Labour Code* Part II, to immediately eliminate the danger.

You are IN ADDITION HEREBY PROHIBITED, in accordance with paragraph 145(2)(*b*) of the *Canada Labour Code* Part II, to use crane #220-06 concerning which Notice of Danger No._____ was posted pursuant to subsection 145(3) of Part II, until such time as the direction has been implemented.

Issued in Quebec City on 2001-10-02.

Health and safety officer (signature) & Number
Louis Rodrigue
Direction provided to:
Denis Caron
Occupational Health and Safety Manager

Appendix II

Quebec City, November 7, 2001

In the Matter of *Canada Labour Code* Part II – Occupational Health and Safety

Direction to the Employer Pursuant to Subsection 145(1)

On October 2, 2001, the undersigned health and safety officer went to the work place operated by Compagnie d'arrimage de Québec Ltée, a firm subject to the *Canada Labour Code* Part II and which was then unloading M.V. *Toro*, a vessel moored at Section 107 of Quebec City Harbour.

The undersigned health and safety officer considers that the following provisions were being contravened:

- *Canada Labour Code*, Part II, paragraph 125(1)(*c*) and *Marine Occupational Health and Safety Regulations*, section 14.3
- Following the hazardous situation that occurred at around 7:10 p.m. on October 1, 2001, the employer did not take measures to prevent a recurrence.

In consequence, you are hereby ordered in accordance with subsection 145(1) of the *Canada Labour Code* Part II to immediately take measures so as not to repeat this contravention.

Louis Rodrigue
Health and safety officer
SQ 2460

Summary of Appeals Officer Decision

Decision No.: 03-016

Applicant: Compagnie d'arrimage de Québec Ltée

Union: Canadian Union of Public Employees

Key Words: Accident, communication, radio, vessel unloading, crane, hydraulic shovel, corrective measures, danger, contravention, verbal direction, time limit for providing direction, testimony.

Provisions: 125(1), 145(1), 145(2)(*a*) and (*b*), 145(3)

Summary:

During an inspection in Quebec City Harbour, a health and safety officer (HSO) was informed that an accident had occurred the previous evening. The accident happened when the bucket of a crane smashed into the cabin of a hydraulic shovel operated by a dockworker in a vessel's hold. As a result, the hydraulic shovel was put out of commission. The accident occurred because of inadequate communication between the signaller, the hydraulic shovel operator and the crane operator due to the fact that these workers were not equipped with radios. After noticing that the employees were working in the same conditions as when the accident occurred and that the employer had not taken any measures to prevent a recurrence, the HSO stopped the vessel unloading operations. He subsequently issued a direction to the employer concerning the danger, pursuant to paragraphs 145(2)(*a*) and (*b*) of the *Code*. Slightly more than a month later, the HSO issued another direction to the employer pursuant to subsection 145(1) of the *Code*. After analysing the facts, the HSO realized that the employer was in contravention of the *Marine Occupational Health and Safety Regulations* because he had not taken measures to prevent another accident from occurring. On appeal, the appeals officer (AO) concluded that a hazardous situation did, in fact, exist at the time of the HSO's investigation, notwithstanding what the employer states in its submissions. The AO concluded that the employer's submissions were more of a technical nature and that the errors committed by the HSO did not compromise his conclusion that a danger existed. However, the AO varied the direction concerning the danger by adding reference to a failure to take corrective measures. As a result, the AO revoked the direction issued for the contravention.