ONTARIO COURT OF JUSTICE

Citation: *Ontario (Ministry of Labour) v. Bay Grenville Properties Ltd. et al.,* 2014 ONCJ 349
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B E T W E E N :

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
(ONTARIO MINISTRY OF LABOUR)

— AND —

BAY GRENVILLE PROPERTIES LTD., DOUGLAS WOOD,
UNIVERSITY PLUMBING AND HEATING LTD., and CARMINE BROGNO

Before Justice David A. Fairgrieve
Reasons for Judgment released on July 21, 2014

Alexandra Bednar and Kikee Malik ..... counsel for the prosecution
Norman Keith ..... counsel for the defendants, Bay Grenville Properties Ltd. and Douglas Wood
Cheryl Edwards ..... counsel for the defendants, University Plumbing & Heating Ltd. and Carmine Brogno

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FAIRGRIEVE J.:

[1] The four defendants, two corporations and two individuals, are charged separately in twelve different counts alleging offences under the *Occupational Health and Safety Act,* R.S.O. 1990, c. O.1, as amended. All of the charges stem from a fatal accident that occurred on May 12, 2008, at the Murano Condominium project then under construction on the east side of Bay Street, between Grosvenor and Grenville Streets, in Toronto. Prior to trial, a former co-defendant, Maple Leaf Structural Ltd. ("Maple Leaf"), pleaded guilty to one of the charges against it, and the other charges against Maple Leaf and its supervisor, Richard Dinis, were withdrawn by the Ministry of Labour. The remaining defendants pleaded not guilty and proceeded to trial on the charges alleging various failures to ensure compliance with the provisions of O. Reg. 213/91, as amended, the Construction Projects Regulation made under the *OHSA.*

[2] The accident occurred when Emilio Piccinin, a senior supervisor employed by one of the defendants here, University Plumbing and Heating Ltd. ("University Plumbing"), happened to be visiting the construction site. As he stood outside on what was referred to as the third floor mezzanine level, the roof of a two-storey building connecting the north and south towers of the high-rise condominium project, a piece of 4-inch cast iron pipe, about a foot in length and weighing about eight pounds, fell from the 23rd floor of the north tower above him. The piece of pipe struck Mr. Piccinin on his hardhat as he stood below, causing serious head injuries that, tragically, resulted in his death.

[3] Following an investigation by the Ontario Ministry of Labour, charges were laid against Bay Grenville Properties Ltd. ("Bay Grenville") the project developer and "constructor" under the *OHSA.* Doug Wood, the site superintendent employed by H&R Developments Inc., the general contractor, was charged as a "supervisor" under the statute. As well, two corporate subcontractors and two of their employees were charged. Maple Leaf, the structural subcontractor responsible for, among other things, the operation of the crane and the hoisting activities at the site, and its supervisor Richard Dinis, were charged, as already stated, with offences in relation to their alleged roles in failing to ensure that their work on this occasion was performed in compliance with the provisions of the *OHSA* Regulation. Similarly, the plumbing subcontractor, University Plumbing, and its foreman supervising the plumbers working on the north tower, Carmine Brogno, were charged, respectively, as "employer" and "supervisor" under the *OHSA* in connection with the storage of material, including iron pipe, and the removal of debris on the 23rd floor of the north tower.

The Circumstances Surrounding the Accident

[4] Many of the facts surrounding the accident were not the subject of dispute. While there were significant discrepancies concerning some aspects of the evidence, there was general agreement as to the events that occurred at the time of the accident itself.

[5] The third floor mezzanine where Mr. Piccinin was standing when he was struck by the piece of falling pipe was also referred to by witnesses as the hoisting area, because it was used for the storage of concrete forms and other materials that were lifted or lowered as needed by crane to upper storeys as the project progressed. Maple Leaf, as the structural subcontractor, was responsible for operating the crane and carrying out the hoisting activities. As part of this work, Maple Leaf, according to standard safety procedures, was required to have a person, called a swamper or rigger or spotter, both below, on the ground floor or third floor mezzanine below any overhead work, as well as a second swamper up top where materials were hoisted or moved by the crane. The swamper on either the ground or the third floor mezzanine level not only guided the crane operator in the hoisting of items, but he also had the duty of ensuring that no workers were in the area underneath any overhead work that was being done. Because the crane operator could not see what was happening below, given that the building under construction in-

creasingly blocked his view the higher it got, he depended on the guidance and directions given by both swampers to him by means of a radio connection.

[6] The accident that killed Mr. Piccinin happened at about 3:30 p.m. on May 12, 2008, about 15 minutes after the end of normal working hours, when the crane was engaged in moving the outrigger, as it was called, from the 23rd floor to the 22nd floor so that a shipment of windows could be delivered to the 22nd floor from the ground level when it arrived. As explained in the evidence, the outrigger was a movable structure that was used to provide a landing platform for material that could not simply be hoisted by crane to the floor where it was needed because the concrete slab above it had already been poured. The outrigger in question consisted of a wooden platform resting on two steel H-beams that would be moved by crane and physically pulled by the swamper and another worker into position with the beams resting on the concrete floor. The outrigger would then be secured by shoring jacks placed between the beams and the concrete slab above them. When in position, the outrigger provided a landing platform that protruded from the south side of the tower that was ready to receive material being moved by the crane to that particular location. When the outrigger was moved from one floor to another, the swamper in the initial location had to free the outrigger by removing the jacks and rolling the outrigger out the side of the building to allow it to be lifted further by the crane and moved to its next location. The safety fences or guardrails that otherwise lined the outer perimeter of each concrete slab to prevent anything from rolling or being knocked off, were moved just far enough to create a gap that allowed the outrigger to be either placed into position or removed, and then the safety fences would be replaced to ensure a continuous barrier along the exterior of each floor of the building.

[7] It was not disputed that when the piece of pipe that killed Mr. Piccinin fell off the 23rd floor, an employee of Maple Leaf Structural, Fortunato Calla, was the top swamper working there with another Maple Leaf employee, David Knaz, who was also being trained as a crane operator. They had been directed by their foreman, Richard Dinis, to assist in the movement of the outrigger to the 22nd floor, although Mr. Dinis did not stay to supervise this overtime work. Mr. Calla indicated that he had to leave by 4:00 p.m., so it was arranged that Mr. Knaz, after helping to move the outrigger from the 23rd floor to the 22nd floor, would remain there to act as swamper when the expected shipment of windows was to be hoisted. Differing versions of the precise sequence of events concerning the movement of the outrigger from the 23rd floor were given by Mr. Calla and Mr. Knaz, and it is impossible to say with certainty what stage Mr. Calla was at in the preparations to move to move the outrigger when Mr. Knaz arrived on scene to assist. Mr. Calla was a very emotional witness who claimed to have little memory of the details of the incident. There were also credibility issues with respect to Mr. Knaz, both because he admitted that he initially gave a false statement to the Ministry investigator about having worn a fall-arrest harness and also because he presented a defensive demeanour when testifying. In any event, after Mr. Calla hooked up the outrigger to the crane, and they untied the safety fences and removed the jacks, not necessarily in that order, Mr. Calla gave the

fateful instruction to the crane operator, John Demelo, "to hoist up and trolley out." Despite his frailties as a witness, I accept Mr. Knaz's evidence that he did not actually observe the piece of pipe rolling across the floor, but saw it just as it went over the edge of the slab as Mr. Calla made an unsuccessful attempt to grab it before it fell.

[8] Similarly, there is no reason to doubt the truthfulness of Mr. Calla's evidence that he did not notice the piece of pipe before he saw it rolling towards the edge and then fall from the concrete slab. I accept his testimony that he did not see what caused it to roll, and that he made a desperate effort to prevent it from falling, but was unable to do so. While it is not possible to say exactly where the piece of pipe had been lying, unseen by either Mr. Calla or Mr. Knaz, despite the evidence of both men that they had made at least a quick visual inspection to ensure that the area around the outrigger was clear, it seems irrefutable that the pipe was knocked by the outward motion of the outrigger beam, which propelled it in a southerly direction over the edge of the concrete slab. While the floor inside the building was relatively level, the concrete on the balcony was sloped slightly downward. Mr. Calla testified that he could see a person walking below, that his yelling and screaming were apparently not heard, and that he saw the piece of pipe strike Mr. Piccinin on the head.

[9] The evidence also established that at the time the pipe fell, Ricardo Ramos, the swamper below, was not in his proper position on the third floor mezzanine level underneath the overhead work. Instead, he had gone off to retrieve a radio or battery from the Maple Leaf trailer, as directed by Mr. Calla. As a result, there was no one present to warn anyone else who might be in the vicinity, including Mr. Piccinin, that overhead work was going on and to keep away from the hoisting area.

[10] In those circumstances, the conclusion appears inescapable that Maple Leaf bore, if not necessarily sole responsibility, at least primary responsibility for the tragic accident that occurred. Mr. Calla clearly should not have given the direction to the crane operator to move the outrigger out from the building before ensuring that there was nothing in its path that could be affected by its movement. Even more obvious was the careless failure of the Maple Leaf swamper on the 23rd floor to ensure that Mr. Ramos, the swamper below, was in his proper position both to direct the crane operator with respect to the movement of the outrigger once it had cleared the building, but also to safeguard the hoisting area underneath. Indeed, since Mr. Calla, it was agreed, had been the person who had instructed Mr. Ramos to leave the third floor mezzanine area and failed to ensure that he had returned before proceeding with the movement of the outrigger, it is impossible not to lay this serious departure from the specific "Flying Form" procedure he was obliged to follow at the feet of the Maple Leaf worker.

Maple Leaf Structural Ltd.'s guilty plea

[11] Numerous references were made in the evidence at trial, without objection, to the fact that Maple Leaf had earlier pleaded guilty to a charge that, as an "employer", it had failed to ensure that the measures and procedures prescribed by s.

37(1) of O.Reg. 213/91 were carried out in the workplace located at 825 Bay Street, Toronto, contrary to s. 25(1)(c) of the *OHSA*. The charge, Count 9 in the information, was particularized by stating that "[t]he defendant failed to ensure that an outrigger platform was moved in a manner that did not endanger a worker." The relevant part of the Regulation that was violated reads as follows:

> 37. (1) Material or equipment at a project shall be stored and moved in a manner that does not endanger a worker.

Two other charges against Maple Leaf were withdrawn at the time of its guilty plea. The charge in Count 7, referring to the requirement in s. 26.3(3) of the Regulation that a worker be adequately protected if the guardrail system were removed temporarily to perform work around the opening, and the charge in Count 8, referring to the requirement in s. 44 for warning signs adjacent to the hoisting area, were both withdrawn by the prosecution. The three same charges against Richard Dinis, charged as a "supervisor" employed by Maple Leaf, were withdrawn by the prosecutor following the guilty plea entered by his corporate employer.

[12] While the guilty plea of a former co-defendant and the withdrawal of other charges against that entity and its supervisor have no probative value so far as the adjudication of the charges against the remaining co-defendants is concerned, it is still relevant to observe that the finding of guilt already made against Maple Leaf is entirely consistent with the evidence led at this trial concerning the participation of the Maple Leaf employees in the fatal accident. The admitted negligence on the part of Maple Leaf, supported as it was by the evidence here, also provides an appropriate backdrop for an assessment of whether the evidence warrants casting the net of culpability wider than it already has been to capture the alleged failure of the remaining co-defendants to discharge the duties placed upon them as well by the *OHSA* to ensure compliance with the requirements imposed by the Construction Projects Regulation.

The Present Charges

[13] Bay Grenville and Doug Wood were each charged in separate counts as a "constructor" and as a "supervisor," respectively, with four different offences alleging failures to ensure that "the measures and procedures" prescribed by four different provisions in O. Reg 213/91 had been carried out. Likewise, University Plumbing was charged as an "employer" and its foreman at the north tower, Carmine Brogno, was charged as a "supervisor" with the same two offences, set out in four separate charges. For each of the charges referring to a specific section of the Regulation, the charge against each defendant was particularized in identical terms.

[14] It appeared to be conceded that Bay Grenville fell within the definition of "constructor" in s. 1(1) of the *OHSA*, since the term includes "an owner who undertakes all or part of a project … by more than one employer", which in turn is defined to include a sub-contractor who, *inter alia,* contracts for the services of one or more workers. Although Mr. Keith submitted that Doug Wood, as site superintendent for

the general contractor, H&R Developments Inc., should not be found to be a "supervisor," I think that all of the evidence compels the conclusion that Mr. Wood was "a person who has charge of a workplace or authority over a worker," the statutory definition of "supervisor" in s. 1(1). Ms. Edwards, on behalf of her clients, did not dispute that University Plumbing was an "employer" and that Mr. Brogno was a "supervisor," given his authority over the other University Plumbing plumbers working on the project's north tower.

[15] Count 1 (against Bay Grenville) and Count 10 (against Mr. Wood) each allege that the defendant, on May 12, 2008, committed an offence by

> … failing to ensure that the measures and procedures prescribed by s. 34(1) of O. Reg. 213/91, as am., were carried out on the project...
>
> Particulars: The defendant failed to ensure that overhead protection was provided at the third floor mezzanine connecting the north tower and the south tower at the project.

The relevant section of the Regulation in question provides as follows:

> 34. (1) If material may fall on a worker, overhead protection shall be provided,
>
> (a) at every means of access and egress from a building or other structure under construction; and
>
> (b) above every area where work is being carried out.
>
> (2) Overhead protection shall consist of material capable of supporting 2.4 kilonewtons per square metre without exceeding the allowable unit stress for the material used.

[16] Similarly, Count 2 (against Bay Grenville), Count 11 (against Mr. Wood), Count 5 (against University Plumbing) and Count 14 (against Mr. Brogno) allege that each defendant committed an offence by

> … failing to ensure that the measures and procedures prescribed by s. 35(1) of O. Reg. 213/91, as am., were carried out on the project…
>
> Particulars: The defendant failed to ensure that waste material, debris and/or reusable material, including iron pipe, was removed from the 23rd floor of the north tower to prevent a hazardous condition from arising.

The relevant section of the Regulation in question provides as follows:

> 35. (1) Waste material and debris shall be removed to a disposal area and reusable material shall be removed to a storage area as often as is necessary to prevent a hazardous condition arising and, in any event, at least once daily.

[17] Count 3 (against Bay Grenville), Count 12 (against Mr. Wood), Count 6 (against University Plumbing) and Count 15 (against Mr. Brogno) allege that each defendant committed an offence by

> … failing to ensure that the measures and procedures prescribed by s. 39 of O. Reg. 213/91, as am., were carried out on the project…

> Particulars (as amended at trial): The defendant failed to ensure that material, including iron pipe, was piled or stacked in a manner that prevented it from rolling on the 23rd floor of the north tower.

The relevant section of the Regulation in question provides as follows:

> 39. Material and equipment at a project shall be piled or stacked in a manner that prevents it from tipping, collapsing or rolling.

[18] Finally, the fourth set of charges, Count 4 (against Bay Grenville) and Count 13 (against Mr. Wood), allege that each defendant committed an offence by

> … failing to ensure that the measures and procedures prescribed by s. 44 of O. Reg. 213/91, as am., were carried out on the project…
>
> Particulars: The defendant failed to ensure that warning signs were posted in prominent locations and in sufficient numbers adjacent to a hoisting area located on the third floor mezzanine connecting the north tower to the south tower on the project.

Again, the relevant section of the Regulation reads as follows:

> 44. (1) Signs meeting the requirement of subsection (2) shall be posted in prominent locations and in sufficient numbers to warn workers of a hazard on a project.
>
> (2) A sign shall contain the word "DANGER" written in legible letters that are at least 150 millimetres in height and shall state that entry by any unauthorized person to the area where the hazard exists is forbidden.
>
> (3) Without limiting the generality of subsection (1), a sign shall be posted
>
> > (a) adjacent to a hoisting area;
> >
> > . . .
>
> (4) No worker shall enter an area in which a sign is posted other than a worker authorized to work in the area.

[19] The twelve charges, then, can be summarized as follows:

> (i) Bay Grenville & Mr. Wood:
> Failing to ensure overhead protection at 3rd Floor hoisting area;
>
> (ii) All four defendants:
> Failing to ensure removal of debris and material from 23rd Floor to prevent a hazardous condition;
>
> (iii)All four defendants:
> Failing to ensure that material, including iron pipe, on the 23rd Floor was piled or stacked in a manner that prevented it from rolling;
>
> (iv)Bay Grenville & Mr. Wood:
> Failing to ensure proper warning signs adjacent to the 3rd Floor mezzanine hoisting area

[20] While there was a good deal of overlap both in the allegations and in the repetitive nature of much of the evidence, it is clear that the evidence against each individual defendant with respect to each individual charge must be considered separately.

Strict Liability Offences

[21] There was no issue that the offences charged here are to be regarded as strict liability offences. In the well-known passage from the judgment of Dickson J., as he then was, in *R. v. City of Sault Ste. Marie* (1978), 40 C.C.C. (2d) 353 at pp. 378-9 (S.C.C.), public welfare offences generally fall within the second category of offences described in the following terms:

> 2. Offences in which there is no necessity for the prosecution to prove the existence of *mens rea*; the doing of the prohibited act *prima facie* imports the offence, leaving it open to the accused to avoid liability by proving that he took all reasonable care. This involves consideration of what a reasonable man would have done in the circumstances. The defence will be available if the accused reasonably believed in a mistaken set of facts which, if true, would render the act or omission innocent, or if he took all reasonable steps to avoid the particular event. These offences may properly be called offences of strict liability.

This conclusion seems intended to be consistent with Dickson J.'s observation, at p. 370, that the Law Reform Commission had recommended "that an accused should never be convicted of a regulatory offence if he establishes that he acted with due diligence, that is, that he was not negligent," as well as his acceptance, at p. 374, of "the principle that punishment should not be inflicted on those without fault."

[22] In considering the particular pollution offence charged in *Sault Ste. Marie*, Dickson J. stated, at p. 376, the prohibited act would be committed by those who undertake the activity (in that case, the collection and disposal of garbage) "who are in a position to exercise control of this activity and prevent the pollution from occurring, but fail to do so." After observing, at p. 377, that a municipality could not slough off its responsibility by contracting out the work, when it was in a position to control those hired and to supervise their work through the provisions of a contract or municipal by-law, Dickson J. stated the following:

> One comment on the defence of reasonable care in this context should be added. Since the issue is whether the defendant is guilty of an offence, the doctrine of *respondeat superior* has no application. The due diligence which must be established is that of the accused alone. Where an employer is charged in respect of an act committed by an employee acting in the course of employment, the question will be whether the act took place without the accused's direction or approval, thus negating wilful involvement of the accused, and whether the accused exercised all reasonable care by establishing a proper system to prevent commission of the offence and by taking reasonable steps to ensure the effective operation of the system. The availability of the defence to a corporation will depend on whether such due diligence was taken by those who are the directing mind and will of the corporation, whose acts are therefore in law the acts of the corpora-

> tion itself.

In the context of a prosecution under the *OHSA*, consideration must, of course, be given to the specific duties and responsibilities imposed by the statute as well.

[23] Part III of the *OHSA* sets out the duties imposed by the statute on a constructor (s. 23), an employer (s. 25) and a supervisor (s. 27). Framed in very broad terms in order to achieve the protection of the health and safety of workers, the obvious objective of the legislation, a constructor is required to ensure that measures and procedures prescribed by the Act and Regulations are carried out and that every employer and worker complies with the Act and Regulations as well. The duties imposed on an employer and a supervisor are similarly stated in both general and specific terms, with an overarching duty requiring, in the case of an employer, that prescribed measures and procedures are carried out in a workplace and, in the case of a supervisor, that every reasonable precaution be taken in the circumstances for a worker's protection. As stated by Sharpe J.A. in *Ontario (Ministry of Labour) v. Hamilton (City)* 2002, 58 O.R. (3d) 37 (C.A.),

> The *OHSA* is a remedial public welfare statute intended to guarantee a minimum level of protection for the health and safety of workers. When interpreting legislation of this kind, it is important to bear in mind certain guiding principles. Protective legislation designed to promote public health and safety is to be generously interpreted in a manner that is in keeping with the purposes and objectives of the legislative scheme. Narrow or technical interpretations that would interfere with or frustrate the attainment of the legislature's public welfare objectives are to be avoided.

At the same time, it is to be observed that all of the charges have been particularized by the informant who laid the charges, as well as by the prosecutor at trial who limited the allegations concerning the offences charged to the facts surrounding the fatal accident. The focus of the evidence and submissions at this trial was not on any question of statutory interpretation, but whether the offences as particularized had been made out by the Crown, and if they had been, whether an individual defendant had established that it or he had exercised due diligence to avoid the failure to ensure compliance that the law required.

[24] In *R. v. Timminco Ltd.* (2001), 153 C.C.C. (3d) 521 at p. 530 (Ont. C.A.), after stating that the Crown need not prove a mental element to make out a strict liability offence, such as actual knowledge of a particular hazard, Osborne A.C.J.O. stated:

> Section 25(1)(c) simply requires that an employer "shall ensure that… the measures and procedures prescribed are carried out in the workplace." In fact, use of the word "ensure" suggests that the Legislature intended to impose a strict duty on the employer to make certain that the prescribed safety standards were complied with at all material times.

Of particular relevance to this case, given the suggestion that the freak nature of the accident that caused Mr. Piccinin's death was not reasonably foreseeable and could not, except in hindsight, have been prevented by any of the defendants, is Osborne A.C.J.O.'s reminder that foreseeability is not an element required to be proved by

the prosecution, but (at para. 28) "the foreseeability of a hazard is properly to be considered as part of a due diligence defence."

[25] Similarly, having already found that the evidence established negligence on the part of Maple Leaf and its primary responsibility for the fatal accident, it seems pertinent to repeat the observations made by Bellamy J. in *Ontario (Ministry of Labour) v. Enbridge Gas Distribution Inc. et al.,* 2010 ONSC 2013 (CanLII); leave to appeal to C.A. dismissed (Watt J.A., in Chambers), 2011 ONCA 13 (CanLII) at para. 24:

> The *OHSA* strives to make every party, every employer and every individual in the workplace responsible in some measure for health and safety. Accidents can and do happen. However, they do not always happen simply because of one incident. They can happen because of several incidents or omissions, as the appellants contend was the case here. The responsibilities under the Act overlap, creating a redundancywhich operates to the advantage of workers. The parties in this appeal described this as the "belt and braces" approach to occupational health and safety, which means the Act and Regulations use more than one method to ensure workers are protected, So, if the "belt" does not work to safeguard a worker, the backup system of the "braces" might, or vice versa. If all workplace parties are required to exercise due diligence, the failure of one party to exercise the requisite due diligence might be compensated for by the diligence of one of the other workplace parties. The purpose is to leave little to chance and to make protection of workers an overlapping responsibility.

Accepting this guidance to the the principles applicable to a case of this kind, I turn next to the specific charges against the individual defendants.

Failure to ensure overhead protection at the third floor hoisting area

[26] Bay Grenville and Mr. Wood are charged with having failed to ensure compliance with s. 34(1) of O. Reg. 213/91, particularized as "fail[ing] to ensure that overhead protection was provided at the third floor mezzanine connecting the north tower and the south tower at the project."

[27] In my view, the prosecutor has failed to prove the *actus reus* of the charge as particularized. The third floor mezzanine level was designated as the hoisting area for the project. It was used for storing the concrete forms, as well as other material and equipment that the crane lifted or lowered as the construction of the towers progressed. It is difficult to see how a highrise tower could be built without having such a hoisting area. If "overhead protection" is taken to mean simply an overhead structure of some kind, like the roof covering the sidewalk on Bay Street adjacent to the project or the entrances or exits of the building, then it clearly has no application to the hoisting area. The reference in s. 34(2) of the Regulation to "overhead protection" consisting of "material capable of supporting 2.4 kilonewtons per square metre" above every area where work is carried out suggests, I think, that the prescribed measure was not aimed at the location of the kind of work necessarily carried out in a hoisting area. Even if a more expansive definition of "overhead protection" is given, consistent with the remedial interpretation appropriate to such worker safety pro-

visions, the evidence established, in my opinion, that the "overhead protection" that could be provided in the circumstances was in fact provided. The unchallenged evidence was that there were safety fences or guardrails lining the outer perimeters of all of the floors until windows or balcony doors were installed. The fences had a solid panel along the bottom that prevented anything from rolling off or falling from the concrete slabs above. When the outrigger was moved, something that happened frequently or at least every few days, the safety fence would have to be untied from the outrigger and removed temporarily, but it was quickly replaced afterwards by the swamper or other worker who, in any event, would have remained at the location where the outrigger had been and been in a position to ensure that nothing fell through the temporary opening. I am not overlooking Ms. Bednar's reference to the opinion expressed by the crane operator, John DeMelo, that the safety fence should be viewed as "fall protection" rather than overhead protection, but I do not find the distinction he drew to be very compelling.

[28] The thrust of Ms. Bednar's submissions concerning this count make it clear, I think, that the prosecutor's concern was not really overhead protection above any area where work was being carried out by workers or at the door from the north tower, the subjects covered by s. 34(1), but rather access to the third floor mezzanine by workers using it as a shortcut between the two towers, particularly, as disclosed by the evidence, when the coffee truck arrived during the coffee breaks, or at lunch, or at the end of the day when leaving the workplace. The prosecutor's complaint, it appeared, was that there was ready access to the third floor hoisting area without any barricades, at least after the door that had once been there had been removed. While this was undoubtedly a valid concern, particularly if the swamper was not there to warn people to stay away if hoisting operations were going on, I think that it is a separate complaint that does not import the overhead protection provision of the Regulation.

[29] If I am wrong in that regard, and the Crown has proved a failure to provide overhead protection in the hoisting area as prescribed by s. 34(1), I am nonetheless satisfied that Mr. Wood and Bay Grenville, by implication, have demonstrated on a balance of probabilities that due diligence was exercised by them to prevent that failure. Much of the evidence called by these two defendants with respect to due diligence, and many of the submissions made by Mr. Keith on their behalf, was of general application to the construction project as a whole and not limited simply to the issue of overhead protection.

[30] I think that any determination of whether due diligence has been established must first take into account the size and nature of the construction project, not because the safety standards imposed by the Regulations will vary, but because the means to meet those standards will reflect the complexity of the project. Mr.Wood testified that the Murano Condominiums was a $96 million project that involved the construction of two towers, a 35-storey building to the north and a 45-storey tower, joined by a 3-storey building and a multi-level parking garage. There were an average of 25 trade subcontractors working on the site at a given time, some with many

workers employed there. It was estimated that Maple Leaf, the structural contractor, had about 60 workers on site, and University Plumbing 20 to 30. By any measure, this was a very large project involving careful planning and management. I accept Mr. Keith's submission that Bay Grenville retained a competent and experienced site superintendent, Doug Wood, and his employer, H&R Developments, to manage the project. Mr. Wood was assisted by two assistant site superintendents and they provided a constant presence on site to deal with subcontractors and safety issues.

[31] Bay Grenville had subcontract agreements with both Maple Leaf and University Plumbing that required the subcontractors to comply with the *OHSA*, the Construction Projects Regulation, and Bay Grenville's own project-specific safety requirements. These agreements required a senior representative of the sub-trades to expressly acknowledge Bay Grenville's expectations with respect to health and safety. A safety manual was developed specifically for the Murano project by Bay Grenville and provided to all trade subcontractors prior to their working at the project. The site superintendent for Maple Leaf, Robert Saccucci, was required to sign an acknowledgement and declaration that he had received and read the Bay Grenville Project Safety Project and that all necessary precautions would be taken to ensure the health and safety of their workers and compliance with the legal requirements imposed by the *OHSA* and Regulations. I am satisfied that these measures were not simply window-dressing, but demonstrated a genuine commitment and conscientious effort to ensure a safe workplace.

[32] Specifically with respect to overhead protection, Bay Grenville's Safety Program Manual set out the following:

> Overhead protection or appropriate barricades and pedestrian control measures must be provided where work is being carried out above a means of access/egress or work area.

All the Maple Leaf employees who testified, as well as Mr. Wood and his assistant, Scott Robinson, gave evidence that safety fence was installed on every floor of both towers. Its purpose was to prevent workers from falling or material from being kicked or rolling off the edge of the building. Mr. Kremezis confirmed that the safety fence was always in place when plumbers were working on a floor installing pipes or mechanical systems.

[33] Maple Leaf, which had exclusive use of the third floor mezzanine area and control over hoisting operations, had a written Safety Policy and Program Manual that contained a specific section on "Flyforms" that applied to the movement of the outrigger and other material as well. It provided:

> When hoisting fly forms … no loose material should be left on the form … the form must not be flown over workers. Workers must be removed from the path of the form or made aware of the process either by sounding the horn or by any other means.

Similarly, Maple Leaf had a written flyform procedure in place at the time that stated:

> 4. The ground area which is under the fly form path as it leaves the building

> will be taped off and a worker will be present at ground level to monitor access to that area, both by the public and on site personnel. A police officer may be required to control vehicular traffic.

All of the Maple Leaf employees, including Mr. Calla, Mr. Ramos, Mr. Knaz and Mr. DeMelo were aware of Maple Leaf's fly form procedure and were required to acknowledge receipt and understanding of the flyform procedure set out in the Maple Leaf Safety Policy and Program manual. In addition, Maple Leaf conducted regular weekly "toolbox" safety meetings where safety issues were discussed, including a meeting on April 16, 2008, where Mr. Roccasalva instructed workers again that they were required to follow the established safety procedures for hoisting and moving the outrigger platform.

[34] As a further indication of the constructor's commitment to maintaining a safe construction site, H&R Developments also engaged the TRH Group ("TRH") to provide consulting services to ensure that both site safety conditions and workers were in compliance with the *OHSA* and Regulations and Bay Grenville's project-specific safety requirements. A THR inspector, usually Owen Waite, conducted random weekly inspections of the project to identify any hazards and to make written recommendations for the improvement of health and safety there. The THR consultant would be accompanied by Mr. Wood or one of the assistant site superintendents, and a weekly inspection form would be completed. Mr. Waite testified that immediate action was taken by Mr. Wood in response to any hazards that were identified, with the foreman of the sub-trade being contacted by Mr. Wood, directions given to address the problem, followed by verbal confirmation or a visual inspection. It is of considerable significance, I think, that the safety consultants never raised any concerns about the flyform procedure being followed by Maple Leaf.

[35] With respect to that procedure, Mr. Dinis testified that Ricardo Ramos always worked as the ground swamper, where one of his primary functions was to ensure that no workers gained access to the hoisting area when the crane was conducting a lift overhead. Mr. Dinis had assigned Mr. Ramos to be the ground swamper when the outrigger was to be moved on the afternoon of the accident, and Mr. Ramos was returning to the third floor hoisting area when the incident occurred. It was not disputed that Mr. Calla's departure from the standard practice was unauthorized and completely unexpected.

[36] Mr. Wood testified, truthfully I am satisfied, that he had never seen anyone take a shortcut through the third floor hoisting area himself, nor had anyone ever reported to him that that had occurred. The evidence never made clear why anyone would regard the hoisting area as a shortcut in any event, since there was ready access between the north and south towers inside through the 2nd floor, and the third floor Maple Leaf staging area was congested with wall forms and other concrete forms covered, it was stated, with grease and form oil. Mr. Wood had seen the door in place deterring access to the third floor mezzanine from the north tower, as Mr. Dinis confirmed, and was not aware that it had ever been removed. While Mr. Knaz testified that he did not remember a door at that location before the May 12th incident, I suspect that he may either have a faulty recollection or a reason to embellish

the seriousness of the never-reported problem with other workers intruding on the hoisting area. I am also satisfied that Mr. Wood was not an insulated or remote site superintendent. I accept his evidence that he walked through the site every day, that sub-trade workers and foremen were comfortable talking with him about any issues, and that it was, as he put it, a co-operative rather than a confrontational environment.

[37] Taking all of the circumstances into account, I find, at least on a balance of probabilities, that Mr. Wood took every reasonable precaution to avoid a failure to provide adequate overhead protection at the third floor hoisting area. He had no reason to foresee Mr. Calla's rather bizarre departure from the entrenched flyform practice that had proved perfectly safe in the past. Movement of the outrigger was a commonplace action that did not require his personal intervention or supervision, in my view. A site superintendent of a project on this scale would necessarily have to rely on others to perform their jobs in accordance with the law and the systems put in place to safeguard the workers there. While Mr. Piccinin's death remains an appalling tragedy, I do not think it is possible to fault Mr. Wood in any way. In my view, he has discharged the burden of establishing the defence of due diligence and is entitled to an acquittal on the charge. It follows that Bay Grenville should be acquitted as well.

The "housekeeping" charges

[38] All four defendants are charged with having failed to ensure compliance with s. 35(1) of the Regulation that requires the removal of waste material and debris to a disposal area and reusable material to a storage area "as often as is necessary to prevent a hazardous condition arising and, in any event, at least once daily." The charges are all particularized to allege that "the defendant[s] failed to ensure that waste material, debris and/or reusable material, including iron pipe, was removed from the 23rd floor of the north tower to prevent a hazardous condition from arising."

[39] I think it makes sense to deal with the charges against University Plumbing and Mr. Brogno first. Again, I am not satisfied that the Crown has proved beyond a reasonable doubt the *actus reus* of the offences charged. The position of the Crown is essentially that the piece of cast iron pipe that fell from the 23rd floor and killed Mr. Piccinin must have been debris left by the University Plumbing plumbers, Mr. Macoretta, the apprentice who did some work on the 23rd floor on May 12, 2008, or the journeyman plumber, Mr. Kremezis, who was on vacation on May 12th, but had worked there with Mr. Macoretta the previous week cutting off short lengths of 4-inch cast iron pipe from the pipes to be installed as soil stacks in each unit. The Crown relied on photographs taken of the 23rd floor that showed lengths of pipe laid on the floor for work to be completed as well as ends of cut-off pipes. Other photographs showed, it was argued, both cut pipes from the risers and other pipe that was reusable material that was not secured in any way to prevent it from rolling. Mr. Knaz, the Maple Leaf employee who assisted Mr. Calla in preparing for the removal of the

outrigger, stated that "there was shit all over the place" on the 23rd floor, and that "the place was a bloody disaster." Later in his evidence, he backtracked somewhat, stating that the 23rd floor was "messy," but not in the immediate area of the outrigger platform where, both he and Mr. Calla testified, they had made a visual inspection to ensure that it was safe to move it. Likewise, the evidence of P.C. Langille, the police photographer who described pieces of pipe "all over the place," was contradicted by the photos and the evidence that, unknown to her, the outrigger shoring jacks had been placed in a pile there by Mr. Calla and Mr. Knaz, and the two 4X4 pieces of wood were placed there by Mr. Calla to secure the second piece of 4-inch pipe that he said he took from the floor in front of the outrigger between its two beams.

[40] The issues with respect to these charges involve questions of fact that turn on the assessment of witnesses' credibility and whether the evidence on which the Crown relies is sufficiently reliable to discharge its burden of proof. In essence, I agree with Ms. Edwards' submission that the evidence called by the defendants raises at least a reasonable doubt concerning one or more of the essential elements of the offence charged.

[41] The evidence of the University Plumbing employees was that they removed waste material to disposal areas to the side of the work area against the walls or to what was referred to as the hoist suite, next to where the hoist would be located once it was high enough to reach the floor they had been working on. Both Mr. Kremizis and Mr. Macoretta testified that they cleared debris in this manner after each task, after each day, and again after completing their work on each floor. I am unable to reject outright their evidence in this regard, particularly since Mr. Wood and Mr. Robinson testified that in their experience, University Plumbing workers cleaned up on a daily basis and left materials in safe and secure places. Similarly, both plumbers testified that the photos that were filed did not accurately depict the condition in which they had left the 23rd floor prior to the accident, implying that the actions of other workers, perhaps from Maple Leaf, could have moved or carelessly knocked the pipe or other material left by them. While admittedly unlikely, I cannot say with certainty that there was no interference by anyone else with the materials they had disposed of there.

[42] More compelling, it seems to me, is the opinion evidence given by the defence expert, James Wilkinson, that no hazardous condition, an essential element of the alleged offence, arose from the materials shown in the photographs taken on the 23rd floor. Mr. Wilkinson, a civil engineer who had worked for many years conducting forensic investigations and advising the Ontario Ministry of Labour, testified that the removal of waste material by University Plumbing, as well as the laying out of pipes on the floor near the areas where they would be used, were consistent with industry practice and the guidance provided by the Construction Safety Association. He testified as well that it was relevant that there was a perimeter safety fence around the entire 23rd floor to contain any loose material, that the 23rd floor was not a high traffic area at the time, given that the plumbers generally worked in the absence of other trades, utilizing their own materials, and that one or two pieces of 12-inch long iron

pipe, unlikely to roll on their own without a significant force applied, as well as the number and location of cut ends found on the 23rd floor, did not constitute a hazardous condition. While Ms. Bednar challenged Mr. Wilkinson's opinion in cross-examination, his evidence remained unshaken, in my view, and I am entitled to accept it.

[43] Ms. Edwards also pointed to the evidence given by Mr. Waite that the TRH inspections confirmed regularly, including an inspection on May 9, 2008, the last workday before the day of the accident, that housekeeping on the site, including the removal of debris and storage of materials by University Plumbing workers was ongoing and acceptable. On one occasion in January 2008, cut ends of pipe had been observed by the safety consultant on the 9th floor, but the issue was brought to the attention of Mr. Brogno and immediate corrective action was taken. It was also observed that no Ministry of Labour orders were ever issued to University Plumbing in relation to debris or material storage on any of the numerous occasions on which Ministry inspectors had attended for routine inspections prior to the accident.

[44] Where the cast iron pipe that fell came from remained a mystery at the conclusion of the evidence. Ms. Edwards advanced a theory that Mr. Calla may have retrieved the piece of pipe, as well as the second piece he placed by the 4X4s, to be used as rollers for moving the outrigger in once it had been delivered to the 22nd floor. While that theory might have been met initially with considerable skepticism, particularly given the evidence of both Mr. Calla and Mr. Knaz that only a half-inch copper pipe could be used for the purpose without being crushed, Mr. Wilkinson's testimony that a cast iron pipe, even with a 4-inch diameter, would be suitable for that purpose lent it greater credence. Ms. Edwards also pointed to the use by Mr. Calla of available cast iron pipes when he provided the demonstration on the video of how the copper pipes are normally used, as well as the discrepancy between Mr. Knaz's evidence that the copper rollers were kept in the Maple Leaf construction trailer and Mr. Calla's insistence that they would have come from a toolbox on the top floor of the project. Without necessarily accepting the theory, I think it is enough that it at least leaves a reasonable doubt about where the pipe in question might have come from and why it was in such close proximity to Mr. Calla and the outrigger.

[45] A reasonable doubt that there were any deficiencies in the removal of debris or storage of materials by University Plumbing employees that in fact created a hazardous condition is sufficient to require a dismissal of the "housekeeping" charges against both University Plumbing and Mr. Brogno. If they are acquitted, I do not see any basis on which Mr. Wood or Bay Grenville could be convicted. All four defendants are acquitted of these charges.

The unsafe storage of pipe charges

[46] The same four defendants are also charged with contravening s. 39 of the Regulation that requires material and equipment to be "piled or stacked" in a manner

that prevents it from "tipping, collapsing or rolling." The charges were particularized to allege that "the defendant(s) failed to ensure that material, including iron pipe, was piled or stacked in a manner that prevented it from rolling on the 23rd floor of the north tower."

[47] In my opinion, these charges can be dealt with quite summarily. I accept Ms. Edwards' submission that the Regulation does not prohibit workers setting out work materials, such as lengths of pipe lying flat on the floor or fittings put neatly in work areas, for work at a construction site the next day. Neither does s. 39 require that material be piled or stacked. Rather, it requires that *if* material is piled or stacked, it must be in a manner that prevents it from tipping, collapsing or, the relevant word here, rolling. The evidence here was that pipe was stored on pallets with banding until it was used by the plumbers. The pipe that was found on the 23rd floor on May 12, 2008, was left lying flat on the floor by Mr. Macoretta for use the next day adjacent to the areas where it would be installed, not piled or stacked. In any event, there was no evidence of any risk of the pipe rolling in the condition in which it had been left.

[48] Since the Crown has failed to prove the *actus reus* of the offence, Mr. Brogno and University Plumbing are acquitted of the charges. Again, if the subcontractor cannot be found guilty of the alleged infraction, I see no reason for reaching a different conclusion with respect to the constructor and its site superintendent. All four co-defendants are acquitted.

The alleged failure to post warning signs adjacent to the hoisting area

[49] Bay Grenville and Mr. Wood are also charged with having contravened s. 44 of the Regulation requiring prescribed "DANGER" signs in prominent locations and in sufficient numbers adjacent to the hoisting area stating that entry by unauthorized persons was forbidden. The particulars identify the hoisting area in question as the third floor mezzanine connecting the north and south towers of the project.

[50] While I find this charge to be the closest call among the various charges, I feel obliged to give effect to the presumption of innocence concerning the *actus reus* of the offence and give the benefit of the reasonable doubt with which I am left to the defendants. I accept that the Ministry investigator did not observe any signage at the relevant location when he attended the scene after the accident occurred, but there was a considerable delay during which any number of events could have transpired. It was apparent that there had been a chaotic scene after Mr. Piccinin was struck, involving a number of workers gathering in the area and then ambulance personnel who would naturally have given priority to treating the victim and removing any obstacles to removing Mr. Piccinin and taking him to the hospital as quickly as possible. There was evidence from several witnesses who testified, including Mr. Knaz, Mr. Calla, Mr. Robinson and Mr. Wood, that they had observed signage warning workers of overhead work in the hoisting area. It was stated that the sign by the exit from the north tower had letters about six inches high and was attached to a ply-

wood stand or pedestal. Signs were also taped to the windows of suites leading directly to the third floor mezzanine. Since Mr. Piccinin was familiar with the site, and everyone working on the project knew that Maple Leaf used the third floor mezzanine as the hoisting area, I do not think that an absence of signage can be inferred simply from Mr. Piccinin's presence in the location, although I recognize that his visit to that location came after normal working hours when one probably would not anticipate hoisting operations to be continuing. There was evidence that some workers used the mezzanine level as a shortcut despite warnings from Mr. Ramos, the ground level spotter, as well as the use of caution tape to block the entrance during hoisting operations, so their presence in the area likewise says little about whether the requisite signs were posted. I am inclined to think that the required sign had probably been removed by someone at some time prior to the accident on May 12, 2008, but I do not think that I can make a finding beyond a reasonable doubt that that was the case based on the evidence I heard.

[51] Again, even if I am wrong in failing to be persuaded beyond a reasonable doubt that the signage was absent, I would still find that Mr. Wood probably exercised due diligence in all of the circumstances. Without repeating all of the earlier observations concerning Mr. Wood's efforts to create a work environment where everyone was conscious of safety concerns, Mr. Keith pointed to the Bay Grenville Safety Program Manual that required signs to warn of overhead dangers and the obligation of trade contractors to supply signs identifying any hazards to other workers. I accept Mr. Wood's evidence that he specifically asked trade contractors to ensure signage in areas where they were removing the safety fence during hoisting operations in doorways to suites and to warn of any exposed edges or fall hazards. It is also significant, I think, that no reports of inadequate signage were ever received by Mr. Wood. In particular, the TRH safety consultants' reports consistently recorded observations of good use of hazard signage. It would be very surprising if Mr. Waite, as well as the Ministry inspectors who made site visits, neglected to notice such a glaring omission as warning signs adjacent to the hoisting area. I am satisfied that Mr. Wood was an extremely capable site superintendent who took all reasonable steps to ensure compliance with this part of the Regulation and that he was not negligent in discharging his legal duties in this regard. While I am mindful of Bellamy J.'s observations concerning the overlapping responsibilities and redundancies imposed by the *OHSA,* one must also remember that the statute does not impose the equivalent of ministerial accountability or responsibility, where culpability can be found without fault on the part of the individual defendant.

[52] Bay Grenville also benefits from the absence of any negligence on Mr. Wood's part. These charges against both defendants are dismissed as well.

Disposition

[53] I am satisfied that it would be wrong to impose liability on any party other than Maple Leaf Structural Ltd., which has already admitted its responsibility for the very sad events that caused Mr. Piccinin's death.

[54] All of the charges against the remaining defendants will result in verdicts of acquittal.

Released: July 21, 2014

Signed: “Justice David A. Fairgrieve”