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Citation: *R. v. Reliable Wood Shavings Inc.*, 2013 ONCJ 518

Ontario COURT OF JUSTICE

B E T W E E N :

HER MAJESTY THE QUEEN

— AND —

RELIABLE WOOD SHAVINGS INC.

Before Justice Peter N. Bourque
Reasons for Judgment
September 18, 2013

Shantanu Roy ..... for the Crown
John Ilingworth ..... for the accused

BOURQUE J.:

Overview

[1] On July 14, 2009, Glen Gallinger was employed by the defendant Reliable Wood Shavings Inc. ("Reliable") to recover wood shavings and sawdust from a silo at Northern Wide Plank Flooring ("Northern") in Schomberg Ontario. He was the operator of a "blower truck". He was carrying out his task alone. He backed his truck underneath the silo and began to carry out the task of transferring the wood shavings from the silo (above the box of the truck) into the truck. It is the nature of that task which will form the subject matter of this action.

[2] Two employees of Northern went to the silo after a time and could not find Mr. Gallinger. He was eventually found inside the truck box and buried under an amount of

sawdust. Notwithstanding their efforts to locate him, and then revive him, he died later in the hospital.

[3] The defendant is charged with four offences under section 25 of the *Occupational Health and Safety Act* (the "*Act*"). They are offences under sections 25 (1) (c), 25 (1) (a) and 25 (2) of the *Act*.

[4] The Crown has admitted that counts 1 and 2 refer to different parts of section 25 of the *Act* and could apply to the same facts and thus if I make a finding of guilt upon both, then one should be stayed, according to the principle in *Kienapple*.[1]

The Standard of Proof

[5] The offences are "strict liability" and the burden is upon the Crown to prove the *actus reus* of the offence beyond a reasonable doubt. The Crown need not prove *mens rea* on the part of the defendant. If that standard is met, then the defendant may escape conviction by proving, upon a balance of probabilities that every precaution reasonable in the circumstances was taken.[2] As stated in many cases in Ontario, the legislation is to be generously interpreted in a manner that is in keeping with the purposes and objectives of the legislative scheme.[3] However, it must be interpreted in a manner consistent with the procedural rights of the accused.[4]. This due diligence defence "imports a standard of objective reasonableness, an honest subjective belief is not enough. The defence is contextual."[5] The question is not that proving that the defendant took "all" reasonable care, but that that he took all of the care that a reasonable person might have been expected to take in the circumstances.[6]

[1] [1975] 1 R.C.S. 729.
[2] *R. v. Sault Ste. Marie (City)*, [1978] 2 S.C.R. 1299.
[3] *Ontario v. City of Hamilton* (2002), 58 O.R. (3d) 37.
[4] *The Queen v. Brampton Brick*, (2004) 189 O.A.C. 44.
[5] *R. v. Stelco Inc.*, [2006] O.J. No. 3332, at paragraph 29.
[6] *R. v. Rio Algom Ltd.* (1988), 46 C.C.C. (3d) 242 (Ont. C.A.).

Crown evidence

Admitted evidence

[6] On Tuesday July 14, 2009 at 6:00 a.m., Northern, located at 5930 Lloydtown Aurora Road in Schomberg, Glen Gallinger, a worker under the Occupational Health and Safety Act, was employed as a driver by the defendant to engage in the task of transferring sawdust from a silo to the box of a blower truck. Silo/dust collector is a structure where shavings are stored. The defendant is a corporation that purchases and collects wood shaving and saw dust from companies like Northern and delivers material to buyers, such as N.S. Bauman Inc. and occasionally to farmers.

[7] The victim had attended at the workplace in response to notification from Northern, that the silo dust collector was full and needed to be emptied. The victim arrived at site at 5:30 a.m. and was met by two employees of Northern; Hugo Vidella and Omar Vidella who let him into the site. He went to the silo/dust collector. The Videllas went to the flooring plant.

[8] Shortly thereafter the silo emptied. The Videllas went to search for the driver and could not find him. They searched the box of the truck and Hugo went into the truck and dug with hands to find Gallinger. They tried to start the truck, but were unable to move it and they got Shawn Peebles, who was driving by the dust collector, and he moved the truck out of the silo and into an open area. The search for victim continued.

[9] Vidella noticed a remote control switch and a piece of wood sticking out. Hugo Vidella was a carpenter and reported to Brent Peebles (the owner). Omar Vidella was a supervisor/foreman of Northern.

[10] In a subsequent conversation with a Ministry inspector, Omar Vidella advised the inspector that in the past, he noticed loading of trucks but did not stay to observe the total activity.

[11] During the transfer process, Mr. Gallinger became engulfed in a pile of wood shavings and sawdust. Workers found the victim buried in the box and was alive, but he died in hospital on July 15, 2009.

[12] The cause of death was "hypoxic ischemic encephalopathy" as a result of suffocation in a toxic environment, namely the wood shavings.

The Witnesses

Shawn Peebles

[13] The witness worked as a manager at Northern. He described the scene where the silo/dust collector was located apart from the main building which manufactured wood floors. The sawdust and shavings travelled along a metal overhead conduit to the silo/dust collector. He stated that he had seen trucks loading before but did not really watch the process. He described several photographs showing the silo/dust collector which was a tall narrow building with an opening for the truck to back into the building. A door above the truck box, was controlled from a switch box attached to a long chord, which itself was attached to a box on the outside of the silo/dust collector. The witness stated that an employee named Hugo Vidella came to him and needed assistance to move the truck out of the building as he thought the driver of the truck may be inside. The witness went to the area and got in the truck and started the "moving sidewalk" to start moving the sawdust out of the back of the truck, and then moved the truck outside of the building. He continued to unload the truck in this fashion as another employee named Omar Vidella was searching in the back for the driver.

[14] Omar said he found someone and the witness joined Omar in the truck and they pulled Glen Gallinger (the driver of the truck) out of the truck and laid him on the ground. They attempted CPR for some 5 minutes before help arrived but there was no pulse or heartbeat.

[15] The witness described several photographs from the scene. The picture of the truck showed a platform on the top of the cab, overlooking the box. The witness said that he had

seen on occasion, at a different location, a driver standing on this platform while sawdust was going into the truck.

[16] The witness says that the procedures at the plant have changed, and the truck remains under the silo and when the tuck is full, a driver is sent from the defendant company to take the truck away, and leave another truck to be loaded. In other words, the driver of the defendant company no longer participates in the loading of the sawdust into the box of the truck.

[17] The witness also identified a fork on the end of a pole which was found in a pile of sawdust which was beside the truck. He also stated that with regard to the silo, it was an extremely dangerous place, (there had been at least two fires) and being inside the silo underneath the doors was more dangerous. He agreed that nowhere on the silo were there any signs warning of any danger whatsoever.

Hugo Vidella

[18] The witness has worked in several capacities for Northern for several years. He describes that about a week before this incident, he saw the driver Glen Gallinger come into the area in a Reliable truck and pick up a load of wood shavings. The witness did not specifically look at the defendant's actions as he was doing other things. He describes that upon passing, he saw only the legs of the driver inside the truck box. That may be some evidence that the driver was not just inside the box, but also inside the metal front of the shed.

[19] He described generally the operation of the wood chip and sawdust disposal system. The sawdust was drawn by fans from the main building across an enclosed aqueduct and into the silo. There is a light system in the main building to let them know when the silo needs to be emptied. Reliable is called and as the equipment needs to be shut down when the silo is emptied, it is usually done in the morning but it is sometimes done at noon. The driver backs the truck into the silo underneath doors. The first part of the truck is filled first and the driver then pulls the truck forward to allow the rest of the sawdust to fall into the back of the truck.

There is a flail system to dislodge the sawdust but it clearly does not work all of the time, and, in fact, the witness seemed to believe that it did not work very well as it was only in the bottom of the silo, and for it to work, there should have been other flails installed at several points up the silo.

[20] It was his opinion generally that the drivers would stand on a ledge inside the box of the truck and use a long handled fork (about 7 feet long) to cause the sawdust and wood chips to begin to fall from the silo into their trucks. He identified the fork in one of the pictured exhibits. He also said that to get closer to the silo opening, he believed that the drivers would stand on a two-by-six piece of wood placed across the top of the box, partway back from the front. He believed that this would get them closer to the opening. He stated that the piece of wood was placed inside the silo area. He did not observe any of the drivers actually do this but this was his understanding from talking to others.

[21] On July 14, 2009, he stated that he and his son (Omar) got to work at 5:30 and the Reliable truck was there at the gate. They let him in the gate and the truck drove around to the silo as they went into the main building. He stated that his son said that he did not know where the driver was (as the unloading of the silo had stopped). They looked around and eventually the son climbed up the side of the truck box and said he saw the driver in the sawdust pile in the box of the truck. The witness climbed into the back of the box and tried to get the driver out but with the sawdust very much in the air, he could not see and could not breathe. He stated that at some point he saw two broken pieces of wood sticking up from the sawdust in the back of the truck box. He stated that he got out and covered his face with his shirt and tried again but he was again forced out. He tried to move the truck forward out from under the silo but he could not start it. He saw Shawn Peebles drive by and he got him to come and Shawn Peebles moved the truck outside and eventually some distance away. The witness stated that he went into a nearby building (the Quonset hut) and called 911. When he returned to where the truck had been stopped, he saw his son and Shawn behind the truck trying to revive the driver. The fire personnel attended soon after but the driver was dead.

Coroner's Report

[22] The report of the coroner along with a letter from the Centre of Forensic Sciences was filed. It confirms that the driver died from the effects of suffocation, and the report noted the existence of various wood shavings in the mouth, nose and throat of the driver. Also noted was the presence of marijuana in the blood of the driver although it cannot be determined if the driver was suffering any type of impairment.

Wayne Murphy

[23] The witness was an investigator with the Ministry of Labour. He described his role in the investigation. He identified various pictures filed as exhibits in this matter, showing the silo, and the truck where it was left. Of note in his evidence was the finding of two manuals in the truck cab, one was a general employee handbook and a "Safety Policy and Procedure Manual". Both appeared to be accessible and visible to the driver of the truck.

Nicholas Evans

[24] This witness was the lead investigator for the Ministry of Labour. He spoke of his various attendances at the scene and other locations. Based on his interviews with persons at the scene, he came to the conclusion that this event probably happened as Glen Gallinger was attempting to loosen the material stuck in the bottom of the silo. There were no eyewitnesses to the event. Discovered amongst the wood shavings inside and just outside of the truck were two broken pieces of wood, which were clearly a long two-by-six which had broken. The inference is that they were somehow involved in the incident.

[25] Of note he produced in evidence three documents received from the defendant company. One dated March 5, 2008, is an acknowledgement signed by Glen Gallinger of receipt of various documents from Reliable setting out the "Policies and Procedures" at Reliable and how to conduct himself "Professionally". A document confirms a demonstration session held on August 31, 2007 for various protection equipment. The final page contains a document entitled "Loading Procedure at Mill-Blower Trucks".

[26] With regard to the document entitled "Loading Procedure at Mill-Blow Trucks", two of the items are as follows:

> 5. When ready to load, untie straps, climb onto catwalk using 3 point connection (2 feet 1 hand...2 hands 1 foot), then roll tarp;
>
> 8. If material will not fall on its own, climb onto catwalk using 3-point connection and poke up at material to loosen the shavings/sawdust allowing material to fall into truck.

[27] The witness has some difficulty with this directive. It is apparent that the failure of the material to drop is a failure of the equipment. It is obviously not operating according to specifications. The operator has to be within 1 to 2 feet of a 27 foot column of sawdust and wood chips (some 70 to 100 cubic yards of material), and is actively "poking" at the material to loosen it.

[28] The witness issued two "workplace Orders" against Northern and two "workplace Orders" against Reliable. The investigator also visited another site where Reliable drivers pick up wood shavings and sawdust from a gravity fed silo. Of interest is the fact that at this alternate site, there has been recently installed a strap where the driver can attach and prevent him from falling into the box of the truck.

[29] The witness also issued further orders to Reliable and required Reliable to provide a temporary plan to reduce the risk and also provide a risk assessment of the sites. Exhibit 24 was the provision of the interim matters. It is similar to the Exhibit 15 in many ways. It adds a specific admonition for the driver to not get into the box, but it still speaks of reaching with some type of stick from the catwalk to loosen the material. It does not reference some type of tethering device (a strap attached to a beam for example) to actually stop the driver from falling into the box.

[30] The witness interviewed Don Mashinter, the president of Reliable. It was Mr. Mashinter's theory that the driver had put the two-by-six lumber across the truck and sat on it and used the fork to try and loosen the sawdust. That would explain the broken piece of wood found in the sawdust after the accident. Don Mashinter stated that he had specifically admonished the driver Glen not to do that under any circumstances. As part of his

investigation, he noted that some witnesses said that Don Mashinter had advocated for the installation of the "flying Dutchman" device to loosen the material in the silo.

[31] The inspector took several measurements. Filed in this case were descriptive sales material and photos and drawings of the subject truck. Included in the photos and drawings was a device called a "rake". This device is a series of horizontal bars attached by vertical bars. It sits inside the front of the box. It is related to another mechanism which moves material in the box toward the rake. The rake moves back and forth assisting the "blowing" of the sawdust material out from the truck. There is no description of this device in the exhibit which would lead anyone to believe that it was in any way designed to be stood upon.

John Newton

[32] The witness has worked at Reliable for some seven years as a driver. He described that upon being hired, he received a manual but cannot remember the specific documents that he saw. He described that for the first two weeks of his hiring, he would travel with another driver and go to all of the sites to get knowledge as to how to pick up the wood shavings at the various locations, including Northern.

[33] He described Northern in detail and there were a series of photographs (Exhibits 30 "A" through "J") which were taken after the incident with the witness showing various aspects of the job there.

[34] In essence it was his evidence that :

(i) Upon arriving, the truck would be backed under the silo, but not the whole way as there was no room for the whole truck;

(ii) The operator would get the workers to stop the machinery;

(iii) The operator (without any assistance from persons at the scene) would climb up onto the catwalk and then climb into the truck and stand on the second lower rung of the "rake" which was near the front inside of the cab;

(iv) He would use the pendant on the length of electrical cord to open the cantilever doors;

(v) If the material started to come out, he would stand back and let it fall;

(vi) About 95 per cent of the time, the material would not come out and the operator would use a two-by-two stick to poke the material;

(vii) To reach the material, he would stand inside the box of the truck upon a device known as a "rake" which is located near the front of the box;

(viii) He would take the two-by-two stick in two hands, and without being able to see the opening, he would start working at the corners of the hopper and push at the material until it began to come out. He described that the material, would make a sound and if it was fully loosened, it would come out like "water";

(ix) He would have to quickly hit the switch on the pendant to close the doors before the material come over the sides of the truck;

(x) He would then get out of the truck and then pull the truck forward and then get back into the box, this time standing in the middle of the box on top of the material already loaded. He would then open the doors and if the material was again stuck, would use the 2 x 2 stick in the same fashion to loosen the material;

(xi) It would take anywhere from 15 minutes to an hour to prod the material in this fashion before it would fall into the box of the truck;

(xii) The pictures showed his locations. While he was prodding the material and standing on the rake, he was facing the outer wall of the silo and could not see what he was doing unless he lowered his head and then looked up. It would appear that he was not directly underneath the opening of the silo;

(xiii) The rake consisted of horizontal rails a few inches wide. With two hands upon the two-by-two stick, the operator is balancing himself upon this rail;

(xiv) While performing this operation, there are no safety harnesses fitted, at least at this location (there is evidence that after this accident, another location installed safety harnesses to prevent an operator from falling into the box).

[35] He stated that he trained the deceased when he was employed. He stated that some time before the accident, the deceased showed him a fork like object (the witness identified it in the exhibits as being the one located at the scene of the accident in the box of the truck) attached to a long handle and also a long one-by-six piece of wood. The witness stated that the deceased said that he used these items to make it easier to free the materials form the silo. The deceased explained that he would put the board across the top of the box and then sit on

it and reach into the material with the fork and loosen it. The witness indicated that he told him that he thought that the board may not be safe to sit on. The witness did not think that the deceased actually sat underneath the opening of the silo.

[36] The witness indicated that the Northern location gave him the most difficulty. He stated that the silo was clogged 95 per cent of the time. The flail mechanism rarely loosened the material and was a fire hazard. He stated that there was a vibrating mechanism in the silo that was so weak (in comparison to other silos) that it did not help in loosening the materials.

[37] The witness indicated that at another location he would sometimes stand upon the metal railing across the top of the box to dislodge the material, even though that was not the instructed procedure.

Defence

Don Mashinter

[38] The witness is the owner, along with his wife, of the corporate defendant Reliable Wood Shavings Inc. He is in the business of transporting wood shavings and sawdust from mills to other users of the product including farmers and particle board makers. He has been in the business since 1977 and his company has been in business since 1987.

[39] He stated that in 2009 he had 9 or 10 drivers and a total of 15 employees. He now has 6 drivers.

[40] He described several different systems for collecting wood shavings including taking up from the ground and collecting bags of the shavings into a trailer.

[41] He discussed the silo system as it was at Northern. The material goes from the production building through a chute (operated by a fan at the silo) and into the silo from the top. At the bottom is the clam gate and operated by the pendant on the chord.

[42] The witness indicated that he had concerns with the system. He did not like the flail and preferred some type of vibration system to loosen the material. He stated that opening

and closing the doors several times could create some vibration which sometimes helped in loosening the material. He also did not like the fact that when the truck was underneath the silo, there was no room for a person to go alongside the truck and everything had to be done from the front. He also did not like the lighting conditions and some timers were put on the lights. He indicated that he spoke to the owners (on two occasions about some of these concerns) but nothing else was done other than some discussions about a "air blaster" system which the defendant knew nothing about and in any event nothing else was installed.

[43] At this location he described the material as a “dirty wood” and “compacts pretty solid, very fine and dense and hard”. His description of the process to get the material out of the silo and into the truck in a similar fashion to the witness John Newton.

[44] He states that after opening and closing the doors to see if the material will come out, (he admitted that most of the time it didn't), you would have to climb onto the front of the truck cab and then (because of the way the opening was shaped) climb into the bed of the truck and onto the rake. Using a two-by-two 10-foot stick, the operator would “poke” at the material to loosen it. While the job in total should have taken between 20 minutes and half-hour, he described that this poking of the material could on its own take a half-hour. He stated that the doors would not be fully open at this stage and that the material when loosened would come out slowly, and takes some 10 to 20 seconds, at which point the driver would climb out of the truck and control the doors from the ground.

[45] He described that on some occasions when the material was particularly stuck, the driver would get workers to come and assist and they would climb up the outside of the silo and open doors and poke the material in the hope that it would be dislodged.

[46] The witness reviewed his firms Health and Safety Manual (Exhibit 28, Tab 7) which he said was produced by him in collaboration with a health and safety consultant. He stated that all new employees got a copy. He did not refer to any part of this manual in his evidence. He also referred to the employee manual (Exhibit 28, Tab 8) which was also given to each new employee. At page 26 of the manual was a 15 paragraph description of loading procedure at mill - blower trucks. He specifically referred to paragraph 4 (checking for

unfamiliar odours - which was a reference to sawdust fires), paragraph 6 (getting a spotter - which he admitted was a rarity), paragraph 7 opening the hopper doors slowly and with caution and not wider than the truck box - to avoid spillage), paragraph 8 (I will refer to this in detail) and paragraph 9 -move the truck forward to get the rest of the material into the box. The witness described that there was a flail mechanism some 6 feet up the silo which could be used to loosen material above the flail. It could not be used until the material below (some 6 feet) had fallen from the hopper.

[47] In cross-examination, he admitted that to see whether the material had come down up to the flail, the operator would have to bend down to look up the silo. He disagreed with the Crown that he would actually have to move his head forward closer to the opening of the silo.

[48] With regard to item 8, he admitted that at Northern it was impossible to poke the material from the catwalk. The operator had to stand inside the box, on the "rake" and prod the material. He stated that the 3 point contact was still possible if one rested ones posterior upon the side of the box. This procedure was not noted in any of the instruction materials provided to operators (Exhibit 15).

[49] I find this admission telling, as it now puts the operator very close to being underneath the material, and in a position of clear danger, if he cannot get quickly out of the box. It is not just a problem of falling into the box, he is already in the box. I am also somewhat sceptical of his assertion that to check whether the material has cleared up to the flail, you don't need to put your head up under the metal lip and toward the silo.

[50] The defendant spoke of their training procedures and confirmed that the deceased went out five times with experienced drivers to learn the job. He also spoke of the safety equipment in the cab of the truck and specifically that several switches would have to be on to activate the "rake".

[51] The witness spoke of a time in June 2009, where he had heard from the dispatcher that the deceased was using a "new method" to loosen the material in the silo at Northern. The

witness spoke to the deceased and made a memorandum of the conversation the next day (Exhibit 28, Tab 6). He stated that the deceased stated that he would use a fork (shown to the witness and identified by him in Exhibit 6) and sit on a board in the front of the truck over the rake to loosen the material. He was asked if he sat under the hopper and he said no but that he moved it back as the sawdust fell. The witness did not think that it was proper to use the board and told the deceased not to use it. He also stated that the deceased agreed not to use it. He stated that he had a follow-up conversation with the deceased a few weeks before the accident.

[52] On the day after the accident, the witness stated that he was told by Shawn Peebles that an object was found in the sawdust material behind the truck. The witness attended and found in the material the fork which is shown in Exhibit 5 and 6.

[53] Finally, the witness felt that the defendant, on the day of the accident, used a board at the rear of the box to sit on and poked almost below the material. As a result, and not having any three point contact, when the material came down he was engulfed and fell into the box.

[54] The witness in cross-examination admitted that he had a good working knowledge of all of his company's locations and knew of the particular difficulties at the Northern location. He agreed that to dislodge the material was at times a long and hard process and it was not that unusual to presume that his workers may take other steps to make the work easier (He was referred to John Newton's evidence about his steps taken at another location). He also admitted that it was within his power to have insisted that the Northern Prime owners provide a system that functioned properly or he would not buy their material anymore. He never did so. I believe that he was aware that the several factors at the Northern location made this a difficult and dangerous job for his employees, after all he spent some time talking about some recommendations to Northern. He was aware of some steps that could be taken by Northern. There is no evidence of any follow up with them.

[55] Ultimately it was his view that Glen Gallinger had died because he had not followed the procedures (as verbally passed on to him by Mr. Mashinter and others) for standing on the rake and not using the "board". He believed that these oral procedures (which differed

from the written procedures) provided a safe method of dislodging the material at Northern. He was further of the opinion that by specifically telling Glen Gallinger not to use the "board method", that he was fulfilling his responsibilities under the *Occupational Health and Safety Act*.

[56] Finally, he described the present method of retrieving the material from Northern which involves leaving and empty truck under the silo and having the Northern employees empty the silo on a regular basis so that it does not become "plugged" at the bottom. When the truck is full, Reliable is notified and a driver is sent to pick up the truck and leave another to continue taking the sawdust. This method was devised by Mr. Mashinter and was not dictated by the Ministry. In his evidence, the witness indicated that there were economic problems with this method, but there were no details given as to what were the increased costs of this method.

Analysis

The Workplace Scene

[57] Northern maintained a sawmill and wood flooring manufacturing facility in Schomberg, Ontario. In order to vacate saw dust and other wood debris from the manufacturing area, Northern utilized a system whereby blowers were used to transport the debris from the wood flooring building along a chute for approximately 80 to 100 feet into a cylindrical silo. The silo was about 27 feet tall and was fed from the top. The saw dust and other debris fell to the bottom of the tower and the level of the material build up. Depending on the level of activity in the factory, the silo would be full in 3 or 4 days. There was series of lights within the factory to let Northern know when the silo needed to be emptied.

[58] A Northern employee would contact the defendant company and notify them that the silo needed to be emptied. The material would be emptied mainly in the morning, before work at the facility commenced, as all the machinery had to stop to allow the emptying of the silo.

[59] At the base of the silo, there was constructed a steel shed which allowed open topped trucks to back into the shed and underneath the bottom of the silo. The silo had two cantilevered doors, and when opened, the material would fall, by the action of gravity, into the box of the truck. On the outside of the shed was a control panel and attached to the panel was a long electrical chord and at the end was a two button switch, which controlled the opening or closing of the doors. Because the switch was on a long chord, it allowed the operator to be inside the shed (and near the opening of the silo). It should be noted that nowhere on this silo or steel shed was there any notices of any danger, nor was there any posted instructions on how to operate the device.

[60] In theory, the driver need just back his truck underneath the doors and from outside the building, operate the doors and the material would fall into the truck. When the front of the truck was full, it was necessary for the operator to move the truck forward so that the balance of the material would fall into the rear portion of the truck.

[61] As set up on July 14, 2009, no Northern employee was involved in the opening of the doors or the filling up of the truck. This entire task was performed by the driver employed by the defendant Reliable Wood Shavings Inc. There is no indication that the defendant had ever requested Northern to do the loading of the truck or assist in the loading of the truck.

[62] There was a significant complication in the smooth operation of this silo, in that, up to 95 per cent of the time, the weight of the sawdust material (and perhaps moisture content of the material) led to the material "clumping up" at the bottom of the silo, and forming something of a plug. Inserted inside the silo, some 8 to 10 feet from the bottom of the silo was a steel rod with chains attached. It was designed to spin for a short period of time (no more than 10 seconds to prevent heat build-up from the device) and to free up the "plug" and allow the material to drop freely into the box of the truck.

[63] In practice, this device (called a "flying Dutchman" or a "flail") rarely cleared the plug, as by Mr. Mashinter's evidence, the plug was below the flail and the flail would only clear material above it.

[64] I largely accept the evidence of John Newton with regard to his usual practise. I have set out his evidence above. Of importance is the fact that the operator is standing inside the box, on a device (the rake) which is not at designed to be stood upon, placing ones face up against a metal wall, using two hands to hold a two-by-two foot piece of wood and poking at the material for upwards of an hour in different places to get the material to loosen and fall. I find that the operator would at least on some occasions have to stop, bend down to look underneath the metal wall to see the progress of the "poking", and this would by necessity bring the operator closer to the opening of the silo. I also find, from the evidence of Hugo Vidella, that on at least one occasion, the operator of the truck was right inside the metal wall. (He could only see the operator's legs). The operator is thus inside the box of the vehicle, below the opening and anywhere from one to two feet from the edge of the opening of the silo.

[65] It would appear from the evidence (the direct evidence of Hugo Vidella and the existence of broken wood and a seven-foot fork mixed in with the sawdust in the box of Glen's truck), that Glen Gallinger would stand on a rim inside the truck and use the fork to loosen the material and thus allow gravity to break the "plug" and let the material fall into the truck. There was some evidence of a practice he used which allowed the operator to move further into the box by standing partially on the rim of the truck and partially on a two-by-six piece of lumber which would be placed across the width of the box.

[66] The only evidence as to the location of the 2' x6' piece of lumber was that Mr. Gallinger had assured Mr. Mashinter that he was not directly under the chute opening when he used this method.

[67] I believe that I am stating the obvious, that this mass of material had a considerable weight, and had the obvious potential to engulf someone who happened to be underneath it when it fell. The means which had to be used at Northern to get the material to fall into the box necessitated that the operator position himself within 2 feet of the silo opening and poke upwards for times estimated by the witnesses from 15 to 30 to 60 minutes. The location of this shed and silo necessitated that at a minimum, the operator had to get into the box. While there was some noise associated with the fall of material, I do not find that there was any

reliable warning of the potential fall of the material. The material could fall at any time and the contents of the silo could empty in 10 seconds, and at times would "fall like water".

[68] I watched and listened with interest as the witness Mr. Mashinter spoke of the mechanism to release this material. He seemed to be of the opinion that training and experience at this mill would result in a safe environment. I felt no such assurance as I listened to all of the evidence. That a person, standing on the rake, with his face against the metal side of the silo shed, perhaps in the weather, holding a 10 foot stick in two hands and poking (without being able to see) in a mass of material, and somehow relying on his hearing to know when the material is about to fall, so he has time to avoid the fall of material, does not conform to common sense.

The Mechanics of this Accident

[69] No one witnessed the accident. The circumstantial evidence leads to the inexorable conclusion that the deceased, during an attempt to loosen the material at the opening of the silo, somehow fell into the box at the same time that the material fell quickly into the box, engulfing him and covering him so quickly and to such an extent that he could not rise out of it quickly enough to allow him to breath freely. He was asphyxiated by the material.

[70] The witness Vidella stated that when he arrived on the scene, the truck was parked as far as possible into the silo. The witness Shawn Peebles could not remember the location. Accepting Vidella's statement, and accepting the evidence of John Newton as to the usual practice, the accident must have happened when the deceased was filling the front of the box, and he had not pulled the truck out to fill the rear. Based on that information and the other evidence, I find that there were only two methods the deceased could have used to loosen the material namely:

1. standing on the rake inside the box and using two hands on the 2 x 2 stick to attempt to dislodge the material;

2. sitting on the 1 x 6 board across the open box and using the "fork" to dislodge the material.

[71] The fact that the "fork" was found inside the box and also that the broken one-by-six board was found in the material in the box, is strong evidence that the deceased was utilizing the second method.

[72] Notwithstanding either of the above scenario, I find that with regard to *actus reus* of the offence under count's 1 and 2, the offence has been proven. The loading of the blower truck was not conducted in a safe manner.

[73] With regard to counts 3 and 4, they are more fully discussed below under the heading of "due diligence".

Due Diligence

[74] In reviewing due diligence, I am mindful of the words of my brother Justice Paciocco in *R. v. Thomas G. Fuller and Sons Ltd*, 2012, ONCJ 731, where he stated:

> [49] As a matter of law, though, the phrase "all reasonable care" cannot and is not understood to require the accused to take each and every precaution that would be reasonable to take in the circumstances. As indicated, due diligence is a negligence based standard. The pertinent question is whether the accused "took all of the care that a reasonable [person] might have been expected to take in the circumstances.

[75] The following are the specific steps taken by the defendant.

[76] The defendant retained the services of a third party consultant to assist in preparing a safety manual. I find this was commendable especially for such a small business. I note, however, that no one was consulted about a safe means of getting the "stuck" material from the silo and into the truck. The defendant involved himself in safety issues. The owner advocated for some sort of vibrating device to loosen the material. He did not like the flail mechanism.

[77] The owner prepared a direction (Exhibit 15) for what in his opinion was a safe method of unblocking the plugged up material. That direction however, was shown to be something of a "myth" (at least with regard to Northern). The direction speaks of dislodging the material by standing outside of the box and supporting yourself on three point to use the stick

to dislodge the material. Both John Newton and Mr. Mashinter agreed that the standard method of dislodging the material was to stand inside the box on the rake. This puts the driver inside the box when the material starts to fall. Notwithstanding Mr. Mashinter's assertion that you have time to move it, the material starts to move (he said it made some sounds before falling) this was not confirmed by Newton. I cannot find that this material has any regular method of falling. When it falls, it falls. As a further matter, I can't see how anyone could maintain a three point contact with the truck when you're using two hands to poke above you with a stick. Three point contact is a combination of hands and feet.

[78] In and of itself, Exhibit 15 does not, in my opinion, address many issues of safety. Specifically, it may implicitly recognize this material as being dangerous, but it never says so. Item 8 does not specifically tell operators to stay away from the silo opening. It does not warn of the danger of the falling material. The Safety Manual also omits to warn of the inherent dangers of being in the vicinity of 70 cubic yards of material, which may come falling down at literally any time. These materials are clearly defective in this regard.

[79] I can and do also take into account the oral safety procedures as expressed by the defendant and illustrated by John Newton. It augmented the written materials, and for the purpose of arriving at my decision, I take the total procedure (both written and oral) into account.

[80] The owner arranged a safety fall demonstration for the employees, in 2007. I note in the evidence that it was a demonstration of a safety harness, which was not utilized by the company at this or any other location.

[81] The owner specifically told the driver Glen not to use his board method to poke at the material. He states that he spoke to him again, shortly thereafter.

Analysis

[82] It is impossible to know exactly how this accident happened other than to determine that the driver was attempting to dislodge the material which was behaving in its usual fashion, that is, stuck in the silo.

[83] Can I make any findings on these charges without being satisfied how exactly the accident happened? I believe that I can. The charges speak of the steps that can be taken by the employer to protect the worker from unsafe situations, either by training or by taking corrective action to make the work environment safe.[7] The allegations concern the unsafe situation. With regard to the conversation between Mr. Mashinter and the deceased, I think that it should have been something of a "wake-up call" to the defendant, that his oral procedure was very difficult and employees would be searching for an "easier" way. It should, I believe, have led to some form of random "on-site" supervision. Surely Mr. Mashinter, or some other more experienced driver could have attended the same during one of Mr. Gallinger's jobs at Northern.

[84] The argument was raised at the outset that a combination of the particulars in the information and the sections and regulations of the *Act* (specifically sec 56 of the regulations) combined to lead to the conclusion that this case is not maintainable under section 25 (1)(c) of the *Occupational Health and Safety Act*. *R. v. Sheehan's Truck Centre Inc.*[8] deals with this issue, in the context of an injury occurring at a car dealership when employees are moving vehicles (up to sale) on the lot. I believe that case can be distinguished on its facts in that:

(a) the truck being used was the stock for sale;

(b) there was no evidence of material handling on the premises;

(c) there was no evidence that the truck was being used for and processing, manufacturing material movement or other [non sales related] activity;

(d) In our case the truck was being used and it had a material handling capability in the use of the rake and the blower; and,

(e) In our case, the action was indeed happening in the interior of a building.

[85] I must assess whether the method for removal of material as described by Mr. Mashinter and John Newton was a method of removal which could be considered to be reasonable in all of the circumstance. In other words even if Mr. Gallinger died using another

[7] *R. v. St. Lawrence Cement Inc.*, [1993] O.J. No. 1442.
[8] [2001] O.J. No. 4510 (C.A.).

method, is the method described by the defendant such that it constituted "every precaution reasonable in the circumstances".

[86] The defendant argues that if I take into account all of the circumstances in this case, I can find that the "every precaution reasonable in the circumstances was taken". He asks me to consider the reasonableness of the actions of the defendant in the context of the size of his business(it was small), the fact that they were working with the silo owned and controlled by another (Northern), that the system had been working for several years without incident. He pointed out that he had specifically told the deceased not to use the board method, and in the context of his operation (small with less formal structures), that was sufficient oversight of this employee. He believed that this system was sufficient for the employees' protection. I agree that I can take into account all of these circumstances

[87] The defendant argues in this case, that the danger was not in his equipment but at the workplace location of a third party; Northern. He states that he should not bear the same responsibility as if it was a fault in his own equipment. He points out that Northern called them to the premises, let them in and turned off the device to blow the sawdust into the silo. All this is true, but when it came to the operation of the silo, Northern was not present except in very rare cases. Pulling the truck under the silo was done without any direction from Northern. Operating the silo doors was done solely by the Reliable employee. Most importantly, all aspects of manually removing the material from the silo was done by the Reliable employees.

[88] In fact the procedure developed to get the material out was a procedure devised by Mr. Mashinter. He may have spoken to Shawn Peebles about it, but it was his procedure. It places, in my opinion the bulk of the responsibility for the ultimate safety of the manual procedure upon Reliable.

[89] It may very well be that Northern bears a great deal of responsibility in the death of Glen Allan Gallinger. That however does not relieve the defendant of responsibility. The

employee was under the supervision and control of the defendant at all times. Obligations under the statute are joint and several[9].

[90] The relative size of the company can also be taken into account. I agree with the defendant that his company cannot be compared to the resources available to a large steel or other manufacturing concern. Having said that, it cannot be an excuse for a failure to take all reasonable steps in the circumstances. The defendant did in fact give consideration to the proper movement of the material. He was aware that other steps could be taken.

[91] For the following reasons, I find that the procedure as set out by the defendant does not pass the test of every precaution reasonable in the circumstances.

(a) The operator was forced to dislodge material in a "manual" fashion in 95 per cent of the time. This was not just a rare occurrence, this was the everyday occurrence. The hazard occasioned by this was eminently foreseeable;

(b) Nothing about the manual removal was according to any user specifications for the silo device, in other words the designer of the device had not provided a proposed method for manually removing the material (at least there was no evidence of any method);

(c) The method was not in accordance with the written instructions of the defendant. The defendant testified that he had considered and prepared these instructions so the transfer could be done in safety. While he insisted that the ad hoc method was also safe, it would be clear to anyone that staying out of the box is inherently safer than being inside the box.

(d) The rake upon which they were to stand in the box was not designed to be stood upon. There was no level area to stand only a 2" by 2" metal rail.

(e) There was no safety strap or harness system to stop the operator from falling into the box

(f) The method of standing with two hands holding the prodding stick makes a proper 3 point connection impossible. I do not find that leaning the buttocks on the ledge of the truck affords a proper third point for attachment.

(g) Attempting to perform this procedure "blind" without seeing what you are doing is inherently unsafe. How can the operator see any movement of the

[9] R. v. Stelco [1989] O.J. No. 3122.

material? How can the operator know where the prodding stick is contacting the material?

(h) Assuming that the operator must bend down to see then that puts the operator in a most unstable condition and clearly would put him closer to the opening of the silo. As a matter of common sense, how could an operator maintain that type of position for 15 minutes let alone an hour?

(i) The defendant gave no explanation for why he did not press for any of the changes that he spoke about (a proper vibrating mechanism) with Northern.

(j) I believe that I can look at post accident conduct in assessing what was reasonable in all of the circumstances. (*R. v. Dana Canada Corp*., [2008] O.J. No. 4487). What I cannot do is treat them as an admission of liability. I think that it is relevant that the present procedure, leaving a truck at the site which is filled more regularly by Northern personnel thus preventing the plugging up of the device, was instituted by the defendant shortly afterwards and continues to this day. I assume that the defendant pays some economic cost as the truck is tied up for several days at a time, but I had no evidence that its cost was prohibitive.

[92] What I never heard from the employer was his going to the people at Northern and demanding that they install a system that actually worked as designed. Neither counsel could show me a case where the situation was so inherently dangerous, that the employer should not have sent his employees to the site. Clearly, there is a strong economic incentive to allow work to continue. However, as stated by Sharpe J. in *R. v. City of Hamilton*, (2002) 58 O.R. (3d) 37, at par 16:

> [16] 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.

[93] The alternative ultimately was not to buy material from Northern. Surely there could have been a system designed with did not as its core matter, involve a person placing himself within 2 feet of a huge mass of heavy material and balancing himself inside a truck, using

both of his hands to manipulate an ad hoc poking stick to loosen the material with the purpose of having it fall down right beside him.

[94] It is not necessary in this case that I go that far in extending the jurisprudence as I feel that there were options open to the defendant to ameliorate the situation as it existed at Northern. However, I can think of no reason why, in the context of the aims and objectives of the legislation, that an employer, with full knowledge (as was here) of an inherently dangerous and continuing situation created by the failure of the equipment on site to work in any reasonable and safe manner; should not as part of his duty under this legislation, refuse to send his workers into such a situation.

[95] In reaching my conclusions in this case, I am prepared to accept that the preponderance of evidence would lead one to conclude that the driver was sitting on a board across the box and poking the material with his fork. That, in and of itself does not in law relieve the employer of liability. As stated in *R. v. Dofasco Inc.*, [2007] O.J. No. 4339 (ONCA):

> [26] In this regard there seems to be some confusion as to what meaning ought to be attributed to deliberate acts. This does not mean an act by an employee to intentionally injure oneself. That stretches credulity. It does mean however, that on occasion an employee may make a conscious decision to disobey an instruction or work practice in order to get his or her work done. Indeed, that is what occurred in the present instance.
>
> [27] The injury he suffered was as a result of his deliberate act, but it was an act done in furtherance of productivity in the work undertaken for the employer and not for any other reason. To suggest that the responsibility for the injury, pain and suffering rests squarely on his shoulders would be unfair because defects in the process for performing the work in question and the absence of a physical guard contributed significantly to the accident.

[96] I find that even accepting that scenario in the demise of the driver, I can still make findings with regard to these charges. As stated in *R. v. Timminco Ltd.*, "As a policy consideration, where the hazard in question is caused by equipment that the employer has a

special knowledge and control over, it is appropriate that the employer bear the burden of proving a defence".[10]

[97] The actions of the worker in this case, trying to devise an easier method to dislodge this material, is eminently foreseeable in my opinion. In fact, when the deceased spoke to Mr. Mashinter about this method, he described it as being "easier". The prescribed method is extremely hard, even for someone who is physically fit. Holding up and poking with a stick for upwards of an hour must be exhausting to say the least. John Newton testified that at another mill (Millcraft) he went out onto the railing of the truck to dislodge the material. That to was against procedure, but it may have been the only way to get the material to fall. To paraphrase Justice Keast in *R. v. Grant*, "any wrongdoing of the (the worker) is not a defence, unless the actions of the worker are unreasonably foreseeable".[11]

[98] I have found that the actions of the worker, via seeking to dislodge the material in an easier fashion was very foreseeable and thus his failure to follow the employers specific admonition in this regard was not all that was reasonable in the circumstances.

[99] As also stated in *R. v National Wrecking*, [2005] O.J. No. 3538, "155.....finger pointing....will only work when it validly fits into a due diligence defence....the party pointing the finger must take all reasonable steps of their own before finger-pointing will succeed".

[100] The employer did not do what to me is the most logical thing to do and that is to insist that Northern provide a system of loading the material into the truck was worked as advertised. Whether that meant to install a vibrator, or attend when the load was half or less full, or some completely different system is irrelevant. This employer did nothing in that regard. Judging from his evidence in this matter, I don't think he appreciated the danger. He was of the opinion that his employees could cope with this obviously defective and unsafe system.

[10] [2001] O.J. No. 1443, at paragraph 25.
[11] [2002] O.J. No. 3347.

[101] It follows logically from my comments above that I do not think that the defendant has proved to me on a balance of probabilities that every precaution reasonable in the circumstances was taken.

Count 1 and 2

[102] Section 45 (a) Ont. Reg. 851, states:

> Materials , articles or things, required to be lifted, carried or move, shall be lifted, carried or moved in such a way and with such precautions and safeguards, including protective clothing, guards or other precautions as will ensure that the lifting, carrying or moving of the material, articles or things does not endanger the safety of any worker.
>
> Section 45 (c) Ont. Reg. 851 states:
>
> Material, articles or things, to be removed from a storage area, pile or rack, shall be removed in a manner that will not endanger the safety of any worker.

[103] Section 25 (1) (c) *Act* states:

> An employer shall ensure that, the measures and procedures prescribed are carried out in the workplace.

[104] The defendant will be found guilty on both counts but as per the dictum in *R. v. Kienapple*, count 1 will be stayed.

Count 3

[105] Section 25 (2)(a) of the *Act* states:

> Without limiting the strict duty imposed by subsection (1) and employer shall, provide information, instruction and supervision to a worker to protect the health or safety of the worker.

[106] The information provided consisted of the onsite training with another driver for a week, the provision of the direction for the loading procedure (Exhibit 15), and the two manuals. The defendant spoke to the deceased about the issue of the board method of poking

the material in the silo. The fact that the method used at Northern was not contained in any written material, and in fact was quite different from the material makes it difficult for the defendant to show compliance with this section. The fact that I have found that the verbal method employed at Northern has not been shown to constitute due diligence on the part of the employer makes it doubly difficult for the employer to comply.

[107] The defendant will be found guilty on count 3.

Count 4

[108] Section 25 (2) (h) states:

> Without limiting the strict duty imposed by subsection (1) and employer shall take every precaution reasonable in the circumstances for the protection of a worker.

[109] Notwithstanding arguments raised by the defence, the factual and legal findings that I have made above would lead to a finding of guilt on count 4. I specifically find that the steps taken by the defendant do not constitute any precaution reasonable in the circumstances.