WCAT Decision Number: WCAT-2013-00703
WCAT Decision Date: March 14, 2013
Panel: Warren Hoole, Vice Chair
Andrew Pendray, Vice Chair
Sherryl Yeager, Vice Chair

Introduction

[1] In February 2009 the appellant employer, a large construction company, was in the midst of preparing a rock slope site (the worksite) for installation of a run-of-river hydroelectric project. Specifically, the employer's workers were engaged in drilling, blasting and scaling the rock slope.

[2] On the morning of February 21, 2009, the employer suspended its construction operations on the worksite due to a "near miss" incident. In an internal investigation report regarding that "near miss" incident, the employer described a situation in which a rock had travelled down the rock slope and struck a hoe drill located on the lower portion of the worksite, causing an estimated $65,000 in damage to the hoe drill. The root cause of the rock fall was identified by the employer's internal investigation report as being due to an excavator having been engaged in work on a heading of the worksite which was above the area being worked on by the hoe drill (and its associated crew). The employer's internal investigation report set out that as a result of the February 21, 2009 incident a new job hazards analysis had been created, and that from that point forward only one heading on the worksite would be worked at a time.

[3] The following day, February 22, 2009, construction operations on the worksite resumed.

[4] On that same morning, a young worker employed at the worksite as a rock scaler tragically died when he was struck by a rock measuring between 5 and 6 feet in diameter. The rock had rolled down the rock slope into the area of the worksite in which the young worker was completing some rock-drilling activity.

[5] In the immediate aftermath of the young worker's death, the Workers' Compensation Board, operating as WorkSafeBC (Board), issued an inspection report[1] in which it issued an order citing the employer for violating section 20.97 of the *Occupational Health and Safety Regulation* (Regulation) to the *Workers Compensation Act* (Act), which requires that scaling and like work must be undertaken from the top down, and that any area into which material will fall must be kept clear of workers and equipment. The employer did not request a review of that order.

[1] IR 2009113820051, dated February 24, 2009.

[6] After investigating the circumstances of the young worker's death, the Board concluded that the employer had committed further violations of the Act and the Regulation. The Board issued orders to that effect in two separate inspection reports dated March 31, 2010[2]. Again, the employer did not request a review of the orders set out in those inspection reports.

[7] Subsequently, in an inspection report dated March 31, 2011[3], the Board informed the employer that it had, pursuant to section 196 of the Act and Board *Prevention Manual* (Manual) item D12-196-6, determined that the circumstances of the young worker's death and the employer's February 22, 2009 violations as identified in the prevention orders warranted a "presidential" administrative penalty in the amount of $250,000 (the penalty order). Presidential penalties are substantially higher than the usual penalty options available to the Board, and may only be imposed where the employer has committed a high risk violation wilfully or with reckless disregard; and a worker has died or suffered serious permanent impairment as a result.

[8] The employer objected to the imposition of the presidential penalty, and requested a review of the Board's March 31, 2011 decision. In *Review Reference #R0130850*, a review officer confirmed the amount of the penalty levied by the Board.

[9] The employer now appeals *Review Reference #R0130850*. On appeal, the employer takes the position that it did not act either wilfully or with reckless disregard in committing the violations identified by the Board in the above-noted investigation reports. Further, the employer argues that the evidence does not support a conclusion that the violations that it committed resulted in the young worker's death. As a result, the employer says that a penalty in the amount of $250,000 was inconsistent with Board policy, and ought not to have been imposed.

[10] Also participating in the appeal are the young worker's family and trade union. In addition, the Board provided submissions in response to the employer's position.

[11] We considered whether the employer's appeal should proceed by way of written submissions (the method of hearing requested by the employer) or oral hearing. In our view, there is little dispute about the underlying facts of the appeal. Rather, the dispute turns on how these facts are applied to the Act and applicable policy. These issues may be as effectively addressed through written submissions as through oral submissions. The employer's appeal may fairly proceed by way of written submissions.

[2] As set out in Inspection Report 2010110870023 and Inspection Report 2010110870022.
[3] Inspection Report 2011110870029.

Issue(s)

[12] What is the proper quantum of the penalty order?

Jurisdiction and Procedure

[13] The Workers' Compensation Appeal Tribunal's (WCAT's) jurisdiction in this appeal arises under subsection 239(1) of the Act, as an appeal of a final decision of a review officer under paragraph 96.2(1)(c) of the Act confirming a Board order respecting an occupational health and safety matter under Part 3 of the Act.

[14] Pursuant to subsection 238(5) of the Act, the WCAT chair appointed a three-member panel to hear the employer's appeal.

Background and Evidence

The worksite

[15] In February 2009 the employer was preparing a hill in order that a penstock could be installed on the worksite. In essence, this involved increasing the angle of the slope of the hill to facilitate the installation of a large pipe to transport water to a hydroelectric station.

[16] In the Board's investigation report of the February 22, 2009 incident (the Board investigation report), the preparation of the worksite for that penstock installation was noted to have been approximately 51% complete by January 2009. The Board inspection report set out that the employer's intention was to achieve, through blasting and scaling, an 87% slope profile on the steepest portion of the mountain for installation of a 256-metre penstock. The Board noted that the activity undertaken by the employer in preparing the rock slope had been to have excavators clear and scale organic and blasted material from work areas and roads on the worksite, and to have those excavators cast much of the material down the slope (generally to one side of the slope[4] due to the topography of the mountain, which provided a natural chute that carried material away from the planned area for the penstock installation).

[17] Prior to the February 22, 2009 incident, the employer had contracted an engineering firm to advise its personnel on the rock slope excavation and blasting design and on slope stabilization measures.

[4]From the bottom of the rock slope looking up, the materials generally were cast down the right side of the slope. The penstock installation was to take place on the left side of the rock slope site.

[18] In a September 11, 2008 report, the engineering firm indicated that the full height of the face and crest of the rock slope required scaling to remove loose blocks that could be potential sources of rock fall.

[19] The Board investigation report sets out that the work that was being completed on the worksite involved crews working at two headings (benches)[5] of the rock slope. The Board indicated that the drill and blast crew would generally work on one bench, while the earthworks crew would simultaneously work on another bench. Between February 5 and February 20, 2009, blasting at the Bench 4 area had lowered the elevation of that bench from 236 to 221 metres.

[20] Geotechnical engineers from an engineering firm attended the worksite on three occasions in February 2009 prior to the February 22, 2009 accident.

[21] In a February 8, 2009 report, the engineering firm noted that it had attended the rock slope site from February 2 to 5, 2009, and that blasting conducted on February 4, 2009 had exposed a final wall that required review at the next site visit to determine necessary support measures. The engineering firm indicated that it was:

> recommended to remove potentially unstable blocks at the crest using an excavator

[22] The engineering firm was on site again from February 12 to 14, 2009. In a February 17, 2009 report, the engineering firm recommended rock anchor bolting to stabilize some of the new rock face that had been exposed above Bench 4.

[23] The engineering firm was again on site from February 17 to 20, 2009. The February 22, 2009 engineering report sets out that the employer's personnel were on site during that period of time and that discussions had been held on the proposed stabilization measures for the rock face above Bench 4, as well as on the issues of controlled blast design and construction schedule. The engineering firm recommended again in that report that the full height of the rock face from 221 to 238 metres (above Bench 4) be scaled, that anchors be installed, and that a large boulder located uphill from Bench 4 that was in the way of the future penstock installation point be removed. Figure 1 of the February 22, 2009 engineering report provides a clear picture of Bench 4, the newly exposed rock face above Bench 4, and the location of the rock anchor bolting above that face that had been proposed in the February 17, 2009 engineering report, near the tree line, at an elevation above 246 metres.

Prior incidents at the worksite

[24] The February 22, 2009 accident was not the first rock fall incident at the worksite.

[5] The two benches are generally referred in the evidence as Bench 4 and Bench 21, with Bench 4 being up the slope from Bench 21.

[25] As set out in the Board investigation report, on February 8, 2009, shortly after a blast, a rock had rolled down the slope and struck an excavator, causing less than $2,500 in damage. The Board noted that in response to this incident the employer built a catchment berm below Bench 4 to contain falling rocks, and also had supervisors monitor the worksite.

[26] The Board investigation report noted that subsequent to the February 8, 2009 incident, the supervisory personnel at the worksite had frequently documented the hazards of loose rock and the potential for rock fall incidents during their daily crew meetings, and had reminded the crew of the controls for these hazards in pre-task instructions (these controls included being aware of the hazard, using a spotter to alert others of rock movement, and obtaining clearance before travelling on roadways on the worksite).

[27] On February 21, 2009, another rock fall incident occurred. On that date, workers were engaged in work activities on Bench 21 while an excavator operator was working near the Bench 4 access road (uphill from Bench 21) casting loose material downhill. One of the employer's supervisors observed a large boulder (estimated to be 5 feet in diameter) rolling down the hill from the area in which the excavator was working. The boulder landed near the two drills positioned to work on Bench 21, striking a hoe drill and causing an estimated $65,000 in damage.

[28] In its internal incident investigation report of the February 21, 2009 rock fall incident, the employer set out that there had been a number of witnesses to the rock fall, including the young worker. The employer's internal incident investigation report described the rock fall as a rock having been dislodged by an excavator working on a higher level of the worksite, travelling down the rock slope, taking an "unusual path," and striking the hoe drill. The report noted that on prior occasions, work had been done as it had been on February 21, 2009 (that is, work being completed by excavators at an area of the worksite above where other work was being completed below) with no rock falling and taking that "unusual path" or falling into the area where the hoe drill was located.

[29] As set out in the Board investigation report, after the February 21, 2009 incident the employer's construction manager ordered that work cease at the worksite until a new work plan could be developed to prevent a recurrence of a fall such as that which occurred on February 21, 2009. Notably, the Board interviewed the employer's earthworks engineer[6], and the earthworks engineer stated that at the safety stand-down meeting that occurred after the February 21, 2009 rock fall incident, it had been determined that no upslope work would occur above crews working on the rock cut, and that new written work plans and revised job hazard analysis sheets were developed to reflect that change in practice.

[30] Under the heading "Corrective Actions," the employer's internal incident investigation report of the February 21, 2009 incident set out that:

[6] Subsequent to the February 22, 2009 incident.

> ***New JHA** [Job Hazards Analysis] **created. All work in lower bench stopped[,] only one heading on cut will be worked from this point forward. Work was shut down for rest of day/workers directed to update workplans and JHA.***
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> [emphasis in original; underlining added]

February 22, 2009

[31] Work resumed at the worksite on February 22, 2009. The earthworks crew determined that the excavator operator would commence his day by clearing Bench 4 of blasted material, and that he would subsequently move farther uphill to prepare that terrain for future drilling activity. Of note, the excavator operator indicated in his interview with the Board that he had not checked the terrain uphill of Bench 4 for unstable material prior to commencing his planned duties on February 22, 2009.

[32] The hazard analysis form completed by the earthworks crew on February 22, 2009 noted the existence of the hazard of rolling rock as a result of excavation work being carried out above other workers. The preventative measure identified in the hazard analysis form for the earthworks crew on that date was to not " work above others."

[33] The young worker and his brother arrived at the worksite and commenced their work day by undertaking some hand-drilling, scaling, and dusting (with an air wand) above Bench 4 near the crest of the rock slope. They were subsequently told to stop scaling in that area, however, due to the fact that there were other workers undertaking drilling work below them on Bench 4. The blast engineer directed the young worker and his brother to hand-drill the large boulder located just above Bench 4, as recommended by the engineering firm.

[34] While the young worker and his brother undertook the task of hand-drilling the boulder above Bench 4, the excavator operator finished clearing above Bench 4 and then moved the excavator above the crest of the rock slope to conduct further work (as directed by the earthworks foreman). The excavator was several hundred feet to the right of the young worker and his brother at the time of the fatal incident.

[35] While this work was going on at Bench 4 and above, the earthworks superintendant was providing traffic control at the base of the hill to keep personnel from entering Bench 21 or the main access road.

[36] In his interview with the Board, the excavator operator described his work above the crest of the rock slope as involving gathering small rocks in an area approximately 50 metres upslope from the crest of the slope, and approximately 20 metres from the tree line. The excavator operator indicated that while he was working in that area it had

started to rain at a moderate rate, and that he had noted some wet material sloughing from the banks that he was working on.

[37] The excavator operator stated that while completing this work he noticed, to the left of his machine and somewhat downhill, a rock of approximately 5 to 6 feet in diameter rolling on some rough ground just above a level of smoother ground that had been scaled approximately one month earlier. The excavator operator indicated that he lost sight of the rock briefly, but that he had then observed that the rock had continued to roll down the slope. The excavator operator stated that he had therefore used his radio to warn the drilling crew located at Bench 4 that there was a rock coming toward it.

[38] The young worker was engaged in hand-drilling the large boulder just above Bench 4 at that time. As a result, he was wearing hearing protection and did not have a radio. Unfortunately, while those around him did hear the radio warning from the excavator operator and did attempt to notify him, the young worker did not hear the warnings. He was struck by the rock that the excavator operator had observed rolling down the slope.

[39] The witnesses recounted, as noted in the Board's investigation report, that the rock partially fragmented after striking the young worker and the boulder above Bench 4 that he had been drilling, and that the rock then struck the hoe drill positioned on Bench 4.

[40] In its internal incident investigation report of the February 22, 2009 rock fall[7], the employer set out that on the morning of February 22, 2009, the excavation team working on the rock slope had held a meeting in which it was emphasized that:

> *no work should take place above other workers as a result of the near miss incident the day prior, as discussed during the Shut Down Meeting. At the conclusion of the meeting, the Excavation Team confirmed that it would clear off the loose materials from Bench 4 to allow the Drill and Shoot and the Excavation Team would work*

[41] The internal investigation report indicated that the excavation team arrived at the worksite at approximately 6:30 a.m. and commenced work clearing rock off of Bench 4 at that time. The excavation team continued to work on clearing Bench 4 (with one break to allow others to pass by on the access road below) until sometime between 9:30 a.m. and 10:00 a.m. The employer's internal investigation report set out that:

> *Sometime after 9:30 am, [Mr. T, the excavator operator] had completed clearing Bench 4 and had moved his excavator to the vertically higher location between PI 28 and PI 27, above where [the young worker] and his brother, [Mr. A], were drilling the boulder .*

[7] Completed by the employer on March 22, 2009.

> *At approximately 1:00 pm, [Mr. T] noticed a large boulder start to move in the vicinity of the tree line. According to [Mr. T], the boulder initially appeared to stop moving but then resumed its path and started moving towards the edge of PI 28. For a brief period, [Mr. T] was not able to see the entire rock as it was partially obscured by the organic materials that had been stockpiled to the west of his excavator. [Mr. T] then noticed that the rock was following a natural trough in the geography at PI 28 that flowed down the slope and into the area where [the young worker] was working below. It became apparent to [Mr. T] that the rock would not stop, once it moved onto the previously machine scaled slope and he immediately radioed a warning to the workers below. [Mr. A] and [Mr. C] were standing at the hoe drill directly below the boulder on which [the young worker] was working and heard the warnings from [Mr. T] over the radio . Immediately prior to the time of impact, [Mr. A] and [Mr. C] tried to verbally warn [the young worker], but their efforts were not successful .*
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> *While the exact location of [Mr. T's] excavator at the time of impact is not known, the photographic evidence places [Mr. T] working in the organic materials up to the tree line of the [location] on the day in question.* ***These activities may have disturbed the surrounding ground conditions.*** *Further, it was raining for the first time in several weeks and the temperature was such that there was significant thawing occurring.* ***All of these factors, including the blasting activities that took place some time prior, could have contributed to the release of the rock that ultimately killed [the young worker].*** *The possibility that the rock was struck by the machine and placed in motion does not seem to be supported by the evidence gathered to date. Additional monitoring of upslope areas, above workers, is being considered.*
>
> [bold emphasis added]

Board investigation

[42] In the Board investigation report, the Board concluded that the worksite had many areas in which workers and other road users were exposed to unstable or loose materials. The Board noted particularly that in the area above Bench 4, there were numerous loose rocks of varying sizes evident on the face of the rock cut, in close range of the crest of the hill and within the 50-metre area uphill from the crest of the hill.

[43] We note that a review of the photographs of the worksite confirms the Board's observations in this regard. The employer does not seriously dispute the Board officer's conclusions on this point.

[44] The Board inspection report also noted that there was unstable rock and debris in the area below the Bench 4 access road.

[45] Again, we note that a review of the photographs obtained by the Board confirms those observations and the employer does not seriously contest this point.

[46] After completing its investigation, the Board concluded that the evidence did not support a conclusion that the excavator operator had struck the rock involved in the fatal February 22, 2009 incident directly or indirectly through striking another object. The Board further concluded that it could not determine whether the excavator operator had disturbed the rock or the surfaces the rock was close to when he had engaged in scaling some area near the tree line or when he had stripped some overburden from the area in the hours prior to the incident. The Board concluded that:

> It is possible, that while he worked in proximity to the rock, he had previously disturbed it or the underlying or adjacent materials and did not realize that he had done so. It is also possible that some other equipment operator working on a different crew may have disturbed the rock on a previous occasion when brush and forest debris was removed.

[47] The Board further went on to note that prior logging activity, recent blasting operations, vibration transmitted through the ground by drilling, and the change in seasons could all have affected the surface stability of objects in the area.

[48] The Board ultimately concluded that the underlying factors in the February 22, 2009 incident and fatal accident were:

- Loose material hazards upslope from work areas;
- Deficient safety planning and supervision; and
- Lack of effective risk assessment.

[49] The four violation orders issued to the employer on March 31, 2010 were for violations of the following:

- Section 4.1 of the Regulation, which requires that a workplace must be planned, constructed, used and maintained to protect from danger any person working at the workplace. The Board determined that the employer had conducted work processes simultaneously in locations above and below each other on various slopes that were not adequately maintained to control the hazards from movement of unstable materials.
- Section 21.42 of the Regulation, Pre-drilling Requirements. The Board determined that machine-drilling and hand-drilling on Bench 4 (and the boulder above) began

without first clearing loose material uphill that had the potential to fall and inflict injury.

- Section 115(2)(a) of the Act. The Board determined that the employer had failed to correct known workplace conditions, specifically unstable materials that were repeatedly identified in risk assessments done over a period of several weeks that were hazardous to the health and safety of the employer's workers.
- Section 115(2)(e) of the Act. The Board determined that the employer had failed to provide an effective system to ensure through site assessment that scaling was conducted and that the employer did not have in operation an effective scaling plan. The Board further determined that the employer had not effectively instructed and trained its workers to ensure that unstable materials were removed or stabilized prior to conducting work in locations where the material of unstable materials posed a hazard. Finally, the Board determined that the employer directed its workers to work in areas made hazardous by the presence of unstable materials and where their work activity could cause unstable materials to move to active work areas downhill. In short, the employer did not take reasonable measures to ensure worker safety.

Recommendation for Administrative Penalty

[50] In the March 22, 2011 Recommendation for Administrative Penalty report, the Board officer indicated that she was of the view that the employer knew of the presence of unstable materials; was aware of the risks the unstable materials presented to workers; and understood the applicable safety requirements. The officer concluded that:

> The evidence demonstrates the employer had control of the construction activity at the site and the opportunity, knowledge, resources and ability to safely manage and remedy the unstable material hazards. However, the employer did not institute effective controls and take reasonable measures to effectively manage, minimize or eliminate the hazards. The evidence further demonstrates the employer had experienced supervisory personnel at many levels of supervision involved with the work. However, the unsafe conditions and practices persisted despite their active presence and direction at the worksite.
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> These violations, together, created a high risk of serious injury or death to several workers. The employer committed the violations knowingly and with reckless disregard for worker safety. **The violations caused the young worker's death.**
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> [emphasis added]

[51] In support of her conclusions that the employer had acted with reckless disregard, the Board officer pointed to the fact that the employer was a large, sophisticated employer, with significant experience not only in blasting and scaling activities, but also with

respect to construction of run-of-river hydroelectric projects. The Board officer indicated that despite this experience and level of sophistication, the employer had permitted excavators to scale material uphill while workers were working below them, in terrain that was steep and had many unstable materials present. The Board officer set out that, on that basis alone, she considered the employer to have exhibited reckless disregard for worker safety.

[52] The Board officer further pointed to the fact that the employer had updated its work plan subsequent to the February 21, 2009 rock fall incident with the apparent intention of not having any work down below until the work uphill was completed. The Board officer noted that despite this fact the employer had workers working below the level of the excavator on February 22, 2009. She concluded that:

> In light of the events of February 21, 2009, the potential consequences of [the employer's] work practices ought to have been obvious to its supervisory personnel. That incident, which caused significant damage to equipment downhill, is a basis to conclude that [the employer] must have foreseen the potential consequences to its workers if it were to be repeated. Nevertheless, and in spite of written recognition of that hazard, work proceeded essentially as it had before without sufficient safety controls being implemented. A reasonable employer in [the employer's] position following the events of February 21, 2009 would have realized the significant probability a similar incident could occur with a substantial risk of harm to its workers. [The employer] took entirely insufficient steps to prevent that likelihood. In this regard, I consider [the employer's] conduct in failing to implement sufficient measures to be a marked departure from what I would consider to be the conduct of a reasonable employer.

[53] In concluding that a presidential penalty was warranted, the Board officer again noted what she considered to be the employer's failure to take appropriate steps in light of the readily apparent hazard posed by rocks and other unstable materials at the worksite, the employer's history of incidents and near misses (at various other projects), and the fact that the employer was of such a size that the presidential penalty would not have an unduly harsh financial impact, noting its 2008 combined payroll (across four classification units) of $82,370,258. The officer noted that in the classification unit applicable to the worksite, the employer's 2008 assessable payroll was $33,004,017, which would lead to a Category A penalty of $75,000, with a maximum 30% upward variation leading to a penalty of $97,500.

Review Division

[54] In its submissions to the Review Division, the employer took the position that while a Category A penalty was warranted for the February 22, 2009 violations, a presidential penalty was not. The employer indicated that it would leave the issue of variance to the review officer.

[55] In upholding the presidential penalty, the review officer in *Review Reference #R0130850* noted the four orders in the March 31, 2011 inspection report which were determined to have been causative of the February 22, 2009 incident, and concluded that while in his view the employer could not be said to have acted wilfully in committing the violations identified, it had acted with reckless disregard.

Submissions

[56] The employer indicated that it agreed with the review officer that it had not acted wilfully in committing the violations that caused the death of the young worker. The employer submitted further that it had not acted with reckless disregard in committing those violations, and that as such a presidential penalty was not warranted. Further, the employer submitted that a reasonable person in its position on February 22, 2009, without the benefit of hindsight, would have assumed that it was safe for the young worker to scale the boulder just above Bench 4 on that date. In this regard, the employer submitted that the engineering firm had not informed it that further scaling was required in the area above the rock face. In short, the employer submitted that it was not reasonable to foresee the risk of that rock falling on February 22, 2009, either on an objective or subjective standard.

[57] Finally, the employer argued that even if it were to be found to have acted with reckless disregard, the evidence fell short of showing that its actions in that regard "resulted in" the young worker's death on February 22, 2009, thereby precluding a presidential penalty.

[58] The union submitted that a presidential penalty was not appropriate given the employer's prior demonstrated commitment to safety.

[59] The family of the young worker submitted that the employer ought to have realized that its failure to take steps to ensure the safety of its workers were likely to cause injury or death to the young worker. The family submitted that the employer had not cared about that likelihood, and that as a result the young worker was killed. In the family's submission, the employer's failure to abide by the new work plan following the February 21, 2009 incident demonstrated a reckless disregard for the young worker's safety and caused the young worker's death.

Reasons and Findings

Preliminary issues

[60] There are two items which arise from the submissions of the parties which need to be addressed prior to providing our reasons on the appropriate quantum of the penalty in this case.

[61] The first item arises from the employer's submissions as to the appropriate standard of proof to be applied in this appeal. The second item arises from the worker's provision of a September 15, 2012 report (the Louvros report) which it submits ought to be accepted as expert opinion evidence. The employer objects to the Louvros report being accepted as evidence at all, let alone expert opinion evidence.

Standard of proof

[62] The employer has argued that the standard of proof to be applied in determining whether its actions in committing the violations identified by the Board caused the young worker's death should in fact be something beyond the balance of probabilities, but short of the criminal standard of beyond a reasonable doubt.

[63] In support of this submission, the employer has cited the case of *Jory v. College of Physicians and Surgeons of British Columbia*, [1985] B.C.J. No. 320 (BCSC). In that case, the complainant physician had been convicted by the council of the College of Physicians and Surgeons of "infamous conduct," following an inquiry. The B.C. Supreme Court overturned that conviction, and in so doing applied the legal standard of proof of "clear and cogent evidence" to its consideration of the evidence. That standard of proof has been described by this province's Court of Appeal as being "close to, but not beyond reasonable doubt,"[8] and has been regularly applied by professional bodies (such as the College of Physicians and Surgeons and the Law Society of British Columbia) engaged in professional conduct reviews.

[64] For a time, the courts of British Columbia also applied the "clear and cogent" evidence test as the applicable evidentiary standard in civil trials involving allegations of sexual assault. As was noted in the case of *B.G. v. British Columbia*, 2003 BCSC 1890:

> [118] The plaintiffs must prove on a balance of probabilities that they were physically and sexually assaulted. However, allegations of sexual abuse in civil proceedings are subject to a heightened evidentiary standard. This was discussed in the recent case of *Gorman v. Tyhurst* (2003), 13 B.C.L.R. (4th) 81, where the Court noted that in civil cases involving morally blameworthy conduct, the serious nature of the allegations and the often considerable delay between the events and the trial gives rise to certain evidentiary implications. At para. 6 Huddart J.A. stated:
>
> > The common law recognizes these and other difficulties, in cases where morally blameworthy conduct is alleged, as well as the gravity of the consequences, by demanding an exacting analysis of the evidence and a standard of proof on the balance of probabilities commensurate with the occasion: *Bater v. Bater*, [1950] 2 All E.R. 458 (C.A.) at 459; *Continental Insurance Co. v. Dalton Cartage Co.,* [1982] 1 S.C.R. 164 at 171;

[8] *K. (I.F.) v. College of Physicians and Surgeons of British Columbia*, 1998 CanLII 4713 (BCCA).

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> *R. v. Oakes* (1986), 26 D.L.R. (4th) 200 (S.C.C.) at 226; *M. (J.L.) v. H. (P.)* (1997), 31 B.C.L.R. (3d) 155 (S.C.) at paras. 117-120.
>
> [119] It has consistently been held that the "clear and cogent" standard is the applicable evidentiary standard where allegations of sexual or physical abuse are raised in a civil trial: See *V.(J.L.) v. H.(P.), supra, B.(M.) v. British Columbia, supra,* and *H.F. v. Canada (Attorney General), supra*.

[65] However, the Supreme Court of Canada has now rejected this separate evidentiary standard. In *F.H. v. McDougall*, 2008 SCC 53 (CanLII), a unanimous court expressly rejected the argument that in civil cases involving particularly grave allegations against a defendant (such as sexual assault), the court ought to apply a higher degree of probability which was commensurate with the situation at hand. The court concluded that:

> **40** Like the House of Lords, I think it is time to say, once and for all in Canada, that there is only one civil standard of proof at common law and that is proof on a balance of probabilities. Of course, context is all important and a judge should not be unmindful, where appropriate, of inherent probabilities or improbabilities or the seriousness of the allegations or consequences. However, these considerations do not change the standard of proof .
>
> **45** To suggest that depending upon the seriousness, the evidence in the civil case must be scrutinized with greater care implies that in less serious cases the evidence need not be scrutinized with such care. I think it is inappropriate to say that there are legally recognized different levels of scrutiny of the evidence depending upon the seriousness of the case. There is only one legal rule and that is that in all cases, evidence must be scrutinized with care by the trial judge.
>
> **46** Similarly, evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test. But again, there is no objective standard to measure sufficiency. In serious cases, like the present, judges may be faced with evidence of events that are alleged to have occurred many years before, where there is little other evidence than that of the plaintiff and defendant. As difficult as the task may be, the judge must make a decision. If a responsible judge finds for the plaintiff, it must be accepted that the evidence was sufficiently clear, convincing and cogent to that judge that the plaintiff satisfied the balance of probabilities test.

[66] In our view, the reasoning of the Supreme Court of Canada in *McDougall* is controlling.

[67] We do not consider that a case involving an administrative penalty or fine should receive some higher level of scrutiny than a case in which an employer has simply been cited for a violation without receiving a fine. We consider that in all cases, the evidence before the panel must be scrutinized with care. The standard of proof does not vary with the gravity of the misconduct alleged or the seriousness of the consequences for the person/employer concerned. We therefore conclude that the applicable standard of proof in this case is that of a balance of probabilities.

[68] We note further in this regard that section 196(3) of the Act provides that administrative penalties will not be imposed if an employer has exercised due diligence to prevent the circumstances that have led the Board to consider that an administrative penalty is warranted. The Board's Manual item D12-196-10 sets out that the Board will consider that the employer has exercised due diligence if the evidence, on a balance of probabilities, shows that the employer took all reasonable care. WCAT is, of course, required to apply the published policy of the board of directors of the Board in making its decision, subject to the application of section 251 of the Act.

[69] In our view, it would make little sense for the employer to be able to avoid having to face an administrative penalty by proving, on a balance of probabilities, that it had been duly diligent, while at the same time the Board was required to prove that the employer's actions had resulted in the worker's death on some more stringent standard of proof.

The Louvros report

[70] As part of its submissions, the family attached a September 15, 2012 report from Mr. Peter Louvros. Mr. Louvros indicated in that report that he had 25 years of experience working in the slope stabilization industry, had developed training programs for new scalers for more than 15 years, had been previously accepted as an expert witness in a wrongful death suit in determining the origin of a 5 foot diameter rock that had struck an individual, and authored a manual on slope stabilization safety procedures.

[71] The family requested that Mr. Louvros' report be accepted by the panel as expert evidence, while the employer submitted that Mr. Louvros' report was irrelevant, biased, and ought not to be considered by the panel.

[72] Based on Mr. Louvros' background, it would appear that he would be an appropriate individual to accept as an expert in the field of slope stabilization. However, there are significant issues with his report that limit the weight that can be given to his evidence in this case.

[73] The most glaring issue with respect to Mr. Louvros' report is found within the section of the report entitled "Employment with [the Employer]." Commencing on page 2 of the report, Mr. Louvros indicated that he had previously worked for the employer from 2006 to 2008 and that he had found himself in "a constant battle" with the employer's

management regarding rock fall safety concerns and that the employer generally had not wanted to spend what he considered to be sufficient money on rock-scaling efforts. Mr. Louvros indicated that he ultimately resigned his position with the employer in 2008 due to what he viewed as its lack of support for his rock-scaling and stabilization division.

[74] While there is nothing set out in WCAT's *Manual of Rules of Practice and Procedure* regarding the need for expert witnesses to be unbiased or impartial, in our view, an expert opinion that reveals bias is less entitled to weight. We note in this regard page 624 of Mr. Justice Sopinka's *The Law of Evidence in Canada*, 2nd Edition. We also note rule 11-2 of the *BC Supreme Court Civil Rules*, which requires experts to remain neutral and not act as advocate. We consider these principles to apply with equal force to WCAT experts. Because Mr. Louvros reveals bias in his opinion, it therefore merits limited weight. Indeed, in our view, Mr. Louvros had a pre-developed view of the employer's rock slope stabilization procedures and its safety record when engaging in blasting and rock scaling activities prior to having attended the worksite or having been made aware of the circumstances of the February 22, 2009 incident. This pre-developed view creates, at the very least, a reasonable apprehension of bias with respect to Mr. Louvros' opinion regarding the employer's operations at the worksite.

[75] We further agree with the employer that much of Mr. Louvros' report contains irrelevant information regarding a different worksite. There is nothing within Mr. Louvros' report which would explain why we ought to consider the information in this section of his report, and we have therefore not done so.

[76] Despite the above-noted issues with Mr. Louvros' report, the fact remains that he did attend at the worksite on February 26, 2009. We have therefore reviewed the information he has provided regarding his attendance at the site, while keeping in mind the above-noted concerns regarding his views about the employer's operations generally.

[77] Mr. Louvros indicated in his report that upon attending the fatality site on February 26, 2009, he had been pointed to three fragments of rock that he was told were left from the rock that had struck the young worker. Mr. Louvros indicated that, in his view, that rock had been previously blasted. This view, he stated, was based on the fact that the rock fragments he observed were "fresh granite rock" that matched the rock near the location of the excavator. Mr. Louvros acknowledged that the rock also matched some of the surface rocks between the tree line and the brow of the hill above the accident site, but concluded that there was "no evidence" that a rock had come from within or around the tree line.

[78] Mr. Louvros further indicated that his examination of the area around the excavator suggested that the excavator had been engaging in breaking down larger rocks on February 22, 2009. Mr. Louvros opined that the rock that had struck the young worker had come from the area around the excavator. The family relied on Mr. Louvros' report

in submitting that the rock that killed the young worker had originated from the worksite and was in fact a rock that had been blasted in the course of the employer's site preparation activities.

[79] After reviewing the entirety of the Louvros report, and considering the context in which we have found it was drafted, we are of the view that Mr. Louvros' opinion as to the location of the rock that killed the young worker prior to having commenced rolling, as well as his opinion that that rock was clearly a previously blasted rock, are entitled to little weight. In our view, Mr. Louvros' opinion on both of those counts amounts to little more than speculation.

[80] With respect to whether the rock was one that had been blasted or was simply a surface rock, Mr. Louvros appears to acknowledge that it could have been either. Despite that acknowledgement, he has nonetheless concluded that the rock must have been one that had been blasted by the employer as there was "no evidence" that the rock was one that had come from the tree line area above where the blasting had occurred. We note that there is no direct evidence as to where the rock that struck the young worker originated from, given that it was already moving when it was first observed by the excavator operator. That there is no evidence that the rock came from the tree line above the blasting area cannot, in our view, be said to provide support for a conclusion that that rock was one that had been blasted. Rather, it would seem to us that the only reasonable conclusion to take from Mr. Louvros' observations of the rock that struck the young worker is that the possibility that it was a rock that had been blasted by the employer's work activities was just as likely as the possibility that it was a surface rock that had been located on the tree line above the worksite area.

What is the proper quantum of the penalty order?

[81] The Board's authority to levy administrative penalties is set out in section 196 of the Act as follows:

> **196** (1) The Board may, by order, impose an administrative penalty on an employer under this section if it considers that
>
> (a) the employer has failed to take sufficient precautions for the prevention of work related injuries or illnesses,
>
> (b) the employer has not complied with this Part, the regulations or an applicable order, or
>
> (c) the employer's workplace or working conditions are not safe.
>
> (2) An administrative penalty which is greater than [$500,000.00, subject to Consumer Price Index adjustments] must not be imposed under this section.

> (3) An administrative penalty must not be imposed under this section if an employer exercised due diligence to prevent the circumstances described in subsection (1).

[82] The Board's Manual provides direction as to how the Board should exercise its discretionary authority to levy administrative penalties. Applicable policies set out in the Manual are binding on us pursuant to subsection 250(2) of the Act. The Manual provides for several different types of administrative penalties.

[83] The most common type of penalty is sometimes referred to as a "table" penalty because it is calculated with reference to a table or grid relating the amount of the penalty to an employer's payroll. The amount of a table penalty also depends on whether the penalty is found to be a "Category A" or "Category B" contravention. Category A penalties are intended to apply to instances where a serious injury or death has occurred, or where a high risk of serious injury or death was present, or where the non-compliance with the Act or Regulation was wilful or with reckless disregard. Category B penalties apply for any other violations.

[84] A table penalty may be adjusted upwards or downwards by as much as 30% to take into account specific circumstances of each case, such as the nature of the violation, the degree of actual risk created by the violation, whether the employer knew about the situation giving rise to the violation, the extent of the measures undertaken by the employer to comply, the extent to which the behaviour of other workplace parties contributed to the violation, the employer's history, and the financial impact of the financial penalty on the employer.

[85] Another type of penalty is the type that was assessed on the employer in this appeal, and that we have referred to as a "presidential" penalty. Such penalties require the approval of the president of the Board, and are relatively unusual and significantly more costly than a table penalty.

[86] As the employer has not taken the position that a penalty is not warranted in this case (and in fact acknowledged at the Review Division that a Category A penalty was appropriate), we consider the question to be answered in this appeal to be whether a Category A table penalty or a presidential penalty is the appropriate regulatory response to the circumstances of the February 22, 2009 rock fall accident.

[87] The Manual describes presidential penalties at policy item D12-196-6 as follows:

> **2. Penalties up to $250,000**
>
> With the approval of the President or delegate, the Board may impose an administrative penalty of up to $250,000 where:
>
> (a) the employer has committed a high risk violation wilfully or with reckless disregard; and

(b) a worker has died or suffered serious permanent impairment as a result.

[88] The policy establishes criteria for imposing a presidential penalty. An employer must commit a "high risk violation" with "reckless disregard" or "wilfully" and the violation must have a causal connection to a worker's serious injury or death. We will consider each of these criteria in turn.

High risk violation?

[89] The Manual discusses the meaning of a "high risk violation" at policy item D12-196-2 "Administrative Penalties – High Risk Violations" and suggests that three factors should be considered: 1) the likelihood of an injury occurring; 2) the number of workers affected; and 3) the likely seriousness of any injury. That policy item also sets out a list of violations that are assumed to be high risk in the absence of evidence showing the contrary. Violations not on that list may still be considered for administrative penalties.

[90] The prevention orders issued by the Board in this case identified both a failure on the part of the employer to provide for the safety of its workers on a general level as required by section 115 of the Act, and specific failures to follow scaling and drilling requirements set out in the Regulation.

[91] One of the items identified in the list of violations that are assumed to be high risk is a situation in which the employer has permitted workers to be exposed to situations or conditions that are immediately dangerous to life or health. In our view, an argument could certainly be made that the workers engaged at the worksite were exposed to such a situation when the employer continued to allow work to be conducted on multiple levels of the worksite, despite the near miss incident on February 21, 2009. However, the issue of whether the violations were high risk in nature need not be determined on the basis of assumption.

[92] Rather, after taking into account the factors required to be considered by policy item D12-196-2, we are satisfied that the violations committed by the employer in this case were high risk in nature. We note particularly that the employer did not challenge the violation order in which the Board concluded that it had failed to comply with section 21.42 of the Regulation by failing to clear loose material from the face of the rock slope above Bench 4 prior to allowing drilling activity to begin. In our view, the employer's failure to comply with that section of the Regulation and to allow drilling activity to take place below previously blasted areas such as those on the rock face directly above Bench 4 created a likelihood of a serious injury occurring.

[93] While we acknowledge that the incidents of February 21 and February 22, 2009 are in some ways factually dissimilar (most notably in the fact that the February 21, 2009 incident occurred when an excavator was intentionally casting rocks and debris down the slope site), we are of the view that the significant damage created by the

February 21, 2009 rock fall incident made clear that allowing work to go on at lower levels on the worksite prior to the upper area having been cleared of loose material carried with it a high risk of injury to those working below.

[94] The photographs of the worksite make plain that there was much loose or unstable material (including large rocks) present on the rock slope above the two benches where the employer's workers were working. In our view, the employer's failure to address the unstable materials on the rock slope, and allowing drilling work to go on below that unstable and loose material despite the fact that a rock fall was identified in its own internal hazard analysis forms as being the "worst that could happen," created a high risk to the health and safety of the employer's workers.

[95] It is perhaps worth noting at this juncture that the employer has not, either at the Review Division or in its submissions in this appeal, argued that the violations that it committed were not high risk in nature.

[96] After considering the circumstances of this case as a whole, we are satisfied that a high risk violation was present such that the first criterion for imposing a presidential penalty is satisfied.

Wilfully or with reckless disregard?

[97] The issue of whether the employer acted with wilfulness or with reckless disregard in relation to the contravention orders lies at the heart of this appeal.

[98] We will address each of the above-noted terms in turn.

[99] In our view, the term wilful generally suggests that in addition to knowledge, there must be some exercise of will or conscious choice. We agree with the comments of the review officer in *Review Reference #R0058376* that in finding that an employer has wilfully committed a high risk violation, one must conclude that the employer had actual conscious awareness of the fact of the risk or violation when the violation was committed. In short, what is required is a deliberate or intentional violation.

[100] We are prepared to find that the employer wilfully engaged in the practice of having work completed on higher levels of the worksite while other workers continued to work at other levels, despite its ongoing awareness that engaging in such practice carried with it some risk of injury to the workers below. We note again that it is clear that the employer was aware of the risk posed by engaging in this practice, given that its own safety inspection reports prior to the February 22, 2009 accident date identified the hazard of falling rock, and set out that when scaling no one ought to be working at higher levels when other workers were working below.

[101] However, we are not prepared to conclude that the employer consciously set out to violate the sections of the Act and the Regulation that it did on February 22, 2009. We agree with the review officer that the fact that the employer had retained the engineering firm and formulated rules about where work would be done in relation to other work indicates that the employer was in fact making some effort to address the risk presented by potential rock fall incidents. While the employer appears to have ineffectively implemented those rules, we are not convinced that it was deliberately or intentionally circumventing the law.

[102] We turn then, to the issue of whether the employer acted with reckless disregard in committing the high risk violations identified by the Board.

[103] In its submissions, the employer referred to a number of cases (both from the courts and various administrative tribunals) including *Cormack v. Mara (Township)*, 1989 CarswellOnt 4 (ONCA); *R. v. Whittle*, [1994] 2 SCR 914; *R. v. Sansregret*, [1985] 1 SCR 570; *Law Society of Upper Canada v. Kadir Baksh*, 2004 ONLSHP 13 (CanLII)[9]; *Studer v. Cowper*, [1951] SCR 450; *Kingston (City) v. Drennan*, (1897) 27 SCR 46; *R. v. Tutton*, [1989] 1 SCR 1392; *R. v. Creighton*, [1993] 3 SCR 3; and *R. v. Beatty*, [2008] 1 SCR 49.

[104] The family also referred to the *Sansregret* and *Tutton* cases, as well as *R. v. Anderson*, [1990] 1 SCR 265.

[105] Both parties also referred to a prior decision of this tribunal, *WCAT-2010-00104*, which contained an extensive analysis of reckless disregard, as well as commentary by prior Review Division and WCAT decisions. The panel in *WCAT-2010-00104* also referred to *Sansregret*, *Tutton*, *Beatty, Cormack*, and *Anderson*. After conducting a review of the case law and legal definitions of the term reckless disregard, the panel set out his interpretation of acting wilfully or with reckless disregard at paragraph 116:

> Upon consideration of the foregoing, I agree with the reasoning in *Review Decision #R0058376*, in which the review officer found that in determining whether there has been reckless disregard in any case the concern is not just whether the person failed to take reasonable care based on what the person knew and the other circumstances, but it must be possible to describe the failure by language such as “wanton,” “heedless,” “extreme,” “gross” or “highly irresponsible.” However, I question the suggestion that only in exceptional cases will the Board be able to obtain sufficient evidence that a violation was committed “knowingly” or with “reckless disregard.” It is not necessary that the Board have direct evidence of the employer’s state of mind. If a court may infer the necessary mental

[9] A decision of a hearing panel of the Law Society of Upper Canada.

> element from the conduct which is found to depart substantially from the norm, for the purposes of finding criminal liability, so too may the Board draw an inference from an employer's conduct regarding the employer's state of mind.

[106] We agree with the above excerpted analysis. We consider that a mere lack of diligence does not establish recklessness or wilfulness. We consider that such modifiers as "wanton," "heedless," "extreme," "gross," or "highly irresponsible" must also be applicable to the conduct in question. We further agree with the panel in *WCAT-2010-00104* at paragraph 118 where it indicated that reckless disregard:

> means doing or omitting to do something which the employer should recognize as likely to cause damage or injury to its worker, not caring whether such damage or injury results.

[107] With this analysis in mind, we conclude that the employer's circumstances reveal reckless disregard in relation to the contravention orders.

[108] We take a general approach to the issue of reckless disregard rather than limiting our consideration to the fatality alone. In our view, the evidence shows that the employer knew of the slope instability and the risk of boulders rolling downhill. This was apparent from its safety meetings where workers were advised to be conscious of this risk and "look out" for falling debris.

[109] However, despite ongoing knowledge of this risk, the employer made inadequate efforts to scale the slopes above its workers. We do not refer particularly to the area only above the young worker in this case. We refer generally to the worksite. It is inconceivable that such a worksite would not have a carefully monitored and effective scaling program in place. The worksite was constantly experiencing heavy vibration from blasting and drilling. Rocks do not necessarily descend a slope in a predictable pattern – a rock could hit anyone anywhere and "looking out" is an ineffective safety measure to deal with such a serious risk.

[110] Further, some workers, as in the case of the young worker, would be wearing hearing protection and carrying out loud work such that at times a worker might not be able to hear a verbal warning to escape from an approaching rock. Finally, the employer is experienced in this type of work. It ought to be well aware of its obligation to control the risk of boulders and debris rolling down a slope that is subject to such extensive blasting and drilling operations.

[111] In these circumstances, we would describe it as "heedless," "wanton," "extreme," "gross," and "highly irresponsible" for the employer to have known that there was a potential for rocks to roll through the worksite but not take adequate steps to contain this risk by way of a detailed and carefully monitored scaling program.

[112] The employer says it carried out proper scaling. However, we disagree. We rely on the Board's Incident Investigation Report to establish the inadequacy of the employer's scaling. The employer's project manager also concedes this point in the following exchange with a Board investigator:

> [Board officer] Q. Okay. Well, I asked [the Drill and Blast Superintendent] that, and he indicated that there had been attempts...recent attempts to get more scaling power, and [the Construction Manager] said that they had adequate scaling people there and they weren't seeking more. So, it's just something that's a discrepancy. Just wondered about that. Well, from our observation, we... We're not saying that more hand-scaling needed to be available. It could have been done by machine, it could have, you know, accomplished by other means. But it is our view that more scaling needed to be done there. Would you share that view after seeing the site?
>
> A. Without question.
>
> Q. Yeah.
>
> A. It was... it was not properly scaled.

[113] The contravention orders issued by the Board capture the general notion that an employer in such circumstances must take effective steps to deal with the risk of debris falling on workers at a worksite such as the one in question in this appeal. The employer did not take such steps, despite knowing of the risk of falling debris over a lengthy period prior to the incident. In our view, scaling was not a secondary concern that required occasional attention. This was amongst the key safety issues on this particular site. We therefore find that the employer's failure to deal with this safety issue amounted to a safety violation evidencing reckless disregard.

Causation

[114] That is not the end of the analysis. Having concluded that the employer engaged with reckless disregard in a high risk safety contravention, we must consider the last requirement for a presidential penalty: causation. Here, as already noted, we are not persuaded that the rock that killed the young worker was a blasted rock or some other kind of rock that should have been controlled through effective scaling activities. It is possible that the rock that killed the worker was within the worksite. However, it is equally possible that the rock came from some other location away from the worksite and outside of the employer's scaling responsibility.

[115] Because we are unable to find on a balance of probabilities where the rock came from or whether it would have been controlled by adequate scaling, we cannot conclude that the worker's death resulted from that safety violation. It follows that, notwithstanding the

employer's misconduct in this case, all the requirements for a presidential penalty are not satisfied and we must therefore cancel the presidential penalty against the employer. We turn now to consider whether some other type of penalty is warranted.

Table penalty

[116] Although it did not expressly address the issue in its submissions on appeal, as we have noted above, the employer acknowledged in its submissions to the Review Division that the circumstances of this case warranted the imposition of a Category A penalty. We agree.

[117] The employer's indication that a Category A penalty is warranted in this case constitutes an admission that it acted without due diligence. Even if the employer were not admitting that to be the case, we would have been prepared to make that finding. We note in this regard that the notion of due diligence is well understood and demands not merely an absence of negligence but also the more rigorous obligation to actively take all reasonable steps to ensure safety contraventions do not occur.

[118] In this case, while the employer took some steps to ensure that safety contraventions did not occur at the worksite, we are not satisfied that it took all reasonable steps. Clearly, the employer ought to have done much more with respect to clearing the loose and unstable material above Bench 4 prior to allowing drilling to proceed at that level. We note again that, regardless of the recommendations of the engineering report (which appear to have been focused on the stability of the rock face alone), the photographic evidence before us makes it plain that there was loose material on the worksite at levels above where drilling was occurring. It was reckless for the employer to allow drilling to continue in such circumstances and in direct contravention of section 21.42 of the Regulation.

[119] Further, the employer did not exercise due diligence in that it failed to have an effective scaling plan for the worksite. That failure led directly to repeated situations, including the situation on February 22, 2009, in which work was being done at multiple levels of the worksite, placing workers located at lower levels of the worksite at unreasonable risk of injury from falling rock. While it is not known whether the work being conducted by the excavator operator at a level of the worksite above Bench 4 on February 22, 2009 was a cause of the rock fall accident on that date, it is, in our view, clear that the prudent and reasonable course for the employer to have taken would have been to not allow such multi-level work to continue, and that its failure to do so reflects an absence of due diligence.

[120] In summary, we are satisfied that the employer did not demonstrate due diligence in relation to the orders set out by the Board. Because the employer did not act with due diligence, and because it otherwise accepts that it should be subject to an administrative penalty, we conclude that an administrative penalty is appropriate under the table method.

[121] As the employer's contraventions in this case involved a death, pursuant to policy item D12-196-6, we agree with the employer's conclusion that a Category A penalty is appropriate.

[122] In accordance with the Manual, the Category A penalty is to be calculated on the basis of the employer's assessable payroll in 2008. Given the employer's payroll, a basic Category A penalty in this case would be $75,000

[123] We note, however, that table penalties may be varied up or down pursuant to policy item D12-196-6. The policy item describes various factors to consider in assessing whether or not to vary the basic amount of a Category A penalty.

[124] Here, perhaps because the focus of the appeal turned on the presidential penalty, the parties did not file submissions on whether, if the quantum of the penalty was instead calculated using the Category A table, the resulting basic amount of the penalty should be varied up or down. In its submissions to the Review Division, the employer merely indicated that it would leave the issue of variation of the Category A penalty to the review officer.

[125] In our view, the issue of variation factors appears to us to have been an obvious one to address in the course of submissions, particularly as both parties have experienced representatives. Accordingly, we have not sought further submissions on this point.

[126] We are satisfied that the circumstances of this case warrant the maximum 30% upward variation of the Category A penalty. As set out above, we consider that the nature of the hazard created by the employer's violations in this case was high risk. Further, we note that despite knowing about the situation giving rise to the violation (in that it repeatedly noted in its hazard forms the risk of rock falls), the employer allowed that situation to continue for a significant period of time. Finally, we note that the employer had significant experience in this type of project, but nonetheless failed to implement an adequate system for scaling and drilling the worksite. In our view, the combined effect of the employer's failure to comply with the Act and Regulation and the nature of the hazard created by the failure warrants a 30% upward variation of the penalty.

[127] In reaching this conclusion, we acknowledge that subsequent to the February 22, 2009 incident, the employer took steps to comply with the orders issued by the Board. However, such steps could and should have been taken prior to the February 22, 2009 incident. As a final point, we note further that, given the employer's size, we do not consider that the financial impact of the penalty, even with the 30% upward variation, would be unduly harsh.

Ancillary matter

[128] The family of the young worker submitted that there was an evidentiary basis upon which the penalty in this case ought to be raised to the statutory maximum of

$596,435.35, and requested that, as the Board had not turned its mind to this issue, the matter ought to be returned to the Board for further investigation.

[129] The family did not request a review of the Board's March 31, 2011 decision to impose the presidential penalty, nor did it appeal *Review Reference #R0130850*. As a result, in order to consider the family's argument in this regard, we would have to exercise our discretion (as discussed at item #3.3.1 of WCAT's *Manual of Rules of Practice and Procedure*) to address an issue raised by the respondent to an appeal in relation to the decision under appeal.

[130] It is not necessary to go into a lengthy consideration of whether to exercise our discretion in the circumstances of this case, however, as our finding on the lack of causation for the presidential penalty would apply equally to the analysis for a statutory maximum penalty. Therefore, the family's argument that a statutory maximum penalty was warranted in this case could not succeed. As a result, we decline to refer this appeal back to the Board for consideration of a statutory maximum penalty.

Conclusion

[131] We vary *Review Reference #R0130850*. We confirm that the employer committed high risk violations with reckless disregard; however, we cannot conclude that the employer's violations resulted in the young worker's death. We therefore must find that a presidential penalty is not warranted in this case. Instead, we find that a Category A penalty, with an upward variation of 30%, is appropriate. We leave it to the Board to calculate the amount of that penalty, based on the employer's payroll in the year prior to the February 22, 2009 accident.

[132] No request for reimbursement for appeal expenses was received and none are apparent. We consequently make no order regarding expenses of this appeal.

Warren Hoole
Vice Chair

Andrew Pendray
Vice Chair

Sherryl Yeager
Vice Chair

AP/jkw/gw