IN THE PROVINCIAL COURT OF NOVA SCOTIA
Citation: R. v. Nova Scotia Power Inc., 2008 NSPC 72

Date: December 1, 2008
Docket: 1714395
Registry: Sydney

Her Majesty the Queen (Department of Environment and Labour)

v.

Nova Scotia Power Incorporated

Decision on Sentence

Judge:	The Honourable Judge Anne S. Derrick
Heard:	November 13, 2008 in Sydney, Nova Scotia
Written decision:	December 1, 2008
Counsel:	Peter Craig, for Her Majesty the Queen Department of Environment and Labour Daniel Ingersoll and Rebekah Powell for Nova Scotia Power Incorporated

By the Court:

Introduction

[1] On December 4, 2004, Joey Wrice was working day shift at the Nova Scotia Power Thermal Generating Station at Lingan, New Waterford. He was alone in the Tripper Gallery of the plant, performing coal handler duties. NSPI's practice of having a single worker during the Tripper Gallery day shift had been in place since the mid 1990's.

[2] A detailed description of the Tripper Gallery and the movement of coal along conveyor belts and into coal hoppers is found in the Agreed Statement of Facts attached as Appendix "A". The coal hoppers at Lingan are approximately 15 meters (49 feet) in depth and 8 meters (25 feet) wide. There are two conveyor belts approximately six feet apart: in the concrete floor next to the belts there are slots through which the coal is directed into the hoppers. When coal is needed in a particular hopper, the Tripper Gallery worker moves the conveyor tripper system to the needed unit and coal is then discharged through the floor slots into the hopper.

[3] The floor slots in the Tripper Gallery are about 14 inches wide with a 4 inch kick plate to prevent tools sliding into the coal hoppers. The slots enable the coal to be channeled into the hoppers and also provide ventilation to alleviate methane gas build up from the coal.

[4] At approximately 12:30 p.m. on December 4, 2004, Mr. Wrice's hard hat was found near the slot opening in the Tripper Gallery floor for coal hopper 3-B. A search of the plant was undertaken to locate Mr. Wrice. It was not until almost 10 hours later, at 22:15 hours on December 4, that Mr. Wrice was discovered in coal hopper 3-B, dead. His body was found fourteen feet inside the coal hopper buried in coal. NSPI has acknowledged that Mr. Wrice went through a slot in the Tripper Gallery floor which explains how his body came to be in the hopper below.

[5] On November 30, 2006, an Information was sworn charging NSPI with two offences under the provincial *Occupational Health and Safety Act*. The two counts in the Information provided that:

Count 1: ***Nova Scotia Power Incorporated, as an employer***, failed to ensure that a means of fall protection or an equivalent level of safety was provided as prescribed by Section 7(1) of the Fall Protection and Scaffolding Regulations, and did thereby commit an offence contrary to Sections 13(1) and 74(1) of the Occupational Health and Safety Act.

Count 2: ***And furthermore at the place and date aforesaid***, failed to ensure that a guardrail(s) was/were provided as prescribed by section 9 of the Fall Protection and Scaffolding Regulations, and did thereby commit an offence contrary to Sections 13(1) and 74(1) of the Occupational Health and Safety Act.

[6] On October 22, 2008, NSPI pleaded guilty to Count 1 in the Information. The

Crown offered no evidence on Count 2 and it was dismissed at the conclusion of the sentencing hearing on November 13, 2008.

The Fall Protection and Scaffolding Regulations

[7] Section 7(1) of the *Fall Protection and Scaffolding Regulations* provides as follows:

> Where a person is exposed to the hazard of falling from a work area that is
>
> (a) 3 m or more above the nearest safe surface or water;
>
> (b) above a surface or thing that could cause injury to the person upon contact; or
>
> (c) above an open tank, pit or vat containing hazardous material,
>
> (i) the person shall wear a fall arrest system that includes a full body harness, a lanyard and an anchor point and that otherwise complies with Section 8,
>
> (ii) a guardrail shall be provided that meets the requirements of Section 9,
>
> (iii) a personnel safety net shall be provided that meets the requirements of Section 10,
>
> (iv) temporary flooring shall be provided that meets the requirements of Section 14, or
>
> (v) a means of fall protection shall be provided that provides a level of safety equal to or greater than a fall arrest system.

[8] NSPI's sentencing submissions indicate that on December 22 and 23, 2004, Nova Scotia Power placed a metal cord length-wise along the Tripper Gallery floor

slots. By mid-February 2005, grating had been installed in the slots. The installation of the grating brought the Tripper Gallery floor into compliance with section 7 of the *Regulations*. (*NSPI Submissions, paragraph 43*)

The Cause of Death Issue

[9] NSPI's guilty plea was entered on the basis of the agreed upon facts which include the following statements:

> *The Crown takes no position on the cause of death of Mr. Wrice. The Court is not being asked to make a determination in this regard.*

[10] NSPI had pleaded not guilty to the OHSA charges on May 2, 2007. The trial was scheduled for the week of January 14 - 17, 2008. Evidence and submissions concerning an engineer's report, which is not relevant to this sentencing, were heard on January 14 and 15. The trial was subsequently adjourned at the request of both counsel to June 16. For three days, June 16 - 18, 2008, evidence was given by three doctors on the issue of what caused Mr. Wrice's death. Dr. Ewa Wozniak, the pathologist who performed the autopsy on Mr. Wrice, and Dr. Vernon Bowes, a forensic pathologist and Chief Medical Examiner for the Province at the time, testified to their opinions that Mr. Wrice's death was caused by asphyxia. *(page 148, Transcript from June 16, 2008, Evidence of Dr. Wozniak; page 179, Transcript from June 17, 2008, Evidence of Dr. Vernon Bowes*) Dr. Matthew Bowes, a forensic pathologist and the present provincial Chief Medical Examiner, and no relation of Dr. Vernon Bowes, testified that this was his opinion as well. *(page 347, Transcript from June 18, 2008, Evidence of Dr. Matthew Bowes*)

[11] All the doctors were subjected to lengthy and vigorous cross-examination by Defence counsel. NSPI made it very clear it did not accept that Mr. Wrice's death had been caused by falling into the hopper and getting buried under coal. What follows is a sampling of the issues raised by NSPI in the cross-examination of the doctors.

[12] The autopsy on Mr. Wrice's body was conducted on December 6, 2004 by Dr. Wozniak. Dr. Wozniak knew that Mr. Wrice had epilepsy. She found coal dust and coal particles in Mr. Wrice's upper and lower airways and also determined that he had mild to chronic bronchitis and severe coronary artery disease. *(pages 14 - 15, Transcript from June 16, 2008, Evidence of Dr. Wozniak*)

[13] Dr. Wozniak acknowledged in cross-examination that she had concluded Mr. Wrice may have been unconscious when he went through the slot and thought that he might have died of a myocardial infarct (heart attack). *(pages 73 and 79, Transcript from June 16, 2008, Evidence of Dr. Wozniak*) Dr. Wozniak testified that she was prepared to entertain the possibility that Mr. Wrice had died of a heart attack notwithstanding the fact that he was found buried in coal. *(page 82, Transcript from June 16, 2008, Evidence of Dr. Ewa Wozniak*) She noted that the two main arteries in Mr. Wrice's heart were stenosed (narrowed), with the circumflex (lower anterior descending) artery showing 80 percent stenosis. *(page 16, Transcript from June 16, 2008, Evidence of Dr. Wozniak*)

[14] NSPI's cross-examination of Dr. Wozniak also brought out that according to toxicology reports Mr. Wrice had sub-therapeutic levels of anti-convulsants in his

system. In other words, Mr. Wrice was at risk of an epileptic seizure notwithstanding that he was taking medication for his condition. *(pages 101 - 102, Transcript from June 16, 2008, Evidence of Dr. Wozniak*) Dr. Wozniak agreed with NSPI counsel that death could occur where a person with coronary heart disease experiences an epileptic seizure and develops cardiac arrhythmia because a diseased heart is less able to withstand the effect of the seizure and the arrhythmia than a healthy heart. (*page 103, Transcript from June 16, 2008, Evidence of Dr. Wozniak*)

[15] Dr. Vernon Bowes, prepared a report of the Chief Medical Examiner with respect to Mr. Wrice. He testified that Dr. Wozniak's autopsy report did not meet the standard expected of pathologists in Nova Scotia. He said that although Dr. Wozniak had been an excellent pathologist, "...this case falls far short of what I would expect of pathologists in the region and for us to adequately assess the cause and manner of death." (*page 236, Transcript from June 17, 2008, Evidence of Dr. Vernon Bowes*) Dr. Matthew Bowes agreed with NSPI counsel that petechial hemorrhage is seen on the heart and lungs of a person who has died from mechanical suffocation. He acknowledged that Dr. Wozniak had made no comment in her autopsy report, either positively or negatively, on the issue of whether Mr. Wrice's heart or lungs showed evidence of petechial hemorrhage. *(page 457, Transcript from June 18, 2008, Evidence of Dr. Matthew Bowes*)

[16] Dr. Matthew Bowes confirmed, as Dr. Wozniak had done, that a person can die of a heart attack with the clinical examination of that heart revealing no evidence of the attack. (*page 368, Transcript from June 18, 2008, Evidence of Dr. Matthew Bowes*) Dr. Wozniak had testified that the autopsy of Mr. Wrice had disclosed no

evidence that he had suffered a heart attack. Dr. Bowes agreed with counsel for NSPI that a person with a 75 percent narrowing of a coronary artery is at risk of a sudden and unexpected cardiovascular event but that a heart attack in these circumstances may not be evident from the heart tissue. *(page 376, Transcript from June 18, 2008, Evidence of Dr. Matthew Bowes*) Dr. Bowes also agreed that an epileptic seizure could lead to cardiac arrhythmia and death, with the risk of death being more pronounced in the case of a diseased heart. *(page 379, Transcript from June 18, 2008, Evidence of Dr. Matthew Bowes*) Dr. Bowes further agreed it was possible that, because of an epileptic seizure and/or a heart attack, Mr. Wrice had been unconscious when he entered the coal hopper through the floor slot on December 4, 2004. *(pages 399-400, Transcript from June 18, 2008, Evidence of Dr. Matthew Bowes*) He acknowledged that while the fact of Mr. Wrice being buried in coal was relevant to the issue of cause of death, it was not determinative. *(page 415, Transcript from June 18, 2008, Evidence of Dr. Matthew Bowes*)

The Balance of the Proceedings

[17] At the end of the doctors' evidence, the trial of NSPI was adjourned to dates in October, November and December 2008. The case returned to court on October 21 at which time counsel requested that it be adjourned to the next day. On October 22, as I noted earlier in these reasons, NSPI entered a guilty plea to the first count in the Information. I was advised by counsel that an Agreed Statement of Facts would be presented to the court in due course. A sentencing hearing was scheduled for November 13, 2008 which is when counsels' oral submissions were heard. Briefs and case authorities had been filed in advance of the hearing.

The Legal Relevance of Mr. Wrice's Death

[18] Mr. Wrice's death was a tragedy. He was only 39 years old. He left behind a family who is heartbroken that he is gone. He had a three year old son, Adam, and a partner, Lynn. His sister, Rita Sheriff, read a Victim Impact Statement at the sentencing hearing. She talked about what Mr. Wrice had meant to her and her family. She described Mr. Wrice's relationship with their parents and the family experiences he would have been part of had he not died. Ms. Sheriff's voice resonated with pain as she talked about her brother. She said in part: "There isn't a day that passes that we don't think of Joey. People say as time goes by it will get easier. They are wrong. It doesn't get easier, you become numb to it all and you tuck your sadness away. You move through life one day at a time. Nothing is going to bring Joey back to us."

[19] Joey Wrice died at work. There is no dispute about that fact. There is a dispute about what caused his death. The Crown originally set out to prove that Mr. Wrice's death was caused by falling into the coal hopper and being buried by coal. However NSPI has actively disputed this as evidenced by the cross-examination of the three doctors. Mr. Wrice's life-threatening conditions of epilepsy and a seriously diseased heart were identified. NSPI's cross-examination of the doctors raised the issue that one or both of these conditions could have killed Mr. Wrice on December 4, 2004.

[20] As the judge in these proceedings, the only facts I consider are the ones that are proven in court or agreed to by the parties. I cannot engage in speculation nor can I reach conclusions in the absence of proof. The evidence of the doctors in June did not prove that Joey Wrice's death was caused by asphyxia from being buried in coal or

from a heart attack or epileptic seizure or some combination of his significant medical conditions. The examination of the doctors raised a number of issues that remain unresolved. If the case had continued to trial I would have heard submissions from counsel on the medical evidence and what, in their opinion, I should draw from it. I may also have heard additional medical evidence, possibly including testimony from doctors called by NSPI. I do not know if this would have occurred but it is reasonable to assume it would have. Where the Crown's expert medical evidence is challenged, the calling of Defence medical evidence is going to be a distinct possibility.

[21] The decision by NSPI to plead guilty on the basis of agreed facts and the Crown's acceptance of that plea meant that no further evidence was brought before me by either party on the issue of what caused Mr. Wrice's death. The Crown is no longer asserting that Mr. Wrice died of asphyxia: the Agreed Statement of Facts indicates that the Crown takes no position on the cause of death. In other words, the Crown is not advancing any opinion or submission before me on what caused Mr. Wrice's death on December 4, 2004. The Agreed Statement of Facts goes on to state that I am not being asked to determine this issue. In any event, given the strenuous challenge to the medical evidence I did hear and the fact that the medical picture of what caused Mr. Wrice's death is incomplete, I am in no position to make a determination as to the cause of Mr. Wrice's death.

[22] The Crown and NSPI have agreed that the sentence for NSPI for contravening the fall protection regulations must be decided without the cause of Joey Wrice's death being known or established. That is the basis on which I must proceed to determine the appropriate sentence for NSPI in relation to the charge to which it has

pleaded guilty.

[23] The fact that the cause of Mr. Wrice's death has not and cannot be determined in these proceedings has not however put to rest the issue of the legal relevance of his death to the sentencing of NSPI. As I will discuss, the Crown has urged me to treat this as a fatality case for the purpose of sentencing whereas NSPI has argued that I should not do so as no causal connection has been made between Mr. Wrice's death and the failure by NSPI to grate or otherwise guard the Tripper Gallery floor slots.

The Penalty Provisions of the *Occupational Health and Safety Act* and the Positions of Crown and Defence on Sentence

[24] Section 74(1) of the *Occupational Health and Safety Act* provides that the penalty for a corporation violating the regulations under the *Act* is a maximum fine of $250,000. Section 75 establishes a range of additional sentencing options, sometimes referred to as "creative sentencing options" that can include: directing the offender to pay to the Minister an amount for the purpose of public education in the safe conduct of the activity in relation to which the offence was committed, and principles of internal responsibility provided for in the *Act* (s. 75(1)(b)(i)(ii); community service (s. 75(1)(d)); and requiring the offender to comply with such other reasonable conditions as the court considers appropriate and just in the circumstances for securing the offender's good conduct and for preventing the offender from repeating the same offence or committing other offences (s. 75(1)(f)). The total of any fine or direct cost incurred by the offender under these provisions cannot exceed the maximum allowable penalty of $250,000.

[25] The Crown's position is that this case is similar to cases where there has been a fatality that can be casually connected to an occupational health and safety infraction. The Crown's recommendation for NSPI's sentence is a penalty totalling $80,000 - $100,000, including the fine and the cost of creative sentencing options.

[26] NSPI's position is that this is not a fatality case. NSPI argues that the death of Mr. Wrice cannot be regarded as an aggravating factor in sentencing as no causal link has been established between the offence committed and Mr. Wrice's death. NSPI submits that the appropriate penalty is a fine of $10,000 plus the sponsoring of three Public Education Sessions (cost: $5000 per session) to be put on by the Nova Scotia Construction Safety Association as part of its newly designed Fall Protection Course. The total cost to NSPI of the fine and the public education sessions would be $25,000.

The Legal Framework for OHSA Sentencing

[27] The legal framework for this sentencing has been constructed by the purpose and principles of sentencing found in sections 718 - 718.2 of the *Criminal Code* (which apply here by operation of the *Summary Proceedings Act, S.N.S. 1989, c. 450 as amended*) and the occupational health and safety cases applying these norms. Norman A. Keith's treatise, "*Canadian Health and Safety Law: A Comprehensive Guide to Statutes, Policies and Case Law*" (Canada Law Book: 2008) references principles of sentencing for occupational health and safety violations that reflect those found in sections 718 - 718.2 of the *Criminal Code*:

> There are three primary objectives of sentencing for a violation of the applicable health and safety legislation. First, there is the deterrence aspect of

> the sentencing process, both specific to the convicted party and generally for the community. Secondly, there is the retribution aspect of the sentencing process, indicating the moral wrong and the need to reinforce the value or standard that was violated. Thirdly, there is the rehabilitation-reform aspect of the sentencing process for the convicted party to be assisted in not repeating the offence.

[28] In *Regina v. Cotton Felts Ltd., [1982] O.J. No. 178,* the Ontario Court of Appeal held that:

> The amount of the fine will be determined by a complex of considerations, including the size of the company involved, the scope of the economic activity in issue, the extent of the actual and potential harm to the public, and the maximum penalty prescribed by statute. Above all, the amount of the fine will be determined by the need to enforce regulatory standards by deterrence...Without being harsh, the fine must be substantial enough to warn others that the offence will not be tolerated. It must not appear to be a mere licence fee for illegal activity. (*paragraphs 19 & 22*)

[29] The *Cotton Felts* decision accorded deterrence in the occupational health and safety context a broad meaning encompassing an emphasis on community denunciation and stigmatization of an act with the result being a moral or educative effect that conditions the attitude of the public. In approving this model of deterrence taken from *R. v. Roussy, [1977] O.J. No. 1208 (Ont. C.A.),* Blair, J.A. in *Cotton Felts* held that deterrence with an educative dimension is "particularly applicable to public welfare offences where it is essential for the proper functioning of our society for citizens at large to expect that basic rules are established and enforced to protect the physical, economic and social welfare of the public." (*paragraph 23*)

[30] A sentence for an occupational health and safety infraction must communicate

a message that emphasizes the essential responsibility of ensuring "corporate good conduct and [enhancing] the well being of the public." *(R. v. General Scrap Iron and Metals Ltd., [2003] A.J. No. 13 (Alta. Q.B.) paragraphs 28 - 30)* Watson, J. in *General Scrap Iron* concluded that sentencing corporations for regulatory offences should be approached with the following in mind:

> (1) the conduct, circumstances and consequences of the offence;
> (2) the terms and aims of the relevant legislation;
> (3) the participation, character and attitude of the corporation offender.
> (*General Scrap Iron, paragraph 35*)

[31] Watson, J. articulated an analytical framework constructed around these considerations, noting that aggravating and mitigating factors must be factored into the sentencing of the corporate offender. *(General Scrap Iron, supra, paragraph 49)* This framework is detailed in *R. v. Meridian Construction Inc., [2005] N.S.J. No. 379*, a decision of the Honourable Judge Alan Tufts of this Court. In *Meridian*, Judge Tufts makes several noteworthy observations about sentencing in the occupational health and safety context:

> ...the fundamental purpose of sentencing is the protection of the public and a respect for the law...The workplace is an inherently dangerous environment...Workers have little power or leverage individually to control safety measures which are necessary to protect them and minimize their risk of injury. They can only collectively bargain or rely on the legislative scheme such as the Occupational Health and Safety Act to protect them. The Occupational Health and Safety Act has as its principle purpose...the protection of workers. The foundation of the Act is the internal responsibility system...which is based on the principle that workplace safety is a shared responsibility...(*paragraph 13*)

[32] In *Meridian*, Judge Tufts also noted that workplace safety risks can readily go undetected in a context that is "largely self-policing." *(paragraph 15)* Sentencing of a corporate offender in an occupational health and safety case is an exercise in balancing a number of factors to achieve a disposition that helps protect workers through deterrence and emphasizes respect for workplace safety and the legislative scheme that embodies this objective.

Principles of Sentencing - Proportionality

[33] Three principles of sentencing must be examined closely in arriving at a fit and proper disposition in this case. They are proportionality, parity and restraint. The principle of proportionality requires that NSPI's sentence be proportionate to its moral blameworthiness for the offence of failing to guard the Tripper Gallery floor slots. Assessing the degree of NSPI's moral blameworthiness requires me to consider whether Mr. Wrice's death is relevant to the sentence. Examining this question requires me to return to the issue of Mr. Wrice's death.

The Relevance of What Happened to Mr. Wrice

[34] The relevance of Mr. Wrice's death to the issue of the appropriate sentence for NSPI would be straightforward and uncontroversial if it had been established that the fall through an unguarded Tripper Floor slot was the cause of Mr. Wrice's death. As discussed earlier in these reasons, that has not been shown and the cause of Mr. Wrice's death remains undetermined in these proceedings. A causal connection between the occupational health and safety violation and the worker's death is

material to fixing the penalty. Watson, J. in *General Scrap Metal* talked about the sentencing of corporate offenders being "sensitive to the facts and circumstances" of the case and held: "When the law speaks to corporations through sanctions, it should do so in a manner which is logically coherent with the factual level of culpability of the corporation." (*paragraph 44*)

[35] In this case, no causal connection has been established between NSPI's failure to provide safeguards for the Tripper Gallery floor slots and Mr. Wrice's death. This does distinguish this case from those where the worker's death was caused by the breach of the occupational health and safety laws, e.g., *Meridian, supra*, where a roof worker fell thirty feet to his death through an open skylight that had been covered with styrofoam. A subcontractor and the foreman for the subcontractor were also prosecuted in relation to the accident. The sentencing judge in the case involving the foreman made the following comments when distinguishing certain other cases: "...although there was a death that was involved there was no 'cause and effect', in other words there wasn't a situation where the breach [of the occupational health and safety laws] was the cause of death." (*R. v. Daniel Magee, unreported decision of the Honourable Judge Claudine MacDonald, October 28, 2003, paragraph 11*) In *R. v. J.D. Irving*, another unreported decision of Judge MacDonald, she referred to the worker's death being the direct result of a failure by the offending company to comply with the *OHSA. (unreported decision, February 3, 2000)*

[36] As dictated by the principle of proportionality, causation is relevant to penalty. In *General Scrap Iron*, Watson, J. refers to the sentencing court considering "the nexus between the damages and the offence." *(paragraph 49)* Judge Tufts noted in *R.*

v. A.W. Leil Cranes & Equipment (1986) Ltd., [2003] N.S.J. No. 525 (N.S.P.C.) that: "Obviously, if there is a fatality, it is clear that the fines are increased..." *(paragraph 19)* The cases I have been referred to indicate this, with $100,000 being well within the range for the fines in cases of death-causing infractions of occupational health and safety legislation. As noted earlier, the Crown is looking for a penalty totalling $80,000 - $100,000 against NSPI.

[37] The Crown in this case has chosen to proceed on the basis that the cause of Mr. Wrice's death has not been proven for the purpose of these proceedings. Perhaps the Crown concluded it would be unable to prove what killed Mr. Wrice or perhaps the Crown saw the benefits of resolving the case on the basis of NSPI's guilty plea and did not view the proof of death as essential to obtaining an appropriate sentence. The comments I have just made are speculative. Whatever the considerations that went into the resolution of this case - and I have not been privy to them - I must arrive at an appropriate sentence for NSPI without knowing if Mr. Wrice's fall through an unguarded Tripper Gallery floor slot was what caused his death. And I cannot conclude that the fall may have been a contributing factor in Mr. Wrice's death where I am unable to determine what caused his death. The fall obviously would not have been a contributing factor if Mr. Wrice was already dead from a heart attack when he went through the floor slot.

[38] As I have been discussing, actual harm is relevant to the degree of a corporate offender's culpability in an occupational health and safety case. However, potential of harm is also a consideration in the context of workplace safety. *(Cotton Felts, supra, page 8; A. W. Leil Cranes & Equipment, supra, paragraph 14)* NSPI submits

that the concept of potential harm applies to situations where no one was harmed but consequences still flow for the company's failure to adhere to legislated requirements. NSPI argues that the potential for significant harm is present in most cases involving breaches of fall arrest protection requirements, yet the fines do not reflect the worst case scenario of what could have happened. NSPI points to references in *R. v. G.B. Roofing (unreported decision of the Honourable Judge David Cole, January 20, 1999*) where the court was asked to consider the case of a worker who fell 65 feet and "miraculously did not die." That company received a $17,000 fine with an additional $5000 for an advertisement about the accident. NSPI submits that result is to be contrasted to the case of *Meddis Health and Pharmaceutical* (also referred to in *G.B. Roofing*) which resulted in a fine of $70,000 (victim surcharge of $5000) where a worker fell to his death.

[39] Even the Crown has acknowledged that there is no exact parallel between occupational health and safety cases where the worker is killed and ones where the infraction exposes the worker to the risk of death. The Crown has nonetheless urged me to treat the fatality cases as providing guidance in the sentencing analysis. Having reflected on this I have concluded there has to be a distinction made where no proof exists that the contravention of the *OHSA* caused the worker's death. In my opinion, NSPI cannot be treated as it would have been had it been established that Mr. Wrice was killed by the fall through the Tripper Gallery floor slot.

[40] However, the fact that no causal connection has been established between Mr. Wrice's fall through a slot and his death does not, in my opinion, render the fact of what happened to Mr. Wrice irrelevant to my analysis. My analysis is informed by

what I do know about happened to Mr. Wrice; he fell through an unguarded Tripper Gallery floor slot. I do not know the circumstances of how that happened - was he unconscious when he fell or was he already dead - but I do know that it happened. I also know, from the submissions of counsel, that no one else had ever fallen through these slots before but a supervisor had once climbed down through a slot to retrieve a scraper that had fallen into the coal hopper. The slots were therefore a potential hazard, someone could fit through one and someone, Mr. Wrice, did eventually fall through, which would not have happened if the slots had been guarded. This is not to say that had the slots been guarded Mr. Wrice would be alive today. The medical evidence I heard raised the possibility that he was already dead when he went through the slot. What can be said however is that Mr. Wrice falling through a Tripper Gallery floor slot, whether he was already dead or merely unconscious, indicates that the slots were a hazard, at the very least to an unconscious worker. What Mr. Wrice's fall shows is that an unconscious worker - I think it is very unlikely that Mr. Wrice was conscious when he went through - could have fallen through a slot. Given that Mr. Wrice was found under fourteen feet of coal, such a fall would have been catastrophic. As the *G.B. Roofing* case demonstrates, a person may be able to survive a 65 foot fall, but I cannot think that anyone could survive being buried in fourteen feet of coal.

[41] Occupational health and safety legislation is intended to protect workers from actual and potential hazards. This protection extends to workers whatever their condition. The unguarded floor slots were an actual hazard because a worker fell through one. NSPI is morally culpable for not having guarded the slots which would have prevented this from happening. The slots were not a theoretical hazard, they were a real hazard. This is not a case where an accident could have happened, an

accident did happen. Given the conditions in the coal hopper, such an accident could or would have been fatal, although that has not been proven here.

[42] I do not know in this case if the accident that happened to Mr. Wrice occurred once he was already dead. Obviously if he was dead when he went through a slot then being buried in fourteen feet of coal in the coal hopper made no difference to his ability to survive the fall. In my opinion, I do not need to know if Mr. Wrice was dead when he went through the slot or not. The fact that he went through an unguarded slot tells me that the slots presented a hazard at least to any worker who became unconscious on that section of the Tripper Gallery floor. Occupational health and safety legislation, which required that the slots be guarded, is intended to protect a worker from a hazard, including hazards that workers would be vulnerable to if rendered unconscious or incapacitated for some reason. An example of a safety mechanism intended to protect an incapacitated worker is a kill switch on a piece of machinery.

[43] This analysis brings me to the point of concluding that the unguarded Tripper Gallery floor slots represented a real hazard that had the potential to cause serious injury or death to a worker who fell through one. The failure by NSPI to guard the slots as the fall protection regulations require is a significant failure in the occupational health and safety context where legislated standards seek to eliminate real and potential risks and harms in the workplace. That being said, whatever NSPI's blameworthiness is for contravening the regulations, it is not the same as it would have been if there was proof that Mr. Wrice was killed by his fall through the slot.

[44] This case cannot be assessed as though it was a fatality case. What this means is that the cases where occupational health and safety contraventions resulted in a worker dying do not provide me with guidance. However, this is a case where a fall occurred because there was no fall protection. In my opinion, this case must be assessed on the basis that there was a real hazard with the potential for serious harm which puts NSPI's culpability at a higher level than in a case where the hazard could not be as readily established and/or the risk of harm was less. The sentence should be a calculus of the hazard and the connection to the potential for harm and not merely be driven by what actual harm can be proven. If the occupational health and safety regime is going to achieve its objective to make workplaces safer, then penalizing potential harm is important. We cannot know what might have happened to Mr. Wrice if there had been a grating over the Tripper Gallery floor slots on December 4, 2004 as there is now. It would constitute improper speculation to think that he might have survived. All we can know is that had there been a protective grating, Mr. Wrice would not have fallen into the coal hopper.

Was the Hazard of the Unguarded Floor Slots Foreseeable?

[45] NSPI has argued that it was not foreseeable that a worker would become unconscious and fall through a Tripper Gallery floor slot. NSPI stated in its written submissions that it did not consider the Tripper Gallery floor slots wide enough for a worker to fall through. This was a view shared by management at Lingan, the Joint Occupational Health and Safety (JOHS) Committee and the workers on the Coal Crew who worked in the Tripper Gallery itself. *(NSPI Submissions, paragraph 26*) The slots had been there for twenty-five years and no one had fallen through. In my view that

fact is relevant to the issue of NSPI's moral culpability and therefore relevant to the proportionate sentence issue. It is not being suggested by the Crown that this is a case of a corporate offender who was reckless or wilfully disregarded a hazard: the Crown's position is that this was a hazard that was not identified. This is acknowledged by NSPI's guilty plea. The question that remains is whether it was a hazard that should have been identified. The conclusion I arrive at on this issue is relevant to the degree of moral blameworthiness attributable to NSPI.

[46] I was advised during the sentencing hearing that NSPI did identify a similar hazard at its Trenton plant where the Tripper Gallery floor has slots that are 20 inches in width. In 1982, NSPI installed a guard rail system at Trenton that is fully compliant with the fall protection regulations. The difference, NSPI submits, is that the Trenton Tripper Gallery slots are six inches wider than the slots at Lingan.

[47] Notwithstanding the difference in the width of the slots, NSPI did ensure that the fall hazard represented by floor slots was guarded against in Trenton. Presumably, given the safety inspections carried out in the Lingan plant, the fact that the Lingan floor slots were smaller was the reason no fall protection was installed even though that had been deemed necessary at the Trenton Plant.

[48] NSPI submits that the failure to install fall protection over the slots at Lingan was a misapprehension of the risk. I am satisfied that is the most plausible explanation for why the hazard was not addressed. As counsel for NSPI pointed out in his submissions, the JOHS committee made up of management and union membership carried out plant inspections to identify safety issues. The Tripper Gallery

was one of the areas inspected. There were also Coal Crew inspections in the Tripper Gallery. The floor slots were in plain view and everyone familiar with the operation of the Tripper Gallery would have been aware of them and their function. It is not reasonable to think they would have been overlooked. It makes far more sense, as NSPI has submitted, that they were not seen as constituting a hazard. It was not expected that anyone could or would fall through them. There was no reason for workers to cross over them as there were safe passages from one side of the Gallery to the other that did not involve stepping over the slots. Workers worked alongside the slots but as noted earlier, in twenty-five years, no one had fallen through. David Walker, a supervisor and management member of the JOHS Committee, who had told investigators about slipping through the slots to retrieve the scraper, also said when asked, that he had felt safe working in the Tripper Gallery and identified no hazards there prior to December 4, 2004. Furthermore, it was ten hours before Mr. Wrice was located in the coal hopper even though his hard hat had been found next to the slots. This indicates that even with Mr. Wrice missing, it was some considerable time before the search focused on the possibility that he might have fallen through a slot. There was, I am told, a frantic plant-wide search for Mr. Wrice before the slots were identified as the possible site for his disappearance.

[49] Also in support of its submission that the Lingan Tripper Gallery floor slots were not seen as presenting a hazard, NSPI points to the fact that the Department of Labour did not issue a stop-work order after Mr. Wrice's body was retrieved. The Crown argues that this decision should not be seen as an endorsement of the safety of the unguarded slots but merely a practical realization of the implications for the power grid that a stop-work order would have represented. Department of Labour officials

did issue a verbal order on December 22, 2004 for the installation of a metal cord to "enhance" the floor slots. NSPI was proceeding to install the cord but had wanted a "field" trial. The cord was installed and subsequently, grating, at a cost of $82,000. (*Agreed Statement of Facts, paragraphs 22 and 23*)

[50] NSPI made a serious miscalculation in assessing the safety of the Tripper Gallery floor when it assumed the slots were not big enough to allow a person through and therefore were not hazardous. But David Walker knew it was possible to fit through the slots. That implicates NSPI with the knowledge that the slots presented a real hazard. Having said that, I do not find, as Judge Tufts did in *Meridian*, that this was an accident waiting to happen. I do not think it was as obvious as that although it should have been apparent that a fall was a possibility. It should have been foreseeable that a worker could become unconscious. In the *Maritime Paper Products Ltd.* case (*unreported, Crown's Authorities, Tab 6*) a worker was rendered unconscious by a seizure and fell through an unsecured hole above a slow-moving conveyor belt. NSPI's guilty plea is an acknowledgement that it should have recognized that the slots were a hazard and secured them in compliance with the fall protection regulations.

Principles of Sentencing - Parity

[51] The principle of parity in sentencing requires that "a sentence should be similar to sentences imposed on similar offenders for similar offences committed in similar circumstances." (*section 718.2(b), Criminal Code*)

[52] This case does not lend itself easily to comparisons. As I have already found, it is not similar to occupational health and safety cases where a causal connection between the infraction and a worker's death has been established. This is not a case where a hazard was identified and nothing was done. NSPI did not fail to conduct safety procedures such as toolbox meetings (the Coal Crew), or JOHS meetings and inspections. It is not similar either in terms of the offence or the circumstances, to the *Meridian* case, for example, where failures such as I have just described were identified. (*Meridian, supra, paragraph 17*) This is also not a case where safety policies were inadequate with a lack of proper policies and an impoverished corporate safety culture which were found in *R. v. Town of New Glasgow, [2008] N.S.J. 123* to have directly contributed to the dangerous conditions that produced the trench collapse. (*paragraph 41*) The penalties and surcharges levied in *Meridian* and *Town of New Glasgow*, both fatality cases, totalled approximately $110,000. In *JD Irving*, a fall fatality case where the offender failed to provide fall protection equipment or training in fall arrest, the total penalty including victim surcharge was $115,000.

[53] NSPI submits that sentencing in this case should be informed by cases where there was no injury because it has not been proven that the fall caused Mr. Wrice's death. However this is not a case like *R. v. Elks Fabricators* or *R. v. Four Seasons Roofing (unreported decisions of the Honourable D. William MacDonald, March 13, 2002 and August 13, 2003*) where there were no actual injuries, just infractions that could have led to a worker being injured. In this case, there was an actual fall; it is not a case of the hazard of the slots being identified before anyone fell through them. Mr. Wrice did fall through even though I cannot say what effect that fall had on him. I will note that NSPI's proposal in relation to sentencing does contemplate a larger penalty

than the ones imposed in *Elks* and *Four Seasons Roofing* which is an indication that NSPI is not drawing a direct comparison between this case and those decisions.

[54] In *R. v. A.W. Leil Cranes & Equipment* the occupational health and safety infractions did result in very serious injuries although no fatalities. Judge Tufts had the following to say: "With respect to the extent of harm and potential harm, thankfully, there were no fatalities with respect to this accident, although the potential certainly existed for that to have occurred." *(paragraph 14)* A.W. Leil Cranes & Equipment was a company much smaller than NSPI. The total penalty imposed, with victim surcharge, was $26,800. In that case, Judge Tufts was able to determine what the actual harm was to those injured by A.W. Leil's contravention of the *OHSA* and considered that along with the other relevant factors in a sentencing of this nature. It was not a case where the issue of the potential harm had to be examined closely as Judge Tufts had actual harm to work with. Consequently the issue of potential harm was not discussed.

[55] As I said when I started to discuss the issue of parity, it is a challenge to find an applicable comparator case to this one. It is not a case where it has been shown that a fatality was caused by the breach of the law. However it is a case where an actual fall did occur and the potential for a serious injury or death from such a fall can only be described as significant.

Principles of Sentencing - Restraint

[56] The principle of restraint requires the sentencing court to apply a measured

response in determining the sentence that best satisfies the purpose and principles of sentencing. In an occupational health and safety case this means that the fine imposed must be no greater than is required to meet the objectives of sentencing. *(Meridian, supra, paragraph 22*)

NSPI's Safety Practices and Culture - Before and After December 4, 2004

[57] The Crown concedes that since Mr. Wrice's death NSPI has taken a number of significant steps to improve safety. NSPI is undertaking an extensive audit of its Lingan Plant operations to identify any areas of the Plant where new or additional fall protection measures are required. In October 2008, the President of NSPI directed the company to undertake a Fall Protection Audit of all NSPI facilities and work sites. The estimated cost for the audit is $100,000 to $250,000, not including the cost of any work that the audit identifies as being required. (*NSPI Brief, paragraph 44*)

[58] In the Crown's submissions, these initiatives on the part of NSPI significantly reduce any need to consider specific deterrence in sentencing. I agree. NSPI has responded in a responsible, focused and timely fashion to the tragedy of Mr. Wrice's death and are taking critical steps to identify any fall hazards that require attention. This, and the specific steps taken by NSPI in relation to the Lingan Tripper Gallery floor slots themselves, shows that NSPI is committed to avoiding another floor slot accident or similar event and speak to the rehabilitation dimension of the sentencing analysis.

[59] NSPI has had a significant range of safety initiatives and practices in place

since before December 2004 to ensure workplace safety and encourage workers to identify hazards. These include: monthly Joint Occupational Health and Safety (JOHS) Committee inspections of areas of the Lingan plant, monthly coal system inspections by the Coal Crew foremen, daily opportunities (Tailboard meetings) for workers to identify at the start of crew shifts any hazards that may be present at the work site, the ability of workers to refuse to work because of a hazard, and meetings of the Local Union Executive with Plant Management to discuss safety issues. *(NSPI Submissions, paragraphs 28 - 31; 39*)

[60] NSPI has also developed division specific Safety manuals, such as the Thermal Production and Transmission and Distribution division Safety Manual, with each employee being provided a copy. The manuals identify safety rules employees are required to follow. One such rule requires workers to report hazardous situations to a supervisor. The Lingan Plant, to the present time and prior to 2004, operates with a Safety Program that includes the safety practices I referred to above as well as safety training and orientation (including how to report a safety concern), a review of the NSPI Safety Manual, area inspections by the Plant Manager and individual work groups as well as the JOHS Committee, risk assessment reviews, incident investigation and follow up, job observations, quarterly air sampling, and employee orientation training including employee rights to refuse work. *(NSPI Submissions, paragraph 59; Schedule "G", NSPI Book of Schedules*)

[61] NSPI also points to other indicators of its commitment to workplace safety: a substantial safety budget of $700,000 with each individual unit having its own safety budget, a safety excellence charter, a safety excellence newsletter, safety stand-downs,

and intra-company safety awards which represent a commentary on how NSPI is viewed in the broader corporate community. (*Schedules "J', "K", "L", and "M", NSPI's Book of Schedules*) NSPI boasts of favourable injury statistics compared to other utilities in Canada. (*Schedule "N", NSPI's Book of Schedules*) The Lingan Plant has surpassed the one million "man" hours mark without injury, which, NSPI says, is a significant achievement given the size of the plant, the number of workers employed there and the fact that it is a twenty-four hour operation.

NSPI's Prior Record for Breaching the OHSA

[62] NSPI has a previous conviction in 1995 for a violation of the *OHSA* that resulted in a $4400 fine. The facts and circumstances were entirely different from the ones before me. The offence did not occur at the Lingan Plant or any of the other Thermal Generating Plants. For such a large corporation with so many work sites, a single prior offence speaks of a very good safety record. A prior record can be considered as aggravating, but NSPI's is neither recent nor, in my opinion, related to the case I am considering. I do not regard it as a factor in this sentencing.

Determining An Appropriate Sentence

[63] This is a tragic case. Mr. Wrice went to work on December 4 and never came home again. No sentence will heal the hearts of the Wrice family or provide any comfort to them for their loss. This case will conclude without any finding of what caused Mr. Wrice's death. His family will, quite understandably, always wonder if Mr. Wrice might be alive had he not been able to fall through a floor slot. It is speculation as to what Mr. Wrice's condition was when he slid down through the slot

but the fact that he was able to fall through means that his family is left to speculate whether NSPI's failure to guard the slots contributed to Mr. Wrice's death. That is a heavy burden for them to bear and is one of the consequences of NSPI not recognizing that the slots presented a hazard.

[64] As I have reviewed in some detail, Mr. Wrice's death is not one of the consequences of NSPI's breach of the law in this case. This is not a fatality case in the sense of the death being caused by what NSPI failed to do. A serious fall occurred and that was caused by NSPI's failure to comply with the *Fall Protection and Scaffolding Regulations* but that is as far as NSPI's culpability goes.

[65] NSPI made a submission that the fall protection regulations are vague. I do not see how they are. In any event, NSPI entered a guilty plea for not having complied with them, acknowledging that it should have identified the Tripper Gallery floor slots as a hazard and secured them as it has now done. There does not appear to me to be an issue about vagueness.

[66] The Crown has been clear it is not suggesting that NSPI cut corners or flagrantly disregarded safety to improve its profit margin. There has been no suggestion that NSPI is a bad corporate citizen or engaged in a "wilful surreptitious violation." I have found that the failure to identify the floor slots as a hazard was a misapprehension on the part of NSPI. I accept that NSPI did not think the floor slots at Lingan presented a hazard to workers. This makes NSPI less culpable than if it had adverted to the problem and failed for whatever reason to do something about it. Punishment should be mitigated by this lesser degree of culpability and by other

factors such as NSPI's prompt action to make the floor slots safe and its undertaking an extensive assessment of whether other fall hazards exist at Lingan.

[67] The primary goal in sentencing NSPI is general deterrence; the sending of a message to other corporate employers that safety in the workplace must be rigorously maintained with hazards being identified through a critical assessment of what could happen over a broad range of possibilities including a worker becoming unconscious. Satisfying the imperatives of general deterrence in sentencing however has to be accomplished in a manner that reflects the particular circumstances of the case. General deterrence may mean different things in different cases. For example, the facts of a case may require that the principle of general deterrence be expressed in the sentence as "a warning to others" who would view a less substantial fine as "a mere licence for illegal activity." *(Cotton Felts Ltd., supra, paragraph 22)* Crafting a sentence that is intended to carry that kind of message is a different exercise than I am confronted with where NSPI has a demonstrated commitment to the safety of its workers and has an excellent safety record.

[68] In my view the sentence in this case should convey the message that mistaken assumptions about safety can have dangerous consequences. This is a case where it was possible to envision a fall through a floor slot: David Walker figured out that he could slip through a slot and did so. Had awareness of the fact that a human body could fit through the slots translated sooner into the installation of the bars that exist now, Mr. Wrice would not have ended up in the coal hopper. I do not think that a fine of $10,000, for a company the size of NSPI, adequately expresses the message that should emerge from this case. Having accounted for the mitigating factors that apply

in this case, NSPI's guilty plea, its safety record and the steps it has taken since Mr. Wrice's accident to address and enhance workplace safety, I am imposing a fine of $25,000 given the fact that a serious fall was the consequence of NSPI's failure to guard the slots. I am also ordering that NSPI pay, as it has proposed, for three of the Public Awareness sessions being developed by the Nova Scotia Construction Safety Association which at $5000 a session totals $15,000 for this educational component of the penalty. A Victim Surcharge of $3,750 on the fine brings the total sentence for NSPI's breach of the fall protection regulations to $43,750. Once I hear from counsel I will afford NSPI a reasonable period of time to pay the $28,750 for the fine and surcharge.

Anne S. Derrick
Judge of the Provincial Court of Nova Scotia

APPENDIX "A"

R. v. NSPI

Agreed Statement of Facts

1. Nova Scotia Power has approximately 1,800 employees. Nova Scotia Power provides 97% of the electrical generation, transmission, and distribution in Nova Scotia.

2. Nova Scotia Power produces this electricity through its fleet of five thermal, one tidal and 33 hydro plants, as well as four combustion turbine and two wind turbine sites and provides the electricity it produces to 479,000 residential, commercial and industrial customers.

3. The Lingan Thermal Generating Station situate at 2599 Hinchey Ave in New Waterford, Nova Scotia is one of Nova Scotia Power's five thermal generating stations.

4. Lingan Thermal Generation Station is a 600-MW plant and is the largest producer of electricity in the Province. The plant produces electricity by way of four units each capable of producing 150-Megawatts of electricity. The four Units were designed by professional engineers over a span of several years. Unit 1 was commissioned in 1979. Unit 2 was commissioned in 1980. Units 3 and 4, extensions of Units 1 and 2, were commissioned in 1983 and 1984 respectively. The Units may be fueled by oil or coal; however, coal is the main fuel used at Lingan.

5. Coal is supplied to each of the four units at Lingan via coal hoppers that sit adjacent to the boilers which create the heat to turn the turbines that in turn generates the electricity. Each of the units at Lingan has four inline hoppers (or silos) that supply the boilers with coal, each hopper is identified as A, B, C, and D. The four hoppers for each of the four units are inline; there are sixteen inline Coal Hoppers at the Lingan plant. The top of each Coal Hopper reaches to the underside of the floor of what is known as the Tripper Gallery.

6. The Coal Hoppers for each of the units at Lingan are loaded using two tripper belt conveyors which operate North to South in the Tripper Gallery. The two belt conveyors run parallel over the Coal Hoppers. There are openings in the floor of

the Tripper Gallery on either side of each belt conveyor directly over the top of each of the sixteen Coal Hoppers. The coal is fed from the two conveyor belts through these openings on either side of each conveyor belt. These openings are 360 mm wide and have a 101 mm high kick plate at the junction of the floor and the opening. The openings provide an entry point for the coal as well as providing ventilation for the hoppers to alleviate methane gas buildup from the coal.

7. Coal is directed off of the belt conveyors by a movable Tripper unit which operates on top of each belt conveyor; each Tripper is equipped with chutes which direct the coal from each belt conveyor directly into the opening in the Tripper Gallery floor. The hoppers are filled from the centre of each hopper along the length of the Tripper Gallery. The F2 tripper is on the east side of the centre and the F1 tripper is on the west side. The trippers are controlled and moved by the operator using an electrical control panel located on the wall. The panel indicates when the trippers are in the correct position for filling each hopper. The trippers are stationary while the hopper is being filled. The Tripper cannot be moved remotely; the operator must be at the panel to move the Tripper.

8. From the time the four units at Lingan were completed until the mid 1990s two workers were assigned to the Tripper Gallery during the day, seven days a week. One worker would attend in the Tripper Gallery during the overnight shift to load coal as required. From the mid 1990s to date one worker is assigned to the Tripper Gallery during the day shift seven days a week and one worker attends in the Tripper Gallery during the overnight shift to load coal as required.

9. The worker, also referred to as a coal handler, controls the movement of the conveyor tripper system from a control panel located on a wall situated approximately in the centre of the room. When coal is needed in a particular bunker the operator moves the conveyor tripper system to the needed unit and coal is then discharged into the coal hopper. The coal hoppers are approximately 15 meters (49 feet) in depth and approximately 8 meters (25 feet) in diameter.

10. At times during the loading process of coal into the hoppers, coal spills on to the walking surface of the Tripper Gallery floor. It is the duty of the coal handler to ensure that the coal is put into the hopper. This function is performed manually by the coal handler, by raking or shoveling the coal into the hopper.

11. Each Tripper is equipped with stairs on each side of the tripper and a platform which enable workers to cross over each of the belt conveyors. Each set of stairs and platform is equipped with a guardrail.

12. The two belt conveyors are approximately six feet apart. The Tripper Gallery floor including the area between the two belt conveyors is made of concrete.

13. Each belt conveyor and associated floor openings end short of the south wall of the Tripper Gallery providing an area for passage from one side of the Tripper Gallery to another and to the area in between the two belt conveyors.

14. The floor openings in the Tripper gallery floor are up against the edge of each side of the belt conveyors. There is no walkway or standing area between the floor openings and the belt conveyors. The floor openings do not run the entire length of the Tripper gallery floor.

15. An emergency pull chord is attached to each side of the belt conveyor. The pull chord when activated stops the belt and any associated coal loading operation within seconds of activation.

16. The floor openings in the Tripper Gallery were protected by a 101 mm. kick plate but were not equipped with any other form of fall protection.

17. Prior to December 4th, 2004 Alfred Joseph Wrice (d.o.b. June 19, 1969), a member of the NSPI labour pool received the following training in, or received a review of, the following procedures:

    (a) WHMIS

    (b) Safe Start Module One

    (c) Respiratory Protection

    (d) Respiratory Fit Test – Labour Pool

    (e) Confine Space Awareness

    (f) Tripper Floor Operation – up to two weeks

    (g) Orientation 0 Site Specific

    (h) Safe Work Practices

    (i) Heat Stress

    (j) Emergency Evacuation Procedures

(k) Hazardous or Chemical Emergency Procedure

(l) Emergency Oil Spill Response

(m) Medical Emergency

18. On December 4, 2004, Mr. Wrice was alone while performing coal handler duties in the Tripper Gallery. Mr. Wrice was working day shift and his duties consisted of, but were not limited to, being responsible for loading the coal bunkers via the coal trippers, which are located on the sixth level of the coal fired generating station.

19. At approximately 1230 hrs December 4, 2004, Mr. Wrice's hard hat was found near the slot opening in the coal tripper floor near coal bunker 3-B, a plant wide search commenced to locate Mr. Wrice.

20. At 2215 hrs on December 4, 2004, Mr. Wrice's deceased body was found in Unit # 3, hopper 3-B, fourteen feet inside the coal hopper. He was pronounced dead at the scene shortly thereafter by the local Medical Examiner once he was extracted by Nova Scotia Power emergency responders. Mr. Wrice entered the bunker through a slot opening in the Tripper Gallery floor.

21. The Crown takes no position on the cause of death of Mr. Wrice. The Court is not being asked to make a determination in this regard.

22. The NSDEL did not issue a stop work order to NSPI on either December 4th or 5th nor did the NSDEL require any immediate modifications be made to the Tripper Gallery floor.

23. The floor openings are now equipped with bars designed to eliminate any fall hazard created by the floor openings in the Tripper Gallery. This grating system was engineered and installed at a cost of approximately $82,000.00