SUPREME COURT OF NOVA SCOTIA
Citation: *R. v. Gooch*, 2024 NSSC 4

Date: 20240104
Docket: CRH 507413
Registry: Halifax

Between:

His Majesty the King

v.

Jeff Gooch

Judge:	The Honourable Justice D. Timothy Gabriel
Heard:	May 24 - 30, 2023 and June 28, 2023, in Halifax, Nova Scotia
Oral Decision:	December 29, 2023
Written Release:	January 4, 2024
Counsel:	Alex Keaveny, for the Provincial Crown Jack MacDonald, for the Defence

By the Court:

[1] A young man named Brandon Alcorn died on March 13, 2018. He died while working with Dana Munroe and the accused, Jeff Gooch. The three were installing "blueskin" on the walls of the entrance tower of a new Kent Building Supply store (then) under construction on Cutler Avenue, in Dartmouth, Nova Scotia ("the worksite"). His death was tragic and need not have happened. The Crown says that Mr. Gooch, who was the foreman of the three-man subtrade installing blueskin to the tower of the structure, is responsible. He is charged with a single count, pursuant to *Criminal Code* (CC) s. 219(1): criminal negligence causing the death of Mr. Alcorn.

[2] The Court expresses its gratitude to counsel for their courteous and professional conduct of the case, within the context of the anguish which Mr. Alcorn's death has caused his family, friends, co-workers, and everyone else aware of what happened to him.

Factual background

[3] At all relevant times, Mr. Gooch acted in the capacity of Supervisor and foreman for a company called Insulated Panel Structures ("IPS"). He was working with Messrs. Munroe and Alcorn. The accused and Mr. Munroe had earlier completed the front of the entrance tower prior to Mr. Alcorn's arrival for work on March 13, 2018. He was late that day, not arriving at the worksite until approximately 10:00 a.m. After his arrival, as the three were working on the right-hand side of the tower, Mr. Alcorn fell off of the far right edge of the canopy, 18 feet to the ground. This occurred approximately ten minutes after his arrival. He was fatally injured and died later that afternoon.

[4] Video footage of the worksite was obtained days later from the security cameras of another business in the vicinity. During the approximately ten-minute interval between his arrival and the fall, the accused and Mr. Munroe had set up their tools, which included a paint tray containing primer, and had begun some work on the right-side of the tower.

[5] Mr. Alcorn, for his part, was engaged in measuring and cutting the lengths of blueskin for application to the structure by his two co-workers. He appears to have cut two to three such lengths of blueskin. He was engaged in rolling out another such

length, walking backward doing so. He ultimately walked backward off of the far right edge of the canopy.

[6] The accused and Mr. Munroe (who were intent on their task of installing the measured sheets of blueskin with which Mr. Alcorn had provided them) were not immediately aware of what had occurred. They were alerted by another worker on the ground, Danny Holloway. When so notified, they descended from the canopy to assist. The accused remained with Mr. Alcorn, while Mr. Munroe ran to the office of Maxim (the General Contractor) to alert them as to what had happened. He then returned to the scene as well.

[7] Both the accused and Mr. Munroe provided statements to the police, on March 13, 2018, and to Occupational Health & Safety ("OHS") on March 15, 2018. Mr. Gooch, himself, also gave a written report to his employer on March 13, 2018. The Crown alleges that the accused, during the course of the statements said some things which were untrue. He said them while unaware that video footage subsequently obtained from a building in the vicinity, was available. The Crown argues that the statements, which are conceded to have been voluntarily provided, constitute after-the-fact conduct (lying) which betrays a consciousness of guilt.

[8] This matter proceeded as a blended *voir dire*. One of the issues with which the Court had to deal related to these statements. This gave rise to a procedural issue.

Procedural Issue

[9] The Crown has alleged that Mr. Gooch's supervision of the worksite, and specifically his supervision of the deceased, Mr. Alcorn, was criminally negligent on March 13, 2018. The Crown further contends that this led to Mr. Alcorn's death that day.

[10] The after the fact conduct upon which the Crown relies arises out of statements made by Mr. Gooch to his employer, the police, and to Occupational Health & Safety (OHS). As noted, the first two were provided on March 13, 2018. The statement to OHS was rendered two days later.

[11] The Crown argues that there were marked discrepancies in the statements between what had actually occurred, and what Mr. Gooch had said occurred. The Crown asks the Court to conclude that the accused was lying when he made the statements, and draw an inference of an "awareness of guilt" on his part. Otherwise,

the argument continues, why would Mr. Gooch have made these untrue statements in the first place?

[12] The Defence contends that the statements and the video footage of work done the prior day is merely bad character evidence. Counsel contends that the Crown is trying to make the accused look like someone who is a liar, hence, someone likely to have to have committed the offence because they are of bad character. Alternatively, they submit that there are reasons why the statements were made as they were, other than because of a guilty mind. This argument will be addressed further on in these reasons.

[13] However, this was a blended *voir dire*. Both the trial and the evidentiary matter were heard as one. Mr. Gooch sought to testify, but argued that he should be permitted to testify strictly for the purposes of the *voir dire* aspect of the proceeding, without having been deemed to have waived his right to remain silent at the conclusion of the Crown's case. Succinctly put, he wished to testify so as to provide an explanation for the contradictions in his statements, but not face any cross-examination with respect to anything else.

[14] Defence counsel was aware from the outset that this evidence would be called, and what the Crown would be seeking to use it for. The agreement was nonetheless made to have this matter proceed in a blended fashion. Having agreed to do so, the accused (in my view) should not be permitted to bifurcate what had been blended (*voir dire* and trial) and choose to give testimony in the first but not the second.

[15] The three statements of the accused will be considered later in these reasons. I will return to them after discussion of the salient portions of the various witnesses' testimony, to determine their significance (if any) within the context of the evidence as a whole.

[16] As to the evidence as a whole, I will not refer to each and every portion of it as provided by each and every witness, or even (necessarily) to each and every witness. I have nonetheless considered all of it, as well as the documentary and video taped evidence.

Witness Testimony

Scott Andrews

[17] The general contractor hired to provide supervision for the construction of the Kent store (henceforth the "Kent project" or “project”) was Maxim Construction ("Maxim"). Scott Andrews was Maxim's site superintendent. In that capacity, he was responsible for ongoing daily operations, which included the coordination and supervision of compliance with Maxim's safety requirements by all sub-contractors.

[18] He testified that IPS had been hired to install metal siding panels. Part of its job required the application of blueskin from heights. While so doing, IPS, and indeed all sub-trades working on the project, were required to follow both Maxim's and their own safety policies. Like all other sub-trades, IPS employees were required to attend Maxim's orientation and to provide proof of fall protection training. They did so.

[19] As befits his duties with respect to monitoring compliance with safety regulations, Mr. Andrews was especially concerned with the more dangerous safety issues, including situations where workers were working from heights, or were too close to the edge and not tied off. He mentioned that he had observed IPS at times using harnesses and lanyards as fall protection on the Kent site. He also said that Maxim required the use of fall protection measures if work was to be done within 10 feet of a roof edge.

[20] When the suggestion was put to him in cross-examination that staying 6 feet back from the edge constituted an appropriate fall protection safeguard on March 13, 2018, he disagreed somewhat. He stated that staying back from a leading edge would constitute a form of fall protection and also, that he was aware that some contractors do use that "6 feet from the edge" rule of thumb. However, he emphasized that he goes by Maxim's 10-foot requirement.

[21] Pursuant to his key duties, Mr. Andrews testified that he inspected the work being conducted by the many sub- trades and their employees and work crews at the worksite (generally) on a near daily basis.

[22] He estimated that he has been in charge of workers’ safety on over 100 job sites, often having up to 50 tradespeople employed per site at any given time. When monitoring for safety issues on the construction site, he indicated that he is specifically looking for "anybody not following our [Maxim's] safety policies.”

[23] When asked what action he would take if somebody was not following the proper policy, he responded to the effect that it would depend on the nature of the transgression. For something like not wearing a hard hat, perhaps a verbal warning

would suffice. If it was something more dangerous, it would have to be rectified right away. The dangerous examples to which he specifically made reference included "not tied off while too close to the edge" and " working without safety glasses". In a few instances, over the years, where individuals or specific sub- trades repeatedly would not adhere, he had been required to take action to remove them from the site.

Mr. Andrews was referred to a Maxim orientation form with respect to Brandon Alcorn (Exhibit 1, Tab 20). It indicates that Mr. Alcorn's first day on site was January 2, 2018. The form was filled out on March 5, 2018. The document bears both the signature of Mr. Alcorn and Mr. Andrews at the bottom. The latter is indicated to

have been the person delivering the orientation. It is reproduced below:

MAXIM

ORIENTATION FORM
Job Name: Kent Dartmouth Crossing [illegible]
Job Number – 17202

Employee's full name (PRINT): ______
Employee's Company: IFS
Date: March 5th 2018 First Day on Site: Jan 2 2018
Person delivering the orientation: ______
Employee's Foreman of job site: ______

Topics to be covered (Put a check beside each as covered):
1 ☑ Company Safety Policy
2 ☑ Employees' responsibilities
3 ☑ Employers' responsibilities
4 ☑ Safety committee member's names
5 ☑ Emergency Response Procedures including Office phone number and name of Safety Advisor
6 ☑ PPE policy and specific job site requirements
7 ☑ Environmental Plan
8 ☑ Occupational Health and Safety Act
- -Right to Know
- -Right to Participate
- -Right to Refuse
- -Right to Make Complaint

9 ☑ Job site specifics
- -Civic Address
- -Lunch facilities and Washrooms
- -Emergency contact person, phone numbers, and location
- -Muster Station Location

10 ☑ Who to contact in an emergency for the employee and Health Card Number
Name ______ Phone # ______
Health Card Number (optional) ______
Any Medical Conditions (optional) ______

11 ☑ Safety Training: (Provide copies of Certificates)

Training	Yes	No
WHMIS trained?	✓	
First Aid / CPR Training (Level of Training)		
Fall Arrest Training	✓	
Confined Space	✓	
Power Elevated Device	✓	
Forklift	✓	
Powder Activated Tools Training	✓	
Supervisor Training		✓
Scaffolding User Training		✓

12 ☐ Corporate Rules (Maxim Construction Inc. Disciplinary Policy)

I, ______ understand and will comply with the company's safety policy, safe work practices and job procedures. I have been made aware of my rights and responsibilities as outlined in the Occupational Health and Safety Act and will comply with wearing the proper safety equipment and personal devices and clothing required by regulations and my employer.

I will notify my employer of any unsafe conditions or acts that may be of danger to myself, my employer or other people.

I will take every reasonable precaution to protect the safety of other people and myself.

Employee's signature ______ Date March 5 2018
Trainer's signature ______ Date March 5/18

Revised: November 2, 2015 **SEND TO OFFICE & FILE ON SITE** © Maxim Construction Inc. FORM-14

[24] Mr. Andrews was next referred to Maxim "NS Safety Manual" (Exhibit 1, tab 21). This document begins, at page 1, with a notification to the user that "the safety information in this manual does not take precedence over the Occupational Health & Safety Act, regulations and codes of practice". It is a voluminous document, some 470 pages in length. It covers topics such as "policies/responsibilities", hazard assessment, safe work practices, job procedures, rules, personal protective equipment ("PPE"), maintenance program, training and safety measures,

inspections, investigations, environmental policy, emergency preparedness, records and statistics, and a harassment policy.

[25] Maxim's inspection policy (Exhibit 1, Tab 21, page 209) includes the following:

> To determine the extent of hazards in the work place and assign controls to them, a system of formal inspections will be conducted on a regular basis by this company on all work sites.
>
> The project supervisor/foreman will be responsible to do weekly **job operations formal inspections** on his/her work site/s. The requirement to do this inspection weekly is a minimum frequency. More than one inspection a week may be required as site conditions change.
>
> The Corporate Safety Advisor or his delegate will conduct a minimum of **monthly formal inspections** of the work sites. A written report will be required for each work site and a copy will be posted at the site and reviewed with site supervisor and senior management.
>
> The Maxim Construction Inc. office will also be inspected by one person of management and one employee quarterly using the new **office inspection checklist**.
>
> Corrective action on those items identified as serious, through a system of priorities, will be completed as soon as possible with the workers made aware of any potential danger to their health and safety arising from any inspection. Priorities are the same as posted on the hazard assessment forms.
>
> [Emphasis added]

[26] The form requiring completion by the site supervisor on a weekly basis is reproduced below:

210

MAXIM

JOB OPERATIONS AND CONDITIONS OF WORK SITE

To be completed by the site superintendent on a weekly basis

Project name: ______________________ Job no. ________ Date: ________

Person(s) conducting inspection: (Print) ______________________

	Adequate (Yes / No)	Priority	Action Required	By Whom Contractor Name	Date Completed
1. Housekeeping/sanitation					
2. Fire prevention and control					
3. Electrical installations					
4. Guards on tools and equipment					
5. Ladders, walkways, ramps					
6. [illegible]folds, work platforms					
7. Personal protective equipment:					
A. Hard hats worn					
B. Eye/face protection					
C. Lifelines / safety equipment					
D. Dust masks/resp. protection					
8. Cranes/hoists - inspection/maintenance					
9. Heavy equipment - operations and control					

ANY ADDITIONAL COMMENTS FROM SITE INSPECTION

____

____

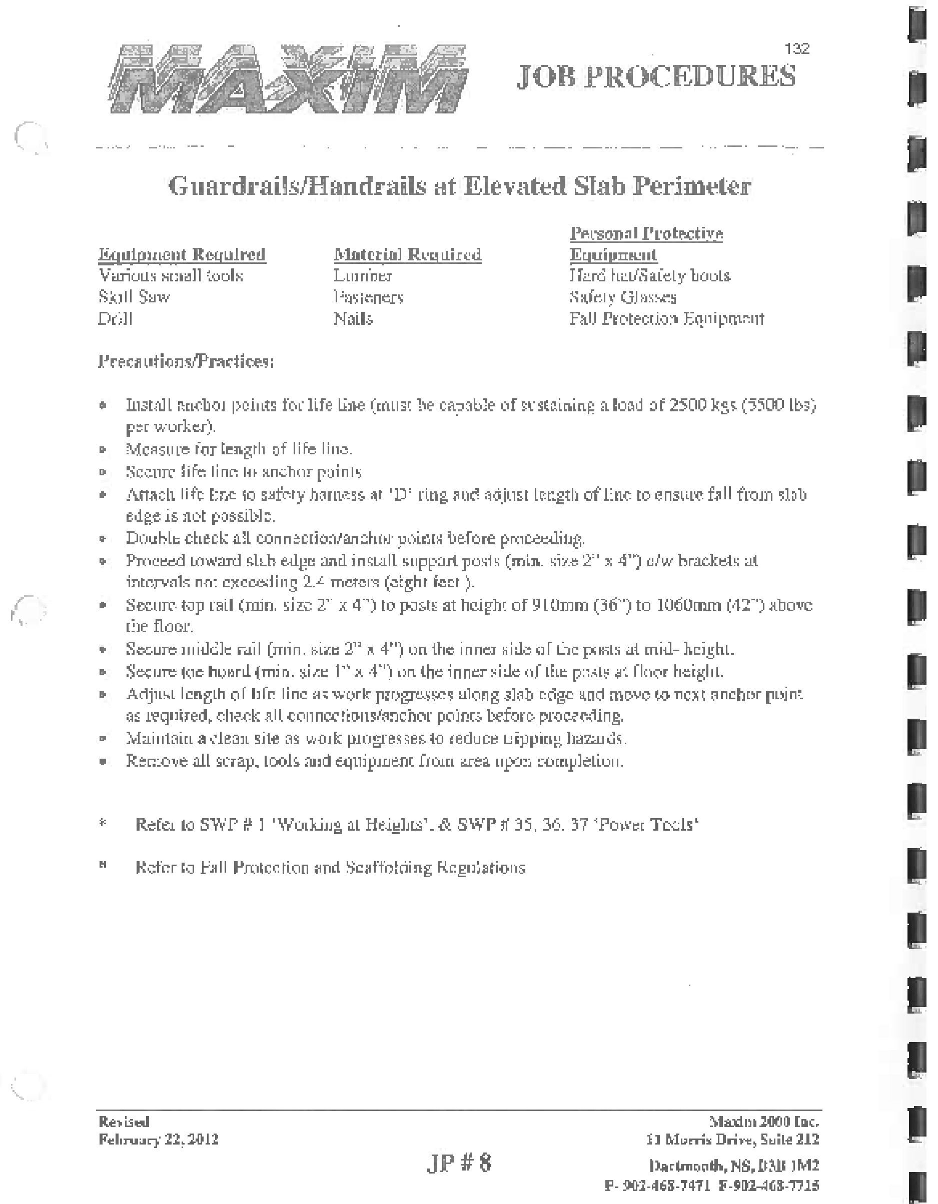
____

____

Page 1 of 2

[27] Maxim's "monthly formal jobsite inspection guidelines" (Exhibit 1, tab 21, pages 219 – 220) include admonitions to "always refer to the Occupational Health & Safety Act and the general occupational safety regulations when conducting an inspection"; "During an investigation always check for compliance to the use of PPE" (personal protection equipment); "Before starting an inspection notify the person in charge of the site … where you are and what you are doing."

[28] The document also references, among its job procedures, "the use of guardrails/handrails at elevated slab perimeter” (Exhibit 1, tab 21, page 132). This is also reproduced below:



MAXIM JOB PROCEDURES 132

Guardrails/Handrails at Elevated Slab Perimeter

Equipment Required	Material Required	Personal Protective Equipment
Various small tools	Lumber	Hard hat/Safety boots
Skill Saw	Fasteners	Safety Glasses
Drill	Nails	Fall Protection Equipment

Precautions/Practices:

- Install anchor points for life line (must be capable of sustaining a load of 2500 kgs (5500 lbs) per worker).
- Measure for length of life line.
- Secure life line to anchor points
- Attach life line to safety harness at 'D' ring and adjust length of line to ensure fall from slab edge is not possible.
- Double check all connection/anchor points before proceeding.
- Proceed toward slab edge and install support posts (min. size 2" x 4") c/w brackets at intervals not exceeding 2.4 meters (eight feet).
- Secure top rail (min. size 2" x 4") to posts at height of 910mm (36") to 1060mm (42") above the floor.
- Secure middle rail (min. size 2" x 4") on the inner side of the posts at mid- height.
- Secure toe board (min. size 1" x 4") on the inner side of the posts at floor height.
- Adjust length of life line as work progresses along slab edge and move to next anchor point as required, check all connections/anchor points before proceeding.
- Maintain a clean site as work progresses to reduce tripping hazards.
- Remove all scrap, tools and equipment from area upon completion.

* Refer to SWP # 1 'Working at Heights', & SWP # 35, 36, 37 'Power Tools'

* Refer to Fall Protection and Scaffolding Regulations

Revised
February 22, 2012

JP # 8

Maxim 2000 Inc.
11 Morris Drive, Suite 212
Dartmouth, NS, B3B 1M2
P- 902-468-7471 F-902-468-7715

[29] Next, the company's "corporate personnel protective equipment policy" is reproduced:

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MAXIM

CORPORATE PERSONAL PROTECTIVE EQUIPMENT POLICY

The following will be observed and practiced by the company when the company undertakes any job or contract and are to be followed by all sub-contractors and their sub-contractors on site.

- All employees, trade contractor employees, guests, and visitors will wear CSA Approved safety boots, long trousers, shirts, CSA approved hard hats, and any other specialty PPE required for the job site.
- All PPE used by the company will be within the requirements of the Occupational Health and Safety Act and recognized standards.
- All PPE used by the company will be maintained in accordance with manufacturer's instructions and requirements. All fall arrest equipment (Harness/ lanyard /safety lines) must be inspected annually. (Serco 902-468-7300, Total Fall Protection 902 481 0132, Hercules SLR 902-482-3120 or Bridgeport Wire & Rope 902-468 0300).
- Company issued PPE will be inspected at time of issue and before each use by the employee using the PPE.
- All PPE that is of questionable reliability, damaged, or in need of service or repair will be removed from service immediately.
- All PPE that has been removed from service will be identified as "**OUT OF SERVICE**" and will not be returned to service until repaired and inspected by a qualified person.
- No piece of PPE will be modified or changed contrary to the manufacturer's instructions or specifications, or the Occupational Health and Safety Act, Regulations, or Codes of Practice.

- **The safety information in this policy does not take precedence over the Occupational Health and Safety Act, Regulations, or Codes of Practice.**

Adam Tiller GSC, B. Eng.
President

February 20th, 2018
Dated

Revised
Feb 20, 2018

Page 1 of 1

Maxim Construction Inc.
13 Morris Drive, Suite 212
Dartmouth, NS, B3B 1M2
P- 902-468-7471 F-902-468-7715

[30] Finally, reference is made to the corporate rules (Exhibit 1 tab 21, page 162, the disciplinary guidelines (page 163) and an information sheet (Exhibit 1, tab 21, page 184):

162

CORPORATE RULES

1. The corporate safety policy will be read and followed by all personnel employed by Maxim Construction Inc.

2. All employees will be aware of their responsibilities under the Occupational Health and Safety Act.

3. Vehicle/equipment operators will have a valid license and operating "ticket", when required.

4. Consuming alcohol or illegal drugs during working hours, breaks, and lunchtime is prohibited and may be grounds for immediate dismissal. Employees who are taking over the counter or prescription drugs are to notify their supervisor in confidence.

5. All buildings on Maxim sites are designated as "No Smoking". Smoking in a building, or within 16' of the building, is prohibited and may be grounds for immediate dismissal.

6. Fall protection is to be worn at heights over 3 meters or over any dangerous terrain or at any time while using power elevated devices i.e. Scissor lifts or zoom booms – failure to comply will result in <u>suspension</u>.

7. All unsafe acts and conditions, accidents, and near misses are to be reported to your supervisor immediately. When this is not practical, you must report the incident within 24 hours to your company safety advisor or supervisor / foreman.

8. All employees are to practice good housekeeping at the work site.

9. CSA approved [illegible] d hats and safety boots will be worn at all times by **Maxim Construction Inc.** personnel at the work site.

10. Fighting, horseplay, practical jokes, or otherwise interfering with other workers is prohibited and may be grounds for immediate dismissal.

11. Theft, vandalism, or other abuse or misuse of company property is prohibited and may be grounds for immediate dismissal.

12. Earphone type radios or players and radios are not allowed on the site. Radios found on site will be confiscated.

13. Shirts are to be worn by all personnel while working on company time. While working on job sites, no ties, tank tops, cutoffs, shorts, loose or ragged clothing permitted.

Adam Tiller GSC, B. Eng.
President

February 20th, 2018
Dated

Maxim Construction Inc.
11 Morris Drive, Suite 212
Dartmouth, NS, B3B 1M2
P- 902-468-7471 F-902-468-7715

DISCIPLINARY GUIDELINES

In the operation of our safety program, non-compliance can result in near misses and serious accidents which cause injury and property loss. The following guidelines are intended to provide compliance and incentive to work safely.

The sequence of administering disciplinary procedures will be:

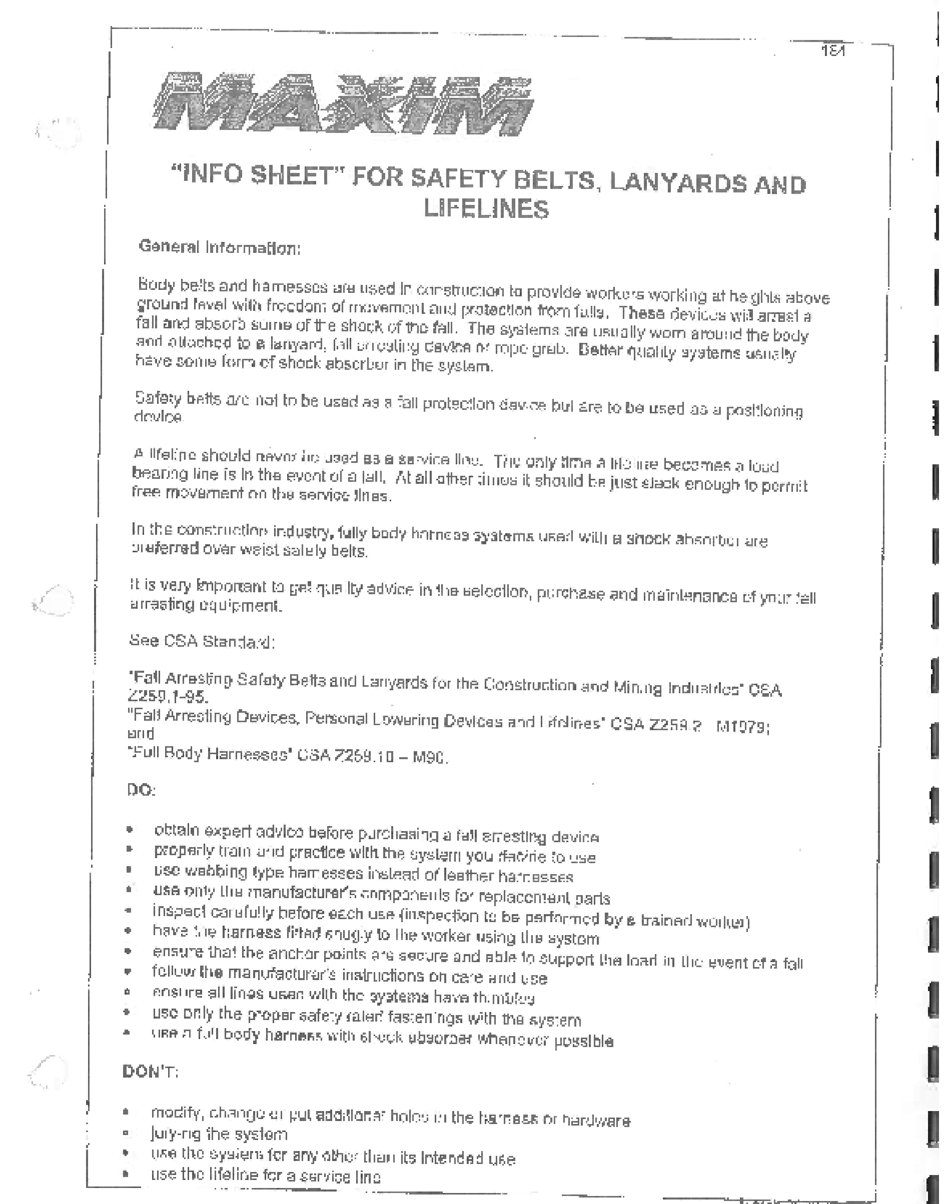
1. The Steps of Disciplinary Action
   a) Tell employee the rule violated.
   b) Discuss the purpose of the rule and the danger involved.
   c) Complete an employee reprimand form. (Warning)
   d) Advise the employee of the consequences of a further violation (termination of employment).
   e) Copy of all Reprimand forms to be mailed to Union Office.

2. The sequence of administering disciplinary procedures will be; at the discretion of Maxim
   - Verbal Warning(s)
   - Written Warning(s)
   - Termination of Employment.

3. The following actions may result in immediate dismissal:
   a) Negligence resulting in major property damage and/or serious injury.
   b) Deliberate violation of company safety policy or rules.
   c) Fraud, theft, or Criminal Code conviction.
   d) Driving a vehicle or working on a job site while under the influence of alcohol or illegal drugs.
   e) Falsification of sick benefits or WCB claims.
   f) An accumulation of "Warnings".

4. Disciplinary Action for Subcontractors
   Subcontractor employees, with regards to safety, are to be treated as Maxim Construction Inc. employees. However the subcontractor has the primary responsibility of discipline. If a subcontractor does not discipline an employee then Maxim Construction Inc. must reprimand both the employee and the subcontractor.

February 2018



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MAXIM

"INFO SHEET" FOR SAFETY BELTS, LANYARDS AND LIFELINES

General Information:

Body belts and harnesses are used in construction to provide workers working at heights above ground level with freedom of movement and protection from falls. These devices will arrest a fall and absorb some of the shock of the fall. The systems are usually worn around the body and attached to a lanyard, fall arresting device or rope grab. Better quality systems usually have some form of shock absorber in the system.

Safety belts are not to be used as a fall protection device but are to be used as a positioning device.

A lifeline should never be used as a service line. The only time a lifeline becomes a load bearing line is in the event of a fall. At all other times it should be just slack enough to permit free movement on the service lines.

In the construction industry, fully body harness systems used with a shock absorber are preferred over waist safety belts.

It is very important to get quality advice in the selection, purchase and maintenance of your fall arresting equipment.

See CSA Standard:

"Fall Arresting Safety Belts and Lanyards for the Construction and Mining Industries" CSA Z259.1-95.
"Fall Arresting Devices, Personal Lowering Devices and Lifelines" CSA Z259.2 - M1979; and
"Full Body Harnesses" CSA Z259.10 – M90.

DO:

- obtain expert advice before purchasing a fall arresting device
- properly train and practice with the system you decide to use
- use webbing type harnesses instead of leather harnesses
- use only the manufacturer's components for replacement parts
- inspect carefully before each use (inspection to be performed by a trained worker)
- have the harness fitted snugly to the worker using the system
- ensure that the anchor points are secure and able to support the load in the event of a fall
- follow the manufacturer's instructions on care and use
- ensure all lines used with the systems have thimbles
- use only the proper safety rated fastenings with the system
- use a full body harness with shock absorber whenever possible

DON'T:

- modify, change or put additional holes in the harness or hardware
- jury-rig the system
- use the system for any other than its intended use
- use the lifeline for a service line

March 2008

[31] Returning to Mr. Andrews' testimony, before March 13, 2018, he recalled no safety infractions by IPS. This was consistent with his recollection that he had observed no work being done unsafely by the company. He did not observe Mr. Alcorn's death himself. As to the written hazard assessments which IPS was required to file as part of Maxim's requirements, Mr. Andrews did not recall seeing any of them, but felt that they were probably "at our office".

[32] Mr. Andrews agreed that the document found at Exhibit 1, tab 2C was an example of a field level hazard assessment, completed by IPS. It was dated March 12, 2018 (the day before Mr. Alcorn's death) and was signed by Jeff Gooch, Dana Munroe, and Brandon Alcorn. The document lists one of the work tasks to be performed that day as "blue skinning". The specific hazards listed include slips/trips/falls; working at heights; other trades; garbage; weather; sharp edges; bending/twisting. In the adjacent column is found IPS's "plans to eliminate/control" the hazard. Listed sequentially, the control measures noted are: "keep area clean, <u>stay back 6 ft. or 100% tie off</u>, clean as you go, dress for conditions, 100% PPE, stretch before walking." (Emphasis added)

[33] As earlier mentioned, Mr. Andrews agreed in cross-examination that he was aware that some contractors may use 6 feet from the edge as a safe distance to work without fall protection. He added, however, that he "goes by" Maxim's 10' requirement". He also agreed that, in the final analysis, for a worker to completely stay back from a leading edge is the best form of fall protection.

[34] Finally, he agreed (in cross-examination) that Maxim's policy would forbid a worker from coming to work while intoxicated. He said it was not allowed because it is not safe. Somebody could get hurt and/or cause an accident.

Barry Oxner

[35] Mr. Oxner is a proprietor of "Total Fall Protection", a business operating in Dartmouth Nova Scotia. He was qualified to offer opinion evidence on the inspection and use of fall protection equipment. He said that fall protection was required while working on the canopy upon which Mr. Alcorn had been engaged. The height of the canopy was 18 feet above ground. He said that the implementation of fall protection measures and/or use of fall protection equipment, when working at or over 3 m (10 feet), is a legislative requirement. He provided a written summary of his opinions dated April 17, 2019, insofar as they relate to the present case. This included the following observations:

Upon review of the "Hazard Assessment" dated March 12, 2018 the following items were noted under "hazards to consider"

a) Slips/trips/falls this received a 2 rating
b) Working at heights this received a 1 rating
c) Sufficient training this received a 4 rating
d) Tripping hazard this received a 2 rating
e) Working from heights/roofs this received a 1 rating

Hazards identified were;
Working at heights rank 1 Requires 100% tie off
Fall protection was not in use at various times during the day
Scissor lift rank 2 Inspect daily
Not all workers were trained for the AWP
Harness rank 2 Inspect daily
No documentation available
Working near edge rank 2 Stay back 6ft
This was not enforced

The ranking chart listed the following injury & probability:
Rank 1 Catastrophic- may cause death or injury or company shut down
Rank 2 Critical- may cause severe injury, severe occupational illness or major property damage

This document was signed by Jeff Gooch March 13, 2018.

Upon review of the "Field Level Hazard Assessment" document dated March 12, 2018 the following items have been noted:

Item #23 aerial lift was identified as a hazard
Item #26 Slips/trips were identified as a hazard
Item #32 Harness/lanyard inspected was identified as a hazard
Item #33 100% tie off with harness was identified
Item #34 Tie off points were identified as a hazard

The "Total Safety Task Assessment" section lists the task of installing the blue skin with the following hazards listed;

a) slips/trips/falls
b) working at heights

The plan is to keep the area clean, stay back 6ft or 100% tie off.

This document was signed by:

1. Jeff Gooch
2. Dana Munroe
3. Brandon Alcorn

Upon the review of these documents I would note that;

1. The paperwork was filled out as required
2. Items on the paperwork were noted but not necessarily checked
3. Identifying the hazard and its consequences did not seem to go hand in hand
4. The monthly "Hazard Assessment" sheets were not verified by all workers
   January 3, 2018 only signed by Brandon Alcorn
   February 5, 2018 no signatures
   March 12, 2018 signed by Jeff Gooch, Dana Munroe, Brandon Alcorn
5. Work site checks by the supervisor (Jeff Gooch) to review the assessments did not occur or were ignored.

Item #2
Equipment

Please review the Total Fall Protection report

Page 1 of the IPS Job Hazard Analysis defines the equipment to be used for working at height and in mobile equipment (work platforms) as the following:

1. Full body harness
2. 6ft shock absorbing lanyard
3. Double lanyard
4. Retractable lanyard
5. 5/8 lifeline
6. Rope grab
7. Engineered anchor

During the initial investigation for Labour and Advanced Education no rope grab was identified with the site equipment.
Because of the types equipment that were presented it would be presumed that the fall arrest/tie off system would consist of the following equipment:

1. Full body harness
2. 5/8 vertical lifeline
3. Anchor point
4. Rope grab
5. Shock absorbing lanyard or shock absorbing lanyard

Upon review of the anchor point the label was unclear and the anchor had sustained damage, it should have been deemed a failure . Upon review of the manufacture's directions, the anchor point was not designed to be secured to the Q deck and would fail in the event of a fall.

As mentioned, no rope grab was presented during the initial inspection, therefore there would be no way to attach a shock absorbing lanyard to the vertical lifeline.

The work area did not have any easily accessible areas that could be used for approved anchor systems. The work area should have had a visual warning system placed at an approved distance from the two edges to warn workers of the fall hazard.

A proper set up for this work would have had the scissor lift turned so that workers could have exited through the side gate directly onto the roof instead of climbing over the edge. A barrier system could have been set up on each side of the exit gate and be attached into a warning line that would have been back a safe distance from both edges. This would have removed the need for fall protection.
Review of the video shows that no worker was attached to the lift during its movement and no worker was attached to any roof anchors.

[36] Mr. Oxner continues in the following manner:

Item #3
Accident/Incident Investigation Form Dated March 13, 2018
Supervisor; Jeff Gooch

Jeff Gooch statement; Brandon was just showing up to work. We loaded the scissor lift with gear and went up to the canopy. I told Brandon to install the butterfly clip on the Q decking of the canopy. I started unloading the scissor lift. Turned back and Brandon had fallen off the canopy 42 feet away from where we were working.

Timeline;

10.02.26. 3 workers in lift moving up to canopy. None appear to be attached to lift.
10.02.54. 2 workers climb out of lift at edge while 3rd worker passes out product. It does not appear that any worker unattached from lift to climb on canopy.
10.03.25. 3rd worker climbs out of lift and gets back in to pass out more product.
At no time during this period is any worker tied off. Work continues on the façade of the building with Brandon walking back and forth to the edge of the canopy.
10.07.01 2 workers prepping wall for product while Brandon lays out sheets on the deck. To this point there has been no action to install an anchor point in the work area or a stop work situation to set up a safe work area.

10.09.01 Workers continue to work on façade wall and lay sheets out on deck.
10.10.13 Brandon continues to walk backward unaware of his surroundings and continues off the canopy.
10.10.20 White hard hat worker on ground notices Brandon on the ground. Work still going ahead on canopy.
10.10.30 White hard hat worker on ground makes the workers on the canopy aware of the situation. 1st worker gets in scissor lift but hesitates to come down. Other worker is trying to control product blowing on roof and then gets in lift to come down. Neither are attached to lift
10.10.54 Workers get out off lift and head to Brandon on the ground. Produt still blowing around on canopy.

Notes:

1. At no time does it appear that any worker is attached to the lift as it rises and decends
2. At no time does any worker put a fall protection system, restraint system, barricade or warning line in place.
3. At no time does anybody respond to Brandon walking backwards on the canopy to advise him of the danger.
4. The report of the event occurrence by Jeff Gooch is incorrect.

In closing, this event was avoidable.
This situation was a failure due to the following:

1. The company did not have a supervisor that met the requirement of "competent person" under the regulations.
   competent person" means a person who is
   (i) qualified because of their knowledge, training and experience to do the assigned work in a manner that ensures the health and safety of every person in the workplace, and
   (ii) knowledgeable about the provisions of the Act and Regulations that apply to the assigned work, and about potential or actual danger to health or safety associated with the assigned work,
2. The company did not verify the credentials of its workers
3. The supervisor did not follow the company policy (Assuming that he had been trained by the company on the company's policy)
4. Workers either did not understand their rights as workers or they chose to work in/for an unsafe company. Part of understanding your rights is training in the field of work. I believe that none of these workers had adequate training for the operation of the scissor lift or fall protection.

The conclusions noted in the report are based on information supplied by Halifax Regional Police, the Occupational Health and Safety Regulations, the manufacture of the roof anchor, and opinions for work experience.

If I can be of any further assistance please feel free to contact me.

Respectfully submitted,
Barry Oxner

[37] During his evidence, Mr. Oxner made reference to the Occupational Health & Safety Act, and in particular to the Fall Protection Regulations passed under the auspices of s. 82 of that Act. These included Regulations 21.19 (1) and 21.20 which provide as follows:

> Fall-protection training required
>
> **21.19 (1)** An employer must ensure that a person takes and successfully completes training on fall protection at all of the following times:
>
> (a) before they do any of the following:
>
> (i) use fall protection,
>
> (ii) work in, supervise or plan the work for a work area where fall protection is required; and
>
> (b) once at least every 3 years.
>
> **21.20** Training on fall protection must include all of the following, as applicable to the nature of the work:
>
> (a) a review of all applicable health and safety legislation, regulations and standards;
>
> (b) identification of fall hazards;
>
> (c) a review of the hierarchy of controls that may be used to eliminate or minimize risk of injury from a fall;
>
> (d) the different methods of fall protection and the most suitable application of the methods;
>
> (e) fall-protection and safe-work procedures;
>
> (f) instruction on assessing and selecting specific anchors that may be used for various applications;
>
> (g) instruction on selecting and correctly using fall-protection components, including connecting hardware;
>
> (h) information about the effect of a fall on the human body, including all of the following:
>
> (i) free fall,
>
> (ii) swing fall,
>
> (iii) maximum arresting force, and
>
> (iv) the purpose of energy absorbers,

(i) pre-use inspections of equipment and systems;

(j) emergency response procedures to be used if a fall occurs;

(k) practice in all of the following:

(i) inspecting, fitting, adjusting and connecting fall-protection systems and components,

(ii) the emergency response procedures required by clause (j).

[38] Mr. Oxner said that he was not consulted (beforehand) with respect to appropriate fall protection measures on this project. However, on those occasions when he does consult with respect to such measures, his first objective is to figure out a way to do the job without the need for a harness. His last choice is the use of harnesses.

[39] Some alternative measures may include the use of guardrails, staging, and use of other methods with which to keep workers away from an edge. Sometimes the scissor/boom lift itself may be used, if the tops of the rails are lifted beyond the edge of the roof, depending on the size of the work area involved.

[40] His expressed preference was, accordingly, for "travel restraint" rather than "fall arrest". Mr. Oxner explained that travel restraint was best because, with such a method there is no need for forces to act upon the body to arrest a fall. This is because, if proper travel restraint is used, a person is warned or stopped well before they get to a point where they might fall off.

[41] Within this context, he discussed the implementation of a control zone/warning line. He defined it as the area between the edge and a specified distance therefrom. He said sometimes a guardrail, or warning line is used, but the objective remains the same: to warn the worker to stay away from the other side of the line i.e., the "control zone". He also discussed the varying requirements between the provinces, in their legislation, as to the minimum distance from the edge within which to implement a control zone.

[42] Mr. Oxner discussed (in his direct examination) the types of fall protection equipment with which Mr. Alcorn had been provided. He described it as a harness, a shock absorbing lanyard, and an anchor. The harness, when Mr. Oxner examined it, had been cut by the paramedics on the scene when they arrived to assist Mr. Alcorn, so he had pieced it back together. He opined that the harness, even allowing for the fact that it had been pieced together, would have failed inspection anyway,

because the position of the "D ring" made it appear as though an earlier fall had already occurred in this harness. It appeared that the earlier fall had pulled it out of position, thereby breaking it. It was not up to CSA specifications, as a result.

[43] The lanyard did not measure up either. What he described as "the gate" on the snaplock was not working properly. In his view, the device which he examined should not have been used by a person weighing less than 250 pounds because, in such a circumstance, it would not deploy. The problem was that the hook would not open/close properly. He further said that the safety mechanism on the right side of the device was jamming and holding the "gate", on the left, open. He said this was usually the result of it (also) having been previously exposed to, or used, during a substantial fall, causing it to bend.

[44] Finally, he stated that the anchor used would not pass muster either. He opined that it appeared as though somebody had pried it off of a previous roof and bent it all up in the process. He said the device which he examined was more fit for a one-time use, and it could not be reused safely. He also said that the anchor was of a type that could not be safely used on a "Q deck", such as a one upon which Mr. Alcorn was working. It was designed to work on a peaked roof instead.

[45] Upon cross-examination, when asked about whether an individual's danger of workplace accident would increase if impaired by drugs and alcohol, Mr. Oxner initially replied that he had no experience with respect to drugs or alcohol. When pressed, he agreed that it was unsafe to work from heights while impaired.

[46] He was asked whether, with respect to the anchor, if a worker attached it to the Q deck with 30 screws, it would hold if someone fell. His response was he could not answer that question because he had not read the manufacturer's specifications, and he was not an engineer. He also agreed that the defects in the D ring (to which he had earlier adverted on direct), as well as those with respect to the rebar hook on the lanyard, could have sustained the damage to which he had referred if Mr. Alcorn had worn that equipment when he fell. In other words, the equipment could have been working fine when Mr. Alcorn put it on.

[47] Mr. Oxner acknowledged that he had no idea how much Mr. Alcorn weighed. He also eventually agreed that the particular lanyard could, in fact, be appropriate for individuals weighing between 200 – 386 pounds, and that it was "up to the individual using the lanyard to ensure they are within the proper weight range."

[48] Finally, when referred to the USB footage captured on March 12 and 13th, 2018 (Exhibit 2), he agreed that the footage showed people working on another canopy (to the right of one the one from which Mr. Alcorn fell), one that appeared to be an identical height from the ground. This was work being done by a different subcontractor, and Mr. Oxner agreed that there were no pylons, guardrails, or any of the other types of safety measures or travel restraint measures which he testified that IMP/Mr. Gooch, ought to have implemented as work was done on their canopy. He also agreed that the workers on the other canopy did not appear to be wearing harnesses, either.

Dana Munroe

[49] The Crown called Dana Munroe, who had been working with Messrs. Gooch and Alcorn at the time of the latter's fall, as one of its witnesses. Mr. Munroe is presently employed by the Canadian Coast Guard as a deckhand but, previous to that, had been employed in the construction industry for about 12 years. The entirety of his work in that field had involved the installation of panels on the exterior of buildings. This type of work necessarily involves working with blueskin. He testified that he has worked on sites in Alberta, Iqaluit, Ontario, New Brunswick, Nova Scotia and Newfoundland and Labrador. He had received fall protection training in all of those provinces except Newfoundland and Labrador. In the latter Province, he had been provided with what had been called a "refresher course" in fall protection.

[50] On March 13, 2018, Mr. Munroe had been working as an installer, at the Kent worksite, for approximately 2 to 3 months. He confirmed that his employer was IPS, and he was one of a crew of three, consisting of himself, Jeff Gooch, and Brandon Alcorn. Mr. Gooch was the supervisor of the crew.

[51] He described Mr. Alcorn's job as a labourer, and said that the duties associated with that position were similar to those of an installer, but that an installer has more independence. The labourer's job is to get things that are needed. IPS’s job, at the time, was to install blueskin, which was the weatherproofing membrane applied to the plywood over the tower’s frame.

[52] The sequential steps involved first, the priming of the plywood, then the application of the membrane as a sealant. Necessarily, the blueskin had to be peeled off of large rolls, cut to a specified length, and then applied to the (primed) plywood. At the time of his fall, Mr. Alcorn's job was to cut the blue skin and then hand it,

when cut to specifications, to Munroe and the accused for application to the structure.

[53] Mr. Munroe explained that it was his understanding that fall protection was not required if the work was being done more than 10 feet from an edge of the roof. He explained that if work was happening between 6 feet and 10 feet of the edge, fall protection was required unless a "bump line" was in place. He confirmed no bump lines were used by IPS at the Kent project. Mr. Munroe's understanding was this 10-foot rule was the industry standard and enforced in all the worksites in which he had been involved. Parenthetically, I note that Mr. Oxner had testified that "control zones" or bump/warning lines are not permitted in Nova Scotia, but are permitted in some provinces.

[54] Mr. Munroe was emphatic, both on direct and cross that this was the generally accepted work safe work practice (when working from heights) in all of jurisdictions in which he had worked throughout Canada. He added that he had been taught this both in classroom settings during fall protection courses, and on numerous worksites in multiple provinces over the course of his involvement in the industry.

[55] During his testimony, Mr. Munroe identified the butterfly anchor (Exhibit 6) and testified that on the Kent project it would be installed to the Q decking with screws using power tools.

[56] He stated that on March 13, 2018, Mr. Alcorn had arrived late. By the time of his arrival, he (Mr. Munroe) and Mr. Gooch had completed blue skinning the front of the tower on which they were working. The day previous, all three of them had done the left side.

[57] He further indicated that he did not notice any signs of impairment on Mr. Alcorn's part, although he added that he had did not have a chance to make many observations of the latter while they were on the canopy.

[58] Mr. Munroe added that IPS provided its workers with fall arrest and travel restraint equipment, in the form of harnesses, rope grabs, and anchors. He explained that Exhibit 6 was an example of the type of roof anchor that IPS provided. He testified that he was involved in the installation of a roof anchor countless times, including many times on the Kent project.

[59] The anchor in question contains a series of holes, thirty in total. It is installed by putting a screw through every hole, using a power tool. The entire installation

takes about two minutes per anchor. If the crew was working on an area one day, and had to come back to the same area the next, their practice would simply be to leave the anchor in at the end of the first day. He said he always installs such anchors to Q decking (when they are needed). Q decking is the surface under the roof itself.

[60] On March 13, 2018, the day of the fall, Mr. Munroe's recollection was that he and the accused had just finished some preliminary work on the tower when Mr. Alcorn arrived (late) for work. They had come down from the canopy just before Mr. Alcorn arrived. Munroe thought that the latter's girlfriend had dropped him off, but he was not certain. They spent some time with Mr. Alcorn before they went back up to the canopy (perhaps 10 – 15 minutes).

[61] Mr. Munroe, himself, did not witness Mr. Alcorn's fall, but the latter had only been on the canopy for about 5 to 10 minutes before it happened. He rather thought they were just getting set up on the canopy, which is to say, had begun the process of getting the blueskin and primer out of the scissor lift platform. Some membrane had been installed on the tower the previous day by all three of them, but only Munroe and the accused would have been involved in the priming and the application of the membrane aspects of the job.

[62] The USB film footage (Exhibit 2) at the time, however, showed that Messrs. Munroe and Gooch had actually begun priming, and had applied one or two sheets of membrane (cut by Mr. Alcorn) to the tower before the accident occurred. Mr. Alcorn's fall appeared to have been occasioned while he was walking backward on the canopy unrolling the sheet of blueskin to be cut. He appeared to have kept walking (backwards) right off of the opposite end of the roof to that upon which his two co-workers were situate.

[63] Mr. Munroe explained that on March 13, 2018 he was using the handrail on the scissor lift, while going up to, and coming down from, the roof. He was not planning on using any fall protection while actually on the roof. He added that he was not required to be tied off because the work plan did not involve any of them going any nearer to an edge of the roof than 10 feet. Moreover, the scissor lift, itself, had an extra 6 feet of railing extending upward from the platform itself, and the platform was approximately at the level of the roof edge in the area where the work was to take place. It was his understanding that anchors and the rope were in the scissor lift, but they were not needed because of the height to which the scissor lift rails extended. There was no plan for anybody to be tied off.

[64] Mr. Munroe did not recall whether there had been any discussion between the three IPS crewmembers about fall protection on March 12, 2018. He did point out that they had just done their hazard assessment (previously discussed) which indicated the measures that they were going to take to cope with the perceived hazards. He rather thought that there had been some discussion of the (same) hazards the next day, on March 13, 2018, but was not certain and could not recall any specifics. He did not recall that a roof anchor had been installed on either date. This was because, (to repeat) the work plan had been to stay more than 10 feet away from the canopy edge, so they did not need to be tied off.

[65] When shown the hazard assessment sheet dated March 12, 2018 (Exhibit 1, Tab 20), he had no recollection of having signed it but did acknowledge that his signature was on the document, and that it would be standard procedure for him to sign such assessments. Typically, there would be discussion between the 3 signators and a review of the form (in the work trailer) before they signed. The measures would have been the same on March 13, 2018 as are specified in that hazard assessment sheet, because they were continuing with the exact same work as the previous day.

[66] Mr. Munroe acknowledged that there were aspects of their work on the project which did require 100% tie off. Specifically, he referenced a document in Exhibit 1 (tab 2A), which was a field level hazard assessment with respect to the work that had been performed on January 3, 2018. It involved the installation of panel where they were expected to work much closer to an edge than 10 feet. His testimony was that Mr. Gooch enforced that.

[67] In fact, he said that Mr. Gooch's conduct with respect to safety compared favourably to any supervisor under whom he had ever worked during his construction career. The descriptors which he applied to the safety standards which Mr. Gooch enforced were "on par" and "good". He added that he always felt that if he had a concern about safety he could talk to “Jeff” about it. He cited one earlier occasion, while the two were working on a project in Ottawa, when he had come to the accused with respect to such a concern and Mr. Gooch had immediately acted on the concern and dealt with it.

[68] Mr. Munroe went on to describe the accused as a careful foreman, one who did not take unnecessary risks, one who impressed him with his level of understanding of the dangers of working from heights, and the fact that he always ensured that fall protection in the form of ropes and harnesses, and any others that

might possibly be required due to the nature of the work being performed, were available. He said that he is unaware of any other death or injury related incidents on any other sites which had occurred under Mr. Gooch's supervision.

[69] Mr. Munroe referenced the film footage on the USB (Exhibit 2). He stated that the work which they were doing on March 13, 2018, had them on the right side of the structure (the tower) to which blueskin was being applied. They were back from the edge, a distance greater than 10 feet. If he or Mr. Gooch were to have inadvertently gotten close enough to the edge to have fallen off, they would have come in contact with the rails extending from the platform of the scissor lift, which was stationed immediately adjacent to the roof.

[70] Moreover, the canopy to the right of the tower was 41 feet in length. Mr. Alcorn's task involved cutting membrane 15 feet in length, and he was tasked with unrolling it in a line roughly perpendicular to the positions of himself and the accused. Once unrolled, the membrane would be cut by him to proper length, then be picked up and carried by Mr. Alcorn straight to Munroe and Gooch. Given those requirements, and the dimensions of the roof, it should never have been possible for Mr. Alcorn to be any closer than 20 feet from a leading edge of the roof. In fact, he had no job related need to unroll the membrane any more than 15 feet from where his two coworkers were standing.

[71] Mr. Munroe added that, in fact, the day before when the three had been working on the left side of the tower, Mr. Alcorn had been doing exactly the same job. Never once had Mr. Munroe noticed him walking back any further than was necessary while unrolling the blueskin.

[72] When asked why he told the police “we were just getting set up for the day" when Mr. Alcorn fell, when in fact they had been working already for about 10 minutes on the roof before the fall, he explained that he based his statement on the way he remembered the morning. He also added that he was fairly worked up and had "never before experienced something like this."

[73] He reiterated that there was an anchor and a lifeline in the scissor lift, which would have been available to any member of the crew on March 13, 2018, had they been needed. The roof was a Q deck, entirely amenable to the installation of the anchor which was available to them. He felt that, weatherwise, it was "breezy" that day, nothing extreme, although the wind did get worse after Mr. Alcorn’s fall.

Sergeant Trish Kennedy

[74] Sergeant Trish Kennedy was one of the HRMPD officers called to the worksite on March 13, 2018. She was asked to assist the Department of Labor and had arrived around 11:30 a.m. that day. She estimated that she spent approximately one hour at the site. She described the weather as dry, but overcast and gusty at times. Her colleague, Constable McCrum, was in charge. She took photos of the scene and confirmed that they were to be found in Exhibit 3. At one point, she got on the scissor lift and it lifted her to the level of the roof.

[75] Sergeant Kennedy recalled that there were some pieces of equipment in the lift, although she was unaware of the proper names for the items that she saw. She said that her police belt was clipped to the rail of the scissor lift platform, but she could not recall being asked by any of the OHS officers on site to put on a fall arrest harness while using the lift. She did not recall exiting the platform and going on the roof, however she did take photos of the scene at the direction of OHS.

Constables McCrum and Penfound

[76] Constables McCrum and Penfound also testified, the former provided testimony as to the timing when various officers arrived in relation to the fire service and OHS officers, and the latter as to his having been involved in obtaining the statements from Messrs. Gooch, Munroe, and Holloway.

[77] Constable Penfound testified that the statements were taken on March 13, 2018, and he brought each into the worksite mobile office individually in order to take down what they had to say. He explained to each of them beforehand what was involved and asked each to tell him anything relevant to the incident involving Mr. Alcorn's death. Mr. Gooch provided his statement first, followed by Mr. Holloway and, lastly, Mr. Munroe. Mr. Gooch's statement appeared at Exhibit 1, Tab 10. Whereas page 1 was written by Mr. Gooch personally, the officer himself wrote down the subsequent "Q and A".

[78] Before taking the statements, Constable Penfound had been advised by Staff Sergeant Willett that they were investigating an industrial accident. He was unaware at the time that criminal charges were pending. He described Mr. Gooch (indeed, all three interviewees) as being "quite upset". Moreover, Mr. Alcorn's condition, indeed whether he would live or die, was still unknown at that time. The officer began taking the statements at 10:39 a.m., which he understood to be less than 1/2 hour after the fall. As noted, he started with Mr. Gooch.

OHS Officer Terry Duggan

[79] Mr. Duggan testified that he had been employed by the Province as an Occupational Health & Safety officer for approximately 18 years. His involvement on March 13, 2018 began when his department received notification from Emergency Services of an accident in the area. As he was senior officer (and one of two investigators) for the area, he attended along with OHS officer Trevor Rutledge. He arrived at the site at 10:44 AM, as his office was approximately five minutes away. He and Officer Rutledge attended in separate vehicles.

[80] He was shown photo 4 in Exhibit 3, and confirmed that he was one of the individuals in that photograph. He identified his colleague, Mr. Rutledge, as another such person, and said that the person above them in the photograph on the scissor lift was Mr. Gooch. Duggan had given him permission to go up in the scissor lift and retrieve articles that the crew had earlier left on the roof. Mr. Gooch had gone up with Sergeant Kennedy and OHS Officer Rutledge, around noon that day, so what was captured in the photograph would likely have been Mr. Gooch's third trip in the scissor lift, he recollected.

[81] In addition to speaking with Messrs. Gooch, Munroe, and Holloway, he also spoke with the superintendent of the contractor, Scott Andrews, and took a statement from him. Once he had determined that the site was secure and that there was no further possibility of safety hazards, he proceeded to take photographs with the assistance of Officer Rutledge and Sergeant Kennedy. He then issued a verbal stop work order to Mr. Gooch and Mr. Andrews, and the order was subsequently put in writing.

[82] He identified some of the photographs taken of the area of Mr. Alcorn's fall, as well as the hard hat and harness found proximate to where he lay on the ground. He explained that he had pointed out to Sergeant Kennedy the items that he wanted seized, which included the harness and lanyard and butterfly anchor. Mr. Duggan subsequently engaged a company to identify the three items seized. Mr. Oxner was its proprietor, and it was called "Total Fall Protection". The weather was overcast, cool, and he recalled that a "wind event" was expected that day.

[83] Officer Duggan recalled that Mr. Gooch was wearing a harness, and that he saw additional rope and anchors in the trailer. In his view, OHS regulations would have required, where work was taking place at the height of the canopy, three anchors.

[84] He recollected that the only discussion had with Mr. Gooch prior to obtaining his statement was with respect to his address, and what the interview would be about.

He did not receive any documentation, or review film footage before he spoke with the accused. After the last interview of the day, as he was heading home, Officer Rutledge mentioned that he could go to another business in the area (IKEA) to see if they had film footage of the incident, and Officer Duggan agreed that this was appropriate.

[85] On cross, Mr. Duggan confirmed that there was an additional lifeline present on the scissor lift platform, which was not seized, that Mr. Gooch wore a harness, and he could not recall if Mr. Munro was wearing one as well. He agreed that Mr. Alcorn had been wearing one but his understanding was that the fire department had cut it off. He also agreed that, from 10:44 a.m. onward on March 13, 2018, the weather got progressively worse, with the wind blowing quite hard, and significant gusts lasting into the afternoon.

[86] Mr. Duggan also agreed that, with respect to the anchor seized, it could be appropriate for the roof canopy upon which the work was performed, but he would need to see what was behind the wooden layer on the roof, to confirm that it was long enough to safely enclose the screws to the anchor. He would have needed to physically examine the roof to say for sure.

[87] Officer Duggan confirmed that any time work was being done above 10 feet in height, the OHSA required that fall protection be implemented. He mentioned that there had to be a risk assessment done, and was shown Exhibit 1, Tab 2C, which was the hazard assessment done on March 12, 2018. He was referred specifically to the plan to "stay back 6 feet or 100% tie off". Duggan indicated that Nova Scotia Regulations do not prescribe the required minimum distance for the workers to remain back from an unguarded edge while not tied off, but an assessment still has to be done, one that is based upon the type(s) of hazard(s) being faced, and all of the surrounding circumstances.

[88] Duggan was asked about his testimony at the preliminary inquiry. He agreed that he had testified at the preliminary inquiry that he had been at hundreds of job sites where workers had not, in his opinion, been using proper protection. He also said that a worker should never come to work while impaired, especially while working from heights. He agreed that when planned work stipulates that a worker not be within a certain distance of a leading edge, and the distance is reasonable having regard to all circumstances, then the worker will not be required to "tie off".

[89] IPS owner Cameron Smith, also testified for the Crown, and provided his understanding that there was no requirement for workers to be tied off at <u>all</u> times while working from heights.

[90] Finally, Mr. Duggan mentioned, in a general sense, that there are different types of fall protection mentioned in the regulations. These include fall protection harnesses, guardrails, safety nets, and scaffolding among others.

OHS Officer Trevor Rutledge

[91] Officer Trevor Rutledge also testified. Much of his direct was taken up with commentary upon the video footage that he recovered from IKEA showing work being performed March 12 and 13, 2018 (Exhibit 2). This included footage captured of the very top roof, well above the canopy upon which Mr. Alcorn was working. He agreed that, at one point, it appeared to depict a person walking to the far right of that upper roof and bending to look over each side of the corner. The individual had come from the left while on the upper roof and travelled to the extreme right. He also agreed that there is no way that this individual was wearing any type of fall protection equipment, nor did there appear to be any other type of restraint that was apparent.

[92] Officer Rutledge also agreed that this individual is definitely bending to peer over the side of the very upper roof, that it looked like he was a worker for another sub trade at the site, and not part of the IPS crew, because the IPS crew were all working on the tower, on the left canopy below him. On another occasion, he agreed that there appeared to be two people on that "top roof" (Exhibit 2, March 12, 2018 at 3:24 p.m.) who appeared to go very close to the edge. Officer Rutledge agreed that they similarly did not appear to be wearing any fall restraint or protection, however he did say that he was unsure whether there was an inner parapet wall at the edge, which could be a form of fall protection, if it was there.

[93] The defence elected to call some evidence.

Toxicologist Jennifer Swatek

[94] Ms. Swatek was qualified by agreement to provide opinion evidence in the area of toxicology. She testified that both Delta-Carboxy THC and Delta-9 THC were found in the samples of Mr. Alcorn's blood taken before his death. Her report, dated May 23, 2023, was entered as Exhibit 13.

[95] At trial, Ms. Swatek characterized Delta-9 THC as the principal psychoactive material deposited in the body after the ingestion of cannabis. At page 2 of the report, she describes it as the active ingredient found in marijuana. She describes the drug as a "DEA schedule one hallucinogen. Pharmacologically, it has depressant and reality distorting effects".

[96] The blood sample to which she referred was drawn from Mr. Alcorn's body at 3:20 p.m. on March 13, 2018, almost 5 ½ hours after he had fallen off of the canopy. Even if there was no brain activity at that time, she explained, his body was still alive when the sample was taken. Therefore, it would have continued to actively eliminate the Delta-9 THC from his system from the time that he had ingested it, until the blood sample was taken.

[97] Unlike the situation with respect to alcohol, there is no algorithm with which to mathematically determine what the blood Delta-9 THC level of Mr. Alcorn would have been (earlier, at 10 a.m.) when he ascended to the canopy. There is no generally recognized method of calculating the rate of elimination of Delta-9 THC from one's body, because the elimination rate varies from individual to individual. Ms. Swatek was able to say, however, that the THC levels in the blood of the deceased would almost certainly have been higher, and indeed may have been much higher, at 10 a.m. than the 0.93ng/ml reading garnered at 3:20 p.m. that day. In her report, she noted (page 2) that Delta-9THC generally rapidly leaves the body of a user, but may be present longer in chronic users.

[98] In her view, for a person to walk off the end of a roof, seemingly paying no attention to their surroundings, would be consistent with that individual’s impairment, since this type of behaviour is generally not displayed by sober people. The amount of the substance found Mr. Alcorn's blood "could" be consistent with him having consumed marijuana between 8-10 a.m. on March 13, 2018.

Dr. Neal Sutton

[99] With the consent of the Crown, Dr. Sutton was qualified to provide opinion evidence in occupational health and medicine, including the effects of drugs and alcohol on the human body and in the workplace. Since 1998, Dr. Sutton has been a medical consultant to a number of large employers. For example, he is the medical director at Bombardier Aerospace, and associated similarly with some other well-established organizations. Among his many roles within that genre, he testified that he often drafts and consults with respect to health and safety policies in the

workplace. His qualifications included experience in many positions dealing with requirements relating to working safely from heights, and he has extensive expertise with respect to the impairing effects of drugs and alcohol within that milieu.

[100] In Dr. Sutton's view, there is no acceptable level of Delta-9 THC in a worker's blood when performing tasks such as working from heights. He said that is the industry standard. He said this is because the drug has impairing effects which can negatively impact the user's balance, field of vision, and awareness of their surroundings.

[101] Having previously reviewed the PI transcript, Mr. Alcorn's toxicology report, and the video (Exhibit 2) depicting Mr. Alcorn's fall, Dr. Sutton reiterated that it was impossible to work backward from the Delta-9 THC reading obtained at 3:20 p.m. that day to calculate the exact time of Mr. Alcorn's last drug use, but it was likely that he had either consumed marijuana very late into the night before his fall, or had consumed it after waking up on the morning of March 13, 2018, before arriving at work.

[102] In cross-examination, Dr. Sutton was questioned further with respect to his expressed opinion that Mr. Alcorn was likely impaired when he fell. He testified that although it was impossible to say for certain, his opinion was that Mr. Alcorn, "on a balance of probabilities", was indeed impaired. This was based upon the combination of Delta-9 THC still remaining in his blood at 3:20 p.m. that day, combined with the observations of Mr. Alcorn's behavior that day. Like Ms. Swatek, he observed that ordinarily, a sober person, familiar with their surroundings, would not walk backward off of a canopy.

[103] Moreover, he indicated that, despite his likely impairment, the fact that Mr. Alcorn was in that state would not necessarily have been apparent during his short interactions with Mr. Gooch and/or Mr. Munroe after his late arrival at work on March 13, 2018. Specifically, Dr. Sutton indicated that a person need not have red eyes, or be exhibiting any other overt indicia of impairment, in order to be experiencing the negative cognitive effects of marijuana consumption.

Analysis

[104] The three most pertinent sections of the *Criminal Code* follow:

> Duty of persons directing work

> 217.1 Everyone who undertakes, or has the authority, to direct how another person does work or performs a task is under a legal duty to take reasonable steps to prevent bodily harm to that person, or any other person, arising from that work or task.
>
> Criminal negligence
>
> 219 (1) Everyone is criminally negligent who
>
> (a) in doing anything, or
>
> (b) in omitting to do anything that it is his duty to do,
>
> shows wanton or reckless disregard for the lives or safety of other persons.
>
> Definition of *duty*
>
> (2) For the purposes of this section, *duty* means a duty imposed by law.
>
> Causing death by criminal negligence
>
> 220 Every person who by criminal negligence causes death to another person is guilty of an indictable offence and liable
>
> (a) where a firearm is used in the commission of the offence, to imprisonment for life and to a minimum punishment of imprisonment for a term of four years; and
>
> (b) in any other case, to imprisonment for life.

[105] These provisions were explored in some detail in cases such as *R v. M.R.*, 2011 ONCA 190, where O'Connor, JA, explained:

> [28] The test for criminal negligence as set out in s. 219 requires the Crown to show that an accused's conduct or omission represented a "marked and substantial departure" from the conduct of a reasonably prudent person in the circumstances. See for example, *R. v. J.F.*, 2008 SCC 60 (CanLII), [2008] 3 S.C.R. 215, at para. 9.
>
> [29] The high standard of a "marked and substantial departure" from the conduct of a reasonably prudent person applies to both the physical and mental elements of the offence: *R. v. J.L.* (2006), 2006 CanLII 805 (ON CA), 204 C.C.C. (3d) 324 (Ont. C.A.), at para. 16. In addressing the offence of criminal negligence causing death, a court should first look to the *actus reus* of the offence and determine if the conduct or omission involved meets the marked and substantial departure standard. If it does, the court should then consider the question of whether the *mens rea* is established.

> [30] The mental element for criminal negligence is described as a modified objective test: *R. v. Hundal*, 1993 CanLII 120 (SCC), [1993] 1 S.C.R. 867, at p. 887, Cory J.; *R. v. Tutton*, 1989 CanLII 103 (SCC), [1989] 1 S.C.R. 1392, at p. 1413, McIntyre J. A court must consider the facts existing at the time in light of the accused's perception of those facts and assess whether the accused's conduct, in view of his or her perception of the facts, constituted a marked and substantial departure from what would be reasonable in the circumstances: see *R. v. Tutton*, at p. 1432. In considering this issue, the court should consider whether the accused either adverted to the risk involved and disregarded it, or failed to direct his or her mind to the risk and the need to take care at all. In most cases, the mental element can be inferred from the accused's conduct or omission: see *R. v. Creighton*, 1993 CanLII 61 (SCC), [1993] 3 S.C.R. 3, at pp. 73-74, McLachlin J. (as she then was); *R. v. Hundal*, at p. 872, McLachlin J., concurring; *R. v. Tutton*, at p. 1432, McIntyre J.

[106] In *R v. Javanmardi*, 2019 SCC 54, the court observed that:

> [19] The *actus reus* of criminal negligence causing death requires that the accused undertook an act — or omitted to do anything that it was his or her legal duty to do — and that the act or omission caused someone's death.
>
> [20] The fault element is that the accused's act or omission "shows wanton or reckless disregard for the lives or safety of other persons". Neither "wanton" nor "reckless" is defined in the *Criminal Code*, but in *R. v. J.F.*, 2008 SCC 60 (CanLII), [2008] 3 S.C.R. 215, this Court confirmed that the offence of criminal negligence causing death imposes a modified objective standard of fault — the objective "reasonable person" standard (paras. 7-9; see also *R. v. Tutton*, 1989 CanLII 103 (SCC), [1989] 1 S.C.R. 1392, at pp. 1429-31; *R. v. Morrisey*, 2000 SCC 39 (CanLII), [2000] 2 S.C.R. 90, at para. 19; *R. v. Beatty*, 2008 SCC 5 (CanLII), [2008] 1 S.C.R. 49, at para. 7).
>
> [21] As with other negligence-based criminal offences, the fault element of criminal negligence causing death is assessed by measuring the degree to which the accused's conduct departed from that of a reasonable person in the circumstances. For some negligence-based offences, such as dangerous driving, a "marked" departure satisfies the fault element (*J.F.*, at para. 10; see also: *Beatty*, at para. 33; *R. v. Roy*, 2012 SCC 26 (CanLII), [2012] 2 S.C.R. 60, at para. 30; *R. v. L. (J.)* (2006), 2006 CanLII 805 (ON CA), 204 C.C.C. (3d) 324 (Ont. C.A.), at para. 15; *R. v. Al-Kassem*, 2015 ONCA 320, 78 M.V.R. (6th) 183, at para. 6). In the context of criminal negligence causing death, however, the requisite degree of departure has been described as an elevated one — marked *and* substantial (*J.F.*, at para. 9, applying *Tutton*, at pp. 1430-31, and *R. v. Sharp* (1984), 1984 CanLII 3487 (ON CA), 12 C.C.C. (3d) 428 (Ont. C.A.)).
>
> [22] These standards have much in common. They both ask whether the accused's actions created a risk to others, and whether "a reasonable person would

> have foreseen the risk and taken steps to avoid it if possible" (see *Roy*, at para. 36; Stewart, at p. 248). The distinction between them has been described as a matter of degree (see *R. v. Fontaine* (2017), 2017 QCCA 1730 (CanLII), 41 C.R. (7th) 330, at para. 27; *R. v. Blostein* (2014), 2014 MBCA 39 (CanLII), 306 Man. R. (2d) 15, at para. 14). As Healy J.A. explained in *Fontaine*:
>
> These differences of degree cannot be measured by a ruler, a thermometer or any other instrument of calibrated scale. The words "marked and substantial" departure are adjectives used to paraphrase or interpret "wanton or reckless disregard" in section 219 of the Code but they do not, and cannot, indicate any objective and fixed order of magnitude that would have prescriptive value from one case to another. As with the assessment of conduct in cases of criminal negligence, the assessment of fault by the trier of fact is entirely contextual. [para. 27]
>
> [23] In *J.F.*, Fish J. did not fully explain how to distinguish between a "marked" and a "marked and substantial" departure, as the case did not "turn on the nature or extent of the difference between the two standards" (paras. 10-11). In this appeal, as well, the differences in etymology are not dispositive and need not be resolved. In any event, the parties argued on the basis that the proper threshold for criminal negligence causing death is a "marked and substantial" departure, and that is the basis on which these reasons approach the issue. A conviction for criminal negligence causing death therefore requires the Crown to prove that the accused undertook an act, or omitted to do anything that it was her legal duty to do, and that the act or omission caused the death of another person (the *actus reus*). Based on *J.F.*, the Crown must also establish that the accused's conduct constituted a marked and substantial departure from the conduct of a reasonable person in the accused's circumstances (the fault element).
>
> [Emphasis added]

[107] The authorities appear to require a court to conduct a tripartite analysis before entering a conviction for criminal negligence causing death. Specifically, I must be satisfied beyond a reasonable doubt that the accused undertook an act, or omitted to do anything that it was his legal duty to do; that the act or omission caused the death of another person; and that the accused's conduct constituted a marked and substantial departure from the conduct of a reasonable person in the accused's circumstances. If I have been left in doubt with respect to any of these criteria, I must acquit.

[108] First, although Mr. Gooch did not testify, I must consider the statements he provided to the police, his employer, and OHS. I begin that consideration with a discussion of the law pertinent to how (if at all) they may be relevant as "after the fact" conduct.

A. *The Statements*

[109] Generally speaking, this type of conduct (which used to be referred to as "post-offence conduct") is, now, as referenced above, known as after-the-fact conduct. Many of the types of situations in which it may arise involve incriminating conduct (*R v. White*, [2011] 1 SCR 433; *R v. Monteleone*, [1987] 2 SCR 54), but sometimes it can involve allegedly incriminating statements.

[110] In order to attenuate the risk that speculative inferences may be drawn as a result of conduct exhibited after-the-fact, lacking the context of the event itself, the trier of fact must be cautious as to the manner in which it is assessed, and its inferential value, if any.

[111] The Court in *R v. Calnen*, [2019] 1 SCR 301, reminds us that:

> [116] Even if admitted for a particular purpose, after-the-fact conduct may pose some unique reasoning risks: see D. M. Paciocco, "Simply Complex: Applying the Law of 'Post-Offence Conduct' Evidence" (2016), 63 *Crim. L.Q.* 275. Conduct that is "after-the-fact", and therefore removed in time from the events giving rise to the charge, carries with it a temporal element that may make it more difficult to draw an appropriate inference. This evidence may also appear more probative than it is, it may be inaccurate, and it may encourage speculation. <u>After-the-fact conduct evidence may thus give rise to imprecise reasoning and may encourage decision makers to jump to questionable conclusions.</u>
>
> …
>
> [119] Contrary to certain suggestions made in the courts below, there is no legal impediment to using after-the-fact conduct evidence in determining the accused's intent. The jurisprudence of this Court is clear: after-the-fact conduct evidence may be relevant to the issue of intent and may be used to distinguish between different levels of culpability (see *White (1998)*, at para. 32; *White (2011)*, at para. 42; *Rodgerson*, at para. 20). Specifically, this Court has said that "[w]hether or not a given instance of post-offence conduct has probative value with respect to the accused's level of culpability depends entirely on the specific nature of the conduct, its relationship to the record as a whole, and the issues raised at trial": *White (2011)*, at para. 42. There is therefore "no *per se* rule declaring post-offence conduct irrelevant to the perpetrator's state of mind": *R. v. Jackson*, 2016 ONCA 736, 33 C.R. (7th) 130, at para. 20, per Doherty J.A. As there are also no automatic labels which make certain kinds of after-the-fact conduct always or never relevant to a particular issue, <u>"we must consider all the circumstances of a case to determine whether the post-offence conduct is probative and, if so, what use the jury may properly make of it"</u>: see *R. v. Angelis*, 2013 ONCA 70, 296 C.C.C. (3d) 143, at para. 55.
>
> [Emphasis added]

[112] If there are any inferences to be drawn from such evidence, they are not to result merely from the application of "common sense" to the impugned conduct or statement. Because of this, a trier of fact generally considers such conduct after the evidence, as a whole, has been adduced. It will then be examined within the context of that evidence, which necessarily includes consideration of any alternative explanations for the conduct in question. (See *Calnen*, para 119)

[113] Rules governing the admissibility of after-the-fact conduct, and the manner of drawing inferences from it, have arisen, in part, to distinguish it from mere evidence of bad character. As a general rule, evidence which is called by the Crown for the purpose only of showing that the accused is a bad person, therefore the type of person likely to have committed the acts in question, is inadmissible.

[114] Misleading statements or lies do not qualify as after-the-fact conduct in a vacuum: there must be evidence that the evidence or alibi was intentionally concocted and/or that the accused attempted to mislead the investigative authorities. As the Court said in *R v. O'Connor,* (2002), 62 OR (3d) 263 and reiterated in *R v. Laliberté*, [2016] 1 SCR 270:

> [31] In this case, it is my view that the circumstances in which the appellant made the allegedly false statements to the police and the detailed nature of those statements constitute sufficient evidence upon which a jury could conclude that the appellant fabricated the statements in order to mislead the police and divert suspicion from himself. His first statement was made the same day as the shooting and, importantly, was made to the police at a time when the police did not suspect the appellant and the appellant did not have reason to believe that he was a suspect. The police, as a matter of routine, questioned witnesses who might have information about the deceased's whereabouts prior to the shooting. The appellant's initial statement furnished a complete alibi and, if true, would lead the police to conclude that he was not involved in the offence. That statement and the next two statements were very precise, both as to the appellant's whereabouts and the times he was in the various places. If the jury were to disbelieve the appellant's statements, they might fairly ask why would the appellant tell such detailed and specific lies to the investigators. Why not tell the truth? And how was it that the appellant was so well prepared with a detailed and precise statement about his whereabouts when questioned by the police? In my view, it would be open to a jury to use the evidence of the circumstances surrounding the making of those statements and the nature of the statements themselves to conclude that the appellant fabricated the statements to avoid suspicion.

[115] There is a distinction to be drawn between out-of-court statements by an accused which are simply not believed and (therefore) rejected, and out-of-court

statements by an accused to escape guilt. As the Court noted in *R v. Coutts,* [1998] O.J. No. 2555 (Ont. CA):

> 13 This court has repeatedly drawn a distinction between statements made by an accused (or the testimony of an accused), which are disbelieved and, therefore, rejected and those statements or testimony which can be found to be concocted in an effort to avoid culpability. The former have no evidentiary value; the latter can constitute circumstantial evidence of guilt: R. v. Davison (1974), 20 C.C.C. (2d) 424 (Ont. C.A.), leave to appeal to S.C.C. refused, [1974] S.C.R. viii (S.C.C.): R. v. Mahoney (1979), 50 C.C.C. (2d) 380 at 389 (Ont. C.A.), aff'd without reference to this point (1982), 67 C.C.C. (2d) 197 (S.C.C.); R. v. Sandhu (1989), 50 C.C.C. (3d) 492 (Ont. C.A.), at 499-501; R. v. Levy (1991), 62 C.C.C. (3d) 97 (Ont. C.A.), at 100-103; R. v. Witter (1996), 105 C.C.C. (3d) 44 (Ont. C.A.), at 52-53. In an oft quoted passage from Mahoney, supra, Brooke J.A. said, at p. 389:
>
> If the jury accepted the evidence of the Crown witnesses that the appellant was the killer, disbelief of the appellant's denial was inevitable, but that disbelief could not be treated as an additional item of circumstantial evidence to prove guilt. In my view, the jury ought not, routinely, to be instructed with respect to the inferences that may be drawn from the fabrication of a false alibi in the absence of a proper basis for that instruction, as for example, where there is extrinsic evidence of fabrication, or where the appellant has given different versions as to his whereabouts, one of which must be concocted.
>
> [Emphasis added]

[116] So, too, in *R v. Oland,* 2016 NBCA 58, where it was noted:

> [8] …Significantly, the trial judge did not explain to the jurors that, even if they found the appellant's erroneous statement was a lie, it had no probative value unless they concluded, on the basis of other evidence independent of that finding, that the lie was fabricated or concocted to conceal his involvement in the murder of his father.
>
> [Emphasis added]

[117] In this respect, the Crown points to the captured video footage of Mr. Gooch and Mr. Munroe speaking together after Mr. Alcorn's death had occurred, but prior their respective provision of statements to the authorities. Counsel suggests that this is evidence of them collaborating with respect to what they would tell the police and/or OHS.

[118] With respect, this is a fairly weak basis upon which to ground the inference which the Crown urges. The fact that Mr. Gooch and Mr. Munroe were observed speaking to one another in the aftermath of such a tragic occurrence, without more,

is unremarkable. What would have been remarkable would be if they had not spoken at all in the aftermath of Mr. Alcorn's death. There is absolutely no evidence that they took this opportunity to concoct an alibi.

[119] Nor was there a basis upon which either could have expected that criminal charges would be forthcoming against anybody, at the time their statements were provided. How could they? At the time he conducted the interview, Constable Penfound himself had no idea that such charges were pending. He testified that he thought they were simply investigating an industrial accident.

[120] Dealing with the police statement of March 13, 2018, it is found at Exhibit 1, Tab 10, which is transcribed below:

> "I, Jeff, was setting up are [sic] work area with Brandon Alcorn. I was passing him material and equipment. I turned to get more stuff from my partner Dana when I heard a yell, looked back and saw Danny on the ground getting my attention that's when I noted Brandon had fallen. I didn't actually see him fall or how he had landed. I came down as fast as I could from the roof to see Brandon on his side moving and breathing heavy."

[121] As pointed out earlier, the statement was given less than one half hour after Mr. Alcorn's fall, at a time when, as Constable Penfound noted, Mr. Gooch was visibly upset.

[122] An "accident/incident investigation form" was provided by Mr. Gooch to his employer that same day. This is found at Exhibit 1, Tab 9, and is transcribed below as well:

> "Me and Dana started installing blueskin at 7:30 am on the front of the tower. We finished this by 9 am. Me and Dana went to get a ladder we got back at 10 am at which this time Brandon was just showing up to work. We loaded the sissor [sic] lift with gear and went up to the canopy. I told Brandon to install the butterfly clip on the Q-Decking of the canopy. I started unloading the sissor [sic] lift, turned back and Brandon had fell off the canopy 42 ft away from we were working. There was no work at that end of the canopy. I had my back turned when he fell so I could not see how it happened."

[123] Next, I will set forth the more pertinent sections of the transcription of the 25-page interview provided by Mr. Gooch to Occupational Health & Safety Officers Duggan and Rutledge on March 15, 2018. The transcription was prepared as an aide to the oral interview, recorded on the USB (Exhibit 2):

Page 4

16 **Q.** Right, which kind of leads us to the

17 next question is, on Tuesday, March 13th, 2018 at the work

18 site known as the Kent new building construction located

19 off of Cutler Avenue, a workplace accident occurred. Can

20 you tell me what you know about this?

21 **A.** On Tuesday, we were setting up our work

22 station. It was ten o'clock in the morning. Brandon had

23 just showed up at ten o'clock this day. He told me he had

24 slept in. He -- he donned on his harness, grabbed the

25 tools he usually needs to do his job. Shortly after ten

Page 5

1o'clock, we got in our scissor lift, came up to the edge of

2 the roof where we were going to be working. Dana Munroe,

3 my other co-worker, he -- he jumped out, was inspecting the

4 wall that we were going to be blue skinning. Brandon had

5 jumped out of the lift. I turned around to pass up more

6 material and equipment. I turned around, Brandon was

7 nowhere to be found.

8 At this point, a gentleman on the ground, I

9 believe his name was Danny, we both had heard a loud yell.

10 I seen Danny on the ground. We made eye contact. It hit

11 me hard there that something had happened.

…

Page 6

2 **Q .** Okay. And you said you saw Brandon

3 Alcorn get out of the scissor lift?

4 **A .** Yes.

5 **Q .** And you didn't see which direction he

6 was going to walk towards?

7 **A .** At that time, I was passing up material,

8 I -- turning back and forth continuously, passing up gear.

9 Turned around for a brief second to grab more stuff and

10 turned around and he was nowhere to be seen.

11 **Q .** So, at the time of this unloading that

12 you were doing was there anything on the roof at that time,

13 a canopy?

14 **A .** There was a, I believe a tray, a paint

15 tray, that we use to put the primer product in to roll onto

16 the wall. The next -- that -- that actually was left up

17 there from the day before. Other than that, we didn't have

18 any -- anything loaded on the roof yet. We were still just

19 sort of inspecting what we were coming up against.

20 **Q .** So, to your knowledge, the intent was to

21 work over by the -- where the blue skin ---

22 **A .** Yes, in the furthest inside away from

23 the leading edge.

24 **Q.** Okay.

25 **A .** I was going to have a man in the scissor

Page 7

1 lift. Obviously, he'd be tied off in the lift. There'd be

2 a guy in the inside corner, helping hold the roll of blue

3 skin to apply it to the wall. There was no reason or --

4 there was no work or reason for Brandon to be over in the

5 area he was in at this time. We had finished everything

6 that needed to be done in that area and I have no, no, no

7 ---

8 **Q.** Sure.

9 **A.** --- understanding why he was that far

10 away from us.

Page 9

2 **Q .** And you talked about safety

3 documentation that you had to fill out for Maxim. What
4 about your own company? Do you require any safety
5 documentation for working at the Kent's building site?
6 **A .** Yes, I do a monthly field level hazard
7 assessment of upcoming work. You know, it does change
8 week-to-week sometimes. Some aspects take longer but that
9 and our Tool Box Talk, I fill out the Tool Box Talks and
10 every morning, the boys will inspect their lifts, look over
11 their harnesses, any type of safety gear or equipment that
12 we use that day such as, you know, power tools, manlifts,
13 safety equipment.
14 **Q .** So, did you have any type of Tool Box
15 Talk that morning?
16 **A .** It -- it happened, I believe, on the
17 12th, the Monday.
18 **Q .** And so, you don't necessarily do one
19 every day? You just do one right at the beginning of the
20 week or ---
21 **A .** You -- or as when the procedure changes.
22 You know, and when you have a different aspect of install.
23 **Q .** And so, let's talk a little bit about
24 your safety training. Can you describe briefly what's some
25 of the safety training is that you have?
Page 12
5 **Q .** So, what type of Fall Protection were
6 you going to use -- be using that day?
7 **A.** That would've been lifeline and rope
8 grab.
9 **Q.** Okay.
10 **A.** We didn't have any -- any work to do at
11 the edge of -- in this area. My understanding of training

12 was that on a flat roof, you had to stay away six foot from

13 the leading edge where all of our work was, I believe, in

14 that -- in that confine of being -- being a certain

15 distance away from the edge.

16 **Q.** So, if I understand it correctly, all

17 three of you; yourself, Dana Munroe and Brandon Alcorn were

18 all wearing harnesses?

19 **A.** Yes.

20 **Q.** And if you're not going to need the

21 harnesses, why were -- why did you have the harnesses on?

22 **A.** Well, to -- to go up on the scissor

23 lift, it's mandatory to wear it in the lift itself.

24 **Q.** Okay. And the scissor lift itself, you

25 have training in that scissor lift?

Page 13

9 **Q**. So, based on that, you're indicating

10 that where they were going to work, they didn't need to

11 have any type of Fall Protection because they're beyond six

12 feet?

13 **A**. Yes.

14 **Q.** Without putting words in your mouth.

15 **A**. From the leading edge. That -- that was

16 my interpretation, yes. The man in the lift would've been

17 constantly hooked off because he was -- he would be going

18 up the outside corner, where we would be on the inside,

19 furthest away from the leading edge.

20 **Q**. So, the day of the accident, was there a

21 Fall Protection Safe Work Procedure developed for the work

22 that was going to be done that day?

23 **A**. It -- I don't -- it would've have been

24 made that day but it would've been the same procedure for

25 most of the other work we had -- we had done in that -- on

Page 14

1 that jobsite.

2 **Q.** So, you'd use the same procedure

3 everywhere?

4 A. Well, depending on your install. Like,

5 if you're on the side of the building, you're constantly in

6 the lift. On top of that canopy at times, we -- we were

7 using our rope grab and lifeline.

Page 16

2 **Q .** Okay. So, I think I've already asked

3 this but I'll ask you again. So, prior to starting work on

4 Tuesday, March the 13th, was there any safety meetings,

5 hazard assessments filled out?

6 **A .** There was the Tool Box Talk the day

7 before. On Tuesday, we were doing the same aspect, same

8 install, the blue skin and primer install. So, it didn't

9 change. Our procedure or our work didn't change.

Page 19

16 **Q.** Right. Now, Brandon was wearing a

17 harness, obviously, at the time?

18 **A.** Yes.

19 **Q.** Who owned that harness, do you know?

20 **A.** That would've been supplied by the

21 company.

22 **Q.** Okay.

23 **A.** I believe we had just bought that

24 harness he was wearing. I want to say beginning of

25 September when I was doing the Nova Centre job.

Page 20

Q. Okay. And was Brandon's safety training

2 -- you confirmed that he had Fall Protection?

3 **A.** Yes. He -- when he first showed up, one

4 of our things is like all of our work is done in the air.

5 We don't usually do much ground work, so one of the main

6 things is you -- you have to have your Fall Arrest and

7 working from heights training.

8 **Q.** Right.

9 **A.** He had showed me his certificate when he

10 first came. I gave him our new hire forms and then it's

11 their responsibility to fill those forms out and email them

12 to MacKenzie Smith, who's in charge of all the

13 documentation.

14 **Q.** Okay. Couple of additional questions.

15 So, the safety equipment you say he -- the company owned

16 the harness. What other safety equipment would he have had

17 to have?

18 **A.** Gloves, glasses. We deal with a lot of

19 cutting metal, so sparks are constantly flying where we

20 wear a face shield in that time. This day, like everything

21 was supplied for him. Everything was there. Like, the

22 rope and the butterfly clip.

…

11 **--- INTERVIEW BY MR. RUTLEDGE:**

12 **Q.** ... Just to clarify which wall

13 you guys were planning to work from that day. There was

14 kind of two walls on the canopy. There was a wall that's

15 about 15 feet and another wall was about 42 feet.

16 **A.** Yes.

17 **Q.** Which of those two walls were you guys

18 working on?

19 **A.** We were working on the smaller of the

20 two.

21 **Q.** Okay.

22 **A.** First thing in the morning, Brandon

23 hadn't showed up to work. Me and Dana did the front, the

24 big wall that you were talking about. We did that by

25 ourselves out of the scissor lift.

Page 23

1 **Q.** Okay.

2 **A.** We had finished that area up and moved

3 to the other side. That's when Brandon showed up around

4 ten o'clock in the morning. So, we were just gearing up to

5 switch stations.

6 **Q.** Okay. You mentioned lifeline and rope

7 grab.

8 **A.** Um-hmm.

9 **Q.** I didn't see a rope grab. Where was

10 that located?

11 **A.** We usually have pails, steel pails, or

12 you know, plastic 5-gallon pails that we'll put our tools

13 in.

14 **Q.** Umm.

15 **A.** Those were up in the front corner there

16 of the lift, on the cantilever.

17 **Q.** Was the rope grab there because I don't

18 remember seeing it?

19 **A.** Inside the pail?

20 **Q.** Yeah.

21 **A.** It should've been inside that pail

22 because we had grabbed it out that day.

23 **Q.** Okay. But hadn't had -- you hadn't --

24 didn't use it that day?

25 **A.** No. Like I said, we were just getting

Page 24

up there just to set up. We hadn't even started any work

2 up there.

3 **Q.** On the Monday Tool Box Talk, were both

4 Dana and Brandon present for that?

5 **A.** Yes.

6 **Q.** They were both there?

7 **A.** Yeah.

8 **Q.** Okay.

9 **A.** Monday, yes. Brandon had -- I gave him

10 a work -- a ride to work like I usually do that day, and

11 they were both present.

12 **Q.** Okay. Did they sign off on the Tool

13 Box?

14 **A.** Yes.

15 **Q.** You guys would've documented?

16 **A.** Yeah.

17 **Q.** Okay. The butterfly anchor, where was

18 that going to be attached?

19 **A.** That would've been -- there's a drain up

20 on that flat roof in the centre of our area of work, so it

21 would've been about 15 feet from the inside corner.

22 There's a drain there. It would've been placed right

23 there, closest to the wall.

24 **Q.** And attached to the floor or wall?

25 **A.** To the Q-decking, yes.

Page 25

Q. 1 To the Q-decking?

2 **A.** Yes.

3 **Q.** Okay.

4 **MR. RUTLEDGE:** That's all I have, Terry.

5 **MR. DUGGAN:** Okay. I guess the only

6 question that we ask is, do you have anything you'd like to

7 add?

8 **MR. GOUCHE [sic]:** I -- I'm still just trying to

9 wrap my head around why and how this happened. I -- I

10 still think of why was he over that far away from us? I --

11 I didn't see him going over there. I wasn't paying

12 attention to what he was doing but I just -- I have no

13 understanding why he was that far away from our work area.

14 I just -- I don't know.

15 **MR. DUGGAN:** Okay. All right. If there's

16 no other questions we'll end the interview at 9:37 hours.

[124] Beginning first with the statement to IPS, the Crown takes issue with the accused's assertions in answering the question of what substandard acts/practices and conditions caused or could cause the event? The answer provided by Mr. Gooch was:

- Not using PPE (rope)
- Not being tied off 100%
- Not working in the proper area.

[125] Much of this has to be read in the proper context. The statements above (and there are other statements to similar effect in this document) indicate that Brandon was not in the proper work area when he fell. This is completely consistent with what the accused and Mr. Munroe have maintained all along, and also consistent with the job hazard analysis filled out on March 12, 2018. Mr. Gooch said there was nothing in their work which required them to be closer than 6 feet from a leading edge. Mr. Munroe said there was nothing in their work that we should have brought them closer than 10 feet from a leading edge. Both say that Mr. Alcorn had travelled significantly further away from the proper work area. Had he been required to work in the immediate area from which he fell he would have been required to use PPE and be tied off. I see nothing above inconsistent with these assertions.

[126] Next, in response to the question "basic causes: what specific personal and/or job/system factors caused or could cause this event?", is the answer:

> "I am not sure of the basic causes Brandon was suppose[sic] to install safety gear like the day prior. I am not sure why he was that far away we weren't working there."

[127] As far as accident reoccurrence prevention:

> "When installing safety gear you must stay tied off 100%. You must stay tied off to man lift or scissor lift ect [sic]". Long-term – we will be reinforcing the 100% tie off at all the time."

[128] Checked off as "immediate causes" of the accident are "failure to use PPE, "inadequate guards or barriers"; and "improper position for task".

[129] I see nothing necessarily at odds with what is apparent in the video (Exhibit 2), and the statement. First, Mr. Gooch has maintained that Mr. Alcorn should never have been in the area from which he fell. There was no job-related reason for him to be there. Second, if Mr. Alcorn were to determine that he needed to work in proximity to the edge from which he fell, he should have either been wearing fall prevention equipment, or some form of guard or barrier was necessary.

[130] It is acknowledged that the meaning of some portions of the statement is somewhat obscure. However, allowance must be made for the fact that the statement, although not given as proximate to the fall as the one provided to the police, was nonetheless provided the very day of the fall, and likely at a time when it was still unknown whether Mr. Alcorn was going to live or die as a result of his injuries. I am certainly not prepared to infer, absent of evidence to that effect, that there was anything in the statement concocted or invented for the purposes of evading guilt, whether with respect to potential charges under the Occupational Health & Safety Act, or the criminal charge which was subsequently laid.

[131] As to the police statement, given less than 1/2 hour after the accident, Mr. Gooch basically says he was engaged in "setting up are [sic] work area with Brandon Alcorn. I was passing him material and equipment. I turn to get more stuff from my partner Dana when I heard her yell, looked and saw Danny on the ground getting my attention that is when I noticed Brandon had fallen." (Exhibit 1, Tab 10, page 1)

[132] Clearly, the video (Exhibit 2) shows that Mr. Gooch was not engaged in setting up the work area at the time of the fall. The three men had already begun

work on the right side of the tower, and in fact Mr. Alcorn had cut at least two lengths of membrane from the roll and handed them to his coworkers for application to the right side of the tower. By any measure, however, they had not been working for very long, and it is entirely possible that, like Mr. Munroe, this is the way Mr. Gooch remembered it. The essential point was that Mr. Gooch did not see the fall itself, and this is confirmed by the video of the incident.

[133] Then, there is this:

> “Q – 2 did you see him wearing using any safety equipment? ... he had his harness on but we were just setting up are[sic] work area, so he had not tied off yet.”

[134] This is not only at odds with the fact that they were not "just setting up", but with respect to the subsequent assertions that there was no work-related activity which would have required tie off, because the work plan never involved any of the workers getting closer than 6 feet (Gooch) or 10 feet (Munroe) to a leading edge. Again, however, it is at least arguable that what was meant by indications in the IPS statement, which he provided later that day, was to the effect that FPE equipment was required if Mr. Alcorn were to have been required to work close to the edge from which he eventually fell, and given the much closer temporal proximity to the fall when the police statement was provided, and his emotional upset (which was apparent to Constable Penfound). This (once again) could have been what Mr. Gooch was (rather poorly) attempting to explain. In any event I can state quite unreservedly that I am not prepared to draw any negative inference with respect to anything in either of the statements.

[135] As to the statement provided to Occupational Health & Safety officers, the situation is the same. Again, Mr. Gooch exhibits the same faulty recollection that they were just getting set up on the accident occurred. He also mentions that his plan was to have a man in the scissor lift will be tied off in the left. But he does stress that: "..[.the intent was to work]...in the furthest inside away from a leading edge." (aide to Exhibit 2, p. 6)

[136] He also stressed that:

> "...there was no work or reason for Brandon to be over in the area he was in at this time [at the time of his fall]... I have no, no, no... understanding why he was that far away from us." (Page 7)

[137] Mr. Gooch further evidenced an understanding that there is a requirement to implement fall protection in Nova Scotia when working at heights anywhere over

10 feet (page 11, l.19). But there are different types of fall protection, as Mr. Gooch went on to explain. Travel restraint is one (page 11, l.25). Lifeline rope grabs system is another, so is a "retractable coming up to even rails" (page 12, ll. 1-4). When asked "what type of fall protection were you going to use that day", he responds "that would have been lifeline and rope grab." (P 12, ll 7-8). Importantly, he then adds:

> "We didn't have any...any work to do at the edge of... in this area. My understanding of training was that on a flat roof, he had to stay away 6 foot[sic] from a leading edge where all of our work was, I believe, in that... Being a certain distance away from the edge."

[138] While conceding that they were all wearing harnesses, and upon being asked why they were wearing harnesses if they were not going to need them having regard to the type of work they were doing that day, and if the plan to stay away from the edge, he responded:

> " Well...to go up on the scissor lift, it is mandatory to wear it [tie off/fall restraint] in the scissor lift itself." (Page 12, ll 10 – 23).

[139] It is certainly true that there is no evidence on the video footage (Exhibit 2) showing anybody being tied off while in the scissor lift on either March 12 or 13th, 2018. (Ironically, this includes Officer Trish Kennedy who, even though in the company of Occupational Health & Safety Officer Rutledge, did not tie off when she went up in the scissor lift to the roof either.) The fact remains that a failure to tie off while in the scissor lift did not lead to Mr. Alcorn's death.

[140] Having considered all three statements themselves carefully, and the context in which they were made, there is nothing in them which leads me to draw the inference which the Crown urges upon me.

[141] I shall now proceed to discuss the other evidence.

B. Did Mr. Gooch undertake an act, or omit to do anything that was his legal duty to do?

[142] The most pertinent evidence with respect to this issue was supplied by Crown witnesses Dana Munroe, Scott Andrews, the two OHS Officers Duggan and Rutledge, and Barry Oxner. Most of the details of their testimony has already been reviewed.

[143] With respect to Mr. Oxner, I did not place a great deal of weight on his evidence. When questioned by Defence counsel, he appeared at times to be argumentative and evasive. For example, when he talked about the lanyard and other equipment available to, and worn by Mr. Alcorn, he spent a great deal of time, on direct, emphasizing how that equipment would not conform to CSA standards. It was not until he was asked the question directly on cross as to whether the defects in equipment could have been caused by the very fall that Mr. Alcorn had experienced, that Mr. Oxner conceded that such could have been the case. In other words, he really had no idea whether or not the equipment was satisfactory at the time Mr. Alcorn put it on.

[144] On another occasion during his direct testimony, he opined that the equipment worn by Mr. Alcorn was not appropriate for someone who weighed less than 254 pounds. On cross, when pressed, he conceded that he had no idea how much Mr. Alcorn weighed. Moreover, he also admitted it could be appropriate for someone weighing 200 pounds (90 kg).

[145] Reference to the autopsy report (Exhibit 1, Tab 13) indicates the fact that the deceased's corpse, at a time when all of the internal organs, as well as skin and brain had been removed (presumably fluids, too) weighed 81.7 kg. Mr. Alcorn almost certainly weighed more than 90 kg at the time of his death.

[146] Another example of evasive behavior came when Mr. Oxner was responding to a question on cross-examination as to whether it is ever acceptable to come to a work site and work from heights while intoxicated. His first response was to the effect that "I don't know what intoxication looks like". It was only after two or three more questions along this line that he conceded that an individual should not be intoxicated on the worksite, due to the safety hazard it represents for that individual and their co-workers.

[147] Moreover, much of his evidence dealt with respect to what constituted compliance with OHSA standards. I had the impression that he appeared to automatically conflate a (perceived) failure to comply with such standards with criminal negligence.

[148] With respect to Mr. Andrews, as we have seen, he testified that he did not see Mr. Alcorn's death, but he did say that, up to March 13, 2018 (the date on which it occurred), he had not observed any safety infractions committed by the IPS crew. Moreover, he did not identify any unsafe work procedures or job hazard analyses

submitted by Mr. Gooch on behalf of IPS, to that point, that were inconsistent with safe practices in the industry.

[149] He stated that there were people in the industry (like Mr. Gooch) who considered “6 feet from the edge” an appropriate distance with which to dispense with the use of fall arrest equipment or precautions. He preferred the “10 feet from the edge” rule, which was his employer’s (Maxim’s) standard.

[150] Interestingly, OHS Investigator Terry Duggan agreed that the Nova Scotia OHS regulations do not prescribe a mandatory “tie off” when working from heights closer than a minimum specified distance from a leading edge. He agreed that a very effective form of fall protection is to require workers to stay back a minimum safe distance from a leading edge. He also agreed that, unlike Nova Scotia, some provinces do identify, in their legislation, a minimum “fall hazard area”, or the “safe distance from the unguarded edge” while working at heights. For example, in British Columbia, an employer is responsible for determining the “fall hazard area”, which is to be a minimum of 2 m (6.5 feet) from the unguarded edge. (Exhibit 12, page 7 of 49)

[151] Reference has been made to the job hazard analysis submitted by IPS, and signed by Mr. Gooch, Mr. Munroe, and Mr. Alcorn the day before the latter’s tragic death. At Exhibit 1, Tab 2(c), we have seen that the task identified was blue skinning, and the hazard involved with at work was, said to be “working at heights”. The plan to eliminate or attenuate that hazard was identified as “stay back 6 feet or 100% tie off”.

[152] In fact, Dana Munroe’s evidence was that the plan was never to get any closer to any edge than 10 feet, and that it was the practice of their crew to discuss these things before they signed off on the various Field Level Hazard Assessments that were required, each time they did a different type of work on a particular project.

[153] Moreover, it appears clear that Mr. Gooch was sensitive to the fact that different precautions were required when different distances from a leading edge of a canopy was involved. As earlier discussed, Exhibit 1, Tab 2(a) consisted of a Field Level Hazard Assessment completed on January 3, 2018, the work described was “install panels”. Mr. Munroe testified that this type of work is done while the installer is either on the ground, or, at higher levels, on the scissor lift. Because this latter involves work at heights while very close to a leading edge (from the scissor lift), it requires 100% tie off as specified in that particular assessment.

[154] Likewise, another such document is found at Exhibit 2, Tab 2(b), this one dated February 5, 2018. This time, the work specified was “trim work”. This type of work too, would be done by the worker while standing in the scissor lift very close to the leading edge of the platform. It therefore also required 100% tie off as specified.

[155] The plans of the canopy appear at Exhibit 1, Tab 11, and depict the distance from the tower, to which the blue skinning was being applied, to the far right edge of the canopy. Where Mr. Munroe and Mr. Gooch stood (adjacent to the right side of the tower) at the extreme left edge of the canopy on that side of the tower, it is slightly less than 42 feet to that far right edge. Mr. Alcorn’s job requirement was to roll out and cut 15-inch strips of blueskin, and hand them to his two coworkers.

[156] As has been earlier discussed, this involved, sequentially, rolling the blueskin out, measuring it, and then cutting it. Then he was to pick up the membrane and give it to the others for application to the tower. While doing so, his travel route, backward and forward, took him in a line approximately perpendicular to the other two. There was no job-related requirement or need for him to be closer than 10 feet from the edge (on the narrow side of the canopy, to his left) or closer than 20 feet of the leading edge of the far right end of the canopy.

[157] Moreover, when exiting from the roof (unfortunately Mr. Alcorn never got to do that on March 13, 2018), Mr. Munroe noted that Mr. Alcorn would have to simply walk near the panel wall at the back of the canopy until he reached the tower, and then walk along the tower wall to the scissor lift, whose railing extended well above the height of the canopy on which they worked.

[158] Mr. Alcorn knew what the workplan was. He had the appropriate fall protection training, received Maxim’s orientation, and among other things, knew that he had the right to refuse work which he considered to be unsafe. (Exhibit 1, Tab 20)

[159] He signed the job hazard assessment on March 12, 2018, which constituted an acknowledgement that the plan was never to work closer than 6 feet from a leading edge (indeed, the plan implemented never required him to get closer than 10 feet). The day before, Mr. Alcorn was working on the left-hand side of the tower cutting blueskin without any apparent difficulty and seemed to be keeping the required distance from the edges of the canopy (as best as may be discerned from viewing USB Exhibit 2), while engaged in cutting the blueskin.

[160] I have been left in considerable doubt that Mr. Gooch undertook an act or omitted to do anything that it was his legal duty to do. Accordingly, the Crown's case must fail.

Did the act or omission cause the death of Brandon Alcorn?

[161] In the event that I have erred in my assessment of the first issue, I would, in any event, have concluded that I have not been satisfied beyond a reasonable doubt that any act or omission on the part of Mr. Gooch was responsible for the death of Mr. Alcorn.

[162] In *R v. Hoyek*, 2019 NSSC 7, the Court dealt with an industrial accident which resulted in the death of a 58-year-old mechanic at an auto body shop. The shop was owned and supervised by the accused.

[163] The accused had towed the trailer to the front of the property into an area next to the garage bays, adjacent to a set of acetylene tanks. The deceased and another worker began to strip the van, with the intention that it be scrapped.

[164] During this endeavour, the deceased moved a catalytic converter using an acetylene torch. However, as he attempted to use the torch to remove the steel straps which bound the gas tank to the minivan, the tank ignited, and the worker was trapped under the vehicle. By the time the accused and a co-worker could remove the deceased from under the van, he had sustained severe burns to most of his body. He died of these injuries the next day. Charges under s. 220(b) were laid against the accused.

[165] In his decision, Chipman, J. explained:

> [68] In determining whether a person can be held responsible for causing death, it must be determined whether the person caused death both in fact and in law. Factual causation demands an inquiry into how the victim came to his or her death, in a medical, mechanical or physical sense, and the contribution of the accused to the victim's death. Legal (imputable) causation is concerned with the question of whether the accused person should be held responsible in law for the death that occurred. See *R. v. Nette*, 2001 SCC 78, [2001] 3 S.C.R. 488, at paras. 44-45; *R. v. Shilon* (2006), 2006 CanLII 41280 (ON CA), 240 CCC (3d) 401, at para. 21 (Ont. C.A.).
>
> [69] In *R. v. Kazenelson*, 2015 ONSC 36 (upheld on appeal; *R. v. Kazenelson*, 2018 ONCA 77) Justice MacDonnell discussed factual causation at para. 133:

> [133] Factual causation involves an inquiry into how the death or injury occurred in a medical, mechanical or physical sense, and with the contribution of the accused to that result. The question is generally resolved by asking whether 'but for' the conduct of the accused the death or bodily harm would have occurred: *R. v. Maybin*, 2012 SCC 24 (CanLII), [2012] 2 SCR 30, at paragraph 15; *R. v. J.S.R.*, 2008 ONCA 544, at paragraph 17.

[166] In the earlier case of *R v. Menezes*, 2002 CanLII 49654, Justice Casey Hill also had occasion to discuss this concept:

> 91 The starting point in the chain of causation which seeks to attribute the prohibited consequence to an act of the accused is usually an unlawful act in itself. When the commission of the unlawful act is with the relevant mental element for the crime charged, causation is generally not an issue.
>
> 92 The causation inquiry, other than in sentencing, is generally unconcerned with contributory negligence. As well, a wrongdoer cannot escape the thinskull rule—a wrongdoer must take the victim as found: *R. v. Nette, supra* at 518; *R. v. Creighton, supra* at 377-8. In examining the traceable origin of the chain of events causing death, remoteness may become an issue. If the act of the accused is too remote to have caused the result alleged, causation is not established. If the accused's actions are fairly viewed as only part of the history of the setting in which the prohibited result unfolded, without more, causation is not proven: *R. v. Cribbin* (1994), 1994 CanLII 391 (ON CA), 89 C.C.C. (3d) 67 (Ont. C.A.) at 80 *per* Arbour J.A. (as she then was). However, where the unlawful driving can be said to "still demonstrably influence the actual injury accident beyond serving as its backdrop", causation is established: *R. v. F. (D.L.), supra* at 364.
>
> 93 Likewise, if the triggering of a chain of events is interrupted by an intervening cause, it can serve to distance and exonerate the accused from any responsibility for the consequence: *R. v. Nette, supra* at 507. Put differently, <u>do independent factors exist which might reasonably be said to sever the link that ties the accused to the prohibited result?</u> Or is the chain unbroken with the effect of the accused's actions subsisting up to the happening of the event or consequence? Is there a *supervening* cause such as to insulate the accused from the legal consequences flowing from the death? (*R. v. Cribbin, supra* at 80).
>
> [Emphasis added]

[167] Both parties have referenced the case in *R v. Kazenelson*, 2015 ONSC 3639; aff'd 2018 ONCA 77. At the trial level, Justice MacDonnell observed:

> [133] Factual causation involves an inquiry into how the death or injury occurred in a medical, mechanical or physical sense, and with the contribution of the accused to that result. The question is generally resolved by asking whether 'but for' the conduct of the accused the death or bodily harm would have occurred: *R. v.*

Maybin, 2012 SCC 24 (CanLII), [2012] 2 S.C.R. 30, at paragraph 15; *R. v. J.S.R.*, 2008 ONCA 544, at paragraph 17.

[168] He then went on to elaborate:

> [136] One of the ways that legal causation narrows the field is by means of the doctrine of intervening acts. <u>That doctrine recognizes that in some circumstances other causes may intervene in a way that would make it unfair to attribute responsibility for a resulting harm to the accused</u>. In assessing whether it would be unfair, two approaches have emerged in the case law.
>
> [137] The first approach looks to whether the intervening act was objectively or reasonably foreseeable. An intervening act that was reasonably foreseeable will not usually relieve the offender of responsibility, but an act that can be characterized as "extraordinary" or "unusual" might do so: *Maybin*, at paragraphs 30-31. The more difficult issue is determining what it is that has to be reasonably foreseeable. In *Maybin*, Justice Karakatsanis resolved that issue as follows:
>
>> [It] is the general nature of the intervening acts and the accompanying risk of harm that needs to be reasonably foreseeable. Legal causation does not require that the accused must objectively foresee the precise future consequences of their conduct. Nor does it assist in addressing moral culpability to require merely that the risk of some non-trivial bodily harm is reasonably foreseeable. Rather, the intervening acts and the ensuing non-trivial harm must be reasonably foreseeable in the sense that the acts and the harm that actually transpired flowed reasonably from the conduct of the appellants. If so, then the accused's actions may remain a significant contributing cause of death.
>
> [138] The second approach considers whether the accused's conduct was effectively overtaken by a more immediate causal action that was independent of the accused's conduct, making the intervening act the sole cause in law: *Maybin*, paragraphs 27, 46. <u>For that to occur, the independence of the intervening act must be apparent. It must appear that the insofar as the harmful result is concerned, the conduct of the accused was "not operative at the time of the [harm]".</u> "If the intervening act is a direct response or is directly linked to the [accused's] actions and does not by its nature overwhelm the original actions, then the [accused] cannot be said to be morally innocent of the [resulting harm]".
>
> [Emphasis added]

[169] Appositely, in *R v. Maybin*, 2012 SCC 24, the Court observed:

> [28] In my view, both these approaches are analytical aids — not new standards of legal causation. I agree with the intervener, the Attorney General of Ontario, that while such approaches may be helpful, they do not create new tests that are dispositive. Neither an unforeseeable intervening act nor an independent

> intervening act is necessarily a sufficient condition to *break* the chain of legal causation. Similarly, the fact that the intervening act was reasonably foreseeable, or was not an independent act, is not necessarily a sufficient condition to *establish* legal causation. Even in cases where it is alleged that an intervening act has interrupted the chain of legal causation, the causation test articulated in *Smithers* and confirmed in *Nette* remains the same: Were the dangerous, unlawful acts of the accused a significant contributing cause of the victim's death?
>
> [29] Depending on the circumstances, assessments of foreseeability or independence may be more or less helpful in determining whether an accused's unlawful acts were still a *significant contributing* cause at the time of death. Any assessment of legal causation should maintain focus on whether the accused should be held legally responsible for the consequences of his actions, or whether holding the accused responsible for the death would amount to punishing a moral innocent.
>
> 5. Reasonable Foreseeability
>
> [30] An intervening act that is reasonably foreseeable will usually not break or rupture the chain of causation so as to relieve the offender of legal responsibility for the unintended result. This approach posits that an accused who undertakes a dangerous act, and in so doing contributes to a death, should bear the risk that other foreseeable acts may intervene and contribute to that death. Because the issue is whether the actions and consequences were reasonably foreseeable prospectively, at the time of the accused's objectively dangerous and unlawful act, it accords with our notions of moral accountability. This approach addresses the question: Is it fair to attribute the resulting death to the initial actor?
>
> …
>
> [38] For these reasons, I conclude that it is the general nature of the intervening acts and the accompanying risk of harm that needs to be reasonably foreseeable. Legal causation does not require that the accused must objectively foresee the precise future consequences of their conduct. Nor does it assist in addressing moral culpability to require merely that the risk of some non-trivial bodily harm is reasonably foreseeable. Rather, the intervening acts and the ensuing non-trivial harm must be reasonably foreseeable in the sense that the acts and the harm that actually transpired flowed reasonably from the conduct of the appellants. If so, then the accused's actions may remain a significant contributing cause of death.
>
> [Emphasis added]

[170] Within the context of the case at bar, both the hazard assessment dated March 12, 2018, and the testimony of Mr. Munroe establish that the work plan should never have involved Mr. Alcorn getting anywhere near 10 feet of any of the canopy's edges. On March 13, 2018, the IPS crew was doing exactly the same work as it had

the day previous, albeit now that work was being done on the right-hand side of the tower.

[171] Mr. Alcorn had worked the entirety of March 12, 2018, and at no time on that date did it appear that he ever went back any more than 15 feet when rolling out the blueskin. The following day, he followed the correct procedure once or twice, and then proceeded to walk backwards much further than 15 feet, which caused him to fall off the unguarded edge of the far right of the canopy.

[172] Both Dr. Sutton and Ms. Swatek testified that there were no acceptable levels of Delta-9 THC in a worker's blood when that individual is performing safety sensitive tasks. The drug has impairing effects upon the balance, field of vision, and awareness of surroundings upon the person consuming it. Similarly, both testified that to accurately gauge a person's level of impairment, one looks to the way in which they behave. As earlier pointed out, both agreed that for a person to walk off the side of a roof, seemingly paying no attention to their surroundings, that would be tantamount to a sign of impairment, because it is not common in sober individuals.

[173] I accept Dr. Sutton's conclusion that it is more likely than not that Mr. Alcorn was intoxicated when he arrived for work on the morning of March 13, 2018. Even if I had concluded that failing to ensure that each member of the IPS crew was tied off while performing their job tasks on that date was "an act or omission that was the accused's legal duty to do", I would have been left in significant doubt that such was the cause of Mr. Alcorn's unfortunate and tragic death.

[174] The fact that Mr. Alcorn showed up intoxicated appears to have been an intervening event. I conclude that it is likely that his intoxication caused him to depart significantly from the route which his actual work duties ought to have required, a route to which he appeared to have no difficulty adhering the day prior. Mr. Alcorn's conduct was so grossly inappropriate as to have been virtually unforeseeable on the accused's (or anyone else's) part. It would have had the effect of severing the cause of the death from Mr. Gooch's act or omission (if I had concluded that there was one).

[175] On the basis of my conclusion with respect to this issue alone, Mr. Gooch is entitled to an acquittal.

[176] However, I will go further. Even if I am in error on both of the above issues, I would not have found that the act or omission that was the accused's legal duty to

perform constituted a marked and substantial departure from the conduct of a reasonable person in the accused's circumstances, or a wanton and reckless disregard by him for the lives and safety of others.

D. Did the accused's act or omission constituted a marked and substantial departure from the conduct of a reasonable person in the accused's circumstances?

[177] In R v. Gardner, 2021 NSCA 52, Beveridge, J. explained:

> [65] Various terms have been used to describe what is meant by "wanton or reckless disregard". Cory J.A., in *R. v. Waite*, *supra*, whose decision was adopted as a correct statement of the law by three members of the Supreme Court, described the term:
>
> > [62] … The word "wanton" means "heedlessly". "Wanton" coupled as it is with the word "reckless", must mean heedless of the consequences or without regard for the consequences. If this is correct, then it is immaterial whether an accused subjectively considered the risks involved in his conduct as the section itself may render culpable an act done which shows a wanton or reckless disregard of consequences. …
>
> [66] The Ontario Court of Appeal in *R. v. L.(J.)* (2006), 2006 CanLII 805 (ON CA), 204 C.C.C. (3d) 324 referred, with approval, to the comments of Hill J. in *R. v. Menezes*, 2002 CanLII 49654 (ON SC), [2002] O.J. No. 551 (QL), where he wrote:
>
> > [72] Criminal negligence amounts to a wanton and reckless disregard for the lives and safety of others: *Criminal Code*, s. 219(1). This is a higher degree of moral blameworthiness than dangerous driving: Anderson v. The Queen (1990), 1990 CanLII 128 (SCC), 53 C.C.C. (3d) 481 (S.C.C.) at 486 per Sopinka J.; Regina v. Fortier (1998), 1998 CanLII 12917 (QC CA), 127 C.C.C. (3d) 217 (Que. C.A.) at 223 per LeBel J.A. (as he then was). This is a marked and substantial departure in all of the circumstances from the standard of care of a reasonable person: Waite v. The Queen (1989), 1989 CanLII 104 (SCC), 48 C.C.C. (3d) 1 (S.C.C.) at 5 per McIntyre J.; Regina v. Barron (1985), 1985 CanLII 3546 (ON CA), 48 C.R. (3d) 334 (Ont. C.A.) at 340 per Goodman J.A. **The term wanton means "heedlessly" (Regina v. Waite (1996),** 1986 CanLII 4698 (ON CA), **28 C.C.C. (3d) 326 (Ont. C.A.) at 341 per Cory J.A. (as he then was)) or "ungoverned" and "undisciplined" (as approved in Regina v. Sharp (1984),** 1984 CanLII 3487 (ON CA), **12 C.C.C. (3d) 428 (Ont. C.A.) at 430 per Morden J.A.)) or an "unrestrained disregard for consequences" (Regina v. Pinske (1988),** 1988 CanLII 3118 (BC CA), **6 M.V.R. (2d) 19 (B.C.C.A.) at 33 per Craig J.A. (affirmed on a different basis** 1989 CanLII 47 (SCC), **[1989] 2 S.C.R. 979 at 979 per Lamer J. (as he then**

> **was)). The word "reckless" means "heedless of consequences, headlong, irresponsible": Regina v. Sharp, supra at 30**.
>
> [Emphasis added]

[178] At the risk of further repetition, even if I had concluded that the accused had failed to perform an act or been guilty of an omission which he was under a legal duty to observe in the circumstances, and even if I had concluded that that act or omission had caused Mr. Alcorn's death, I would not have concluded that the "act or omission" was a marked and substantial departure from the conduct of a reasonable person in Mr. Gooch's circumstances.

[179] First, there is no regulation under Nova Scotia's OHSA requiring tie up when working closer than a specified distance from a leading edge. It is a decision which must be made having regarding to all exigent circumstances.

[180] Second, there is no evidence that the hazard analysis submitted by IPS (signed by Mr. Gooch, Mr. Munroe, and Mr. Alcorn) caused Mr. Andrews, or anyone else at Maxim the slightest bit of discomfiture.

[181] Third, the crew working on an adjacent canopy, performing work that was (at least) very similar to that being done by the IPS crew, was not tied off either, nor did they appear to have any more extensive or different fall protection measures in place than IPS.

[182] Fourth, the crew working on the very top roof could be seen (at times) walking around carrying items from one end of it to the other, without any fall arrest mechanisms that would have either kept them away from a leading edge, or have circumscribed their movements while on the roof to keep them away from an edge. In fact, the workers were observed moving around quite freely, and on at least two or three occasions were observed getting very close to a leading edge, and/or peering over. Mr. Rutledge did say that there might be a small parapet (unseen) which would keep that latter individual from getting to the edge, however that was speculative.

[183] Fifth, OHS Officer Duggan confirmed that he had been at hundreds of job sites where workers had not, in his opinion, been using proper protection. Presumably, that means "protection" as prescribed by the relevant provincial OHSA, or the regulations pursuant thereto.

[184] Finally, Scott Andrews agreed that some contractors may use "6 feet from the edge" as a safe distance to work without fall regulation, even though he "goes by"

Maxim's 10-foot requirement. No minimum distance is prescribed in the Nova Scotia legislation, rather the individual responsible for the crew must take all of the prevalent factors into consideration when designing a work plan and hazard protection measures.

[185] Indeed, failure to comply with the relevant OHSA regime, even if it had been established, does not necessarily equate to a "marked and/or substantial" departure from the conduct of a reasonable person in Mr. Gooch's circumstances. I have little to no evidence before me as to what ordinary industry standards would have required in these circumstances, in any event.

Conclusion

[186] I have not been satisfied of Mr. Gooch's guilt beyond a reasonable doubt. In fact, as noted earlier, I have been left in substantial doubt with respect to virtually all of the criteria which the Crown was required to prove. Accordingly, an acquittal is entered.

Gabriel, J.