Citation: 2023 NBKB 084

Date: 2023 06 05

Docket: FCR-3-2022

IN THE COURT OF KING'S BENCH OF NEW BRUNSWICK

TRIAL DIVISION

JUDICIAL DISTRICT OF FREDERICTON

BETWEEN:

HIS MAJESTY THE KING

– and –

JASON ANDREW KING

Date of Hearing:	April 11-14, 17-20, 24-28, May 2, 10, 2023
Date of Decision:	June 5, 2023
Before:	Justice E. Thomas Christie
At:	Burton, New Brunswick
Appearances:	Patrick McGuinty and Christopher Lavigne for the Crown
	Patrick Hurley, K.C. and Sabrina Winters for Jason King

Christie, J. (Oral Decision)

INTRODUCTION

[1] On August 16, 2018, Michael Henderson died following an incident at a construction site in Fredericton, New Brunswick. He was employed on the site by Springhill Construction Ltd. and worked under the supervision of the accused, Jason King. Mr. King stands before this court charged on a one count Indictment that reads:

> On or about August 16, 2018 at Fredericton, New Brunswick did, by criminal negligence cause the death of Michael Henderson, contrary to s. 220(b) of the Criminal Code of Canada and amendments thereto.

[2] That section of the *Code* states that:

> 220. Every person who by criminal negligence causes death to another person is guilty of an indictable offence and liable
>
> (a) *omitted*
>
> (b) in any other case, to imprisonment for life.

[3] The substance of the offence is set out in s. 219 of the *Code*. The Crown also invokes, in the alternative, s. 217.1 of the *Code*. The provisions state as follows:

> 217.1 Every one 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.
>
> 219 (1) Every one 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

[4] The incident occurred on a construction site on property owned by the City of Fredericton. It was known as the Barker Street Wastewater Treatment and Pumping Plant (the Plant). At the relevant time, a secondary clarifier was under construction. The clarifier construction was part of a four-phase program of improvement to the City's infrastructure aimed at enhancing the process of treating the liquid waste generated within the City before it is then discharged into the Saint John River. It was on the construction site of this clarifier that the incident of August 16th occurred.

[5] At the start of the trial, counsel submitted an agreement as to the timeline of certain events leading up to, and shortly following, the incident that resulted in Mr. Henderson's death. Mr. Henderson's death occurred when a large pneumatic rubber plug that was installed in a pipe that connected to a hole (or sump) in the middle of the clarifier in which he was working, let go from its position. The hole was eight feet deep. When the plug released into the hole, it pinned Mr. Henderson against the wall of the hole and approximately 32,000 litres of water flooded instantly into and filled the hole to overflowing. Mr. Henderson was pinned against the wall with such force that he could not move and frantic attempts to rescue him failed. The parties agree that the cause of Mr. Henderson's death, as determined by the forensic pathologist, was asphyxia due to drowning.

[6] In these reasons, I will summarize the evidence presented by the witnesses in the order it which it was presented. I will then provide a summary, in narrative form, of the facts which I find to be established beyond a reasonable doubt. Arguments of counsel will be reviewed, and

the relevant law will be discussed and then applied to the facts. This is not a case where, generally speaking, the evidence presented is in dispute.

WITNESS SUMMARIES

Dan Harvey

[7] The manager of the treatment Plant, Mr. Dan Harvey testified. He described the layout of the Plant, as it exists following the upgrades, as consisting of two aeration basins, two secondary clarifiers and a UV building which was also being built as part of the overall project. The construction of the new clarifier was part of Phase 3 of the program that began in 2017. It was a large construction project under the general oversight of the Canada British Consulting Limited (CBCL). CBCL was involved in the preliminary design, the final design, the tendering and awarding of the construction contract. It also had a representative on site during construction to ensure it was completed to specifications and to generally oversee contract administration. Mr. Harvey was involved in the initial design concepts of the project as the City's representative.

[8] Springhill Construction had been awarded the construction contract which included the UV building and the clarifier where Mr. Henderson died. CBCL would oversee Springhill's work for compliance with the design parameters. Of particular concern in this matter is the construction of what was known as the second secondary clarifier. It is a large round concrete pond wherein waste, which travels from the aeration ponds, is circulated and separated before it is then moved to the UV building for either discharge into the river or routed back to the aeration ponds for further processing as needed.

[9] The new clarifier under construction measures one hundred and eighteen feet in diameter and eighteen feet deep. The floor of the clarifier slopes toward the middle where there is found another hole that is a further 8 feet deep below grade and 42 inches in diameter. The incident that claimed Mr. Henderson's life occurred within this hole, in the middle of the new clarifier.

[10] Until May or June of 2018, Mr. Stephen King was the Site Supervisor for Springhill on this project. The accused, Mr. Jason King, took over at that time and was site supervisor for Springhill at the time of the incident involving Mr. Henderson. Mr. Harvey testified that safety on the construction project was the responsibility of Springhill. With that said, he testified that if a safety issue had come to his attention, he would generally report it to CBCL's on-site representative, Mr. Cole DeMerchant. If there was something obvious and of immediate concern, Mr. Harvey would address it personally, and without delay, with Springhill employees.

[11] There were regular site meetings, usually held bi-weekly, in the board room of the Plant. Regular agenda items included discussion of any safety issues. Attendees at these regular meetings included representatives of the City, CBCL and Springhill. In addition to Mr. Harvey's presence at such meetings, City Plant Supervisor, Doug Sewell would attend. He reported to Mr. Harvey. Mr. Sewell was considered to be the regular contact between what was happening on the construction site and the City. Minutes of these meetings were prepared by Springhill representative, Josh Lawrence. Mr. Lawrence would circulate these minutes to all participants and the minutes were kept. What was clear from Mr. Harvey's evidence was that there had been ongoing discussions, leading up to the date of the incident, about the need to conduct leak testing for one of the pipe systems leading into the new clarifier. However, no final process or timeline was finalized during these site meetings. At site meeting Number 16, on August 7, 2018, the issue of testing for leaks in the pipes running underneath the clarifier was raised. But again, there was no final decision on when or how the testing would be conducted.

[12] Mr. Harvey did not recall if he had been told that Springhill would be doing the leak test by using a pneumatic plug, referred to during this trial as, 'the plug'. The City owned several plugs that were stored at the Plant, one of which had been loaned to Springhill for its use on site. A plug is a large rubber device that is inserted into a pipe and inflated and used to stop the flow of liquid through a pipe. Mr. Harvey had no specific recollection of discussions with Springhill pertaining to the competence of its workers to use the plug, the existence of any safety manual

for the plug, nor the need to ensure that no one was working near the plug when it was in use. Mr. Harvey said that there would have been maintenance records on file for the plugs owned by the City, although he could not speak specifically of any records related to the plug at issue, having been marked as Exhibit P5. Mr. Harvey did not know of any specific training given by Doug Sewell to Springhill workers on the proper use of the plug.

[13] Mr. Harvey was a long-time employee of the City and had come to Fredericton from Saint John in 2005 where he was the Manager of Water and Waste responsible for Saint John's water and sewer systems. He was familiar with the use of the type of plug that was to become an issue in this case (Exhibit P5). In his experience, plugs of this type were used as a means of holding back water while working on a job where water might be leaking into the site. Mr. Harvey testified that, during his time in Fredericton, the plug was never used for leak testing. Nevertheless, the use of the plug was discussed at the site meetings for the testing and Mr. Harvey recalled his direction that the plug would need to be braced in place to keep it from moving. How that bracing should be constructed was not discussed, but the need to do so was.

[14] Turning to the events of August 16th, 2018, Mr. Harvey recalled that work on the clarifier was, by then, approximately 85% complete. Mr. Jason King was by then Springhill's on-site supervisor. Mr. Harvey was working that day and would have, he said, probably walked to the site at some point. Around noon he left for lunch and returned around 12:45 to 13:00. Upon return, he noticed that fire trucks were on site. Mr. Harvey testified that no specific safety plan related to the leak test had been finalized. From his experience in the use of such plugs, he would not put a person in the hole in the middle of the clarifier when the plug was being used.

[15] Mr. Harvey testified that the reason he would not put a person in the hole where the plug was being used was because the plug could come loose. He testified by asking the rhetorical question, "How obvious a proposition would that be?".

[16] Returning to the issue of on-site safety, Mr. Harvey testified that while Springhill was responsible for maintaining a safe worksite, any of the participants at the site meetings were free to raise safety issues. He had no recollection of WorkSafe NB appearing on site to do any inspection.

Cole DeMerchant

[17] At the time of the incident, CBCL's onsite project observer was Mr. Cole DeMerchant. He was on site daily. His job was to monitor all aspects of the clarifier's construction to ensure compliance with project specifications. This included being certain that proper materials were being used, that the workmanship complied with the plans, inspection of the rebar placement and, generally, observe the work being done. He was required to make weekly written reports to CBCL – reports that were shared with Springhill and the City.

[18] Mr. DeMerchant had regular contact with the construction crew, including Mr. King. While Mr. DeMerchant is presently a licensed, professional engineer he was, in August 2018, a graduate engineer-in-training.

[19] In May or early June 2018, Mr. DeMerchant began working fulltime for CBCL at the Plant site having taken over the role occupied until then by another CBCL employee, Mr. Avery Gilks. At the time of Mr. DeMerchant's arrival on the job, Mr. Stephen King was Springhill's site supervisor. Mr. DeMerchant confirmed that in or around June 2018, Mr. Jason King took over that function. Mr. King and Mr. DeMerchant interacted with each other regularly throughout each workday. It was Mr. DeMerchant's view that Springhill was responsible for safety on the project.

[20] Mr. DeMerchant was aware that the City expected that there would be a leak test performed of the piping system that ran from the manhole, down and under the clarifier to where it existed into the hole in the middle of the clarifier. In the weeks to several months prior to the incident, he had discussions with Mr. King as to the procedures that could be developed to test the whole new piping system. Those discussions included potentially capping or plugging the system at various locations. Water could then be introduced into the system and its height measured over time to detect any lowering of the water level which would signify a potential leak.

[21] While there had been discussions concerning the process or procedure to be used, Mr. DeMerchant was of the view that no final decision had been made. But the need to do such testing was not in dispute.

[22] On the morning of August 16, 2018, Mr. King and Mr. DeMerchant continued their discussions on how to do the leak test. This included the use of a measuring rod to determine any change in water level in the manhole. Initially, water would be pumped into the manhole and it would flow within the piping system. Being a new piping system comprised in part of concrete, the concrete would need to cure, with water in it, for a set period of time to generate accurate measurements of any water loss in the system.

[23] Mr. DeMerchant's evidence was that, to the best of his recollection, the last discussion with Mr. King about the leak test occurred around 11:30 the morning of August 16th. His expectation was that Mr. King would start to conduct the test later that afternoon. During the morning, Mr. DeMerchant had seen Mr. Henderson on the slab floor of the clarifier clearing up regular debris. Around 11:55, Mr. DeMerchant left the site for lunch and testified that, by the time he had left, he had no understanding that water would be introduced into the manhole while he was away. Mr. DeMerchant believed he arrived back from lunch around 12:45. He was met at the gate by a frantic Springhill employee who exclaimed, 'It has been too long – he's gone!" He

then saw Mr. King who told him that 911 had been called. No emergency vehicles had yet arrived.

[24] During cross examination, Mr. DeMerchant told of his early experiences with other construction projects he had worked on while a student. On certain projects, the owner would provide a session specifically dedicated to safety issues and concerns relative to a specific job site. When he joined CBCL, he was given orientation on safety issues by way of a safety manual and a power point presentation. It took one day to complete and CBCL's Safety Officer would sign-off on its completion.

[25] Mr. DeMerchant was familiar with the design plans and drawings for the project. He testified that there was nothing on the plans that indicated a specific hazard associated with the hole in the middle of the clarifier. This was not a surprise since he stated that no such warnings are, generally speaking, marked on drawings. Typically, the safety requirements are met by adherence to all provincial safety regulations.

[26] Mr. DeMerchant testified to a site-specific safety meeting he had with the labour crew for Springhill and Springhill's representative. He said there may have been more than one such meeting. There were also weekly 'Toolbox' meetings with the Springhill crew to discuss the upcoming work and to identify any potential safety hazards. These meetings were typically held in or around the construction trailer and included the Springhill supervisor.

[27] Mr. DeMerchant did not recall if WorkSafe had ever made a visit to the site before the August 16th incident. Mr. DeMerchant recalled that Mr. Doug Sewell, who worked under Mr. Harvey with the City, was on site regularly. There were not regular meetings with Mr. Sewell *per se* but, since Mr. Sewell worked at the Plant, he was often around. Mr. Sewell was noted as not being shy about identifying any hazards he noticed around the clarifier project. Mr. DeMerchant specifically recalled Mr. Sewell asking for guardrails to be installed around the top

of the clarifier. Mr. DeMerchant also felt free to raise safety issues directly with Mr. King noting one occasion when he told Mr. King that Mr. Henderson needed to have his harness on at a specific location he was working, and that Mr. King addressed the concern within minutes.

[28] Mr. DeMerchant spoke of the bi-weekly site meetings he attended that were typically held in the Board room of the Plant. Representatives of the City and Springhill were present. At such meetings, any new safety issues were raised as well as follow-up on issues arising from previous meetings. Josh Lawrence for Springhill would prepare and circulate minutes of the meetings. As far as Mr. DeMerchant could recall, safety issues raised would be recorded in the minutes.

[29] Mr. DeMerchant testified that, in general, all participants in a project have a responsibility to raise safety issues. His practice was to raise them with Mr. King who would address the issue as needed, or if it was of immediate concern, Mr. DeMerchant felt he could raise it directly with the employee. Any safety issues of note were followed by a written report. One example he gave related to a concrete boom truck that, while backing up without a spotter, hit and broke a power pole. This was the only written report he recalled producing. Such written incident reports would go to Springhill and the City. Mr. DeMerchant testified that several months after the August 16th incident, the City hired a Safety Representative, Mr. Ouellette, who did visit the site thereafter and who Mr. DeMerchant described as 'proactive'. There was, to Mr. DeMerchant's recollection, no specific City safety representative who visited the site before the August 16th incident.

[30] Returning to the plan to test for leaks, Mr. DeMerchant confirmed that it was a requirement of the City that such testing be done. The City did not want to take ownership of the project without that test. The only way Mr. DeMerchant could foresee such a test being done was to put the system under pressure externally, meaning to fill the piping system with water. Then, it would be left for a period of twenty-four hours to cure and then a further twenty-four hours to determine if there were any leaks in the system determined by using a measuring rod.

[31] During the bi-weekly site meetings, there was no final set process or timeline for completing the test. During these meetings there would have been reference to the use of the plug – but no decision was made, nor did Mr. DeMerchant recall any direction from the City that a plug was not to be used for that purpose.

[32] On the morning of August 16th, Mr. DeMerchant examined certain of the concrete forms and rebar. He noticed that Mr. Henderson was cleaning the floor of the clarifier but did not recall seeing him in the hole. A City truck arrived and delivered a hose near the hydrant. Mr. Keith Lovely was the City employee making the delivery. There may have been another City employee as well, but Mr. DeMerchant was not certain. Mr. DeMerchant recalled that, just before his lunch break, he discussed with Mr. King the general plan to fill the piping system and measuring to determine any lowering of the water level. The extent of Mr. DeMerchant's expected involvement in the testing process was to measure the water levels.

[33] Mr. DeMerchant did not recall being advised by Mr. King on the morning of August 16th, and before he left for lunch, that the plug had already been installed and the test would begin. However, Mr. DeMerchant made note of saying that his testimony should not be construed as meaning that Mr. King did not so advise. Nevertheless, when he went for lunch that day, Mr. DeMerchant recollection was that he was unaware that the test was going to begin while he was away. His expectation was that Mr. King was, at some point that day, going to fill the line for testing and that the plug would be used for that purpose. Mr. DeMerchant had little experience in the use of the plug.

Keith Lovely

[34] Mr. Keith Lovely has been employed by the City for thirty years. He is an Operator III and worked primarily out of the Barker Street facility. On the morning of August 16th, he was

tasked by Mr. Sewell to bring a hose to the hydrant next to the clarifier and set it up so it could be used by Springhill. Mr. Lovely arrived just before lunch and set the proper valve in place on the hydrant and purged the lines and the hose. He left the hydrant on but had turned off the valves. He was told by Dave Sewell that Springhill would be doing the leak test that day but was not exactly sure of when it would be done.

Carter Dunphy

[35] Carter Dunphy, an employee of the City who worked as an Industrial Mechanic in the Plant, testified. His position was that of a Water Tech. He has extensive experience working with pumps, motors, bearings and instrumentation. He is currently the foreman. Even though he worked at the plant, he had little involvement with the construction project that was underway on August 16th. As noted, an earlier phase of the project involved the construction of the UV building. The UV building is meant to provide a final stage of purification before release of treated waste into the river system.

[36] Mr. Dunphy had experience working with plugs. During the course of his work with the City, his use of such plugs was to stop or redirect water flow. At some point during the construction of the UV building, Mr. Dunphy was asked by Mr. Doug Sewell to deliver a plug to the UV building for Springhill's use. As was his practice, he would replace the valve on the plug and install a new pressure gauge and hose before each use. He testified that he did this before he delivered the plug to Springhill at the UV building. Prior to each use he would also check all fittings and inflate the plug for twenty-four hours to ensure it did not leak. The City had in their storage facility at the Plant plugs of different sizes. He did not recall which size he delivered to Springhill or if Exhibit P5 was the actual one he delivered. Nevertheless, he testified that he put a plug in the bucket of a loader and drove it to the UV building location and left it there for Springhill to use. It was to be used in a pipe which was intended to prevent water from the river flowing back up through the system during the spring flooding.

[37] He said he had knowledge of how to install, inflate and tie-off plugs. Mr. Dunphy noted that the plug required a gauge to be attached as a means of measuring air pressure in the plug during and after inflation. He was shown Exhibit P6, being a box containing a piece of hose he said looked like a section of hose from Exhibit P5 (the plug), a valve to control the flow and an air pressure gauge. The gauge from P6 was not the type of gauge Mr. Dunphy said he would have previously installed on a plug (being Exhibit P5). It was not a liquid filled gauge being the type commonly used by the City. Similarly, he was unsure if the valve contained within P6 was a City valve.

[38] Mr. Dunphy was asked about the proper sequence of attaching the valve and gauge to the hose. He testified that the proper sequence was the compressor (on which there was a pressure gauge) to the ball valve, to the gauge and then to the hose (compressor → valve → gauge → hose). This was the only way to ensure the gauge gave an accurate reading of the pressure within the plug. As noted, he had not seen the gauge contained in P6 saying that it was not a City gauge. He demonstrated during his testimony the assembly in what he considered to be the proper order but found that the gauge would not attach properly between the valve and the hose. He then tried to attach the gauge to the opposite side of the valve (gauge → valve → hose) and found it would attach. But this sequence of components, he said, would not provide a reliable pressure reading. The inference from Mr. Dunphy's evidence was that when found after the incident, the plug (Ex. P5) had a non-City valve on it and was assembled in the wrong order. Mr. Dunphy testified that he would always inspect the plug between uses to ensure that it was in proper working order.

[39] After he had dropped off the plug to the UV building, he had no recollection of it being returned to the City, but he did believe he saw it located on another part of the construction site in the outdoors. The fact that it was stored outdoors concerned him. He was not asked to move it elsewhere after he delivered it to the UV building. Mr. Dunphy was asked to examine Exhibit P5 and noted that the metal end plate of the plug contained notice that the plug was to be inflated to 25 psi, that one 'must stand clear' during use and, that one must read the instruction manual. On

cross examination Mr. Dunphy noted that he was aware that there were instruction manuals for this plug. Most manuals were kept in the Plant's library. He did not deliver a manual with the plug when he took it to the UV building. He had not read any instruction manual for plug use in the past. Nevertheless, despite not having read the manual, his practice was that City workers do not work near a plug because, if the plug ever came loose, the plug itself, or the flow of water being held back by the plug, would be a hazard. There was no City policy to that effect – just the practice employed. He also testified that in his use of such plugs, he would always 'tie-it-off' to a secondary point so that if it did become loose, it would essentially stay in place. He has never braced a plug. His experience was that he has had no need to have someone go into a confined space where a plug was in use because it would not be safe to do so.

[40] Mr. Dunphy noted that the City required forms to be filled out after each use of the plug as a means of tracking what was done and what parts needed to be replaced. These forms were called Field Level Hazard Assessment Sheets. There was no such form for the use of the plug at the UV building.

Clayton McKeil

[41] Clayton McKeil was employed by Springhill on the clarifier project. He had worked there for over a year at the time of the incident. Mr. McKeil recalled that the crew on August 16th consisted of himself, Eric Henderson, Michael Henderson, Colin King and the accused, Jason King. Jason King gave out their work assignments that morning. Mr. McKeil and Eric Henderson were to be working on the launder. Colin King and Michael Henderson were tasked with cleaning the hole. Mr. McKeil recalled that Michael Henderson was in the hole and would pass up buckets of debris to Colin King.

[42] Mr. McKeil, along with the other workers, took their half-hour lunch break around noon. Mr. McKeil said he did not know that water had begun to flow into the manhole. Around 12:30,

he and Eric Henderson continued with their work on the launder and Michael Henderson and Colin King continued to work cleaning the hole. Shortly after returning to work after lunch, Mr. McKeil testified that he heard a loud 'swoosh' type sound – 'a large push of water'. He looked over toward the hole and saw Eric Henderson and Colin King already there. Mr. McKeil described that he could see water gushing up from the hole and a blue hard hat that sunk beneath the top of the water. He heard a scream. He continued across the clarifier floor toward the hole and saw Eric Henderson in the hole trying to help Michael. Colin King was pulling on a rope. Mr. McKeil testified that he knew there was big trouble. Dark water was bubbling up from the hole onto the clarifier floor. There was, he said, nothing he could do. He ran to get Jason King who called emergency responders.

[43] Mr. McKeil said he had no knowledge of the plan to use water that day for the purpose of leak testing. He testified that there had been no safety plan in place regarding work in the hole. His experience as a journeyman carpenter told him that he would not work in a hole where a plug was being used in case the plug let loose. He noted that he had not previously worked in a situation where a plug was used in such close proximity to a worker.

Jason Beliveau

[44] Captain Jason Belliveau of the Fredericton Fire Department testified to his efforts, and the efforts of others, to free Mr. Henderson from the hole on August 16th. Having received the emergency call at his station it took five minutes to arrive at the scene, which he and others did, shortly before 13:00. He and a colleague descended the staging into the clarifier. He initially thought one person was involved because he could see a person's head above the water. When he got to the hole, the person said, 'It's not me – it's my brother'. Eric Henderson was holding onto Michael's arm. Eric was removed from the hole and Capt. Belliveau took hold of Michael's arm. He tied a rope onto Michael's arm. Capt. Belliveau did not know the construction of the hole or what might be beneath the dark gurgling water. He and his team, despite a variety of efforts, could not pull Michael out.

[45] The only way to see what was in the hole was to drain the water. Pumps were placed in the hole and, as the water receded, Capt. Belliveau could see Michael was pinned against the wall by the plug. He lowered himself into the hole and, with a knife, stabbed at the plug. It deflated. This made it possible to remove Michael from the hole, which they did. There were no signs of life. There was no safety equipment on Michael. Michael's emergency care was turned over to Ambulance New Brunswick responders who were, by then, on scene. Capt. Belliveau recognized Exhibit P5 as the plug he deflated.

Patrick Pickard

[46] Mr. Patrick Pickard is an advanced care paramedic who responded to the scene. He is an employee of Ambulance New Brunswick and, on August 16th, was working as a Clinical Support Specialist. He works separate from, but in support of, the ambulance team of first responders. He was dispatched and arrived at the clarifier at 13:15. He saw a line of firefighters pulling on a rope to try and free Michael from the hole. They were, Mr. Pickard said, 'pulling as hard as they could'. By 13:35, Mr. Pickard and his team were able to start CPR and utilized other methods to revive Michael. Despite their efforts, there was no sign of life - no movement and no breathing.

[47] As he attempted to begin administering medication through Michael's leg, Mr. Pickard noted mottling of the skin on Michael's legs. This was one sign used by paramedics as an indicator that it is time to stop efforts to resuscitate. At 13:39, such efforts stopped. Michael was removed from the clarifier and turned over to the coroner.

Colin King

[48] Michael Henderson's work partner on August 16th was Colin King. He testified that he has worked on-and-off with Springhill from 2003 to 2019. He had been working on the clarifier project. On August 16th the crew consisted of himself, Eric Henderson, Michael Henderson, Clayton McKeil and Jason King as site supervisor. Following the morning meeting, Jason King assigned him and Michael Henderson to do clean up in the clarifier bowl. This included the hole. The plan was to pour further concrete into the hole to raise the floor to the level of the pipe flowing in from the horizontal pipe running beneath the clarifier. Jason King did not direct which of them was to go into the hole. Colin King noted that, given the size of the hole in relation to himself, he had trouble getting in and out of the hole. Its depth was over his head (he testified to being over six feet tall). As a result, Michael Henderson volunteered to do the work inside the hole. Michael would put debris in the basket and pass it up to Colin King. Colin King testified that there had been no safety procedures put in place for getting in and out of the hole.

[49] As the work of cleaning was progressing, there was water "trickling" into the hole from the underground horizontal pipe. Colin King talked to Jason King about this. Colin was directed by Jason King to take the plug down (Exhibit P5) and to insert it into the horizontal pipe and pressurize it to the level identified by the City. The plug (which had been used elsewhere on the project earlier) had been stored at the construction trailer. There was a discussion between Colin and Jason about the gauges. There was the gauge on the plug hose and there would also be a gauge on the compressor used to inflate the plug. The gauge on the plug had sand and debris on its face. Jason King told Colin King to use both gauges and that way there would be a better chance of something close to an accurate reading of the plug's inflation. Colin King brought the plug into the clarifier and handed it down to Michael. He testified that he told Michael to, 'stuff it in as far as he could reach'.

[50] Colin King had used this plug before at the UV building. Stephen King had, on that occasion, given him instructions on how to install the plug. However, his evidence on this point was not at all clear or consistent. He testified that Jason King gave him no specific instructions for its use on August 16th. He testified that the City had told 'us' to inflate to 25 psi. Once the plug was inserted by Michael Henderson, it was inflated. Once inserted and inflated, the steel

end of the plug was facing toward Michael in the hole and would have been at his mid-body level. Colin King testified that Michael was probably standing in the hole as the plug was inflating. It was not a quick process to inflate the plug. Colin King testified that he had not read any instruction manual for proper use of the plug, nor did Jason King instruct him to. Nor did he recall any instructions from Jason King to brace the plug.

[51] After their lunch break, Colin King and the others received instructions from Jason King as to their work assignments for the afternoon. Mention had been made that there was a 'test going on', and that 'water was running'. In cross examination, Colin King stated that, after lunch he knew water was going into the manhole. Michael and Colin had been told by Jason King to finish up what they were doing, i.e., the clean-up in the hole. He and Michael returned to the inside of the clarifier. Apparently, there was still some debris left in the hole and Michael was going to get the rest of it out along with some of his tools. Colin King went to get a bucket and a grinder. As he was walking away from the hole, with Michael inside the hole without any safety harness, Colin King hears the plug let go. He rushes toward the hole and sees Michael's head. He grabs onto Michael and tries to pull him up. In doing so, he tore off Michael's shirt and vest. Colin screams for help. As he looks in the hole, he cannot see the plug. He described how he could see the water rising and overflowing the hole.

[52] Colin King testified that he had not received any confined space safety training. Nor was there any specific safety plan discussed relative to Michael being in the hole that day. He testified about working in a similar, but deeper hole, at the UV building project where he was in the hole with a plug inserted in an adjoining pipe. Colin King testified that there was no safety plan in place in case he needed to be extricated from that hole in an emergency.

Eric Henderson

[53] Michael Henderson's older brother, and fellow worker on the clarifier project, testified. He learned his trade as a carpenter by on-the-job training supplemented with courses arranged in various blocks. Eric had most of his early work in the construction industry through Springhill. He had completed WHMIS training and Fall/Arrest training. Before working on the clarifier project, he had worked for Springhill on jobs at the TD Tower, UNB and the York Arena.

[54] Eric Henderson testified that he was not aware of any training on confined spaces before the incident involving Michael. Nor was he aware of the Springhill Safety Manual or any specific safety plans of Springhill's related to the clarifier project. Eric Henderson noted that there was no tripod over the hole where Michael was working and no known plan to evacuate him if needed. With that said, he acknowledged that safety on the job was 'everyone's responsibility'. Nevertheless, and without singling out Springhill, he felt there was a general reluctance in the industry for workers to be proactive in raising safety issues out of fear that they would not be called back to work the next day.

[55] August 16th began as any normal day on the clarifier project. The group of workers met with Mr. King and received their assignments for the day. Mr. King assigned Michael and Colin King to clean out the hole to prepare it for an expected concrete pour. He described the hole as being approximately eight feet deep and four feet in diameter. The pipe that entered the hole he described as being about half-way up on the inside of the hole. Eric Henderson was aware that there had been discussions between Colin King and Jason King concerning the gauge/regulator that was on the plug since it was obviously dirty or possibly damaged. He understood that Jason King was going to replace the regulator. Eric Henderson had seen the plug on the ground outside of the trailer that morning but had not seen it before. He was unfamiliar with how to use a plug. He knew however, that its intended use was to stop the flow of residual ground water leaking into the hole where Michael and Colin King had been tasked with cleaning. From his experience in construction, Eric testified that carpenters would not be the trades using a plug of this type. That work would be for pipefitters.

[56] Eric Henderson was unsure when the plug was inserted into the pipe, or by whom. He was aware that, during the morning, Michael was working in the hole and Colin King was working above it. Eric noted that there was no ladder to get in and out of the hole and no tripod positioned above it. He testified that it was dangerous to have an elevated large amount of water on one side of the plug and nothing to support it on the other.

[57] After returning to work following lunch, Eric Henderson testified that he heard 'a loud bang' and turned toward the hole and saw a fountain of water shooting out of the hole. Michael was in the hole and Colin King was yelling for help. Eric jumped over the wall, down the staging and rushed to the hole where he could see Michael's hand sticking out. Colin King was trying to pull Michael out. Eric got into the hole and went under water trying to give Michael air. He described it as 'chaos'. He was using a shovel and a knife to try and puncture the plug which had pinned Michael against the wall. Eric estimated that it was about fifteen minutes before the emergency workers arrived and he was moved out of the way.

[58] Eric Henderson testified that he was unaware if Springhill had a designated health and safety representative and that he only knew of Josh Lawrence as the person who worked in the Springhill office and bid on jobs.

Cst. Sebastien Lee

[59] Cst. Sebastien Lee, of the Kennebecasis Police Force, was working a relief shift in Fredericton on August 16th. He and his partner received a call at 13:02 to respond to a call concerning a workplace accident. He arrived four minutes later. When he arrived, he noticed a man standing at the hole trying to pull someone out by the arm. Cst. Lee assisted by trying to physically pull Michael out. Cst. Lee then tried to use a rope. Other first responders arrived and, at approximately 13:30, the plug was punctured, and Michael was removed from the hole. He was presumed dead. At 13:52, a Mr. Fillmore arrived from WorkSafe NB and took control of the

scene. This preserved the continuity of the scene for investigative purposes. Cst. Lee went to the hospital, where Eric Henderson had been taken, and formally shared the news that Michael had died. He also called Michael's mother to tell her.

Francois Boudreau

[60] Mr. Francois Boudreau was, at the relevant times, an investigator with WorkSafe NB. He is an engineer by training and currently works with the Correctional Services of Canada. With respect to the present matter, he worked with another WorkSafe investigator, Kevin Bennett, investigating the incident that took Mr. Henderson's life. Mr. Boudreau recalled that, on August 16th, 2018, he responded to the clarifier site by 17:00 that day. Other WorkSafe employees were already on site. Mr. Boudreau noted that the staging, which had been set up by Springhill to get in and out of the clarifier, had not been properly set up and was unsafe. He hired a different company to install a safer means to get in and out of the clarifier. Mr. Boudreau took statements from various witnesses at the scene.

[61] In addition, WorkSafe hired various companies to recover the items relevant to the accident and to do measurements and testing. As far as WorkSafe was concerned, the hole was considered to be a confined space. As part of Mr. Boudreau's investigation, a tripod was set up over the hole and a person, attached by a harness to the tripod, went into the hole to recover the plug. For work in a confined space three persons were considered necessary for safe entrance to, and to work in, the hole. One person communicated with the person who entered the hole and a third stood by to ensure the person working in the hole could be extracted. The person who entered the hole as part of the investigation was tasked with taking measurements and photographs of the scene. Mr. Boudreau obtained a 'permit' before commencing work in the hole. The plug that WorkSafe retrieved from the hole was turned over to Point of Origins Consultants (Mr. Gary Daneff) for evaluation.

[62] As part of the investigation, Mr. Boudreau and Mr. Bennett interviewed Jason King. A *voir dire* was held during the trial to determine the voluntariness of the interview and the statements made therein. The interview was recorded in full. It was determined by me, for reasons given during the hearing, that the statements and interview were deemed voluntary and that the recorded interview, and the *viva voce* evidence offered within the *voir dire*, would be admissible for the purposes of the trial. Mr. Boudreau and Mr. Bennett interviewed Mr. King and Mr. Bennett had given Mr. King warnings as to his right to say nothing, but if he did, it may be used in evidence. Furthermore, Mr. King had been advised that he could get a lawyer if he so wished. Mr. King also testified that the recording was accurate.

Jason King (Voir Dire)

[63] Mr. King gave evidence as part of the *voir dire*. His *voir dire* evidence consisted primarily of statements of his made during the interview with Mr. Bennett and Mr. Boudreau. Mr. King also testified during the trial proper, and I will summarize below more directly his statements made during the interview. During his examination-in-chief, and during his cross examination, he made statements that were, at times, different than answers he gave during his recorded interview. Again, these issues will be discussed further below. As I ruled at the conclusion of the *voir dire*, his interview and the statements coming from it, were voluntarily made, and the recording was accurate in capturing what took place and was said during the interview.

Roberto Sgrosso

[64] Mr. Sgrosso is employed by WorkSafe NB and is a Certified Industrial Hygienist and a Registered Occupational Hygienist. The Crown asked that he be declared an expert qualified to give opinion evidence with regard to the identification of confined spaces. Having reviewed his

qualifications as submitted by the Crown, and without objection from Mr. King, Mr. Sgrosso was declared an expert.

[65] His duties at WorkSafe include assisting employers determine if a confined space exists on their worksites. In addition, he works regularly on the enforcement and application of *Regulation 91-191* under the *Occupational Health and Safety Act*, SNB 1983, c. O-0.2. Contained within *Regulation 91-191* is a definition of 'confined space' and, he testified, there are times when employers may be uncertain as to what is a confined space and what safety protocols are legally required for work in such spaces.

[66] Mr. Sgrosso testified that he was requested by WorkSafe investigator Kevin Bennett to go to the clarifier site to determine if the hole, in which Mr. Henderson died, met the definition of a confined space. He visited the clarifier within a week of the incident.

[67] Mr. Sgrosso testified at being perplexed as to why he was being asked by Mr. Bennett to give an expert opinion on whether the hole was a confined space as the answer was, he thought, self-evident. A concrete hole eight feet beneath grade and three and one-half feet wide could not be considered as anything other than a confined workspace. He was of this opinion based on various criteria including the dimensions of the hole, that work was being done at the bottom, the difficulty in establishing a means of rescue or extraction of a person from the hole, that it was enclosed in all respects other than the top, it was not intended for human occupancy, access into and out of the hole was limited and water had been trickling into the hole. He calculated that the hole could hold, by volume, 920 liters of water.

[68] In this case, Mr. Sgrosso noted, as I have said, that it was self-evident that the hole was partially enclosed, not intended for continuous human habitation, without a safe way to get in and out and, that any gas from the rest of the system could migrate toward the hole, being the lowest part of the system. As a result, there needed to be, pursuant to *Regulation 91-191*, an

assessment done to ensure the safety of anyone working in the confined space. That assessment must include testing the atmosphere in the hole, determining how many rescue workers would be needed on standby and to ensure safe breathing. This assessment was required to be done before anyone entered the hole.

[69] Pursuant to *Regulation 91-191*, the supervisor on site must do the assessment or identify a person 'competent' to do so. Before entering a confined space there must be a procedure developed. All potential hazards must be 'locked out'. There must be a designed rescue plan with a rescue team that is fully briefed. There needed to be rescue equipment standing by. There needed to be a person dedicated to keep their eyes on the person in the hole and able to communicate freely with them. That person must also be able to extract the person in the case of an accident, typically by a harness attached to a tripod over the hole. In the present case, none of this was done by Mr. King.

[70] Mr. Sgrosso testified that the hazard created by the water in the pipes should have been addressed by having two plugs in use as part of a 'block and feed' system. With the amount of water that was within the system, Mr. Sgrosso noted that he would not have had a person in the hole. In his view, it was ill-advised to do the leak testing with someone working in the hole.

[71] Mr. Sgrosso also noted that s. 263(1) of *Regulation 91-191* set out the legislated requirements of an employer before anyone enters a confined workspace. I note at this point that there is no evidence of action taken by Mr. King (or Springhill) to comply with any of the legislated requirements in this regard. As Mr. King would later testify, he did not even know of the legislated requirements, having never read them. There had been no site-specific hazard assessment done.

Gary Daneff

[72] Mr. Daneff is a principal with Point of Origin Consultants Ltd. He is a professional engineer by training. His work experience includes knowledge of the construction building codes at the Provincial and Federal levels. He has worked with fire protection systems with particular knowledge of hydraulic systems and water pressure measurements. His company has experience in forensic investigations into collisions, fire and water related failures. His company develops the tests necessary for each project they work on. With regard to the type of pneumatic plug at issue here, Mr. Daneff has had no direct past experience. Nevertheless, his professional experience on issues related to the plug, and other work experience, was considered by me to be sufficient to qualify him as an expert in the installation, manufacturer's instructions, use and the failure of a test-ball plug. While I expressed at trial concern over the wording of the declared expertise, Mr. Daneff did have certain knowledge of what specifically occurred with the plug in this incident, and this was of use to the court. No other witness was offered to explain what happened to the plug to cause the incident. Certain other aspects of his testimony, dealing with the proper installation of the plug, and the manufacturer's warnings related to the use itself, were self-evident from reading the manufacturer's instruction manual for its safe and proper use or, by just fully reading the information cast in metal on the head of the plug itself.

[73] Mr. Daneff was retained by WorkSafe to investigate the circumstances as it related to the failure of the plug. After the incident, the plug was delivered to Mr. Daneff's facility for analysis. He noted that, when it was delivered, there were five puncture holes in the plug. He patched them before doing his own testing. He also calculated the volume of water contained within the horizontal pipe running from the bottom of the manhole, underneath the clarifier and exiting into the hole. This volume he estimated to be 18,000 liters. The manhole, being larger in size, but only estimated as being half full at the time of release, contained an estimated 14,000 liters.

[74] Mr. Daneff testified that the setting within which the plug was used, complied with the manufacturer's instructions on the limits of its use (under proper inflation), i.e. the size of the pipe into which it was inserted, the inflated pressure and the amount of head pressure from the water in the manhole and the horizontal pipe. Mr. Daneff also testified as to the manner in which

the plug was inflated prior to the incident. Some of the information on this process came directly from a meeting he had with Colin King as part of his investigation.

[75] Mr. Daneff reported that Colin King told him that on the morning of August 16th, he inflated the plug within the pipe to a pressure of 25psi and then, around 09:45, he disconnected it from the compressor. Mr. Daneff testified that the connections from the air hose on the plug to the valves and gauges connecting to the compressor leaked – they were not airtight. As the air slowly leaked from the plug, being under pressure from the water that had built up in the pipes, it dislodged into the hole, trapping Mr. Henderson.

[76] In addition to the leaking valve connections, Mr. Daneff noted that there was a split where the air hose entered the plug but there was no way to determine if it existed before or after the incident. Mr. Daneff testified that, 'all valves leak', and that for the psi of the inflated plug to remain stable, it needed to be connected to the compressor at all times, with the regulated delivery of air as needed.

[77] Mr. Daneff could not identify any factors in this particular case that would materially increase the likelihood of the plug releasing when it did. As an example, if a solvent had been used to clean the pipe into which the plug was placed, that might create slippery conditions.

[78] The manufacturer's directions were that the air pressure within the plug be 'actively' monitored. This would be, Mr. Daneff testified, only possible with properly calibrated pressure gauges. The manufacturer also recommended that the plug be braced to prevent movement. The manufacturer's instruction manual diagramed different bracing options. In the present case, given the small area within which to work inside the hole, bracing would not have been possible while having a person working in the hole. Above all, the manufacturer recommended that no one should be working in proximity to the plug's 'danger zone' when it was in use. Mr. Daneff expressed the view that once water was introduced into the manhole, while the plug was inserted,

the ‘danger zone’ existed. The existence of the ‘danger zone’ while the plug was in use was repeatedly noted in the instruction manual.

[79] In Mr. Daneff’s opinion, the plug released into the hole due to the water pressure within the piping system acting on the plug that had begun to deflate from the required inflation rate of 25 psi.

Jason King - Direct

[80] I will say at the beginning of this review of Mr. King’s direct evidence at trial (being almost five years after the incident) that there was, when compared to the information he provided in his WorkSafe interview, discrepancies on certain points. Mr. King asserted that his current testimony is more accurate. He testified that, at the time of the interview, he was still trying to mentally analyze what happened. Not enough time had passed. I reject that assertion as being counter to the general view that memory is clearer the closer one is to the incident in question. As time passes, memory can fade, become confused in one’s own mind or be influenced from discussions with others. Where there is material difference between his testimony before me, and his interview with WorkSafe, I rely on the interview being that it was, essentially, contemporaneous to the incident.

[81] Mr. King has worked in construction, essentially, his whole working life. He began with Springhill’s successor, Diamond Construction. His early working life also included time at NBCC, working in the logging industry and running his own business. Through his union, Mr. King had WHMIS and Fall Arrest training. Much of his work in the industry involved concrete.

[82] Recalling back to late 2015, Mr. King testified that Springhill management, Brett Anderson and Josh Lawrence, offered him a promotion to supervisor. He expressed concern to

them that he lacked sufficient experience. He testified that their response was that he would get such experience over time. He testified that he was given no training by Springhill on how to be a supervisor. In January 2016, he was assigned as supervisor on a job at York Arena. Later that spring, the York Arena project stopped, and he was moved to the UV building project which had, by then, started construction. He took over as supervisor from Stephen King.

[83] Mr. King testified that at the UV building project a subcontractor had been using a plug of their own to stop the flow of the river coming back up and into the UV building. It remained in place for two months. Eventually, the subcontractor needed their plug back and so the City offered to loan one of theirs to Springhill. The plug was, Mr. King testified, just dropped off by the City at the UV building. Colin King installed it in a pipe in the UV building. This pipe was similar in size to the hole in the clarifier. A ladder was used to get in and out. There was no discussion, he recalled, about that space (in the UV building) being defined or classified as a confined space. Mr. King initially testified that at that stage, he had never heard that phrase, 'confined space'. I pause to note that, later in his testimony, he did say he was aware of the phrase, 'confined space'. Eventually, Mr. King moved on to other projects that Springhill had underway. In late Fall of 2017, Mr. King was off work on leave.

[84] In January 2018, Mr. King was assigned to the clarifier project as construction was, by then, underway. Flooding in January, which ultimately froze, resulted in the job coming to a temporary stop and Mr. King being sent to a job in Moncton. During the winter Mr. King went between various job sites as required. In February 2018, Mr. King met Mr. Henderson for the first time as Mr. Henderson was on a co-op placement with Springhill. Stephen King had sent Jason King to do Mr. Henderson's orientation. They met in a construction trailer on the clarifier project site. Mr. King walked Mr. Henderson around the site. Mr. Henderson was shown the muster station and where to find tools. Mr. King testified that they discussed the safety rules, safety protocol on site, emergency procedures, who had first aid training and the role of the Joint Health and Safety Committee (which was not active at that time). He also testified that he showed Mr. Henderson where the *Act*, *regulations* and manuals were located in the office and

advised him that if he wanted to read them, he could. He further testified that he would have advised Mr. Henderson of his right to refuse unsafe work.

[85] In April 2018, conditions at the clarifier project were still not suitable to re-start work and Mr. King went to another Springhill job. By May, conditions had sufficiently improved and worked started again on the clarifier project. At that time, Stephen King returned as supervisor. By early summer he left for another job and Jason King was given the supervisor's position at the clarifier project.

[86] Once Mr. King returned to the clarifier project as supervisor, he began to attend the bi-weekly site meetings. The purpose of these meetings was to address issues and keep the project moving. Minutes were kept. Leak testing of the water pipes associated with the clarifier was a topic discussed at more than one meeting. Simply put, it would require filling the lines (pipes), let it sit for twenty-four hours to cure, take a measurement, let it sit another twenty-four hours, and then measure again. He recalled that in one meeting the use of the City's plug for that purpose was discussed. It was Springhill's responsibility to do the test. He did not recall if the need to install bracing for the plug had been discussed at any meeting he attended. Mr. King testified that the manhole had been leak tested earlier by placing the plug into what has been described as the horizontal pipe, at the point where it met the manhole. Colin King installed the plug on that occasion. Later the pipes were cleaned by a subcontractor. Mr. King did not know if a cleaning fluid was used.

[87] Mr. King recalled that during the site meetings in July and August 2018, safety issues were discussed including the concerns over safety vests not being worn by employees, employees walking along the top of the clarifier without fall protection and that a concrete truck had backed into a power pole. An incident Report Form was completed for this latter incident.

[88] As with most other days on the clarifier work site, the morning of August 16, 2018, began as usual. He met with Clayton McKeil, Colin King and Eric and Michael Henderson. Mr. King testified that he assigned their work for the day. He testified that he instructed Colin King that the clarifier floor needed to be cleaned and, "*if they didn't mind*", getting the hole cleaned out. I will note here that the degree to which such wording ("*if they don't mind*") may have been used in testimony to infer that Colin King and Michael Henderson had a choice to clean out the hole, I reject that suggestion. In my view, there was no doubt that Colin King and Michael Henderson were directed by Mr. King, amongst other things, to clean out the hole. It needed to be cleaned in preparation for another concrete pour.

[89] Colin King and Michael Henderson began working at cleaning out the hole as directed. Colin came up out of the clarifier at some point before the 09:45 break to tell Mr. King that there was water trickling into the hole from the horizontal pipe leading from the manhole. Recall that the pipe was protruding about halfway into or across the 42-inch diameter hole in which Mr. Henderson was working. Mr. King testified that Colin King left the clarifier and, telling Mr. King that the continuing trickle of water was making the work in the hole difficult, asked if he could use the plug. Mr. King testified that he and Colin agreed to the use of the plug and discussed the need to clean the pipe and to inflate the plug to 25 psi. Mr. King testified that he thought Colin would be the one to install it having done so before in the manhole and the UV building. Mr. King said he had never installed one. He and Colin discussed the gauges, one of which looked dirty. Mr. King acknowledged that typically there needs to be a gauge between the valve that controls the airflow and the line into the plug. The plug was installed. He went on to say that, having seen Michael working in the hole, he asked Colin why Michael was working in the hole. Colin's reply was that he would not fit in the hole.

[90] I pause to note that even though there is by mid-morning, discussions around using the plug to stop the water trickling into the hole, there was not any mention to Mr. Henderson of a leak test to be done. As the evidence indicates, the plug's only known intended use by that stage was to stop the trickle of water.

[91] Mr. King testified that, around mid-morning, he asked Colin when he expected he and Michael would be finished. Colin's answer was, Mr. King testified, 'around lunchtime'. Believing they would be done by lunch, Mr. King talked to Mr. DeMerchant about doing the leak test while the plug was already in place. He also said to Mr. DeMerchant that he would come in and do the required measurements on the Saturday as needed since Mr. DeMerchant was going to be unavailable to do them on the weekend. Mr. King stated that around 10:45 it had been decided to proceed with the leak test.

[92] To proceed with the test Mr. King needed Mr. Sewell to arrange to get a hydrant turned on and so he texted him at 11:12. Mr. King did not remember a reply but, shortly thereafter, Mr. King said he came out of his office in the trailer and saw that the hose had been connected to the hydrant and the hydrant had the wrench on top signifying he could turn on the flow as needed. This was, Mr. King said, around 11:40 to 11:45.

[93] Mr. King then turned on the water and placed the hose in the manhole at 11:52. Because of the structure of the nozzle on the end of the hose when he put it in the manhole, it began flailing around under the pressure in the hose. He stopped the flow, removed the nozzle, and then put the hose back in the manhole and turned the water back on. Water is now flowing uninterrupted into the manhole which is connected to the horizontal pipe leading into the hole where it is blocked by the plug. Mr. King testified that, as he then looked around the job site, and because there was water flowing into the pipe, he told his crew to go to lunch a few minutes early.

[94] At 11:56, Mr. Henderson can be seen on CCTV video leaving the clarifier for lunch. He and the other workers take their half-hour lunch break. During the break, Mr. King can be seen on video monitoring the manhole and monitoring the clarifier. At around 12:17 Mr. King is in the clarifier. He testified that he was going to see how the plug was holding and check the

readings on the gauges. He noticed that there was still debris, a bucket and tools in the hole. He testified that he was not worried about the final clean because as he stated, “there was very little left”.

[95] The CCTV video shows Mr. King talking to Colin King at 12:33. Mr. King testified that he is telling Colin that there is no need to go back into the hole because the concrete pour was not going to happen until the following week. From that time forward, he has no further discussions with Colin King about his leak test plans. He testified that he did see Mr. Henderson after lunch on the clarifier floor but that he did not see him in the hole after lunch. This may be so due to the depth in the hole Mr. Henderson was working. Mr. King continues flooding the pipe system. At 12:51 he hears hollering coming from the clarifier. He turns off the water supply at the hydrant. He rushes into the clarifier to see what is going on. He can see Clayton, Eric and Colin, but not Michael. He testified he knew the plug needed to be immediately deflated. He looked at the compressor and the line to the plug, which he testified, was still attached. He threw his knife to Eric Henderson in hope that the line could be cut or to stab at the plug to deflate it. Nothing worked. He turned off the compressor as it was still connected to the plug. He noted that the way the gauges had been sequenced on the line was not the way his experience said it was typically done. They were, he testified, set up backwards.

[96] During cross examination Mr. King accepted that, as supervisor, he was responsible for the safety of the crew under him. He had a long family history in the construction industry, and he knew the basic role of a supervisor/foreman. He testified that he knew that his responsibilities included identifying safety risks, coordinating on-site safety and that the overall responsibility for safety, either from equipment or environmental risks, fell to him. In his on-site office were safety manuals but he could not specifically identify any. These on-site manuals included the job specific manual and the Springhill Safety Manual. There were other forms and reports. Mr. King testified that if he had any questions regarding safety or the operation of equipment he would call Springhill’s safety officer, Josh Lawrence.

[97] With respect to the safety manuals, Mr. King testified that he is ‘not a reader’ and had not read any of them. He said he may have looked through the Springhill Manual but did not read it. Furthermore, he stated that he did not know how to identify a confined space but knew that there were specific things that needed to be done once a confined space was identified.

[98] Mr. King testified that once he was promoted to the position of supervisor, he did nothing to inform himself of what was required of him. He said that he was never told by his superiors that he needed to do anything. During cross examination, he was directed to a copy of the 2018 Springhill Safety Manual – a copy of which he acknowledged was in his on-site office but that he had never read. Contained in that Manual is a definition of a ‘confined space’ and certain requirements regarding work in a confined space:

> 1. A work area shall be treated as a confined space when:
>
> a) There is only one exit or when the exits are not easily accessed for emergency escape.
>
> b) Because of construction contents or work activity, which in turn causes the accumulation of hazardous gases, vapors, fumes, or dust resulting in a level that is immediately dangerous to the life and health or in which case an oxygen deficient level could be created.
>
> 2. No employee shall enter a confined space such as a manhole, shaft, tunnel, etc., unless a proper air test is conducted to ensure that the atmosphere is free of any dangerous gases, vapors, dust or fumes and that sufficient oxygen is available.
>
> 3. No employee shall conduct an air test unless they have been properly instructed in the correct procedure and that any required certification is obtained.
>
> 4. When working, the space shall be continually monitored for explosive or toxic gases and or ventilated to prevent the accumulation of gases and oxygen deficient atmospheres.
>
> 5. When work is performed in a confined space, an employee equipped and qualified to render assistance shall be appointed to remain outside and in contact with the employee(s) in the confined space and shall not enter the space without first notifying another person.
>
> [Exhibit P18, Tab 2.]

[99] Mr. King acknowledged he had read none of that information. Nor had he read the portion of the manual which sets out the expected duties and responsibilities of a supervisor. These specified duties are:

1. Promote safety awareness
2. Establish safe work practices
3. Instruct workers
4. Correct unsafe practices
5. Set a good example
6. Correct unsafe conditions
7. Report injuries
8. Enforce safety rules
9. Inspect for hazards
10. Investigate incidents
11. Ensure proper maintenance
12. Conduct toolbox meetings
13. Comply with regulations
14. Identify required training

[100] Mr. King was, at times, unclear in his testimony whether he knew what a confined space was or whether one existed at the clarifier site. However, he did acknowledge during cross-examination that it [the hole] 'seemed quite logical that it would be'. While he acknowledged that he had not specifically read the *Act* or *regulations*, he testified that he knew he was responsible to provide information about safety issues to his workers; that he was required to provide instruction necessary to ensure a safe workplace; and that he was required to supervise activity on-site to ensure worker safety. He acknowledged it was his responsibility (along with others) to oversee safety on the project and that confined space safety must be observed.

[101] With regard to the document entitled the *Health, Safety & Emergency Plan of Springhill Construction Limited Established for the Wastewater Treatment Facility Upgrades Phase 3 –*

New Clarifier, like other reference manuals available to him, he acknowledged he had not read it. He did not know that, contained therein at p. 13, was the direction that:

> Confined Space
>
> Confined Space entry Procedure must be used for any employee who must enter a confined space environment, to perform any work or for any inspection. A confined space means an enclosed or egress or egress (*sic*) and may become hazardous to an employee entering it.
>
> Only properly trained, equipped and supervised workers shall enter confined spaces.
>
> [Ex. P17]

[102] As noted, the evidence before me included an audio recording of an interview Mr. King voluntarily gave to WorkSafe investigators, Mr. Bennett and Mr. Boudreau. I have already concluded that where there is conflict between statements made during the interview and his testimony before me, I accept the information he provided at the time of the interview for reasons I have already stated. My intention in the following section of these reasons is to highlight parts of the interview relevant to aspects of the charge against him.

[103] In an answer to a general opening question of the interview he gave an answer that included the following statements:

> … Mike Henderson was, ahh, in the bottom of the hole cleaning some debris out, we were getting ready for a concrete pour the next day. This was, ahh, shortly after lunch, before one o'clock, I believe.
>
> …
>
> And, ahh, anyways, they, were moving debris from the bottom of the, from the area to get ready for [the] concrete pour. Ahh, at the same time, that pipe that was plugged off – there was a manhole that was still needing a, a water leak test done on it. And ahh, we were partially filling the pipe until they were finished out there and then we were going to continue on with our leak test.
>
> …

> Q. So what was Michael assigned to at the beginning of the shift?
>
> A. Ahh, initially to get that plug installed in the pipe and ahh to get the debris cleaned out of the hole.
>
> [underlined emphasis added in the above and in further quotes below]

[104] Despite the above recorded answer, Mr. King testified that the answer then given was wrong in that Mr. Henderson was not assigned to install the plug and there was no need to put the plug in first thing. He accepted during his testimony that there was a difference, noting that what he says now on that point is 'completely different from what he said back then'. But from his answer as recorded in the quote above, it is clear that, at least at the time of the interview, his recollection was that the concrete pour was to be the next day (not the next week), that he had commenced the leak test and was continuing it while he knew Michael Henderson was finishing up his work in the hole. He went on to state in the interview:

> "So initially I guess they [Colin King and Michael Henderson] would have been pumping water out in order to get it low enough to put the plug into the pipe"
>
> …
>
> Q. Okay, so they, so their job, get the water out first, then clean up the bottom of the pipe?
>
> A. <u>Get the water out, install the plug</u> to keep more water from coming in and then clean the bottom out to prepare for the concrete pour.
>
> Q. Okay, no problem, so that was their job and they, remained in that area?
>
> A. Yes

[105] With regard to the instructions by Mr. King to Colin King and Michael Henderson regarding the installation of the plug, Mr. King answered as follows in the interview:

> Q. Okay, did you oversee this? Did you make sure they both knew what they were doing? Is there, is there any start instructions you gave them?

A. I did give them their instructions.

Q. And they were?

A. Clean the, pump the water out, out of the area, remove any debris from the pipe, install the plug, inflate to twenty-five psi as per the, we always do and basically that was it.

[106] Again, Mr. King says that his answers then were wrong and that he is clear now that he did not give any such instructions. To the best of his ability, he testified, he was trying to give WorkSafe truthful answers as he best remembered on that date.

[107] Mr. King explained during the interview that there were no procedures developed for the installation of the plug nor were there any hazard assessments done before Mr. Henderson went into the hole.

Q. Do you have any hazard assessments documented for, you know? Or is there a procedure for, for this?

A. Ahh.

Q. To put this in – to install it?

A. Not that I can remember.

[108] That Mr. King knew Mr. Henderson was initially in the hole is not disputed. Mr. King knew a ladder was used by Mr. Henderson to get into the hole and then the ladder was pulled up. Returning to the interview:

Q. Okay, so is Colin looking after this part of it? And Michael staying down in the hole?

A. Yes

Q. Okay, how did Michael get in the hole?

A. A ladder.

Q. A ladder, okay, and then once he was down there?

A. I'm assuming they pull the ladder out.

[109] Mr. King stated in the interview that he knew that men were in the hole as he began filling the manhole for the leak test.

> Mr. King: Umm, we were just, we weren't going to totally fill it until the guys came out. We were just getting a head start on it, takes a lot of water and a lot of time to fill and I started to fill it and.

[110] As to whether Mr. King knew Mr. Henderson returned to the hole after the lunch break, Mr. King testified that he did not know. During the interview, he stated the following:

> Q. So, when the, did you see Michael and Colin go back to the area to continue working after their lunch?
>
> A. Ahh, I was talking to them while they were in the clarifier, I can't say for certain if I was talking to them after he was in the hole or not. I'm not a hundred percent clear on that.
>
> Q. Did you know Michael was in, was in there after lunch?
>
> A. I knew that he had more work to do, yes.
>
> Q. He had more work to do, okay, so he continued doing the job that you asked, that you told him to do?
>
> A. Yes.
>
> Q. And you continued running the line?
>
> A. Yes.

[111] As noted earlier, during his testimony before me, Mr. King denied knowing that Mr. Henderson was in the hole after lunch. As far as he was concerned, he had told Colin King and Michael Henderson to move on to other tasks. He testified that he specifically directed Colin King (who was to tell Michael) not to finish the work in the hole that afternoon. This instruction, if given as he testified it was, seems to be at odds with the reality that Mr. Henderson, after lunch finished at around 12:30, was still in the hole approximately twenty minutes later. Mr. King acknowledged that he never told Mr. Henderson that he had begun to flow water into the piping system for leak test purposes. Mr. King also acknowledged during his testimony that it would be

dangerous to be in the hole while there was a full leak test going on. Yet, he testified that he told none of his workers that he had started the leak test, but he knew Mr. Henderson was in the hole.

[112] Mr. King was also asked during the WorkSafe interview what his plan was in the event of an emergency inside the hole:

> Q. Okay, now, you have a worker in the hole, you're the supervisor, not only would I ask you what is your emergency plan to get somebody into the clarifier, what would be your emergency plan to get somebody out of the hole?
>
> A. I know when I was in the hole you could reach the top to get out. So I had a worker there who should have been able to grab him.
>
> Q. Didn't work out that way.
>
> A. No it didn't.
>
> Q. Did you have a plan in place, an emergency plan in place?
>
> A. I didn't even foresee that.

[113] As noted, Mr. King affirmed that the emergency plan he had in mind for an incident in the hole was that there would be someone there who could pull a person out. This was the extent of his understanding of what was needed to fulfill his duty to keep his employees safe. During his interview he discusses his responsibility to his employees:

> Q. The reasons why I am asking these questions is that you are the supervisor to the site.
>
> A. Yes.
>
> Q. You know, your responsibility is to make sure they are safe.
>
> A. Yes.

[114] Mr. King's efforts to inform himself on the dangers of working with the plug were limited to his reading of the metal plate on the plug – although he said he did not recall reading it

completely. He did not read the manufacturer's instruction manual for the use of the plug as illustrated in the following excerpt from his interview:

> Q. Okay, And when the plug gave way, for whatever reason it gave way for, ahhh, the manufacturer's specs do say in the hazards that no one is to be in the hole, you never saw anything like that or you don't?
>
> A. I don't recall reading it.
>
> Q. You don't recall reading it? But you did see the manufacturer's specs?
>
> A. I read the ball.
>
> Q. You read the ball? Okay, that, that was it?
>
> A. Yeah.

[115] I note that embossed on the metal head of the plug, which Mr. King says he had referred to or partially read, are the words, "CAUTION: MUST READ SAFETY BOOKLET BEFORE USING - *MUST STAND CLEAR WHILE IN USE*". His focus on looking at the metal head he said, was limited to identifying the required psi reading.

ARGUMENT AND ANALYSIS

[116] All parties agree that the hole in which Mr. Henderson was working, at the time of his death, meets the definition of a *confined space* in the legislation in effect at the time of the incident. And all parties agree that, as a supervisor, Mr. King was in a position to direct the work of the employees under him and had a legal duty to take reasonable steps to prevent bodily harm to his workers, arising from that assigned work. This captures the language of s. 217.1 of the *Code*. With that said, Mr. King's counsel notes that the language of s. 217.1 is subject to scrutiny for compliance with the *Charter*.

[117] The parties also recognize that this case calls for consideration of s. 219 of the *Code.* Moreover, the parties also agree that the case of *R. v. Javanmardi*, 2019 SCC 54, will be the prime authority, yet in concert with others, for my consideration. Ms. Winter's in argument on behalf of Mr. King drew my attention to para. 23 in *Javanmardi* which includes the following:

> 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 cause 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).

[118] The parties note that there are two pathways for consideration that could lead toward conviction. The first, as articulated by Ms. Winter's during argument, was that the Crown must prove beyond a reasonable doubt that Mr. King committed an act, and that act caused the death of Mr. Henderson. In addition, in committing that act, Mr. King's conduct in doing so must be considered as a marked and substantial departure from that of a reasonable site supervisor in the circumstances. In this case, Mr. King's conduct would be considered in the context of his act of introducing water into the manhole when, it is alleged, he knew it was dangerous to do so and knowing Mr. Henderson was in the hole both before lunch and after it.

[119] The second path toward conviction could be based on the failure or omission of Mr. King to do something he was under a duty to do, and Mr. Henderson's death resulted. His omission must be classified as a marked and substantial departure from what would be expected of a reasonable supervisor in such circumstances. Such duties could be theoretically grounded in s. 217 of the *Code* or in the provisions of the *Occupational Health and Safety Act* and *regulation 91-191*. Regardless of the path considered, whether it was something Mr. King did or something he did not do, but was required to do, the Crown's burden of proof, that being beyond a reasonable doubt, must be met.

[120] Mr. King argues the Crown has not established liability under either path. Regardless of whether liability arises by an act done, or omission, the focus comes back to assessing the conduct of Mr. King that day and whether it was a marked and substantial departure from what would be expected of a reasonable site supervisor in such circumstances.

[121] In answer to the Crown's assertion that Mr. King's actions of introducing water into the manhole when he knew Mr. Henderson was in the clarifier hole, and therefore giving rise to criminal liability, Mr. King argues that the conversation between himself and Colin King on the morning of August 16th was that he (Colin King) and Mr. Henderson would be completed the cleanup by noon. Nevertheless, Mr. King accepts that Mr. Henderson was in the hole when he started to put water into the manhole at around 11:45 and that Mr. Henderson was in the hole for approximately seven minutes after water began to flow.

[122] Mr. King acknowledges that his work as a supervisor may not have been to the level he would have expected of himself. However, he blames this on the failure of his employer, Springhill, to provide him any meaningful training in the full scope of a supervisor's duties and responsibilities. Nevertheless, he points to actions he took after lunch on August 16th to illustrate his efforts to mitigate the risk. He says that he directed Colin King that he (Colin King), and Mr. Henderson, were to move on to other tasks and that there was, 'no need to go back in the hole'. Mr. King acknowledged that he did not give this direction personally to Mr. Henderson. Mr. King argues that his instruction in that regard was intended to remove from danger those working in or around the hole. In his view, the expression to Colin King that Mr. Henderson 'need not go back into the hole' is sufficient to have met the burden on him. Mr. King is not to be held, he argues, to a standard of perfection.

[123] I agree that perfection is not the standard.

[124] In addition, as it relates to liability under s. 217 of the *Code*, Mr. King argues that he is not required to take *all* reasonable steps. He did take, he says, certain reasonable steps once he realized there was a danger and, in doing so, he met his duty. On this point he accepts that there was a risk in these circumstances. He points to his decision to not start the bulk of the test until everyone was out of the hole – although he acknowledges, as noted above, that Mr. Henderson was in the hole when he started it. During his testimony he stated that he did not see Michael Henderson in the hole after lunch. This goes, he argues, to the knowledge component of the liability assessment.

[125] On the issue of the degree of Mr. King's knowledge of specific hazards, his counsel points to the trial division ruling in *R. v. Kazenelson*, [2015] O.J. No. 3370, as an example where specific knowledge of an existing danger gave rise to liability under s. 217 of the *Code*. At para. 128, the court there wrote:

> 128. To prove the *mens rea* for criminal negligence, the Crown must prove *either* that Mr. Kazenelson adverted to an obvious and serious risk to the lives or safety of the workers and failed to act, *or* that he gave no thought to the risk and the need to take care. Further the Crown must prove that a risk of bodily harm that was more than trivial or transitory was objectively foreseeable.
>
> [*italics* in original underlining added]

[126] Mr. King asserts that he had no training in confined space work and no training to be a supervisor. Nor did he have any training in respect of the use of the plug. While these circumstances to not remove the duties that are upon a supervisor, they must be considered, Mr. King argues, in the circumstances of the modified objective test that could lead to any criminal liability on his part. Mr. King also argues that, unlike the risks in *Kazenelson*, risks that were considered to be obvious, the same could not be said of the risks in the present circumstances.

[127] Mr. King argues that his decision to leave the installation of the plug to Colin King signified his recognition of a need to handle the plug installation cautiously because it was Colin

King who had previous experience with the plug. Mr. King also argued that he waited to begin the leak test just before lunch because he knew the men were about to break for lunch. In fact, he dismissed them for lunch slightly earlier than a normal lunch time so they could be removed from the danger area. Mr. King argues that he told Colin King not to continue with the cleaning of the hole because he was aware of the risk. These are all signs, he argues, of a supervisor acting reasonably.

[128] Mr. King also refers me to *R. v. Hoyeck*, 2019 NSSC 7, as a case where a court refused to 'piece together' evidence to then infer that a supervisor had the requisite knowledge supporting criminal negligence. The evidence, he asserts, must be more direct.

[129] Concerning the second path to liability, that Mr. King omitted to do that which he was legally obligated to do, Mr. King accepts that there were obligations under the *Act* and the *regulation* which he did not comply with. That alone is not enough, he argues, as it does not address the *mens rea* component of the offence. This calls on the court to determine what a reasonable site supervisor would do in similar circumstances and then determine if Mr. King departed from that standard to a marked and substantial degree. Reference to the legislated responsibilities, or those set out in the Springhill manuals, are but part of the factors to be considered in determining the standard. The assessment, Mr. King argues, cannot be made in a vacuum. This was the point the court made in *R. v. White*, 2021 PESC 35. In addition to the other factors, Mr. King asks that the contextual analysis of the circumstances include that he was appointed supervisor by Springhill and given no training at the time of appointment or in the time that followed.

[130] Mr. King also points out that there were others on the site who had responsibility for safety. This included the City (through its employees) and CBCL through Mr. DeMerchant. This is particularly so in relation to the City as it was fully aware the leak test was about to take place as evidenced by it supplying the hose and activating the hydrant. Mr. King also argues that the

plug, having been successfully used to keep back the river from entering the UV building, was a reliable piece of equipment that could be used in a similar manner in the clarifier.

[131] Given all the circumstances, Mr. King argues that he acted as any reasonable supervisor would and his behaviour was in no manner a marked and substantial departure of what would be reasonably expected. Moreover, even if he violated the *Act* or the *Code*, that on its own is not the determining factor in deciding whether he departed from a marked and substantial standard, thus leading to criminal liability.

[132] For the Crown, the argument begins by noting that this is not a case which requires the assistance of experts to understand. The basic and necessary precautions for use of the plug are cast in iron on the plug itself. This is a case which requires common sense. Furthermore, it is not a defence, the Crown asserts, to argue that Mr. King was not trained and did not know his obligations. That is why, the Crown argues, we rely on the 'modified objective test' to examine the conduct of the accused. This is a point highlighted in *R. v. Doering*, 2022 ONCA 510 (leave to appeal refused). Essentially, the point is that, while it is useful to examine the accused's own experience, it is an error to rely solely on that experience when determining where the general standard of conduct should be set. If that was the case, the applicable standard would be undefinable.

[133] In this case, I was encouraged by the Crown to examine Mr. King's conduct and liability from the moment he began to introduce water into the manhole, before lunch, when he knew Mr. Henderson was in the manhole. While the explosive release of the water into the hole did not occur until approximately one hour and five minutes later, the assessment of Mr. King's conduct must include the full period of time. Furthermore, the Crown points out that Mr. Henderson was in the hole for approximately fifteen minutes after lunch before the plug released. This does not, the Crown argues, support the testimony of Jason King that he told Colin King that there was to be no further work done in the hole after lunch. Common sense dictates that if Mr. Henderson

went into the hole after lunch for the purpose of gathering his tools, it would not take fifteen minutes to do so.

[134] The Crown argues that this was a case where Mr. King chose to prioritize convenience over safety. This was a preventable tragedy if any of several minor things had been done. Moreover, while there may have been contributing factors caused by the actions of others (i.e., Colin King possibly disconnecting the air hose from the compressor, or the incorrect series of connections between the plug and the compressor) liability rests on Jason King as his actions or omissions were a significant contributing cause of Mr. Henderson's death. While there may have been other influencing 'hands at play', so to speak, the only reason Mr. Henderson was in the hole was because Jason King assigned work that put him there and then, run a hose connected to the hydrant into the manhole, and turned the water on. Causation, the Crown argues, is established.

[135] The Crown asserts that Mr. King knew that Mr. Henderson was in the hole after lunch. The Crown points to Mr. King's answers during the WorkSafe interview that he knew Mr. Henderson had more work to do in the hole after lunch. In addition, while Mr. King testified that he had given specific instructions to Colin King to not return to work in the hole after lunch, Colin King did not testify that he was given such direction.

[136] The Crown also argues that Mr. King knew it was dangerous to have someone in the hole while the leak test was being conducted. His testimony in court, and during the WorkSafe interview, confirms this the Crown argues. Mr. King did nothing to ensure Mr. Henderson was kept safe. Mr. King took no steps to advise Mr. Henderson that water was being introduced into the manhole and, therefore, into the horizontal pipe and against the plug. Mr. King gave no general direction for all workers to stay completely away from the hole once he turned on the water. The Crown also points out Mr. King's testimony that there was no realistic way to advise Michael Henderson of the risky work environment he was being directed to work in because, as

Mr. King testified, ‘Michael Henderson did not come to ask him' – as if there was a duty or obligation on Mr. Henderson to do so.

[137] The Crown emphasized that the only safety plan Mr. King identified for someone working in the hole was his plan to have someone there to pull the person out in the event of an emergency. In other words, Mr. King was of the view that it was permissible to have Mr. Henderson working in the hole because, if something went wrong, someone would grab him and pull him out.

[138] The Crown noted that Mr. Harvey had testified that during the site meetings it was discussed that, if the plug was to be used, it should be braced. Mr. King did not do this. As the Crown pointed out, if it had been braced, no one could fit in the hole to work.

[139] My task, the Crown argues, is to assess Mr. King’s acts or omissions by what would a reasonable site supervisor have done in the circumstances. From there, I am to assess whether Mr. King’s conduct is a marked and substantial departure from that standard.

[140] To assist me in shaping that standard, the Crown says that a reasonable site supervisor, having been told to brace the plug, would have done so. A reasonable site supervisor would have taken meaningful steps to ensure Mr. Henderson knew what was going on and the risk he was in. A reasonable site supervisor would have taken meaningful steps to ensure no worker went near that hole, let alone be in it, during the leak test. A reasonable site supervisor, who may have been unsure about what to do after reading the warning on the plug itself, would have reached out to someone else or found some other source to answer their uncertainties. A reasonable site supervisor would have followed the instructions on the plug to stay clear while in use. A reasonable site supervisor would have been aware of the site-specific safety manual. A reasonable site supervisor would have refrained from putting water into the manhole knowing someone was in the hole at the other end. Ultimately, the Crown argues, Mr. King did nothing to

make sure the leak test was performed safely. Had Mr. King did any of the expected steps, the Crown asserts, Mr. Henderson's death would not have occurred.

[141] The Crown notes that Mr. King had a duty that cloaked him as a site supervisor and that he failed in meeting that duty and that failure caused Mr. Henderson's death. These duties can arise from different sources including s. 217 of the *Code* and from the provisions of the *Act* and *regulations*. From the failure to adhere to the legal duties attached to his position and the death that followed, the *actus rea* is made out.

[142] The *mens rea* is found from a finding that Mr. King's conduct was a marked and substantial departure from what was expected from a reasonable site supervisor. The Crown agrees, perfection is not the standard. It was Mr. King's failure to do anything required of him that gives rise to his criminal culpability. This is a crime that can be based on the omission to do that which was required of him.

Factual Findings

[143] Much of the surrounding factual circumstances are not in dispute. From the testimony provided and the exhibits presented, I provide the following narrative summary of what I find to be the facts that have been established beyond a reasonable doubt – the standard which the Crown must meet. I also will make certain findings relating to the elements of the offence as described in the authorities.

[144] The relevant part of the construction project involved the building of a secondary clarifier to assist in the processing of waste. This project was located at the City of Fredericton's Barker Street Wastewater Treatment and Pumping Plant. The City contracted with Springhill for the construction of the project and Springhill's work was monitored by CBBL. CBBL had been

involved in the design of the project, contract bidding and administration and it had an employee onsite to ensure Springhill's work was completed to specifications. During work on an earlier phase of the project, being what was known as the UV building, the City had provided to Springhill a pneumatic plug to control water flow into a work area or hole not unlike the hole at issue in the clarifier. During the work on the UV building, Colin King appears to have received some form of direction from his then Springhill supervisor, Stephen King, as to how to use the plug. The specifics of any instruction he received is unclear. At some point after its use in the UV building the plug was moved to the clarifier site. The plug, when inflated is approximately four feet long with a diameter of approximately two feet. It is made of a thick rubber membrane. On one end is a metal service plate which identifies the required inflation setting and warnings to review the safety manual and to not work in proximity to the plug.

[145] Jason King had become Springhill's supervisor on the clarifier project in late spring, early summer of 2018. He had previously been a supervisor on various Springhill jobs since the time of his promotion to supervisor in late 2015. At the time of the promotion, he was, by virtue of his work experience, recognized as a journeyman carpenter. His testimony was that he received no training for his new position from Springhill. He did not read any of the basic safety manuals provided by Springhill related to the clarifier job. This included the "*Health, Safety and Emergency Plan – New Clarifier*" manual which deals, in part, directly with the minimum considerations for work in a confined space. Mr. King did not read any instruction manual related to the use of the plug. These manuals and resources were readily available to him either directly onsite, at the City's main building onsite, or if necessary, on-line.

[146] At the time of Mr. Henderson's death, he was working in a 'confined space'. Regardless of the definition of a confined space, whether it be found in the *regulations* or the Springhill manuals, the hole in which Mr. Henderson was working was, by any common sense understanding, a confined space – with the hazards that attach to such work. As such, certain procedures were required, designed to maximize safety and mitigate risk, before anyone set foot inside a confined space.

[147] To the degree that Mr. King may have expressed uncertainty on whether he knew the hole was a confined space, I find that he had sufficient experience in the construction industry to know that, on August 16th, he had directed Mr. Henderson to enter and work in a confined space. As he noted in his testimony, 'it was common sense', that the hole be considered a confined space. Mr. King did not inform himself of the legal obligations upon him as set out, not only in the Springhill manuals, but the duties required of him as someone who has control over an employee's work – duties that are legislative in origin. Even though he testified that he never read any of the defined legislated duties that attached to a supervisor, that does not mean that he was not bound by them and obligated to follow them. It could be no other way.

[148] The need for the leak test to be completed was a requirement of the City. It was discussed at several site meetings leading up to the August 16th incident. While it had been discussed at those meetings, no specific plan had been signed off on by the City. Nor do I intend imply such a sign off was required. It was noted in the minutes of the August 7, 2018 meeting that, "*SCL will be testing using a plug in the near future*." It appears that the ultimate timing of the test was a matter under the control of Mr. King in conjunction with, to some degree, Mr. DeMerchant. Nevertheless, the morning of August 16th began by Mr. King directing that Michael Henderson and Colin King clean up the clarifier knowing that there would be required work in the hole - a confined space. Mr. King made no attempt to implement any safety precautions for any person working in the hole. Colin King confirmed as much during his testimony. Of course, at the time Mr. King gave out the morning work assignments, it did not appear that he had fixed upon a plan to conduct the leak test that day. In any event, Mr. Henderson was directed to undertake work that required him to be in the hole with no meaningful safety precautions taken by Mr. King, whether he planned a leak test or not.

[149] It is to be noted that, on the morning of August 16th, the plug was requested by Colin King for the purpose of holding back water that had been trickling into the hole – water that was making it difficult to clean out the hole as directed. It was not requested by Colin King for the

purposes of the leak test. During the morning, the plug was installed by Mr. Henderson in the horizontal pipe under Colin King's oversight. Colin King told Mr. Henderson to insert the plug, '*as far as he could*' into the horizontal pipe. Mr. Daneff pointed out, at some point in the morning, the purpose of the plug being in the pipe shifted from it holding back a 'trickle' of water to being an essential component of the required leak test of the piping system.

[150] Jason King never told Michael Henderson that he had started the leak test later that morning with the pressure of thousands of liters of water then to be exerted on the opposite side of the plug. Mr. McKeil testified that he was not aware that water was beginning to flow into the manhole. Even Mr. DeMerchant testified that, while he discussed the testing with Mr. King on the morning of August 16th, his expectation was it would not start until the afternoon. Mr. DeMerchant had no idea Mr. King was going to start introducing water into the manhole while he (Mr. DeMerchant) was away at lunch. This lack of sharing with his workers that the leak test was about to begin was, in these circumstances, a failure by Mr. King. It meant that Mr. Henderson had no legitimate opportunity to refuse work that was then becoming exponentially unsafe – as was his legal right to do. Moreover, there is no evidence that the provisions of the *Act* or *regulations* pertaining to Mr. Henderson's lawful right to refuse work that was unsafe had been *explained* to him in a meaningful way by Mr. King during orientation other than pointing to the shelf in the trailer where the information could be found which, Mr. King said, he never read anyway. This too, I find to be a failure on Mr. King's part.

[151] The witnesses who testified on the point were unanimous that it was unsafe to have any person in the hole with the plug inflated while water was being introduced into the system on the opposite side. The Crown notes that no expertise is needed to establish that common sense principle – let alone that it says as much, embossed in steel, on the plug itself. Mr. Harvey testified that the danger was from the plug coming loose. As he testified, "*How obvious a proposition would that be*". Carter Dunphy also testified to the hazard created by the plug coming loose, either from the plug itself or from the water held back by it. Colin McKeil testified that he knew he would not work in a hole where the plug was being used (I note also that Mr. McKeil testified that there had been no safety plan put in place by Mr. King for the testing that

day). I agree with the Crown's assertion – no expert testimony is needed to establish a point of common sense. It is one thing to state the common sense notion that the plug could come loose. But the danger is multiplied from it coming loose inside a confined space of the size here. This compounds the danger in which Michael Henderson was placed by Mr. King and it highlights what, I find to be, a most elementary lack of attention to Mr. Henderson's safety by Mr. King – insufficient elementary precautions in the face of a common sense hazard.

[152] It is without dispute that there needed to have been, pursuant to the *regulations*, and amongst other sources, an identified safety plan in place when a worker is in a confined space. Mr. DeMerchant noted that there had been no discussions with Mr. King around safety requirements for the testing. In this case, the most extensive plan Mr. King could develop, which he did not even share with Mr. Henderson, was that someone be available to pull him out in the event of a need to rescue. I will say at this point that I find it unconvincing that Mr. King put his mind, in any meaningful way, to the contents of a safety plan for Mr. Henderson (or any employee) working in the confined space. I say this because it is inconceivable, from a common sense view that, if he had put his mind to it, the best he could come up with was to have someone pull him out by the arm. Moreover, if he had such a plan, he told no one about it. Colin King testified that no safety plan was put in place to get Michael Henderson out of the hole if needed. Eric Henderson was unaware of any safety plan put in place. In my view, and I find, Mr. King had no safety plan for Mr. Henderson as he worked in the hole, being a confined space. Alternatively, the plan he testified he did have, of being able to grab Michael Henderson and pulling him out, could not be considered acceptable by any standard, and would, without question in my view, be indicative of substandard attention to, and a wanton and reckless disregard of, the required duties of a reasonable supervisor.

[153] *Regulation 91-191*, s. 263(1) sets out the requirements that must be met before a person works in a confined space. These requirements are incumbent upon the 'employer', and pursuant to the *Act*, Mr. King, as supervisor, is deemed to be an employer. While I will describe those requirements below, suffice it to say that Mr. King did none of them.

[154] Returning then to the events of August 16th, once the plug was inserted in the pipe by Michael Henderson, Colin King began to inflate the plug having connected it to the compressor. At some point that morning the plug reached the manufacturer's recommended 25 psi. Work continued in the hole. Michael Henderson would fill buckets of debris and pass them up to Colin King. But, as I noted, Mr. King's plan, at some point that morning, shifted from using the plug to block the water trickling in the hole, which hindered the clean-up, to conducting the leak test. Mr. Henderson was not told of Mr. King's new plan.

[155] Once this transition in Mr. King's plans began, any obligation on him to be alert and responsive to the danger Mr. Henderson faced by working in a confined space to begin with, increased. But Mr. King said nothing to Mr. Henderson. Mr. King began to put water into the system as the necessary first step in the testing scheme and, I find, he did it knowing Michael Henderson was in the hole. He knew Michael was in the hole at the start of the leak test just before lunch and he knew he was still in it after lunch as the test continued. As Mr. King stated in his WorkSafe interview:

> … ahh, we were partially filling the pipe until they were finished out there and then we were going to continue on with our leak test.

[156] Several minutes after Mr. King began the flow of water into the manhole, he called lunch for his crew. During the lunch break, Mr. King can be seen on CCTV wandering the site, checking various items of concern. He was inside the clarifier. He testified that he checked the gauges on the plug assembly. On this point, as I have noted, there seemed to be some confusion in the evidence. Mr. Colin King told Mr. Daneff that he had disconnected the plug air hose from the compressor in the morning after it reached 25 psi, at around 09:45. Jason King's evidence implies the plug was attached and, he was getting acceptable psi readings, as he did not interrupt the leak test to correct any pressure errors.

[157] At some point, however, as Mr. Daneff testified, the plug had deflated below the recommended setting to a point where the pressure from the head of water introduced into the manhole by Mr. King overcame the plug's ability to remain in place. I accept Mr. Daneff's opinion as to why the plug moved. No other explanation was offered. It is worth noting however, that Mr. Daneff's report noted that the, "… *use of the test ball was in accordance with the manufacturer's specifications regarding the subject test-ball plug model and pipe size.*" (Ex. P25). Had the plug remained inflated it would have, according to Mr. Daneff's reading of the manufacturer's specifications, been able to support the pressure of the water coming from the manhole side. Nevertheless, there are manufacture's recommendations for the safe use of the plug, most importantly, that no one be working in proximity to the plug when it is in use. Also, the manufacturer noted that the plug should be braced before use to prevent it from moving. This was not done.

[158] It appears from the evidence that once the workers returned after lunch, around 12:30, each to their assigned duties, Mr. King continued to put water into the manhole. Mr. Henderson continued to clean the hole and Mr. King knew that Mr. Henderson had not completed the clean-up in the hole. I do not accept his evidence that he gave specific instructions not to return to work in the hole after lunch. His answers during the WorkSafe interview indicate otherwise. Afterall, if he had given that direction, why would Mr. Henderson still be in the hole approximately twenty minutes after lunch at all? Colin King did not recall receiving such direction. To repeat the portion of Mr. King's Worksafe interview:

> Q. Did you know Michael was in, was in there after lunch?
>
> A. I knew that he had more work to do, yes.
>
> Q. He had more work to do, okay, so he continued doing the job that you asked, that you told him to do?
>
> A. Yes.
>
> Q. And you continued running the line?
>
> A. Yes.

[159] Mr. King had no viable safety plan in place. He knew Michael Henderson was in the hole, after lunch finishing the clean-up, yet he kept putting water into the manhole increasing the pressure on the plug. Mr. King did not do a hazard assessment before directing that anyone work within a clearly identifiable confined space. He did not place any barrier around the hole during the test to ensure no one went near it. He put water into the system knowing a person was working on the other side of a plug installed in a manner inconsistent with the manufacturer's clear direction. He ignored the Springhill site specific directions for work in a confined space. He did not comply with the legislative provisions that he was required to uphold.

[160] At 12:51, under the pressure of the water that Mr. King had begun to introduce into the manhole approximately an hour earlier, the plug let go. It trapped Mr. Henderson and, despite the best efforts of those on scene, including his brother Eric, Michael could not be removed from the hole. Approximately one minute after the plug released and trapped Mr. Henderson, Mr. King turned off the hydrant stopping the flow of water into the hole. But the force of the plug on Mr. Henderson's chest, and the water that was rushing into the hole, could not be overcome. By the time Michael Henderson was removed from the hole, efforts to revive him were futile.

[161] The following provisions of the *Code* are relevant to the court's consideration. I mention s. 217.1 noting that the Crown has identified it as an alternative route to criminal liability:

> 217. Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life.
>
> 217.1 Every one 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.
>
> 219.(1) Every one 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 of safety of other persons.

(2) For the purposes of this section, "duty" means a duty imposed by law.

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.

[162] The "duty" referred to in s. 219 could arguably arise from s. 217.1 of the *Code*, or most certainly can arise from the provisions of the *Occupational Health and Safety Act* and *regulations*. Furthermore, contained in *Regulation 91-191* at s. 263*ff*, is a litany of what was required of an employer (which, as I have noted above, includes by definition, Mr. King) who directs an employee to work in a confined space. This is not intended in any way to imply that only Mr. King fits the definition of employer. These regulated duties are set out below. Counsel for Mr. King acknowledged that the hole within which Mr. Henderson was working at the time of his death would meet the definition of a confined space set out in *Regulation 91-191*. With that said, counsel for Mr. King would not accept that he understood it to be a confined space at the time of the incident. I find that this argument, that he may not have recognized or understood the hole as a confined space, to have no persuasive effect. Mr. King acknowledged that it was 'common sense' to consider it as such and, of the witnesses who spoke on the issue, they were of the common view that there was no way it could have been considered otherwise. It was so obvious to Mr. Sgrosso that he wondered why he was even being asked by Mr. Bennett to provide an opinion to that effect. Mr. King was experienced in construction and a journeyman carpenter. To argue he did not know that an eight feet deep concrete hole that was four feet wide, with a pipe protruding approximately half-way up the hole and half-way into the hole was not a confined space, is not credible.

[163] As a legislatively defined employer, Mr. King had the following obligations (duties) imposed on him by the *Occupational Health and Safety Act* (as it was at the time of the incident). To begin with, s. 1 of the *Act* defines 'employer' as including:

> (b) a manager, superintendent, supervisor, overseer, or any person having authority over an employee;

[164] The specific duties imposed on him by the *Act* included:

> 9(1) Every employer shall
>
> (a) take every reasonable precaution to ensure the health and safety of his employees;
>
> (b) comply with this Act, the regulations and any other order made in accordance with this Act or the regulations;
>
> (c) ensure that his employees comply with this Act, the regulations and any order made in accordance with this Act or the regulations.
>
> 9(2) Without limiting the generality of the duties under subsection (1), every employer shall
>
> (a) ensure that the necessary systems of work, tools, equipment, machines, devices and materials are maintained in good condition and are of minimum risk to health and safety when used as directed by the supplier or in accordance with the directions supplied by the supplier.
>
> (a.1) *omitted*
>
> (b) acquaint an employee with any hazard in connection with the use, handling, storage, disposal and transport of any tool, equipment, machine, device or biological, chemical or physical agent;
>
> (c) provide information that is necessary to ensure an employee's health and safety;
>
> (c.1) provide the instruction that is necessary to ensure an employee's health and safety;
>
> (c.2) provide the training that is necessary to ensure an employee's health and safety;

(c.3) provide the supervision that is necessary to ensure an employee's health and safety;

(d) provide and maintain in good condition such protective equipment as is required by regulation and ensure that such equipment is used by an employee in the course of work;

(e) co-operate with a committee, where such a committee has been established, a health and safety representative, where such a representative has been elected or designated, and with any person responsible for the enforcement of this Act and the regulations.

9(3) an employer shall develop a program for the inspection referred to in paragraph (2)(a.1) with the joint health and safety committee, if any, or the health and safety representative, if any, and shall share the results of each inspection with the committee or the health and safety representative.

[165] As I understand the *Act*, the above are the legislated, general legal duties required of Mr. King. As noted in s. 219 of the *Code*, a person's responsibility under that section, hinges on a finding that there exists a legal duty binding upon that person. I find that the above sections of the *Act* (including the confined space provisions of *regulation 91-191* set out below) satisfy the requirement that a legal duty to do, or not to do, something applied to Mr. King. Whether he satisfied or met those duties will be considered below.

[166] The general nature and scope of the legislative duties above are refined in *Regulation 91-191* applicable to an employee assigned, as Mr. Henderson was, to work within a confined space. While the parties accept that Mr. Henderson was working in a confined space at the time of his death, I will nevertheless set out the definition as contained within the *regulation* as a means of contextualizing what a confined space is and why regulations are considered necessary. Set out below, after the definition, are the portions of *Regulation 91-191* that apply to work occurring in confined spaces and the preconditions for such work.

262 In this part

"confined space" means an enclosed or partially enclosed space not designed or intended for continuous human occupancy with restricted access or egress and which is or may become hazardous to a person entering it because of its design, construction, location, atmosphere or the materials or substances in it or other conditions, but does not include a development heading in an underground mine;

262.1 *omitted*

Testing, protective equipment and entry

263(1) Where an employee is about to enter into a confined space, an employer shall appoint a competent person to verify by tests that

(a) the concentration of airborne chemical agents or airborne dust in the confined space is not hazardous to the health or safety of the employee,

(b) the concentration of an airborne chemical agent or mixture of chemical agents or airborne dust in the confined space does not exceed 50% of its lower explosive limit,

(c) the level of physical agents in the confined space is not hazardous to the health or safety of the employee,

(d) the percentage of oxygen in the atmosphere in the confined space is not less than 19.5% by volume and not more than 23% by volume,

(e) the concentration, level or percentage referred to in paragraphs (a) to (d) is able to be maintained during the period of proposed occupancy of the confined space by the employee,

(f) any liquid in which the employee may drown or any free flowing solid in which the employee may become entrapped has been removed from the confined space,

(g) the entry of any liquid, free flowing solid or any hazardous substance into the confined space in a quantity that could endanger the health or safety of the employee

has been prevented by a secure means of disconnection or the fitting of blank flanges,

(h) all electrical equipment and machines that present a hazard to an employee entering into, exiting from or occupying the confined space have been locked out, with the machines being put in a zero-energy state and locked out in accordance with sections 239 and 240, and

(i) the opening for entry into and exit from the confined space is sufficient to allow safe passage of an employee who is using protective equipment or emergency equipment.

263(2) *omitted*

263(3) The competent person referred to in subsection (1) shall in a written report

(a) set out

(i) the results of the tests made under subsection (1), and

(ii) an evaluation of the hazard of the confined space

(b) set out the procedures to be followed by an employee entering into, exiting from or occupying the confined space,

(c) identify the protective equipment that is to be used by every employee entering the confined space,

(d) set out the emergency procedures to be followed in the event of an accident or other emergency in or near the confined space, including immediate evacuation of the confined space when an alarm is activated or there is any significant change in the concentration, level or percentage referred to in subsection (1), and

(e) identify the protective equipment and emergency equipment to be used by an employee who undertakes rescue operations in the event of an accident or other emergency.

263(4) An employer shall provide to each employee entering the confined space the protective equipment referred to in paragraphs 3(c) and to each employee who may undertake rescue operations the protective equipment and emergency equipment referred to in paragraph 3(e).

263(5) An employer shall ensure that the written report referred to in subsection (3) and any procedures set out in the report are explained to an employee who is about to enter into a confined space or who may undertake a rescue operation in the confined space and the employee shall read the report and acknowledge that the report and the procedures were explained to the employee by signing a dated copy of the report.

263(6) An employer shall ensure that an employee who is about to enter into the confined space is instructed and trained in the procedures referred to in subsection (3) and in the use of the protective equipment referred to in paragraph 3(c) and that an employee who may undertake rescue operations is instructed and trained in the procedures referred to in subsection (3) and in the use of the protective equipment and emergency equipment referred to in paragraph (3)(e).

263(7) Every employee who enters into, exits from or occupies the confined space shall follow the procedures referred to in subsection (3) and use the protective equipment and the emergency equipment referred to in subsection (3) as required.

264 *omitted*

265 *omitted*

266(1) An employer shall ensure that

(a) all protective equipment and emergency equipment identified under subsection 263(3)

(i) have been inspected by a competent person,

(ii) are in good working order, and

(iii) are at the entrance to the confined space before an employee enters the confined space;

(b) a competent employee trained in the procedures referred to in subsection 263(3) is

(i) in attendance outside the confined space,

(ii) in constant communication with the employee inside the confined space, and

(iii) provided with a suitable alarm for summoning assistance;

(c) the competent employee referred to in paragraph (b)

(i) holds a valid standard-level first aid certificate issued by the Canadian Red Cross Society or St. John Ambulance, and

(ii) is trained in artificial respiration and cardiopulmonary resuscitation;

(d) where required under subsection 263(3), every employee entering into, exiting from and occupying the confined space wears a full body harness attached to a lifeline that is attached to a secure anchor outside the confined space and is controlled by the competent employee referred to in paragraph (b)

(e) where there is more than one employee in the confined space, steps are taken to ensure that any life lines attached to body harnesses worn by the employees do not become entangled; and

(f) an employee who is trained in the emergency procedures refer to in subsection 263(3) and who is fully informed of the hazards in the confined space is in the immediate vicinity of the confined space to assist in the event of an accident or other emergency.

[167] As noted above, I am satisfied that the duties set out in the *Act* and *Regulations* impose legal duties on Mr. King and fall within the intent and meaning of s. 219 of the *Code* when it speaks of duties that arise by the imposition of law. I will not therefore, opine on the application of the Crown's alternative argument as it relates to s. 217 of the *Code*. Before turning to the question of whether Mr. King, by way of his actions or inactions, is in breach of s. 219 of the *Code*, I will deal with the issue of causation, as it pertains to Mr. King's role, in Mr. Henderson's death.

[168] As the Crown correctly points out, it must show that Mr. King's actions (or inactions) were a significant contributing factor in Mr. Henderson's death. It argues from the basic premise that, were it not for Mr. King introducing water into the manhole during a time he knew Mr.

Henderson was working in the confined space of the hole, Mr. Henderson's death would not have occurred. While there may have been other factors at play, the question to be determined is whether Mr. King's actions were a significant contributing cause or factor in Mr. Henderson's death. As the Ontario Court of Appeal noted in *Doering*, at para. 136:

> Ultimately, liability turns on whether the Crown can prove that the accused's conduct amounts to a "significant contributing cause" of the event in issue:

[169] As noted in the opening paragraphs of these reasons, the parties accept the report of the forensic pathologist that Mr. Henderson's cause of death was asphyxia due to drowning. The drowning was caused by the release into the hole of approximately 32,000 liters of water that were in the piping system only because Mr. King put them there. In summary, Mr. King essentially put Mr. Henderson in the hole and then put the water into the system. While it might arguably have been the case that there were intervening acts of others that could have been contributing causes of the plug to deflating, and to be blown out of its position, the singular substantive cause of Mr. Henderson's death was, I find, the running of water into the system while Mr. Henderson was in the hole. As noted in *Doering* at para. 135, it is sufficient to rely on common sense in making such assessments. Running water into the piping system at a time when he knew Mr. Henderson was working in the hole was a significant contributing cause in Mr. Henderson death. The risk that the plug may move during use (regardless of the reason) could not be considered as unexpected. That is why there were specific manufacturer's directions to brace the plug and, above all else, have no one working in proximity to the plug when in use. That is why there are regulations setting the necessary preconditions for work in a confined space. Such risk is foreseeable. As was noted in para. 146 of *Kazenelson*, where the risk related to a swing stage:

> The risk of equipment failure was not only an objectively foreseeable risk it was virtually the entire reason why the provision of a fall arrest system was regarded as the fundamental rule of swing stage work. The failure of the swing stage, even if unexpected, was not an event that was outside the ambit of the general risk animating the requirement for a fall arrest system. It is not necessary that the precise cause of the failure have been foreseen.

[170] Turing to the assessment of the essential elements or considerations of the crime for which Mr. King has been charged, I set out the following from the Supreme Court of Canada in *Javanmardi*:

> 19. The *actus reus* of the 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] 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] 1 S.C.R. 1392, at pp. 1429-31; R. v. Morrisey, [2000] 2 S.C.R. 90, at para. 19; *R. v. Beatty*, [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] 2 S.C.R. 60, at para. 30; *R. v. L.(J) (2006)*, 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. Sharpe* (1984), 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), 41 C.R. (7th) 330, at para. 27; *R. v.*

Blostein (2014), 306 Man. R. 2(d) 15 at para. 14. As Healy J.A. explained in *Fontaine*:

> These differences of degree cannot be measured by a ruler, a thermometer or 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.

> 23. … 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).

[171] It is incumbent upon me to measure the actions of Mr. King against a modified objective standard to determine if any departure from that standard could be properly characterized as being "marked and substantial". I must consider what the standard should be for a reasonable site supervisor in the circumstances of Mr. King. Neither party could identify in the jurisprudence an identified standard that neatly applied to the present circumstances. As with many legal concepts, boundaries are, often by necessity, ill-defined. This is what, I believe, Healy J.A. was saying in the portion of *Fontaine* noted above.

[172] In my view, the standard expected of a reasonable site supervisor on a construction site of this type must include, at a minimum, that the supervisor had familiarized themselves with the legislated duties that were binding upon them as set out in the *Act* and the *Regulations*. Construction sites, by their nature, contain hazards and can be dangerous (as this incident so

tragically proves) and the legislative scheme is meant to reduce and, if followed, hopefully eliminate, that risk. In addition, one should expect that the reasonable supervisor would have familiarized themselves with any site-specific safety plan. Furthermore, the reasonable site supervisor would have familiarized themselves with the basic manufacturer's instructions regarding the safe use of equipment used on the site. These are the basic, fundamental elements of what I find to be the minimally acceptable standard of conduct for a supervisor in the circumstances of Mr. King. I use the phrase 'basic fundamental elements' because, in my view, any failure to meet those basic fundamental elements would, by its very nature, represent a marked and substantial departure from this acceptable minimum standard.

[173] While writing in dissent in *Javanmardi*, Chief Justice Wagner, at para. 66, notes the following, which addresses this appreciation for the need to operate from a base level. His comments also address the argument of Mr. King that his level of knowledge of the legal duties he had, and the risks that existed on the site, are not legal excuses for failing to meet the required standard. Nor can his argument that he was not provided adequate training by Springhill management succeed. Chief Justice Wagner wrote:

> I wish to be clear that, as this Court has repeatedly stated, "[s]hort of incapacity to appreciate the risk or the incapacity to avoid creating it, personal attributes such as age, experience and education are not relevant. The standard against which the conduct must be measured is always the same" (*R. v. Beatty*, 2008 SCC 5, [2008] 1 S.C. R. 49, at para 40). Every person, regardless of his or her professional training, is required to act in accordance with the standard expected of a reasonably prudent person in the same circumstances.

[174] I accept Mr. King's evidence that he was not given any training by Springhill. There was no evidence to the contrary. But whatever the reason, Mr. King did not take the steps one would expect of a "*reasonably prudent person*" to protect Mr. Henderson, having directed him to work in a confined space in the circumstances existing. With that said, it must be established that his acts or omissions give rise to criminal liability as set out on the Indictment.

[175] A further useful summary of what the Crown must prove is set out in *R. v. Sillars*, 2022 ONCA 510 at para. 71:

> On a charge of criminal negligence, the Crown must show that the accused's act or omission represented a marked and substantial departure from the conduct of a reasonably prudent person in the circumstances and that this act or omission demonstrated a wanton or reckless disregard for the lives or safety of other persons: see *R. v. J.F*. 2008 SCC 60, [2008] 3 S.C.R. 215, at paras. 7-10; *R. v. A.D.H.*, 2013 SCC 28, [2013] 2 S.C.R. 269, at para. 61. In a criminal negligence case the Crown must prove either that the accused was aware of the obvious risk to the lives and safety of others but went ahead anyway or gave no thought to that risk.

[176] I am, as noted above, satisfied that Mr. King's actions in running the water into the manhole at a time when he had directed Mr. Henderson to do work in the clarifier hole without any compliance to the necessary precautions for confined space work was a significant contributing cause of Mr. Henderson's death. Included in a minimum base standard of conduct of a reasonable site supervisor would be that Mr. King was required to adhere to the directives in the *Act* and *regulations* – provisions which, by their nature, are intended to reduce safety risks on worksites. I can find no evidence that he followed, in any useful way, any of the provisions which the law required him to follow. He had a duty to run his worksite in conformity to those legislative provisions. The only plan he had to keep Michael Henderson safe was to have someone ready to pull him out by the arm. There is no evidence that he had put his mind to the specific actions required of him before Mr. Henderson was sent to work in the hole, let alone when he started to run water into the manhole.

[177] Even if I accept the limited scope of his safety or rescue plan, it would be one basis (and sufficient on its own) upon which I find his conduct showed a marked and substantial departure from the standard expected of a reasonable site supervisor. In the face of the legislative and regulatory framework required for working in a confined space, his plan to rely on having someone 'pull him out' in the case of the emergency shows, and I so find, a wanton and reckless disregard for Mr. Henderson's life and safety. At the risk of being repetitive, to have failed to adhere to *any* common sense safety precautions, or the basic manufacturer's directions for use of

the plug, or the legislative requirements for confined space work shows, I find, a wanton and reckless disregard for Mr. Henderson's safety. It would be illogical to argue that Mr. King was unaware of the risk associated with running water in the manhole while a worker was in the hole, but then say he had a safety plan to pull him out in the event of an emergency. I make this point not to say that Mr. King made such an argument, but only to illustrate that a self-evident risk exists if a rescue plan, even one as limited as Mr. King's, was needed.

[178] The *Act* and *regulations* imposed legal obligations on Mr. King that he must have complied with *before he sent* Mr. Henderson into the hole. He did not follow the requirements and Mr. Henderson died when the water Mr. King was running into the manhole exploded into the hole drowning him. Mr. Kings actions were a substantial contributing cause in Mr. Henderson's death. His failure to even inform himself of the legal duties he had as a site supervisor, and to acquaint himself with the site safety requirements, shows a failure to meet even the minimum standard expected of a reasonable site supervisor. For Mr. King to have run water into the pipe system when he knew Mr. Henderson was in the hole and relying on a safety plan that consisted of having someone pull Mr. Henderson out in the event of an emergency, represents a wanton and reckless disregard for Mr. Henderson's safety. All this, I so find.

[179] As I note above, it is difficult to define a rigid standard for the expected conduct of a reasonable site supervisor. Context matters in each case. It is for that reason that the 'standard' I described above, must begin with an obligation that a reasonable site supervisor must make themselves aware of the legal duties that are imposed upon a person with their authority in the workplace. I will make no comment on any obligation that might exist, at a corporate level, to ensure, amongst other things, that a supervisor is properly prepared to meet its obligations to workers. To say, as Mr. King did during the trial, that he read none of these legislative obligations falls below the standard in a marked and substantial way. The death of Mr. Henderson resulted from a failure of Mr. King to know what he should do, and a failure to do what he should have known he had to do.

[180] The factor in this case which I find most difficult to understand is that Mr. King's attention to the safety of Mr. Henderson on this occasion was nowhere close to what was minimally required of him. This is not a case where I consider whether what Mr. King did in relation to safety of the workers under his control, was sufficient – essentially, he did nothing he was required to do.

CONCLUSION

[181] Based on my findings above, I confirm that Mr. King's actions were a significant contributing cause of Mr. Henderson's death. In addition, the omissions and failure to comply with the requirements of the *Act* and *regulations* represent a failure to meet even the minimum standard of conduct expected of a reasonable site supervisor. Taken together, the lack of Mr. King's legislative compliance, lack of attention to the site safety manual, failure to heed the obvious safety direction of the plug's manufacturer, a rescue plan which did not in any way address the significance of the foreseeable threat of the circumstances in which Mr. Henderson was placed by Mr. King, all show a marked and substantial departure from a minimum standard and a wanton and reckless disregard for Mr. Henderson's safety.

[182] Mr. King, will you please stand,

On the charge set out in the indictment that:

> On or about August 16, 2018 at Fredericton, New Brunswick did, by criminal negligence cause the death of Michael Henderson, contrary to s. 220(b) of the Criminal Code of Canada and amendments thereto.

On that charge, I find you guilty.

_____

Justice E. Thomas Christie
Court of King's Bench of New Brunswick, Trial Division