Citation: *Yukon (Director of Occupational Health and Safety)* v. *Yukon Tire Centre Inc. et al.,* 2014 YKTC 4

Date: 20140129
Docket: TC 12-06231
Registry: Whitehorse

IN THE TERRITORIAL COURT OF YUKON
Before: His Honour Judge Faulkner

IN THE MATTER of the *Occupational Health and Safety Act,* R.S.Y. 2002, c. 159, and the *Occupational Health and Safety Regulations,* O.I.C. 2006/178;

DIRECTOR OF OCCUPATIONAL HEALTH AND SAFETY

v.

YUKON TIRE CENTRE INC. and PAUL BUBIAK and
NORTH 60 PETRO LTD. and FRANK TAYLOR

Appearances:

Judith M. Hartling	Counsel for Director of Occupational Health and Safety
James Tucker	Counsel for Yukon Tire Centre Inc. and Paul Bubiak
William K. McNaughton	Counsel for North 60 Petro Ltd.
André Roothman	Counsel for Frank Taylor

REASONS FOR JUDGMENT

[1] Yukon Tire Centre Inc. stands charged that it:

> COUNT #1 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as an employer by failing to isolate and effectively control an energy source to wit: a Kenworth truck when a worker could be injured by the unexpected energization or a start up of the machinery or equipment or the unexpected release of the energy source, contrary to Regulation 3.02 of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S. Y. 2002. C. 159.

COUNT #2 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as an employer by failing to effectively control an energy related hazard to wit: a Kenworth truck when it was shut down for maintenance work, contrary to Regulation 3.03 of the Occupational Health and Safety Regulations, O.I.C. 2006/178. *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

COUNT #3 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as an employer by failing to stop and immobilise a machine or equipment which may endanger a worker to wit: a Kenworth truck before being adjusted or repaired contrary to Regulation 1.07(2) of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

COUNT #4 On or about the 15th day of November, 2011 at or near the City of Whitehorse, YT, did unlawfully commit an offence as an employer by failing to develop safe, effective lockout procedures and train workers in the safe and effective use of those procedures contrary to Regulation 3.04(1) of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

COUNT #5 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as an employer by failing to explain verbally and give in writing to each worker the lockout procedures contrary to Regulation 3.04(3) of the Occupational Health and Safety Regulations, O.I.C. 2006/178., *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

[2] Paul Bubiak stands charged that he:

COUNT #6 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as a supervisor by failing to adequately train a worker in the safe operation and related safe work procedure of equipment to wit: a Kenworth truck contrary to Regulation 1.06(a) of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

COUNT #7 On or about the 15th day of November, 2011 at or near the City of Whitehorse, YT, did unlawfully commit an offence as a supervisor by failing to stop and immobilise a machine or equipment which may endanger a worker to wit: a Kenworth truck before being adjusted or repaired contray to Regulation 1.07(2) of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

COUNT #8 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as a supervisor by failing to isolate and effectively control an energy source to wit: a Kenworth truck when a worker could be injured by the unexpected energization or a start up of the machinery or equipment or the unexpected release of the energy source, contrary to Regulation 3.02 of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

COUNT #9 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as a supervisor by failing to effectively control an energy related hazard to wit: a Kenworth truck when it was shut down for maintenance work, contrary to Regulation 3.03 of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

[3] North 60 Petro Ltd. stands charged that it:

COUNT #10 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as an employer by failing to adequately train a worker in the safe operation and related safe work procedure of equipment to wit: a Kenworth truck contrary to Regulation 1.06(a) of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

COUNT #11 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as an employer by failing to ensure that where a mobile equipment operator's view of the work place is obstructed, that the operator not move the equipment to wit: a Kenworth truck until precautions have been taken to protect the operator and any other worker from injury contrary to Regulation 6.38 of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

COUNT #12 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as an employer by failing to ensure a worker, to wit: Allan Lelievre had demonstrated competency in operating equipment to wit: a Kenworth truck to a supervisor or a qualified person contrary to Regulation 6.03(b) of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

[4] Frank Taylor stands charged that he:

> COUNT #13 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as a supervisor by failing to adequately train a worker in the safe operation and related safe work procedure of equipment to wit: a Kenworth truck contrary to Regulation 1.06(a) of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.
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> COUNT #14 On or about the 15th day of November, 2011, at or near the City of Whitehorse, YT, did unlawfully commit an offence as a supervisor by failing to ensure that where a mobile equipment operator's view of the work place is obstructed, that the operator not move the equipment to wit: a Kenworth truck until precautions have been taken to protect the operator and any other worker from injury contrary to Regulation 6.38 of the Occupational Health and Safety Regulations, O.I.C. 2006/178, *Occupational Health and Safety Act*, R.S.Y. 2002, c. 159.

[5] The charges all arise out of a fatal industrial accident that occurred on November 15, 2011 at approximately 3:19 p.m.

[6] Earlier that day, a Kenworth truck operated by North 60 Petro Ltd. was driven to Yukon Tire Centre's shop for work on the truck's drive tires. The truck was a large highway transport truck intended to haul a semi-trailer. The truck had three drive axles and each axle was equipped with dual wheels on each side. The truck was new and was taken to the tire shop to have the tires on the drive axles siped. Siping is a process whereby cuts are made across the tire treads to improve traction in slippery conditions.

[7] Rod McPhail, a North 60 truck mechanic, drove the Kenworth to the tire shop. The truck was parked immediately in front of one of the large overhead bay doors located at the rear of the tire shop, with the front of the truck facing away from the building.

[8] Mr. McPhail set the air park brake and turned the engine off. However, the keys were left in the ignition, where they remained until the accident occurred. Mr. McPhail then returned to the North 60 premises, which were only a few blocks away.

[9] Paul Bubiak is part owner of Yukon Tire and supervises the tire shop portion of the business. Mr. Bubiak assigned Denis Chabot, one of Yukon Tire's technicians, to carry out the siping job on the North 60 truck. Mr. Chabot was an experienced worker and quite familiar with work on large commercial vehicles.

[10] The work involved jacking one side of the truck up, removing the six drive wheels and tires on that side and taking them into the shop where a siping machine was located. After siping, the wheel/tire assemblies would be taken back outside and re-installed on the truck. Once the first six wheels were re-installed, the truck would be lowered and the process repeated on the other side. Mr. Chabot started on the driver's side, then moved to the passenger side.

[11] To raise the truck, Mr. Chabot used three bottle jacks – one under each axle. Normal procedure would be to then place jack stands under each axle and lower the truck onto the stands. Once the wheels had been replaced, the truck would be jacked up again, the wheel stands removed and the truck lowered to the ground. At this point, the wheel nuts would be torqued using a large torque wrench.

[12] It is important to note that it was necessary for Mr. Chabot to work under the truck to place or remove the bottle jacks or jack stands.

[13] In order to get in and out of the shop during the course of the work, Mr. Chabot used a man door adjacent to the bay door. This truck was parked so that the rear most drive axle on the driver's side of the truck was nearest the man door.

[14] Before jacking up the truck, Mr. Chabot placed a set of chocks under the front, steering, axle of the truck on the side he was working on. However, no other precautions were taken to prevent the vehicle from being inadvertently put in motion while Mr. Chabot worked on the truck. In particular, although the engine was off and the park brake set, the keys were left in the ignition. No lockout tags, cones or other warnings against operating the vehicle were utilized.

[15] At the time, Yukon Tire had no lockout policy and it was normal practice to leave the ignition key in the vehicle.

[16] Around 3:00 p.m., Mr. Chabot advised Mr. Bubiak that the work on the truck was almost finished but that he, Mr. Chabot, still needed to torque the wheel nuts. Mr. Bubiak got into the truck and started it up so that it would be warmed up and ready to go when the customer arrived. At the time, Mr. Chabot was working on the passenger side of the truck, likely using the torque wrench.

[17] Mr. Bubiak testified that it was Mr. Chabot who suggested starting up the truck. The Director of Occupational Health and Safety challenged this claim; however, nothing really turns on exactly what was said or who initiated the idea. Mr. Bubiak started up the truck and Mr. Chabot was clearly aware that he had done so.

[18] After starting the truck, Mr. Bubiak went back to the front office of the tire shop and telephoned Frank Taylor at North 60 Petro to advise the truck was ready, or nearly ready, to go. Mr. Taylor said he would have the truck picked up as soon as he found a driver.

[19] At North 60, Mr. Taylor asked Allan Lelievre to accompany Mr. Taylor to the tire shop and drive the Kenworth truck back to North 60's yard. Mr. Lelievre worked for North 60 and reported to Mr. Taylor, who was the manager of Highway Operations. Mr. Lelievre was employed as a dispatcher, not a truck driver; however, he was an experienced driver, held a Class 3 operator's licence, had an air brake endorsement and was, thus, legally qualified to drive the truck when it was unloaded.

[20] Although Mr. Lelievre was an experienced driver, he had not driven the new Kenworth truck before and knew that the truck was equipped with a semi-automatic transmission with which he was unfamiliar. Accordingly, he asked Mr. McPhail about how to operate the truck. Mr. McPhail told him to put the gear selector in automatic drive and to make sure he depressed the clutch pedal fully to the floor.

[21] Mr. Taylor then drove Mr. Lelievre to Yukon Tire to pick up the truck. They proceeded to the rear of the tire shop; Mr. Taylor stopped in front of the Kenworth and Mr. Lelievre got out. Mr. Lelievre says that, as he and Mr. Taylor drove by the passenger side of the Kenworth, he looked down that side of the truck but saw nothing unusual.

[22] After getting out of Mr. Taylor's pick-up truck, Mr. Lelievre walked to the driver's side of the Kenworth. He climbed up on the running board and, using for support a

handle mounted on the sleeper unit of the truck, leaned out and looked toward the back of the truck. From this vantage point, the view of the passenger side of the Kenworth was partly blocked by the sleeper unit and the view of the ground underneath the truck was obscured by the truck frame, the drive axles, the wheels and the mud flaps.

[23] Mr. Lelievre saw nothing unusual. He got into the truck. He did not perform a walk-around.

[24] Mr. Taylor watched Mr. Lelievre get into the truck. He then drove his pick-up truck to the front of the tire shop and went into the office to sign the invoice for the work.

[25] After Mr. Lelievre got into the truck, sat down in the driver's seat and closed the door, he took a few moments to familiarize himself with the truck. The truck's engine was already running. Mr. Lelievre attempted to drive the truck away. This involved putting the gear selector into drive, releasing the park brake and depressing the clutch pedal. The first time Mr. Lelievre tried this operation, the truck did not begin to move forward as he had expected. He reapplied the brake and began the sequence again, this time making sure that the clutch pedal was fully depressed. This time, the truck began to move and Mr. Lelievre drove ahead while beginning to make a left turn to exit the yard. Mr. Lelievre says he checked his driver's side mirror before putting the truck in motion. He could not recall checking the passenger side mirror but said it was his usual practice to do so. Mr. Lelievre had only travelled a short distance when, looking back in the driver's side mirror, he saw a man lying on the ground where the truck had been parked. The man was Mr. Chabot, who had been underneath the passenger side of the

Kenworth when Mr. Lelievre drove off. The truck drove over Mr. Chabot's head and upper chest causing catastrophic and unsurvivable injuries.

[26] Seeing Mr. Chabot on the ground, Mr. Lelievre stopped the truck, got out and ran back. He quickly realized that Mr. Chabot's injuries were extremely serious and he ran inside the shop to get help.

[27] As it happens, Yukon Tire had a system of security cameras operating the day Mr. Chabot was killed. One of the cameras was in the tire shop office, one was in the shop itself and another was mounted on the back wall of the shop focused on the rear yard area. The cameras are date and time stamped (to the hundredth of a second) and the times are synchronized.

[28] Unfortunately, the outside camera does not capture images of the area where Mr. Chabot was working on the Kenworth truck. However, the camera does record Mr. Taylor's truck as he drove away after dropping off Mr. Lelievre. Additionally, once Mr. Lelievre began to drive the Kenworth forward it does come into the camera's field of view. Mr. Lelievre can be seen stopping the truck, jumping out and running back. Thus, given that the video recordings are time-stamped, the time of Mr. Lelievre's arrival can be fairly closely estimated and the time that he put the truck into motion can be fixed with a significant degree of precision.

[29] It also develops that the camera in the shop area captured images of Mr. Chabot going in and out of the shop as he worked on the Kenworth and the time that he last went outside before he was killed can also be rather precisely determined.

[30] From the camera times, it can be inferred that at least two minutes elapsed from the time Mr. Lelievre arrived on the scene until he put the truck in motion, and that he was in the cab for well over a minute. Tests performed by Occupational Health and Safety investigators suggest that it would have taken approximately forty seconds to complete the steps Mr. Lelievre went through before he drove off. However, given the amount of time that passed after Mr. Lelievre was dropped off, and given that little time would have elapsed between the time Mr. Lelievre was dropped off until he entered the cab, I conclude he was in the cab for more than forty seconds. In any case, it appears certain that, when Mr. Lelievre arrived and got into the truck, Mr. Chabot was still inside the shop and not under the truck.

[31] Tragically, it appears that Mr. Chabot came outside after Mr. Lelievre was already in the cab. Since Mr. Chabot's view of the cab was blocked by the sleeper unit, and since the vehicle had been started previously and was already running, Mr. Chabot was not alerted to the danger that the truck was about to be put in motion nor, from his position at the rear of the shop, would he have noticed Mr. Taylor enter the office. The conclusion that Mr. Chabot came outside after Mr. Lelievre was already in the cab is consistent with Mr. Lelievre's testimony that as he was seated in the cab, he thought he heard the man door close. The door is visible in the truck's driver side mirror. Mr. Lelievre looked in this mirror but saw no one.

[32] As indicated, the obstructed view and the already-running truck go some distance to explain why Mr. Chabot was not warned to the danger he faced. However, there is also evidence that while Mr. Lelievre was in the truck, he released the air park brake, then reapplied it and released it again. These actions produce a distinctive and

clearly audible noise, even with the truck running. If Mr. Chabot was under the truck when the brake was applied and released, the sound level would have been in the order of 105 decibels, a sound level akin to that produced by a gas lawnmower or snow blower.

[33] It is extremely unlikely that Mr. Chabot would fail to hear the sound. However, if he was not yet under the vehicle when the brake was operated, he may not have been warned. If he got underneath part way though the sequence of operations he may have heard the sound of the final release of the air brake but been unable to extricate himself in time. Only a brief period of time would have passed from the final release of the air brake until the vehicle began to move.

[34] I have already indicated that the injuries Mr. Chabot suffered when the truck ran over him were unsurvivable. However, the defendants argued that these injuries were not the cause of death. Astonishingly, in my view, they advanced the theory that Mr. Chabot suffered a heart attack.

[35] It is true that Dr. Lee, the pathologist who performed the autopsy on Mr. Chabot's body, found evidence of cardiovascular disease that put Mr. Chabot at a significantly elevated risk of suffering a heart attack. However, there is no evidence that he actually suffered a heart attack. To the contrary, Dr. Lee's opinion was that the findings of the Emergency Medical Service team who attended Mr. Chabot at the scene virtually rule out a heart attack as the cause of death. This is because the EMS team detected what is called PEA – pulseless electrical activity – in Mr. Chabot's heart. Dr. Lee would not

have expected to see PEA if Mr. Chabot had suffered a heart attack prior to being run over and crushed.

[36] It must also be remembered that the law is well-established that causation in criminal and quasi-criminal cases is established when it is shown that the actions of the accused at least contributed to the death outside the *de minimis* range.

[37] To succeed, the defendants must establish at least the possibility that Mr. Chabot got under the truck, suffered a heart attack and died, all in the few seconds available before the truck started to move.

[38] The chance that this is what occurred (or even that Mr. Chabot had a heart attack and managed to fall under the truck) is so vanishingly small as to have no air of reality whatever.

[39] I am satisfied and find that Mr. Chabot got under the vehicle to retrieve one of the bottle jacks. For one thing, he was found with the jack handle in his hand. Moreover, the position of the jacks when John Durr arrived on the scene shows that at least one of the jacks, if not all three, were still under the truck when it was driven forward.

[40] The defendants attempted to argue that the injuries to Mr. Chabot show that he was on his back when he was run over and that he would not have been on his back if attempting to retrieve the jacks. However, even accepting that Mr. Chabot was on his back when the truck ran over him, does not lead me to the conclusion that he was on his back when the accident sequence began. He could have been on his side or rolled

as he attempted to get away. His body may also have been turned over as the truck's tires ran over him. Indeed, he was found face down.

[41] At the end of the day, the fact remains that a jack was still under the vehicle, Mr. Chabot had a jack handle in his hand and he had no other reason to be under the vehicle.

[42] I should add here that it would not have been necessary for Mr. Chabot to be under the vehicle to torque the wheel nuts. That operation is performed with the technician beside, not under, the vehicle.

[43] However, I am satisfied that the torque wrench Mr. Chabot had used was still outside and in the vicinity of the truck at the time of the accident. Investigators found the torque wrench on the ground, located where the driver's side drive wheels would have been situated before Mr. Lelievre drove away. Mr. Chabot had been using the wrench to service the truck and there was no conceivable reason for anyone to bring it to the scene after the accident. Mr. Bubiak insisted that the torque wrench was not there when he first went outside but I'm satisfied that, in the shock of the moment, he simply failed to notice it. Although I find that the torque wrench was on the scene, I do not believe that the torque wrench was in the same position as when found. It wouldn't have been under the vehicle for the simple reason that it is not used under the vehicle. Moreover, there is no evidence that the wrench was damaged, which surely would have been the case had the truck driven over it.

[44] There is no evidence anyone brought the torque wrench to the scene afterward and no evidence anyone moved it, although another witness thought it might have been

leaned up against the bay door when he arrived at the scene shortly after the accident. Most likely, it was leaned up against the back of the truck and fell to where it was found when the truck moved forward. The evidence is insufficient to make a specific finding in this regard, but it is clear that the torque wrench was on the scene prior to the accident and likely would have been visible to anyone who walked around the vehicle.

[45] Mr. Chabot had also been using a set of wheel chocks. These were also found at the scene but were located near the man door. I conclude that Mr. Chabot removed the chocks prior to the accident.

[46] The Director alleges that there were numerous safety failures that led to the accident. With respect to Yukon Tire, the employer, and Mr. Bubiak, the supervisor, the claimed failures boil down to this:

1. A failure to effectively disable the truck while it was being worked on (counts 1, 2, 3, 7, 8 and 9);
2. A failure to develop effective lockout procedures (count 4); and
3. A failure to effectively train workers (counts 4, 5 and 6).

[47] It is beyond doubt that there were failures in each area; otherwise, the accident would not have occurred. However, liability is not absolute. The defendants may defend themselves by proving that they exercised due diligence or, in other words, took all reasonable steps to prevent the accident. The proof that the defendants took reasonable care is on a balance of probabilities. *R. v. Sault Ste. Marie (City),* [1978] 2 S.C.R. 1299.

[48] I turn to deal with the first category of charges; those dealing with the failure to immobilize the truck.

[49] It must be kept in mind that, unlike the other counts, which deal with general failures to implement proper procedures, practices and training, counts 1, 2, 3, 7, 8 and 9 relate quite specifically to the events of November 15, 2011. That being the case, I have come to the conclusion that these charges cannot be sustained.

[50] The employer and the supervisor had a duty to ensure the truck was immobilized until the maintenance work was completed. Clearly, they failed in this duty as the work was not complete until everything was done, including removal of the jacks and other tools.

[51] However, around 3:00 p.m., Mr. Chabot had advised Mr. Bubiak that the job was complete except for torquing the wheels. It is beyond doubt that this conversation occurred because it was what prompted Mr. Bubiak to call North 60 Petro to pick up the truck and to prepare an invoice for the work. It is true that Mr. Bubiak started the truck before all work was complete. However, the torquing job would only take a short period of time and, crucially, did not require Mr. Chabot to work under the truck.

[52] Moreover, around 3:16 p.m., and prior to the truck being moved, Mr. Bubiak and Mr. Chabot had a second conversation during which Mr. Chabot told Mr. Bubiak that the job was finished. The Director challenged the veracity of Mr. Bubiak's evidence in regard to this second conversation, but I am satisfied that it occurred. Although the surveillance video does not capture sound, it, nonetheless, clearly shows Mr. Bubiak and Mr. Chabot in conversation at the rear of the shop at precisely the time in question.

[53] Having been told that the job was complete, Mr. Bubiak or Yukon Tire would have needed to be clairvoyant to realize that, although Mr. Chabot said the work was complete, there was still a jack underneath the truck and that he would later go under the truck in an attempt to retrieve it. In that sense, what occurred was simply unforeseeable and the defence of due diligence is made out.

[54] In the result, counts 1, 2 and 3 against Yukon Tire, and counts 7, 8 and 9 against Mr. Bubiak, must be dismissed.

[55] That leaves for consideration counts 4, 5 and 6 which deal with allegations of failure to develop lockout procedures and to adequately train workers.

[56] Insofar as Part 3 of the *Occupational Health and Safety Regulations* requires lockout procedures, the situation at Yukon Tire may be briefly stated: they had no procedures. To the extent that Yukon Tire's work practices might be argued to constitute a lockout procedure, they were completely inadequate.

[57] The engine was to be turned off, the air brake set and a wheel chock placed. The truck was then jacked up. However, leaving the key in the ignition presented the clear and easily foreseeable danger that the truck could be started and moved unexpectedly.

[58] Mr. Turnbull, a trucking industry safety expert called by the Director, testified, and I accept that, at a bare minimum, an effective lockout policy would involve removal and embargo of the ignition key until all work was completed. Such a policy need not be complex. The practice of the technician putting the key in his pocket would have

sufficed.[1] Better practice would also require the use of lockout tags affixed to the door or other obvious location on the vehicle to warn against energizing or moving the vehicle. Mr. Turnbull also suggested that technicians disconnect the battery or otherwise disable the vehicle's electrical system, but I was not persuaded that this is necessary or even desirable when the service work being performed is limited to wheels and tires. Work on the electrical system, engine or other components might be a different matter.

[59] To return to Yukon Tire's practices, it is true that wheel chocks were to be used, but I agree with Mr. Turnbull that such a chock would not have prevented the truck from being driven away even if it had been in place at the time of the accident. Finally, I note that jacks or jack stands are intended to raise or support the vehicle. They would not prevent someone from driving the vehicle forward or back.

[60] As with the counts already dealt with, Yukon Tire and Mr. Bubiak are liable to be convicted unless they can prove on a balance of probabilities the exercise of due diligence to prevent the accident.

[61] The evidence led satisfied me that, far from being a safety outlier or scofflaw, Yukon Tire made considerable efforts to train its employees and to foster safe work practices.

[62] Yukon Tire's training program was provided by the Tire Industry Association

[1] It might also have satisfied the requirements of Part 3 of the *Occupational Health and Safety Regulations* since s. 3.10 does not require the use of lockout procedures if an energy isolating device (in this case, the ignition key) is under the exclusive control of the technician working on the equipment.

("TIA"). TIA is a U.S.-based group that represents tire dealers and others involved in the tire industry. TIA has developed training programs for technicians installing and servicing passenger cars, light trucks and commercial vehicles. So far as Yukon Tire was aware, the TIA programs were industry standard. Mr. Chabot had taken the TIA courses and was trained and current in servicing commercial vehicles, including the North 60 truck.

[63] Unfortunately, there is a significant omission in the TIA courses. There is nothing in them about lockout procedures, beyond the use of wheel chocks, turning off the ignition and setting the park brake, if so equipped.

[64] There is extensive material about the safe use of jacks, but as the manuals themselves point out, jacks are only intended to lift vehicles.

[65] Yukon Tire based its vehicle immobilization procedures (and its training) on the TIA manuals. Yukon Tire also had a separate safety manual, but it is likewise, silent about lockout procedures.

[66] In their defence, Yukon Tire and Mr. Bubiak called Kevin Rohlwing who is a senior TIA employee with responsibility for developing its training programs. Perhaps not surprisingly, Mr. Rohlwing's opinion was that the TIA programs are the standard for the industry. However, even Mr. Rohlwing was candid enough to concede that the TIA manuals do not include lockout procedures for commercial vehicles. That said, he insisted that the procedures followed by Yukon Tire, such as they were, were standard tire industry practice. Specifically, he offered the opinion that the energy source is controlled when the ignition is turned off – even if the key is left in the switch.

[67] However, even Mr. Rohlwing's own report, filed as exhibit 72, refers to an informal survey he conducted, wherein he asked Kenworth truck dealers in his area what practices they followed when performing wheel and tire service on trucks. *All of them removed the keys.* Moreover, it developed during the course of cross-examination that Mr. Rohlwing himself had authored an article in 2012 entitled "Lockout, Tag Out and Get Out" urging the trucking industry to adopt lockout procedures in view of accidents involving workers being run over by trucks they were servicing. He wrote:

> …drivers are reluctant to give up their keys, but that is the only way that a technician can guarantee that someone doesn't jump in the cab and drive off while they are servicing the tires and brakes. It happened to me when I was a young technician, and I can tell you from first-hand experience that it scares the life out of you.

[68] Confronted with this, Mr. Rohlwing backpedalled, saying that this is now his view and that TIA, itself, is now considering changes, but he continued to insist that Yukon Tire's practices were industry standard in November 2011.

[69] I do not accept Mr. Rohlwing's evidence that simply switching the ignition off, but leaving the keys in the vehicle is sufficient from a safety perspective. Mr. Rohlwing at one point suggested that unexpected energization meant the vehicle somehow starting on its own. This is simply wrong and contrary to what Mr. Rohlwing, himself, stated in the article extracted above.

[70] Lockout procedures are designed so that the vehicle cannot be energized or moved when the technician working on it does not expect it. That is the true source of the danger, and the most likely way for the vehicle to become energized or to be moved unexpectedly is for another person to turn the ignition on.

[71] Leaving the ignition key in the vehicle presented a clear risk that it could be unexpectedly set in motion. That is so even though some additional steps are still necessary, as, for example, putting the vehicle in gear and releasing the parking brake.

[72] I also pause to note that Yukon Tire technicians were forbidden by company policy to move vehicles. Vehicles were moved by sales staff in an effort to keep the interiors clean. This policy was entirely well-intended; it was designed to keep the customer happy, but it increased the risk that vehicles could be moved when the technician did not expect it.

[73] At the end of the day, the employer did not have an effective (or any) lockout procedure in place as s. 3.04(1) of the *Occupational Health and Safety Regulations* requires.

[74] Cal Murdoch, who together with Mr. Bubiak owns Yukon Tire, was primarily responsible for policy development and training. He testified that he was not aware of the legal requirement to have such a policy, nor was he made aware of it during Occupational Health and Safety inspections prior to the accident.[2] Nevertheless, Yukon Tire, Mr. Murdoch and Mr. Bubiak are deemed to know the law. Yukon Tire did not have a lockout policy and has not shown that the vehicle immobilization procedures it used were sufficient to mitigate the reasonably foreseeable risk that vehicles could be put into motion unexpectedly:

> …Logically, an employer who has breached a specific positive obligation mandated by regulation must provide a compelling rationale to support a

[2] The date and scope of these inspections were not made clear in the evidence. There appear to have been two prior "walk-through" inspections, both some years prior to 2011.

> finding that it, nonetheless, took all reasonable care to ensure the safety of workers. (*R. v. Lonkar Well Testing Ltd*., 2009 ABQB 345, at para. 32)

[75] Count 4 also alleges a failure to train workers on the use of lockout procedures. The Director argued that, since the employer had no lockout policy, it follows that it is guilty of failing to train its workers in the use of those procedures. In the limited context of training related to lockout procedures, I agree.

> …The fact that there were no clear explicable rules may be evidence of a failure to train. How do you provide adequate training if there are no rules to follow… *(R. v. Rose's Well Services Ltd. (c.o.b. Dial Oilfield Services),* 2009 ABQB 1, at para. 227)

[76] In the result, I find Yukon Tire guilty on count 4.

[77] Count 5 alleges a failure by the employer to provide lockout procedures to its workers verbally and in writing.

[78] Since no lockout procedure existed, the failure to convey it to the workers logically follows. However, I view this count as containing substantially the same elements as count 4. Count 5 is, therefore, conditionally stayed.

[79] Count 6 charges Mr. Bubiak with a failure to adequately train a worker "in the safe operation and related work procedure of equipment to wit: a Kenworth truck."

[80] The charge, and section 1.06(a) of *the Occupational Health and Safety Regulations,* clearly relate to the *operation* of the truck. The phrase "related work procedure" can only mean procedures related to the operation of the truck. It was never intended that Mr. Chabot operate the truck, nor did he do so.

[81] Moreover, unlike counts 4 and 5, the allegation of training failure is quite general and not specific to lockout procedures, albeit, it can be argued that working safely around, and under a transport truck involves locking it out. However, the Director has not particularized the charge which, on its face, appears to deal with the operation of the truck, not its maintenance, and it would be unfair to find Mr. Bubiak liable for a specific (but unspecified) failure apparently unrelated to the operation of the truck. This is particularly so when Mr. Bubiak and Yukon Tire have been able to show that their training generally was conducted according to a program they reasonably believed was the industry gold standard. Count 6 is dismissed.

[82] I turn now to consider the charges against North 60 Petro Inc. and Mr. Taylor.

[83] Here the Director's allegations center on alleged failures to:

(1) properly train workers especially with respect to vehicle walk-arounds, (counts 10 and 13);

(2) ensure the driver of the truck, Mr. Lelievre, had demonstrated competence in operating the vehicle, (count 12); and

(3) ensure that, where the operator's view is obstructed, the truck not be moved until steps have been taken to protect the operator or other workers from injury (counts 11 and 14).

[84] In considering these allegations, it must first be noted that, prior to November 15, 2011, the company, under the direction of Trevor Piercey, who was then the Operations Manager, had made substantial efforts to improve its safety program. It is true that, unlike Yukon Tire, the impetus for the program was an earlier accident at North 60 Petro that resulted in an investigation and extensive orders from the Director requiring the employer to implement wholesale changes in its safety program.

Nonetheless, the improvements were made, they were significant, and the Director found that the orders had been complied with.

[85] It seems, however, that the incident on November 15, 2011 slipped through the cracks in the system. North 60 Petro had an extensive safety manual. That manual contained a policy requiring extensive pre-trip vehicle inspections and reports. It also required walk-arounds prior to each vehicle use.

[86] In this case, no walk-around was done. In the circumstances of this case, the first question that must be answered is: does it matter? As we have seen, contrary to what the Director initially supposed, Mr. Chabot was not working under the truck when Mr. Lelievre got into it. A walk-around would not have detected Mr. Chabot for the simple reason that he wasn't there.

[87] Nonetheless, I find that the failure to do a walk-around did contribute to the accident. Obviously, the failure is far less egregious than would be the case if Mr. Lelievre had failed to detect a man lying underneath the truck with his legs in plain view. Still, if Mr. Lelievre had done a proper walk-around, he would have seen the jacks and the torque wrench. This would have alerted him to the fact that the work was not yet complete. A walk-around is designed to detect obvious problems with the vehicle as well as any hazards that would result from its movement. It would have been particularly prudent to do one in this case, given that the vehicle had just undergone maintenance.

[88] Mr. Lelievre did not do a walk-around. Mr. Taylor watched Mr. Lelievre get into the truck, but didn't stop or correct him. The last chance to break the accident chain was lost.

[89] The answer to why this happened lies in the seemingly, trivial, mundane aspect of the task at hand. The truck was not starting out on a trip; it was simply being picked up and moved two or three blocks back to North 60 Petro's yard. That is why Mr. Lelievre, who was a dispatcher, not a driver, was asked to drive. That is why no one thought it important that Mr. Lelievre had never operated the truck before. That is why Mr. Lelievre didn't do a walk-around, although he knew he should. That is why Mr. Taylor didn't correct him.

[90] Count 10, 12 and 13 allege training failures. Mr. Lelievre himself stated he had received no training about doing walk-arounds. This may be unsurprising since Mr. Lelievre was not employed as a driver. Despite this, Mr. Lelievre admitted that he was aware of the policy and ought to have performed a walk-around. However, it is not a complete answer for the employer and supervisor to say that the employee was aware of the policy and chose to ignore it. As Mr. Piercey himself acknowledged, training and safety assurance go well beyond simply adopting policies and making employees aware of those policies.

[91] Training should include a hands-on component where employees demonstrate competence, and safety management includes monitoring and enforcement of safe work policies and practices. Proving reasonable care involves:

> …establishing a proper system to prevent the commission of the offence *and* by taking reasonable steps to ensure the effective operation of the system. (emphasis added) (*R. v. Sault Ste Marie,* at p.1331)

[92] As pointed out in *R. v. Altapro Cleaning & Disaster Restoration Ltd.,* 2004 ABPC 197, at para. 95:

> …due diligence entails "communicating adequate instructions of safety precautions to employees, either verbally, or in writing, *and following up to ensure that the instructions are carried out*". (emphasis added)

[93] In this case, the evidence led by North 60 Petro falls short of proving on balance that its training was complete. Nor does it show that it did all it reasonably could to enforce the walk-around policy. Rather the evidence goes the other way. The policy was not enforced, at least for local trips.

[94] Mr. Bubiak testified that when drivers picked up vehicles from his shop, some do a walk-around and some don't. The defendants would have me conclude from this that walk-arounds are not an industry standard practice. Rather, I conclude from this that there are a lot of drivers ignoring the most basic of safety practices.

[95] North 60 Petro and Mr. Taylor urged that they could not be convicted on counts 11 or 14 because those charges allege that they failed to ensure that precautions were taken to protect workers from injury before moving the truck "where a mobile equipment operator's view of the work place is obstructed". They say that the truck was to be driven ahead and the view in that direction was completely unobstructed. However, the work place around the truck includes the rear, the off-side and underneath. The view of those areas is obstructed. That is why the driver should do a walk-around.

[96] Finally, with respect to training, it might be said that Mr. Lelievre was not adequately trained to operate the truck. He had never driven it or even been inside it. The sum total of his instruction was a brief conversation with Mr. McPhail about how to operate the transmission. However, Mr. Lelievre's lack of training and experience in operating this particular truck was not a proximate cause of the accident.[3]

[97] In the result, I find that North 60 Petro and Mr. Taylor failed to adequately train their worker "in the safe operation and related safe work procedure" of the Kenworth truck. Safe operation and safe work procedures around transport trucks require a walk-around. Mr. Lelievre received no hands-on training in this regard and the requirement for walk-arounds was not effectively monitored or enforced.

[98] I find North 60 Petro Ltd. guilty on count 10 and Mr. Taylor guilty on count 13.

[99] Count 12, which deals with the failure to have Mr. Lelievre demonstrate competency, describes the same delict as count 10 and is conditionally stayed.

[100] Counts 11 and 14, the allegations of failure to take precautions before the truck was moved, appear, at first blush, to be separate and distinct from any claim of laxity in training and supervision, but I have already considered the failure to monitor Mr. Lelievre's actions and to correct them, as part and parcel of the failures alleged in counts 10 and 13 for which both employer and supervisor already stand convicted.

[101] Considering that, I direct that counts 11 and 14 also be conditionally stayed.

[3] Although one of the terrible ironies of this accident is that, if Mr. Lelievre had been familiar with the operation of the truck, he would have driven away sooner, probably before Mr. Chabot had a chance to get under it.

[102] There is one additional matter to be dealt with.

[103] As discussed, Yukon Tire maintained a series of surveillance cameras in its premises. Video recorded by these cameras proved to be extremely valuable in shedding light on what actually happened in this case. After the accident, Mr. Murdoch made a copy of the pertinent segments of the video recordings and provided it to the police. A further copy made by the police was used by Occupational Health and Safety investigators and the prosecution. For undetermined reasons, two segments from the original recording do not appear on the copies made by the police. One of the missing segments is of considerable importance as it reveals when Denis Chabot left the shop for the last time and thus establishes that he was not under the truck when Mr. Lelievre got into it.

[104] It is obvious that at least some of the defendants were aware of the discrepancy in the recordings long before trial. However, they took no steps to notify Occupational Health and Safety or the prosecution. Nothing obligated them to make such a disclosure, but it seems odd, if not unfortunate, that they did not do so. This information substantially alters the case and could have led, if not to a resolution then, at the least, to a more expeditious and focused trial.

[105] In the result, I find Yukon Tire Centre Inc. guilty on count 4. Counts 1, 2 and 3 are dismissed. Count 5 is conditionally stayed. All charges against Mr. Bubiak are dismissed.

[106] I find North 60 Petro Ltd. guilty on count 10 and Frank Taylor guilty on count 13.

Counts 11, 12 and 14 are conditionally stayed.

FAULKNER T.C.J.