

Court of Queen's Bench of Alberta

Citation: R v Precision Drilling Ltd, 2016 ABQB 518

Date: 20160916
Docket: 121375455S1
Registry: Grande Prairie

Between:

Her Majesty the Queen In Right of Alberta

Respondent

- and -

Precision Drilling

Appellant

**Memorandum of Decision
of the
Honourable Madam Justice J.B. Veit**

Summary

[1] Frazier Peterson, a floorhand employed by Precision Drilling, was killed as a result of blunt cranial trauma suffered during a “tripping out” procedure in the oilfield Mr. Peterson’s employer, Precision Drilling, was charged with, and convicted of, failing to ensure the health and safety of Mr. Peterson insofar as it was reasonably practicable to do so as required by s. 2(1)(a)(i) of the *Occupational Health and Safety Act* and failing to take measures to eliminate work hazards, or, if elimination is not reasonably practicable, to control the hazard as required by s. 9 of the *Occupational Health and Safety Code* 2009.

[2] Precision Drilling now appeals its convictions on the following grounds: the trial judge’s verdicts are not supported by the evidence, and, the trial judge committed a legal error by admitting and relying on post-offence conduct.

[3] The appeal is allowed; the trial verdicts are set aside.

[4] On count #1, the trial judge misapprehended the evidence. He made a palpable and overriding error when he found “the evidence is clear that an engineered solution was in place with other industry competitors”. That conclusion was contrary to the evidence: only one competitor had an engineered solution on one rig which was a different type of rig than the one on which Mr. Peterson was working. That palpable error was also overriding: the trial judge himself adopted the characterization of this issue as “crucial” to the case, as, indeed, it was, because of its effect on Precision’s due diligence defence. There was a constellation of additional errors, including the trial treatment of evidence relating to torque, which also undermined the trial judge’s verdict.

[5] Although, the trial judge committed no error of law in admitting Precision’s post-incident conduct into the trial, the trial judge’s use of that evidence was not supported by the evidence itself.

[6] On Count #2, the trial judge proceeded on the basis that the Crown had chosen not to make detailed allegations within that count, and applied his analysis on Count #1 to Count #2. Even if Count #2 required Precision to prove, on a balance of probabilities, that Precision had done what was reasonably practicable to control a hazard through the use of reasonably practicable engineering controls, administrative controls and a combination of engineering and administrative controls, the trial judge’s verdict on Count #2 was not supported by the evidence. For example, the trial judge did not consider the evidence that, post-accident, neither the government’s occupational health and safety branch nor the drilling industry adopted what the trial judge thought were necessary engineering and administrative procedures to remedy the hazards involved in tripping out.

[7] Finally, because there was admissible trial evidence on each of the elements of each of the charges, I order a new trial.

Cases and authority cited

[8] **By the appellant Precision Drilling:** *Occupational Health and Safety Code* 2009; **R v Lonkar Well Testing Ltd.**, 2009 ABQB 345 (CanLII); **R v Sunshine Village Corporation**, 2010 ABQB 493; **Housen v Nikolaisen**, [2002] 2 SCR 235; *Criminal Code*, RSC 1985, c C-46 at s. 686(1); **R v Burke**, [1996] 1 SCR 474; **R v Francois**, [1994] 2 SCR 827; **R v Sault Ste. Marie (City)**, [1978] 2 SCR 1299; **R v Courtaulds Fibres Canada**, [1992] Carswell 223, 9 CELR (NS) 304, 76 CCC (3d) 68; **R v Petro-Canada**, 2008 ONCJ 558; **R v CIC Foods Inc.**, 2004 CarswellSask 513; **R v Precision Drilling Ltd.**, 2015 ABPC 115; **R v Dana Canada Corp**, 2008 ONCJ 565; **Ontario (Ministry of Labour) v Linamar Holdings Inc. (c.o.b Transgear Manufacturing)**, 2012 ONCJ 295; **R v Sheppard**, 2002 SCC 26; **R v Precision**, 2015 ABPC, September 30, 2015; **R v Jolivet**, 2000 SCC 29; **R v Rio Algom Ltd.**, 1988 CarswellOnt 188; **R v Value Drug Mart Associates Ltd.**, 2014 ABPC 164; **R v Rose’s Well Services Ltd. (Dial Oilfield Services)**, 2009 ABQB 1; **R v Yebes**, [1987] 2 SCR 168.

[9] **By the respondent Crown:** **R v Burns**, 1994 CarswellBC 576; **R v Rempel**, 2015 ABCA 96, 2015 CarswellAlta 360; **R v Clark**, 2005 SCC 2, 2005 CarswellBC 137; **R v Khan**, 2001 SCC 86, 2001 CarswellMan 578; **R v Sault Ste Marie (City)**, 1978 CarswellOnt 24; **R v General Scrap Iron & Metals Ltd.**, 2002 ABQB 655, 2002 CarswellAlta 869; *Occupational Health and Safety Code*, ss. 7-9; **R v Reid & DeLeye Contractors Ltd.**, 2008 CarswellOnt 7663; **R v Moffit**, 2015 ONCA 412, 2015 CarswellOnt 8675; **Sandhu (Litigation Guardian of) v Wellington Place Apartments**, 2008 ONCA 215, 2008 CarswellOnt 1694; **Prosser v 20 Vic**

Management Inc., 2009 ABQB 177, 2009 CarswellAlta 939; *Aitken v Regina (City)*, 1987 CarswellSask 546; *Aitken v Regina (City)*, 1988 CarswellSask 572; *R v Locke*, 2015 MBCA 73, 2015 CarswellMan 394; *R v Gordon*, 2016 SKCA 58, 2016 CarswellSask 259; *R v Von Maldeghem*, 2005 ABQB 558, 2005 CarswellAlta 1017; *R v MacNeil*, 2009 NSCA 46, 2009 CarswellNS 264.

[10] **By the court:** *Waxman v Waxman* 2004 CanLII 39040; *Fullowka v Pinkerton's of Canada Ltd.* 2010 SCC 5; *R. v St. John's (City)* 2016 NLTD(G) 81; *White Burgess Langille Inman v Abbott and Haliburton Co.* 2015 SCC 23; *R. v. Timminco Ltd./Timminco Ltée* 54 O.R. (3d) 21, [2001] O.J. No. 1443; *Fontaine v British Columbia (Official Administrator)* [1998] 1 SCR 424; *R. v Villaroman* 2016 SCC 33; *R. v Roy* 2012 SCC 26; *Canada v. Saskatchewan Wheat Pool* [1983] 1 S.C.R. 205; *R. v Wholesale Travel Group* [1991] 3 S.C.R. 154

Appendix A: Extract from the trial evidence of Adam Brookes, the only person who was on the rig floor at the time of the incident

1. Background

a) Factual

[11] The accused are a group of entities, Precision Drilling Canada Limited Partnership, Precision Diversified Oilfield Services Corp., Precision Drilling Corporation, and Precision Diversified Oilfield Services Corp and Precision Drilling Corporation operating as Precision Drilling, a Division of Precision Drilling Canada Limited Partnership. Hereafter, all accused will be referred to as Precision Drilling.

[12] All of the basic elements relating to the prosecution - employment relationship, legal responsibility in a limited partnership situation, work site, geographic jurisdiction, and nature of the drilling rig - are the subject of an agreed statement of facts.

[13] Precision Drilling was drilling a well for Novus Energy some 30 kms from Grande Prairie. The particular drilling rig being used, Rig 212, was a telescopic double, conventional, rig. i.e. one with a conventional rotary table mechanism to turn the drill pipe, at the end of which was a drill bit. Historically, rigs of this design created vertical wellbores. Over time, equipment – including mud motors - allowed these conventional rigs to drill directionally, i.e. to deviate wellbores so that a wellbore could be angled slowly to become parallel to the ground surface, or horizontal. The fact that Rig 212's wellbore was in a lazy S formation rather than a straight vertical formation is potentially important on the issue of types of torque.

[14] On December 12, 2010, the rig's crew was "tripping out", that is, it was removing the pipe from a 2,416 meter S-curved well hole. The average length of each pipe making up the drillstring was 9.3 meters; two lengths of pipe were removed from the hole at one time. On December 12, 2010, at about the time of the incident the drillstring weighed 82,000 dekanewtons. Present at the rig were the rig manager or tool push, and the consultant who were in the drilling shack; the driller, derrickhand, motorman, and two floorhands were on the rig floor. One of the floorhands, Frazier Peterson, was severely injured from blunt cranial trauma he suffered during the tripping out procedure; Mr. Peterson died the next day on December 13, 2010. It is that tragedy which is the subject of these proceedings.

[15] The motorman on the rig on December 12, 2010 was Adrian Brookes. At the time, Mr. Brookes had two or two and a half years' experience on drilling rigs as a motorman and a

floorhand; he had never been a driller. The fact that the trial judge described him as a floorhand, rather than a motorman, on the date in question is not material. Approximately 4 years after the accident, on November 25, 2014, Mr. Brookes gave trial evidence which is excerpted at Appendix A. Mr. Brookes is the only person who was on the rig at the time of the incident who gave evidence at trial. At the time of the accident, Mr. Brookes was standing in a position where he couldn't see Mr. Peterson. Mr. Brookes has no memory of what the driller did or said at the time of the accident.

[16] There was no evidence at trial from anyone about how Mr. Peterson was injured; no witness saw any contact of any part of any drilling equipment with Mr. Peterson. It is evident that some part of the drilling equipment struck Mr. Peterson when torque from the drillstring was released, but it is not known, for example, if it was the pipe assembly itself or some part of the overhead assembly of elevators and bails which struck Mr. Peterson. Mr. Peterson's hard hat was not damaged in the incident.

[17] During the overall tripping out procedure - or removal of pipe from the wellbore – taking place immediately prior to the incident in question on December 12, there had been 11 previous instances where sections of pipe had been removed from the drillstring under Rig 212 and these instances showed a consistent pattern that was repeated on the removal which caused the accident.

[18] An Occupational Health and Safety inspector attended at the wellsite on December 12 after the accident and issued an oral stop work order; the oral order was confirmed in writing on December 13, 2010. The stop work order applied only to the one Precision rig on which the accident had occurred, not to all Precision rigs. On December 13, 2010, after Precision had provided a Critical Operating Procedure, COP, document to the inspector, the stop work order was orally lifted; the oral lifting of the stop work order was subsequently confirmed in writing.

During the investigation of the accident, it was learned by the occupational health investigators, and through them by Precision, that another drilling company – referred to as Savannah - had a device on one of its rigs which was not a rig of the same type as Rig 212. No one from Savannah gave evidence at the trial about what its device was intended to do, what it did do and what it didn't do. The evidence at trial was that, at the time of the accident with which we are concerned, the device that was used by Savannah was not mandated by any regulation or promoted by any industry standard.

[19] After December 12, Precision developed an interlock device which it put on all of its rigs. The device took a few hours to develop and approximately \$800.00 to install on each rig.

[20] Between the development and installation by Precision of its interlock device and the trial, the use of an interlock device was not made mandatory by government regulation or adopted by the industry as an operating standard.

[21] The trial evidence of the Crown's expert included:

Q. . . . what was your presumption of the cause of this accident?

A. . . . I was able to ascertain that there was trapped torque in the string prior to the point where the string was pulled out of the well. I can only surmise that this torque is put in there because the rotary table is turned to the right while you're spinning the Kelly off, and that is my understanding.

....

Q. Based on the evidence of Mr. Brookes, what is your conclusion?

A. My conclusion is that the only way that this torque could have been there at the time of the incident is it was trapped because the brake, table brake, was engaged. Had it been disengaged, I don't believe the incident would have occurred. (A.B. p. 258 lines 12-22 and p. 259 Lines 31-38).

b) *Procedural*

[22] As a result of the accident, Precision Drilling was charged with two offences, one under s. 2(1) of the *Occupational Health and Safety Act*, and the other under s. 9(1) of the *Occupational Health and Safety Code*.

[23] Section 2(1)(a)(i) of the Act reads as follows:

Obligations of employers, workers, etc.

2(1) Every employer shall ensure, as far as it is reasonably practicable for the employer to do so,

(a) the health and safety of

(i) workers engaged in the work of that employer

[24] Alberta Regulation 87/2009, passed under the *Occupational Health and Safety Act*, adopts the *Occupational Health and Safety Code 2009* as passed by the Occupational Health and Safety Council on February 9, 2009. That *Code* includes the following provision:

Hazard elimination and control

9(1) If an existing or potential hazard to workers is identified during a hazard assessment, an employer must take measures in accordance with this section to

(a) eliminate the hazards, or

(b) if elimination is not reasonably practicable, control the hazard.

9(2) If reasonably practicable, an employer must eliminate or control a hazard through the use of engineering controls.

9(3) If a hazard cannot be eliminated or controlled under subsection (2), the employer must use administrative controls that control the hazard to a level as low as reasonably achievable.

9(4) If the hazard cannot be eliminated or controlled under subsections (2) or (3), the employer must ensure that the appropriate personal protective equipment is used by workers affected by the hazard.

9(5) If the hazard cannot be eliminated or controlled under subsections (2), (3) or (4), the employer may use a combination of engineering controls, administrative controls or personal protective equipment if there is a greater level of worker safety because a combination is used.

[25] The trial judge convicted Precision of both offences, and imposed a total fine of \$400,000.00. The trial judge's reasons for conviction are reported: 2015 ABPC 115.

[26] During the trial, the judge allowed evidence of Precision's post-incident modifications to its drilling console to be entered as trial evidence. In support of his position, the trial judge declined to follow *CIC Foods Inc.* stating:

In a criminal proceeding any relevant evidence is admissible unless excluded pursuant to one of the exclusionary rules, which themselves have now become dim with the passage of time, or a Charter breach. To be relevant, the probative value of evidence must exceed the prejudicial effect. I am of the view that the modern Occupational Health and Safety Codes require a much broader view of the facts than that participated in the CIC decision, which I decline to follow. Where one is dealing with a strict liability offence, evidence of subsequent repair or remediation is circumstantially relevant to whether the accused exercised due diligence. Subsequent repair or remediation does not, in and of itself, prove that the pre-remediation status was in any way negligent or substandard.

At the end of the day, the evidence of subsequent repair or remediation will have to be weighed along with all other admissible evidence to determine whether in fact the case is made out. (A.B. p. 50, lines 15-27)

[27] The driller on the rig at the time in question was not called as a witness at the trial. This is the trial judge's assessment of the absence of that evidence:

Where is the Driller?

29 The Crown proceeded without the driller as a witness. The Crown's information was the driller could not be subpoenaed as he was working in the USA. I was told no more than that. The driller was central to what actually happened. The primary fault is said to rest with him. Did he put on the rotary table brake? Did he forget to take it off? Did he give his floorhand an "all clear" erroneously? None of these questions can be answered except by reference to other evidence because he was not present as a witness.

30 In a purely criminal prosecution the inferences from not having a key witness may well be different than for this type of regulatory strict-liability offence.

31 No-one told me whether the driller works for the Defendant in its international operations. From the written material he still clearly worked for the Defendant on June 20, 2012 (Exhibit 8, Tab 3) and presumably on October, 2013 (Exhibit 8, Tab 16) since the Defendant was still tracking his certifications.

32 The failure to hear from this witness on this type of regulatory offence works against the Defendant. Although the Crown has satisfied me as to what happened, they need not prove with precision what exact mechanical cause brought about Mr. Peterson's death. The Crown must satisfy me beyond a reasonable doubt only that the deceased was an employee under the company's control and was killed on the job. This would require the Defendant to show on balance that it was duly diligent. The Crown have in fact satisfied me beyond a reasonable doubt that Mr. Peterson was killed by torque released improperly by the driller.

33 Here if the Defence was to show on balance that some other and unpredicted release of non-table torque was the cause of the incident then it was the Defence that needed the Driller much more than the Crown.

2. Standard of review

[28] The parties agree on the standard of review for this appeal, and I agree with them.

[29] Section 686(1)(a) of the *Criminal Code* authorizes an appeal court to allow an appeal where the verdict is unreasonable or unsupported by the evidence, where there has been an error on a question of law, or where there has been a miscarriage of justice.

[30] These principles can be expanded upon:

- although an appeal court may review, re-weigh and re-examine the evidence with a view to determining if the evidence is reasonably capable of supporting the trial judge's conclusion, the appeal court must not substitute its view of the evidence for that of the trial judge;
- findings of fact must not be interfered with unless there is a palpable and overriding error;
- any misapprehension of evidence will only warrant appellate intervention as a miscarriage of justice if the misapprehension goes to the substance of the decision;
- findings of mixed fact and law are to be accorded deference and not overturned absent palpable and overriding error unless an extricable error of law has been made;
- findings of law can only be interfered with if the findings are incorrect. Even then, an appeal court may dismiss an appeal if the incorrect finding of law is harmless, or the evidence is so overwhelming that any verdict other than a conviction would be impossible;
- inadequate trial reasons can only justify an appeal if they are unintelligible and provide no basis for meaningful appellate review.

[31] As to the meaning of "palpable and overriding error", the Ontario Court of Appeal said the following in *Waxman*:

296 The "palpable and overriding" standard addresses both the nature of the factual error and its impact on the result. A "palpable" error is one that is obvious, plain to see or clear: *Housen* at 246. Examples of "palpable" factual errors include findings made in the complete absence of evidence, findings made in conflict with accepted evidence, findings based on a misapprehension of evidence and findings of fact drawn from primary facts that are the result of speculation rather than inference.

297 An "overriding" error is an error that is sufficiently significant to vitiate the challenged finding of fact. Where the challenged finding of fact is based on a constellation of findings, the conclusion that one or more of those findings is founded on a "palpable" error does not automatically mean that the error is also "overriding". The appellant must demonstrate that the error goes to the root of the challenged finding of fact such that the fact cannot safely stand in the face of that error: *Schwartz v. Canada*, [1996] 1 S.C.R. 254 at 281.

[32] It follows from the foregoing that, although a trial judge's findings of fact attract considerable deference, they are not absolutely protected from review.

3. Count # 1

[33] For the reasons that follow, I have concluded that Precision's appeal is allowed and the conviction is set aside.

[34] Although I will set out hereunder my analysis of the constellation of errors in the trial judgment, the most important reason for my conclusion is that the trial judge made a palpable and overriding error when he found that Precision's industry competitors had adopted an interlock device. This finding was contrary to the evidence and, because of its effect on the due diligence defence, that finding had an overriding effect on the trial judge's assessment of the defence position.

[35] The first count against Precision is:

On or about the 12th day of December, 2010, at or near Grande Prairie in the Province of Alberta, being an employer, did fail to ensure, as far as it was reasonably practicable to do so, the health and safety of Frazier Peterson, a worker engaged in the work of that employer, contrary to section 2(1)(A)(1) of the *Occupational Health and Safety Act*, R.S.A. 2000, Chapter O-2, as amended.

[36] Particulars of the offence were neither requested nor provided.

[37] In assessing the evidence, it is important to note that the witnesses were testifying approximately 3 1/2 years after the accident occurred; therefore, it is not surprising that they had poor memories of the day of the accident. It is also important to note that the trial judge heard many days of technical evidence; therefore, it is not surprising that an appeal court, with transcripts of all of the material, has an advantage over the trial judge in assessing the evidence.

[38] In reviewing the trial judge's verdict in relation to the evidence, I will examine three areas: A - the initial error in finding that the *actus reus* was made out by proof of the accident itself; B - the errors made in assessing the evidence, particularly in relation to industry standards and the concept of torque; and, C- the errors made in concluding that the accused had not made out, on a balance of probabilities, that it had done what was reasonably practicable to avoid the death of Mr. Peterson.

A: *The trial judge erred in concluding that the offence was imported by the facts proved at trial*

[39] It is true, of course, that the Occupational Health and Safety charge with which we are concerned is a strict liability offence. The nature of such an offence was identified by the Supreme Court of Canada in *Sault Ste Marie*:

I conclude, for the reasons which I have sought to express, that there are compelling grounds for the recognition of three categories of offences rather than the traditional two:

1. Offences in which *mens rea*, consisting of some positive state of mind such as intent, knowledge, or recklessness, must be proved by the prosecution either as an inference from the nature of the act committed, or by additional evidence.
2. Offences in which there is no necessity for the prosecution to prove the existence of *mens rea*; the doing of the prohibited act *prima facie* imports the offence, leaving it open to the accused to avoid liability by proving that he took all reasonable care. This involves consideration of what a reasonable man would

have done in the circumstances. The defence will be available if the accused reasonably believed in a mistaken set of facts which, if true, would render the act or omission innocent, or if he took all reasonable steps to avoid the particular event. These offences may properly be called offences of strict liability. Mr. Justice Estey so referred to them in Hickey's case.

3. Offences of absolute liability where it is not open to the accused to exculpate himself by showing that he was free of fault.

[Emphasis added]

[40] As can be seen from this outline, all the Crown must prove in this type of offence is the *actus reus*, or the doing of the prohibited act; it does not have to prove that the accused had *mens rea*, or evil intention, or knowledge of wrongfulness or reckless disregard of consequences, or any other subjective fault element. Despite being relieved of the obligation of proving subjective fault, the Crown must prove that the accused did a prohibited act. When dealing with workplace accidents, sometimes proof of the consequence adequately establishes that a wrongful act was committed: for example, if a worker falls through a hole in the floor, or falls off a platform because there was no guardrail, or falls off a roof because the employer didn't provide a safety harness, a court is entitled to conclude that the Crown has proved the necessary *actus reus* - that the employer committed a wrongful act - which puts the accused to a due diligence defence.

[41] Precision does not rely on causation. I do not take that to mean, however, that Precision accepts that, by proving that Mr. Peterson died as a result of the tripping out process in which he was engaged, the Crown has proved that Precision has, *prima facie*, committed the offence.

[42] In the circumstances here, even though no third party was involved, I adopt the analysis made by Orsborn C.J. in *St. John's (City)* as being applicable here:

31 The authorities noted by the trial judge all dealt with incidents involving only the actions or failures of employers. For example, in *Concord Paving* a Concord employee was killed by an excavator being operated by another Concord employee and it was alleged that Concord did not have sufficient flagpersons monitoring the activity. Control of the number of flagpersons was clearly in the hands of the employer charged. And in *R. v. Rose's Well Services Ltd. (c.o.b. Dial Oilfield Services)*, 2009 ABQB 1, (referred to in *Concord Paving*) an explosion injured two workers while they were unloading petroleum. No third party activity was involved. In this context, Graesser, J. said at paragraphs 68-69:

68. In this regard, I am in general agreement with the position taken by the Crown: that to establish the *actus reus* of the general duty offence, the Crown may in some cases stop at the facts of the incident - the accident itself - as proof of the *actus reus*.

69 This position adopts the "accident as *prima facie* breach" concept, which I endorse.

32 I note Graesser, J's reference to "in some cases" and the reference to the application of the 'prima facie breach' approach to the general duty provision -- the equivalent of s. 4 of the provincial Act, not charged in the present case.

33 I agree that, in some circumstances, and depending on the specific offence in question, a workplace accident may, in and of itself, provide evidence of a breach of the offence and that such evidence may be sufficient to amount to proof of the actus reus so as to shift to the employer the burden of proving due diligence. A good illustration of this is *R. v. Seeley & Arnill Aggregates Ltd.*, [1993] O.J. No. 443 (Gen. Div.) -- mentioned at paragraph 72 of *Rose's Well Services*. An employee fell 40 feet to his death from a platform. The offence provision required the wearing of a safety belt if exposed to a hazard of falling more than three metres. The worker was not wearing safety equipment. Logan, J. concluded that proof of a fall of more than three metres was prima facie proof of the worker's failure to wear a safety belt, regardless of what caused the fall. But it is also clear from the judge's earlier references to "the doing of the prohibited act" that the offence -- the absence of a safety belt -- would have been completed even without the fall.

34 Thus while in some circumstances an accident may provide some evidence of the actus reus of an offence, this is simply a matter of common sense and circumstantial evidence. It is not a rule of law. It is of course true, as it was in this case, that an accident or incident may well provide the impetus for an investigation and the laying of charges, but the accident does not thereby become an element of the offence in question.

[Emphasis added]

[43] Even though this case involves an alleged action or failure of an employer, because there is no clear cause for Mr. Peterson's fatal injuries – except of course his contact with rig machinery – there is an insufficient factual foundation to establish an apparent breach of duty by the employer.

[44] As to there being no clear cause of the injuries, I note the evidence that Mr. Peterson's hard hat was not damaged and that the location of the injuries on his head is inconsistent with the usual position he would be in to remove slips. Given that evidence, and the evidence about the number of previous times when this tripping out procedure was carried out without incident, it was necessary for the trial judge to address the evidence to determine whether the prosecution has proved the *actus reus* by simply relying on the accident itself.

[45] The case law which speaks of the "accident as prima facie breach concept" is, at least to some extent, based on the reasoning of the Ontario Court of Appeal in *Timminco Ltd.* It is important to remind ourselves that, in that case, the Crown had proved more than the fact that the employee was injured while working in an area controlled by the employer. The court noted these three pre-requisites to the finding that the Crown had proved the *actus reus* had been met in that case:

2. *The proper interpretation of R. v. Grant Paving*

[29] In my opinion, in order to establish the actus reus of the offence charged, the Crown was required to lead some evidence:

-- that Timminco was Mr. Roesler's employer;

-- that Timminco had a "machine" (the press) with an exposed moving part that may endanger the safety of any person; and

-- that the exposed moving part was not "fenced or guarded", or constructed in such a way that would provide equivalent protection

[46] Here the Crown has proved that Precision was Mr. Peterson's employer and that the drilling rig had the capacity to endanger the safety of any person. What is missing from the Crown's case here is the indication that the employer, Precision, committed any wrongful act.

[47] As Graesser J., upon whose decision the Crown relies, stated in *Rose's Well Services Ltd.* this approach is appropriate in some circumstances: "the Crown may in some cases stop at the facts of the incident - the accident itself - as proof of the actus reus." Just as did Orsborn C.J., I also agree with Graesser J.: there are some cases in which a wrongful act can be inferred but there are others in which a fair inference cannot be drawn.

[48] In *Fontaine*, the Supreme Court of Canada discouraged analysis based on *res ipsa loquitur*:

Since various attempts to apply *res ipsa loquitur* have been more confusing than helpful, the law is better served if the maxim is treated as expired and no longer a separate component in negligence actions. Its use had been restricted to cases where the facts permitted an inference of negligence and there was no other reasonable explanation for the accident. The circumstantial evidence that the maxim attempted to deal with is more sensibly dealt with by the trier of fact, who should weigh the circumstantial evidence with the direct evidence, if any, to determine whether the plaintiff has established on a balance of probabilities a prima facie case of negligence against the defendant. If such a case is established, the plaintiff will succeed unless the defendant presents evidence negating that of the plaintiff. (from the head-note)

[49] The trial judge's reference to *res ipsa loquitur* at para. 57 of his decision repeats an extract from a 1974 text which preceded the decision of the Supreme Court of Canada. In any event, however, as the Supreme Court pointed out, even in its confusing form, the maxim required that "there was no other reasonable explanation for the accident" than negligence on the part of the employer. The trial judge did not carry out that analysis.

[50] The Supreme Court of Canada has, very recently, refreshed our understanding of the use of circumstantial evidence: *Villaroman*. The trial judge would not, of course, have had access to that decision.

[51] In summary on this point, even in civil matters, trial courts are encouraged to assess the specific circumstantial and direct evidence of a case rather than on general principles – see *Fontaine*; it is all the more important to do so in a quasi-criminal context such as this one.

- i) *In the circumstances here, the trial judge's error about the establishing of the actus reus led to an error in dealing with the absence of evidence from the driller*

[52] The trial judge addressed the issue of the absence of evidence from the driller. This absence is, of course, noteworthy since the theory of the Crown's case – although it was not required to prove its theory as it would have been required to prove any particulars specified – was that Mr. Peterson died as a result of an error committed by the driller. The driller was not charged with any offence.

[53] The trial judge appears to have acknowledged that there was no satisfactory explanation by the Crown of its failure to call the driller. The driller was apparently still in the employ of Precision and the trial took place approximately four years after the incident. While it is true that the Crown could not subpoena the driller in the United States, there was absolutely no information whatever provided to the trial judge about whether the driller had been approached to voluntarily come back to Alberta to testify, whether other trial dates could have been chosen that would have accommodated the driller's Alberta work schedule, whether this was a situation in which sworn or affirmed viva voce evidence with the possibility of cross-examination could have been achieved by electronic means, etc.

[54] However, the trial judge concluded his assessment of the driller's absence in this way:

32 The failure to hear from this witness on this type of regulatory offence works against the Defendant. Although the Crown has satisfied me as to what happened, they need not prove with precision what exact mechanical cause brought about Mr. Peterson's death. The Crown must satisfy me beyond a reasonable doubt only that the deceased was an employee under the company's control and was killed on the job. This would require the Defendant to show on balance that it was duly diligent. The Crown have in fact satisfied me beyond a reasonable doubt that Mr. Peterson was killed by torque released improperly by the driller.

33 Here if the Defence was to show on balance that some other and unpredicted release of non-table torque was the cause of the incident then it was the Defence that needed the Driller much more than the Crown.

[55] With respect, I disagree with the appellant's contention that an adverse inference should be made against the Crown because of its failure to call the driller: there are very few situations in which an adverse inference can properly be made against the Crown as a result of failing to call certain evidence. However, if the Crown fails to call certain evidence, it may fail to meet the requirement that it has proved the *actus reus*.

B: If I were wrong in concluding that the accused should not have been put to a defence, then, the verdict of the trial judge was speculative and unsupported by the evidence

[56] Acknowledging that I could be in error in concluding that the Crown did not prove the *actus reus* of Count #1, I then turn to the situation that exists assuming that the Crown did prove the *actus reus*, i.e. that the fact of the accident proved that Precision breached its duty to keep Mr. Peterson safe, Precision was then required to prove, on a balance of probabilities, that it had shown due diligence in preventing accidents during the "tripping out" operation.

[57] The trial judge made the following fact findings:

6 Much of the argument focuses on what the Crown must prove pertaining to the actual *actus reus* of the event. Some of this controversy may be quieted by my factual findings as follows. I am satisfied beyond a reasonable doubt that the accident was caused by:

1. The Driller using the Rotary Table to spin off a connection, followed by;
2. The Driller setting the Rotary Table brake "on" and forgetting to feather out the torque he induced into the drill stem during # 1;

3. The Driller then attempted to lift the drill stem, at the same time as the two floorhands stooped and reached to remove the slips;
4. The trapped torque was released by the Driller lifting the drill stem allowing the whole drill stem and attachments to uncontrollably spin;
5. The lifting hardware (elevator/bales) spun with drill the stem contacting Mr. Peterson's head, ultimately causing the fatal injury.

[58] For the two reasons which follow, I have concluded that the trial judge's conclusions were cumulative and unsupported by the evidence.

i) *Inadequate evidence of how the accident happened*

[59] First, the only evidence of how the accident actually occurred is weak: the floorhand Brookes, who was the only person on the rig floor at the time of the accident, was replete with comments to the effect that he didn't remember specifics of the incident: see Appendix A. This was understandable as the accident has occurred such a long time prior to the day on which Mr. Brookes gave his evidence.

[60] Also, it is to be noted that Mr. Brookes was on the opposite side of the drillstring from Mr. Peterson. His view of what was happening would therefore be obscured.

[61] There was no other evidence about how the accident actually happened.

[62] There was no evidence of connection of the elevators or bails with Mr. Peterson.

ii) *Inadequate assessment of torque in a directional well*

[63] Second, the Crown emphasized the role of trapped table torque in the accident. This was important because the interlock system, which was introduced after the accident, did not deal with torque other than trapped table torque.

[64] Torque itself was explained by many witnesses. The Crown expert explained torque in this way:

In a vertical well . . . when a well is being drilled . . . the bit on the bottom creates resistance . . . while the table is turning the pipe . . . (p. 247 lines 27-29)

In other words, torque is what happens when there is resistance against turning.

[65] The trial judge did not accept that there could be trapped torque other than trapped table torque, i.e. the torque generated as described above as one type of resistance. Despite the evidence to the contrary, the trial judge concluded trapped table torque was the only credible explanation for trapped torque: see paras. 41 and 42 of his decision.

[66] The trial judge noted that neither the Crown's expert, nor the defence expert, was qualified on the issue of torque: see para. 36. One can only assume, therefore, that the trial judge was making a personal assessment of the evidence of torque given by the Crown witnesses and by defence witnesses. However, his basis for doing so is not made clear in his reasons.

[67] The trial judge gave inadequate reasons for rejecting the evidence that established that there were other types of torque than table torque.

[68] The Crown's witness, Mr. Brookes, whose evidence both the Crown expert and the trial judge appear to have accepted, agrees that - even in his limited experience - there were other types of torque:

Q So you would still have torque, even if it had been feathered out?

A Not necessarily, no.

Q But on occasion?

A. On the occasion, yeah, but for the most part, ninety -- 99 percent of the time once it's feathered out, it's released, there's nothing left in there.

[69] That evidence from Mr. Brookes sounds remarkably like the evidence of defence witness Mr. Lundstrom, whose evidence the trial judge quoted in para. 35 of his decision, but rejected:

Q And how would that relate to the -- say, releasing the rotary brake?

A Well, the releasing of the rotary brake may release torque, but it may not release all the torque. So you could put three turns in, you may get three turns back, you may only get one back, and which you don't know down the well is if that the torque has been fully released or it's captured in another part of the wellbore.

So when you go to pull out of the slips, or pull out of the pipe and you start pulling that pipe, that the table may be stationary but as it's pulling there could be torque that would come out.

[70] Part of the reason given by the trial judge for not accepting evidence of the Crown witness Svandrlik was that Mr. Svandrlik was cross-examined in a way which resulted in "highly self-serving answers". However, the fact is that the Crown called Mr. Svandrlik as its witness, and, as the judge himself pointed out, the Crown did not ask to have Mr. Svandrlik dealt with as a hostile witness; in other words, although Svandrlik was an employee of Precision's, he was not hostile to the Crown.

[71] The trial judge specifically rejected the evidence of Dan Lundstrom: para. 28.; he never gave reasons for rejecting that evidence. In relation to the evidence of both Svandrlik and Lundstrom, but perhaps especially in relation to Svandrlik because that witness had been called by the Crown, the trial judge should have alluded to the conclusion of the Supreme Court of Canada in *White Burgess* that the mere fact of employment by a litigant does not make a witness' evidence suspect: "In most cases, a mere employment relationship with the party calling the evidence will be insufficient to do so.": see para. 49. In the situation here, the trial judge was required to do more than to rely merely on the employment relationship to discredit a witness.

[72] In addition to the problems created by rejecting the evidence that there could be trapped torque other than trapped table torque virtually without explanation, the trial judge also accepted that the accident occurred because of trapped table torque on the basis of evidence that was weak: the Crown's expert witness Mr. Romanyk, never worked as a driller and never worked on a directional rig. Therefore, when Mr. Romanyk's evidence about torque conflicts with that of other witnesses, who had experience with directional drilling, the trial judge should have given reasons about why he preferred the evidence of the Crown expert. Indeed, in addition to his lack of experience in directional drilling and his lack of expertise on torque, the Crown's expert also appears to have had trial reservations about the early Pason data on which he had relied for his opinion: A.B. p. 293, line 36. Moreover, the expert's evidence at that point – see lines 39-40 -

appears to suggest that there is torque in the drillstring arising from sources other than trapped table torque:

It doesn't make sense to me how I can have weight on the bit, when I'm nowhere near the bottom of the hole.

In other words, it is necessary for a trial judge to make sense of that expert evidence: torque arises when the bit is on the bottom, when the bit is off the bottom, there should be no torque, but now there is torque even when the bit is not on the bottom, how come?

[73] In any event, using the essence of the Crown's expert witness' opinion about torque, anyone would understand that resistance while drilling could be caused, not only by the bit on the bottom, but by contact with the wellbore, especially when the wellbore was in a lazy S formation. In other words, the evidence of the other witnesses about the creation of torque other than by the table being turned is actually confirmed by the opinion of the Crown's expert. In addition to contact with the wellbore, there was evidence that torque could be created in other ways; for example, the rig manager indicated that a mud motor can cause torque (p. 171 A.B. lines 11, 12.) in addition to torque being caused when the driller rotates the table (p. 149 A.B. lines 12-14). See also pp. 188-189 line 1 to line 13. All of that evidence had to be assessed in order to determine what the torque situation was at the time of the accident.

[74] Finally, the trial judge's comment at para. 43 of his decision, that Precision would have to answer "for how a force so powerful could be so poorly understood let alone managed", does not assist in analyzing the evidence that was actually heard during the trial.

[75] A trial judge is, of course, entitled to give more weight to the evidence of one witness than to the evidence of others, to accept the evidence of one witness and not that of others, or even, within one witness' evidence, to accept some and to reject some. Nonetheless, a trial judge must explain to a litigant why the evidence – here from both Crown and defence witnesses – has not been accepted. Precision has no such explanation from the trial judge and neither has this court.

C. *Errors in assessing what was "reasonably practicable"*

[76] Finally, in dealing with Count #1, I have concluded that the trial judge erred in concluding that Precision had not discharged the burden of proving that it had done what was reasonably practicable to avoid the death of Mr. Peterson.

[77] A trial judge has to identify the appropriate standard of care in the particular situation which is being assessed. It will be rare that a trial judge can do this in a technical field without reliance on expert evidence, and rarer still that a trial judge can impose their own standard of care on an industry. As the Supreme Court of Canada stated in *Fullowka*:

80 With respect to the law, my view is that the trial judge erred by failing to articulate the standard of care to which Pinkerton's was to be held. Although the trial judge acknowledged that Pinkerton's was not an insurer of the mine's safety (para. 752), he nonetheless found that it had failed to ensure that the entrances were properly guarded to avoid incursions (para. 764). This statement is problematic in two respects. To the extent that the trial judge required Pinkerton's to ensure there was no clandestine access to the mine, he imposed an absolute duty, not a duty of reasonable care. Moreover, the trial

judge does not indicate what "properly" guarding the entrances required Pinkerton's to do. Lacking in the trial judge's reasons is any articulation of what constituted reasonable care on Pinkerton's part given the limitation of resources imposed by its contract with the mine owner and Mr. Warren's determination to commit an intentional, criminal act.

i) *Compliance with industry standards*

[78] The trial judge correctly stated that compliance with industry standards and legislation does not, of itself, establish that reasonable care was taken by Precision to safeguard Mr. Peterson: see, for example, Watson J's., as he then was, comments at para. 83 *General Scrap Iron & Metals*. Nonetheless, as Graesser J. put it in *Rose's Well Service*, "Generally, following industry standards would be evidence of due diligence.": para. 217.

[79] Therefore, where, as here, the evidence is that the accused followed industry standards, the setting by a trial judge of standards higher than industry compliance requires assessment, especially where there is no expert evidence on the issue. Here, the trial judge made no assessment of industry standards and legislation. In my respectful view, this was an error. The evidence here set out an overall situation in which there were not only industry standards, but there was a Code which had been legislated by Regulation. The evidence also established that the legislated Code was the subject of ongoing review not only by industry participants, but also by government representatives. Indeed, the evidence here establishes, through the very actions of the Occupational Health and Safety officers, how closely and highly regulated the drilling industry is and was at the time of the accident.

[80] The trial evidence established that Precision met all industry standards and legislative requirements.

[81] Indeed, trial evidence established that that Precision was very concerned about employee safety. It had a good safety record. It emphasized the need for safety. Precision did not rely on apprenticeship training or previous work experience to ensure that its employees were safe. The evidence was that the driller, Trevor Haviland, was experienced, a good communicator, and a person "who would actually set down very strict procedures with his crews . . . to do with tripping procedures and trapped torque . . ."

[82] Indeed, the evidence was that the rig manager and Mr. Peterson had had a discussion about trapped torque immediately after the safety meeting and prior to the tripping out process commencing: A.B. p. 205 lines 12 -30.

[83] Precision had held a safety meeting on the tripping out procedure shortly before the procedure commenced. The procedure itself sounds complicated to a lay person, but it was presumably relatively routine to rig workers. The evidence of the rig manager, or tool push, who was present at the site, but not on the rig floor when the accident happened, included the following evidence about the safety meeting (p. 185 AB. Lines, 9 - 23):

Do you remember what was talked about?

We talked about that at all times before the slips are pulled, to ensure that the weight is taken off the drillstring, let the slips ride for a foot, approximately, so that you know the drillstring weight was off, and then pull the slips. Do not reach down ahead of time.

Did you have any concerns or doubts whether any members of your crew understood that procedure?

Everybody on this crew understood the procedure.

...

But I was observing them lots and this crew was -- really had the emphasis on always asking the driller, Is the torque out?

[84] In addition to evidence about the specific actions Precision took with respect to safety issues, there is also the important evidence to the effect that, after the tragedy which took Mr. Peterson's life, the government allowed Precision to keep drilling, to keep "tripping out", without the adoption of an interlock device. Moreover, after the tragedy of December 12, there was no subsequent consideration, much less adoption, of a standard which required drilling rigs to have the kind of interlock device that Precision eventually adopted. Not only did the government not impose this as a standard safety device, the industry did not adopt this as a safety standard: p. 435, lines 34-39. Given the government's ability, and willingness, to stop drilling that was not being done safely, the government obviously did not require the use of interlock devices on drilling rigs. The importance of this attitude by the government is enhanced by the evidence that the use of "crown savers", or upward travel limiting devices, has in fact been legislated.

[85] Finally, I may not have properly understood the trial judge's reference to "negligence per se": para. 59. Sometimes, of course, that expression refers merely to negligence. More often, that term is used, as did the Supreme Court of Canada in *Saskatchewan Wheat Pool*, in the context of determining whether the breach of a statute necessarily creates civil responsibility:

The doctrine that a breach of the law is "evidence of negligence" is in truth perplexing and difficult of comprehension. It stands as a sort of compromise midway between two extremer views: (1) that a breach of law cannot be treated as prudent conduct; (2) that the ordinance was passed alio intuitu and does not touch civil relations.

("Public Wrong and Private Action", (1914) 27 Harv. L.Rev. 317, at p. 323.)

Professor Thayer's thesis was essentially that prudent men do not break the law. He thus applied the criminal standard of care, breach of which would give rise to penal consequences under the statute, to the civil action.

The majority view in the United States has been that statutory breach constitutes negligence per se--in certain circumstances.

Once the statute is determined to be applicable--which is to say, once it is interpreted as designed to protect the class of persons in which the plaintiff is included, against the risk of the type of harm which had in fact occurred as a result of its violation--the great majority of the courts hold that an unexcused violation is conclusive on the issue of negligence, and that the court must so direct the jury. The standard of conduct is taken over by the court from that fixed by the legislature, and "jurors have no dispensing power by which to relax it", except in so far as the court may recognize the possibility of a valid excuse for disobedience of the law. This usually is expressed by saying that the unexcused violation is negligence "per se", or in itself. The effect of such a rule is to stamp the defendant's conduct as negligence, with all of the effects of common law negligence, but with no greater effect.

[86] However, in this case, we are not dealing with the civil effects of a breach of statute. We are dealing with whether Precision breached a strict liability provision of a statute, the *Occupational Health and Safety Act*. Specifically, the trial judge was called upon to decide whether Precision had, on a balance of probabilities, satisfied its due diligence burden.

[87] It is true, of course, that in strict liability offences, the prosecution is not required to prove negligence of the accused beyond a reasonable doubt; this may be the kind of negligence to which the trial judge was referring. As was stated in the somewhat difficult decision – because of the different groupings of reasoning - of the Supreme Court of Canada in *Wholesale Travel Group* on an issue on which I suggest a majority of the court agreed:

205 This rationale is no less compelling today. Quite simply, the enforcement of regulatory offences would be rendered virtually impossible if the Crown were required to prove negligence beyond a reasonable doubt. The means of proof of reasonable care will be peculiarly within the knowledge and ability of the regulated accused. Only the accused will be in a position to bring forward evidence relevant to the question of due diligence.

206 Nor can I accept the contention that there is little practical difference between requiring the accused to prove due diligence on a balance of probabilities and requiring only that the accused raise a reasonable doubt as to the exercise of due diligence. Professor Webb, in his article, *supra*, deals with this argument in the following terms, at p. 467:

Some might argue that in practice there is no workable distinction between an offence which requires the accused to prove due diligence on the balance of probabilities to avoid conviction, and one that permits the accused to raise a reasonable doubt as to the existence of due diligence. Trial judges will find a way to convict those whom they feel are guilty of negligence, the argument would go, and they will acquit those whom they feel have exercised due diligence, regardless of burdens of proof. This type of reasoning certainly contradicts the statement of the trial Judge in Whyte [*supra*], who contended that in the absence of a balance of probability presumption, he would have found reasonable doubt as to whether the accused had "care and control" of a motor vehicle.

Webb then goes on, at p. 467, to identify the deleterious effects on prosecution of regulatory offences which would result from requiring the Crown to prove negligence:

The "there is no difference in practice anyway" argument also fails to recognize the different quantity and quality of evidence which administrators would be forced to provide to prosecutors in preparation for a case. If an evidential rather than a persuasive burden is adopted, merely raising a reasonable doubt as to the existence of due diligence would then shift the burden of proof to the prosecutors to prove negligence. Prior to any case reaching the prosecution stage, administrators would be under an obligation to collect all the evidence necessary to prove negligence. In effect, prosecutors would be more likely to turn down a request from administrators for a prosecution unless proof of negligence could be established. Given the difficulty in accumulating such information, it is not unlikely that there would be a chilling effect on use of the prosecution mechanism. Once it became noticeable that less cases were reaching the courts, it is possible that regulatees would receive the signal that, in most circumstances, the offence of negligence was not enforceable. [Emphasis in original.]

207 I agree with these conclusions of Professor Webb. To reduce the onus on the accused would, from a practical point of view, raise insurmountable barriers for the Crown seeking to enforce a regulatory scheme.

[88] As to what “due diligence” means in the circumstances, we have, of course the benefit of the Supreme Court’s clear direction in *Sault Ste Marie*:

the accused (can) avoid liability by proving that he took all reasonable care. This involves consideration of what a reasonable man would have done in the circumstances.

[89] In this context, the trial judge was required to assess whether the steps which Precision had taken, including compliance with industry standards and statutory requirements and government enforcement of employee work safety was, on a balance of probabilities, what a reasonable drilling company would have done in the circumstances.

[90] The law is clear that an employer is not an insurer of a worker’s safety. Precision did not have to take all conceivable steps to avoid injury. It was only required to take all reasonable steps to avoid injury. Therefore, where the trial judge assesses some possible courses of action – i.e. letting slips ride, installing an interlock device, it could only be through the lens of assessing not what was possible, but what was reasonable.

(ii) *Mistaken conclusion in relation to competitors’ use of interlock device*

[91] In relation to engineered solutions to the hazards presented by tripping out, the trial judge concluded that Precision should have adopted an interlock device: para. 62 of the decision. This aspect of his reasons raises many problems.

[92] As indicated at the outset, the trial judge made a major evidential error, a palpable error, occurred when the trial judge stated, at para. 61 of his reasons:

Here the evidence is clear than an engineered solution was in place with other industry competitors.

[93] The trial judge was clearly mistaken. The trial evidence was that: one competitor – Savannah - had placed a similar device on one of its rigs, and that drilling rig was not the same type of rig as Rig 212. Moreover, the trial judge concluded that Precision was at fault for not having known of the Savannah device: para. 63. Having made the error concerning the ubiquity of the device in the industry, the trial judge did not turn his mind to the evidence that it was not only Precision which did not know of the Savannah device, but also that the government agency which closely and highly regulated the drilling industry did not know of the device.

[94] It is true, of course, that after-incident evidence can be used to determine what the cost of remediation would have been. However, the trial judge's analysis in this case fails to take into account that it was after the accident on December 12 that the Occupational Health and Safety inspectors became aware of the interlock device and those officials made the existence of that device known to Precision. Once the existence of that device became known to Precision, it was, of course, easy quick and cheap for Precision to come up with an interlock device of its own. Great discoveries breed a multitude of follow-up ideas which may only copy-cat, but which may also actually improve; legislating that one person must come up with a great discovery does not to accord with the concept of reasonable man.

[95] The fact is, however, that there is no evidence that Savannah’s “small bit of common-sense engineering” has had an effect on the drilling industry. Their device has never been

adopted in the Code which regulates safety in the drilling industry. Government inspectors did not shut down rigs that did not have that interlock.

[96] Nor did the trial judge turn his mind to the fact that there was no evidence from Savannah about its interlock, what it did do and what it might not have done. It appears from the judge's comments during the trial that the trial judge himself had some experience in the drilling industry – see, for example, his defining of the expression OD as outer diameter for counsel as well as his remarks at the commencement of the trial that he had some familiarity with the concepts that were being discussed; however, his task was to decide what a reasonable drilling company would do.

[97] Also, as is made clear in para. 63 of his reasons, the trial judge proceeds to make his finding that Precision should have had an interlock device on its rig on the basis that the kind of torque that was released on December 12 was trapped table torque. For the reasons set out earlier in this decision, the decision that the accident was caused by trapped table torque rather than some other type of torque was itself open to question. There was trial evidence, for example the evidence of Mr. Pickering to the effect that the interlock would only solve a problem created by a rotary brake event: p. 437 Lines 30, 31.

[98] The trial judge's comments about simpler technical solutions – such as a light – do not reflect the trial evidence dealing with a bypass of the bypass. See, for example, the evidence of Mr. Pickering at page. 436 lines 25-32::

Are there still risks and hazards, in your mind, associated with the interlock and warning device that you eventually went to?

Yes, absolutely because, like I said earlier, you need the procedures to make that device work. That device has two functions . . . what it does is, you were to have your rotary brake engaged and you went to hoist the drill string, it wouldn't allow you to hoist. So what it is is . . . a signal to the driller that your brake isn't engaged. The driller still needs to release that brake and remove the torque so he still needs to follow procedures by removing the workers from the area and ensuring that they're in a safe area so he can safely remove the torque or release the brake on the rotary table.

Mr. Pickering then goes on to describe problems with a light and with his experience of workers becoming “complacent with a constant light”.

[99] It is clear from the tenor of the trial judge's reasons that the existence of the Savannah solution was a material component of his conviction reasoning. For that reason, the error concerning the interlock device was not only palpable, it was also overriding. Had it not been for that error, the trial judge's assessment of whether Precision had done what was reasonable in the circumstances might have been different.

[100] For the above reasons, the trial judge's conclusion that Precision hadn't shown due diligence because it had not, prior to December 12, 2010, adopted an interlock device similar to the Savannah solution is not supported by the evidence.

iii) *Mistaken conclusion concerning change in administrative procedures*

[101] The trial judge concluded that the post-accident administrative measure of “letting the slips ride” “could have significantly lessened the risk of a floorhand being struck”. He adds, “in the fashion that occurred here”; however, for the reasons previously given, I conclude that since

there is no evidence about how the accident occurred here, the presupposition that the accident occurred in a specific way can, and should, be ignored in considering components of Precision's duty of taking all practicable steps to ensure the safety to Mr. Peterson.

[102] The trial judge's conclusion that the earlier procedure of requiring floorhands to stop and retrieve slips from around the drill stem "was done to avoid damage to the slips or drill pipe" was not reflective of the evidence. See, for example, the evidence of the defence witness Pickering at A.B. p. 439, lines 14-23:

When I was in the industry, on the floor, or drilling, for that matter, or pushing tools, it was a no-no to let your slips ride. And that just means they stay in the table as you pull your drillstring through them. And the reason that we didn't want that or it wasn't the recommended practice was, as you're pulling your drillstring, you can encounter a tight hole and you may need to go back down. And obviously if your slips are in the table you can't and you have to start from a higher tension now than you originally did. And there is the possibility that the dies sit in there, and they kind of float in a capsule, and they could come out and down the hole. But it was just another way to raise the awareness and another way to make sure, or heightening that stay clear.

[103] In any event, the evidence is that Precision issued a letter on December 16, 2010, with respect to a procedure that was to be implemented at all rigs immediately. The first thing to notice about that instruction is that it was issued on December 16, i.e. 3 days after the Occupational Health and Safety inspector had allowed Rig 212 to resume operations. Therefore, it would appear that the instruction of December 16 was not, from the perspective of the government inspector, a necessary safeguard to the drilling operation.

[104] The second thing to notice about that instruction is that floorhands still had to enter the rotary table area to complete the task of pulling slips. Therefore, it may be that the effect of the instruction is one of emphasis rather than one of change.

[105] The third thing to notice about the use which the trial judge made of this instruction. He said:

I am also satisfied that the administrative procedures used by the Defendant were ill-advised and contributed to the tragedy well beyond *de minimis*. This finding would in my view support a finding of guilt to the general Count even if I had endorsed the Defendant's claim about downhole torque as the possible source of this uncontrolled spin of equipment.

[106] It is therefore necessary to review the evidence about administrative procedures. The procedure which satisfied the Occupational Health and Safety officer is found at tab 2, ex. 10. The evidence is that the officer found that document provided safety for the workers on the rig: A.B. p. 60, lines 14-16. The document in question defines the hazard, and the remedy for the hazard; the portion with which we are concerned reads: :

Workers could be struck by the elevators, slip handles or the bales if there is trapped torque in the string.

Driller is to ensure that all trapped torque is released from the drill string prior to latching elevators on the stump.

Personnel must stand clear of the potential swing path of the elevators, bales and slip handles while the Driller hoists the string out of the slips.

[107] In explaining why this change in administrative procedures allowed the officer to authorize Rig 212 to resume work, the occupational health and safety inspector responded:

I felt that the critical operating procedure was a far more detailed document and combined a number of the hazards that were cited on different JSAs into one . . .

[108] Evidence concerning the difference between the administrative procedures that were in place on December 12 prior to the accident and on December 13, the day after the accident, were addressed in the evidence in chief of Mr. Lundstrom:

So, what's the difference between the procedures that existed at the time of the accident versus this procedure that's contained in the COP?

There was procedures at the time of the accident.

Okay. What were they?

The procedures included - - that ensured that there was no torque that was trapped in the table, there was also procedures within our drillers handbook that talked about trapped torque, and not to keep it . . . and what I mean by that is to hold it with - in the underneath the - - rotary table, the critical operating procedure really pulled all of the documents in the different areas and put it into one place. (A.B. p. 316, lines 21-30)

[109] In cross-examination, the prosecutor confirmed that the "point of the critical operating procedures was in fact to pull all these little safety nuggets . . . and put them in one place". (A.B. p. 390 lines 31-32). The prosecutor then continued:

Would it be safe to say that if you're having a five minute safety meeting, you're not going to gather materials from three different places to put together one complete meeting addressing all concerns?

No. I wouldn't say that. A lot of times our supervisors will prepare ahead of time, so they will pull those materials ahead of time, write the meeting ahead of time, and then sit down and review it. Part of what we talk to our people is making sure that they plan their day. So one of the things that we have is a crew changeover meeting they talk about, and in that crew changeover meeting they will talk about the activities for the day. They will explain the operations, if there was potential for a trip that day, or if there was other operations, that's when they would, in theory, talk about that, and that would be a prompt that would (indiscernible).

[110] In other words, the evidence at trial includes evidence that the critical operating procedures which the Occupational Health and Safety officer approved after a life threatening accident was a composite of procedures which already existed in Precision's JSAs and that compliance with this composite document satisfied the experienced Occupational Health and Safety officer that work could safely resume on the rig.

[111] That evidence dealing with the post-accident procedure relating to elevators and bails would have to be assessed in light of the trial evidence that Mr. Peterson's hard hat was not damaged, suggesting, perhaps, that his head did not come into contact with the elevators and bails.

[112] Given the totality of the evidence, it is difficult to understand the trial judge's conclusion that Precision's pre-trial administrative procedures contributed to the death of Mr. Peterson. Part of the reason for that problem is, of course, that the trial judge's reasons on this point were conclusory.

4. Count #2

[113] For the reasons that follow, I have concluded that Precision's appeal is allowed, and the conviction is set aside.

[114] The second count against Precision is:

On or about the 12th day of December, 2010, at or near Grande Prairie, in the Province of Alberta, being an employer where an existing or potential hazard to workers was identified during a hazard assessment, did fail to take measures in accordance with section 9 of the *Occupational Health and Safety Code 2009*, to eliminate the hazard or, if elimination was not reasonably practicable, to control the hazard, contrary to section 9(1) of the *Occupational Health and Safety Code 2009* as adopted by the *Occupational Health and Safety Code Order*, Alberta Regulation 87/2009 pursuant to the *Occupational Health and Safety Act*, R.S.A. 2000, Chapter O-2, as amended.

[115] Particulars of this offence were neither requested nor given.

[116] The trial judge did not address the elements of Count #2; the only references to that count in his reasons for decision are found at paras. 14 and 67 where he says:

Specific Offences:

12 The two counts are as set out in paragraph 2:

13 Count one is the "general offence" whereas count 2 is or could be a more "specific offence".

14 In some instances the specific count requires a more detailed and differential analysis than the general count. Here that is not the case. The Crown has chosen not to make detailed allegations. In the result I am satisfied that the same facts and analysis apply to each count. Where that is the case the specific count will be subject to a conditional stay under the rule in *R. v. Kienapple*, [1975] 1 S.C.R. 729.

...

Result:

67 In the final result I find the Defendant guilty of Counts 1 and 2. Count 2 will be conditionally stayed as discussed in paragraph 14.

[117] Even if the Crown did not have to provide particulars on Count #2, and even if Precision had to prove, on a balance of probabilities, that it had done everything required by s. 9 of the Code, all it would have had to do is to satisfy the trial judge that it had done what was reasonably practicable to control the tripping out hazards by engineering controls, and by administrative

procedures, and by a combination of engineering controls and drilling procedures. I agree that the analysis made in relation to Count #1 could, in the circumstances here, have dealt with Count #2. Therefore, for the reasons which I have set out above in relation to Count #1, I allow the appeal on Count #2.

5. Because evidence was led at trial on which a trier of fact could properly convict, the appropriate relief here is to order a new trial

[118] The Crown has correctly identified the test for determining whether, on a successful appeal from conviction, an acquittal should be entered or a new trial ordered. Indeed, that test has subsequently been approved by the Supreme Court of Canada in *Roy*:

53 The appellant asks the Court to allow the appeal, set aside his conviction and enter an acquittal. The Crown's position is that if the appeal is to be allowed, a new trial should be ordered. The decision as to what order to make turns on whether there is any evidence upon which a properly instructed trier of fact could have convicted. If there is not, then generally entering an acquittal is the appropriate course (see *R. v. MacNeil*, 2009 NSCA 46, 277 N.S.R. (2d) 22, at paras. 16-18; *R. v. D.C.S.*, 2000 NSCA 61, 184 N.S.R. (2d) 299, at paras. 46-50). In my view, that is the appropriate course in this case.

[119] As indicated in these reasons, the errors which I have discerned in the trial judgment are errors in the treatment of evidence. Because there is evidence on each of the elements of each offence, the charges must go back for a new trial.

Heard on the 16th and 17th days of June, 2016.

Dated at the City of Grande Prairie, Alberta this 16th day of September, 2016.

J.B. Veit
J.C.Q.B.A.

Appearances:

Peter Taschuk, QC, David G. Myrol, McLennan Ross LLP
for Precision Drilling

Alana Elliot, Regulatory Crown Prosecutor, Specialized Prosecutions, Edmonton
for the respondent Crown

APPENDIX A – Excerpt of evidence from Adam Brookes

“Tripping out” described p. 17

Instances of not remembering events of December 12 p. 19

What happened on December 12

Q. So on rig 212, speaking about tripping out on this specific rig, how would that be done between the driller, the motorman, the floorhand, what was the process being undertaken on rig 212?

A You would go in, have a safety meeting, you would check all your equipment. Floorhands would - well it's kind of a whole process, it's not really just one or two steps, it goes from the driller release - well you would go in, have a safety meeting, you would go check all your equipment, roughnecks would check the tongs, just as I said prior, the driller would make sure he would be working the hole, once you were ready to trip out you would kill the pumps, the driller would kill the pumps, pull back the - pull back to the kelly, you would rack the kelly back, and you would continue to - or the roughnecks would break it off, you would rack the kelly back and then you would continue to pull out of the hole, do your five percent pull, take your floor check.

THE COURT: Do your five percent?

A Pull. You pull five percent out of - out of the hole, and you have to – regulations I have to -- be a floor check.

MS. MAGILL: And that's after the kelly is removed, and there's a pipe stump in the rotary table?

A Yes.

Q Now let's take us to killing the pump, and pulling back the kelly, can you walk us through the process of detaching the kelly from the drillstring.

A You would pull up to set your slips, you would set the slips for the tool joint, which is just up above the floor, roughnecks would then throw their tongs on, the driller would pull back on the breakout - breakout handle, break the connection, spin either the kelly, if the kelly had a reverse, or - if the kelly bar had a reverse, or else release or spin the rotary table out. Once you were done spinning the rotator -- rotary table out, you would put the brakes on so that way it didn't spin back in through the – or through the trapped torque, you would hoist up on the kelly, pull it back into the kelly sock, and the driller would let down on the brake handle, set it into the kelly sock, roughnecks would go grab the -- pardon my language, the fuckstick, they would unhook the blocks from the -- from the kelly, hook the bails up, from there hook the elevators onto the bails, and bring the - or elevators up, hook it onto the stump of the pipe and continue.

Q Now if the table was being used to break the kelly from the drillstring, what direction would it be turning?

A It would be turning counterclockwise I believe. No, clockwise.

Q Roughly how high up would the drillstring be in the table for workers to attach the bails and the elevators?

A You would have it probably hip height, from the top of the tool trunk, hip height maybe, three feet.

Q And where are the slips located?

A Underneath the tool trunk, right at the floor height.

Q Okay. You recall roughly how wide the bails would sit once they are attached to the drillstring?

A Two to three - two to two and a half feet maybe.

Q And what does --

A Two feet up.

Q -- the driller do while the kelly is being wrapped?

A He's either going down on the controls, or on the brake handle. Well lifting it up first off, running the tigger to pull it back into the kelly sock, going down on the handle, hooking the tigger back up and running the controls to hook the kelly back up, watching over us, making sure that the swing path of the -- of the blocks don't get in the way, or don't hit anything.

Q And in your experience, and this isn't an exact science, but in your experience, if everything is running smoothly, how long does it take to break the connection and rack the kelly?

A It all depends whether or not you're one step ahead, have the blocks or the bails on, or bails and elevators on, if you don't then it could take upwards of 15 minutes in cold weather conditions, on the downside five minutes if you have the bails and elevators already hooked up, then it's quick and simple. All you would have to do is unhook the kelly from the -- or the kelly from the blocks, and two to three minutes.

Q Do you recall on December 12th whether the bails and elevators were set up?

A I don't remember.

Q Was there anything unusual happening while you were racking the kelly on December 12th?

A I don't remember.

Q What is torque a hazard, trapped torque?

A When you pick up off of the -- off the bottom, it releases the trapped torque, it makes the bails -- bails and the elevators spin, and as we all know in this incident, can do some pretty big damage to either equipment or personal, human.

Q Who would be the one to know that trapped torque or trapped table torque exists in the drillstring?

A Typically the driller would be the one to know, everybody else should be aware of it, but the driller is the one that would either feather it out while we're busy doing something, or right off the get-go he would feather it out.

Q On rig 212, was there anything on the rig floor that could warn a member of the rig crew that there was trapped table torque?

A Not at the time, no.

Q Perhaps you can explain to us what happened on December 12th of 2010.

A Well we racked back the kelly, I went through the process of that earlier, we went down to pull up off bottom and when the driller lifted up off bottom the trapped torque was released, I had stepped back, seeing and hearing the -- the sound, we all kind of did our headcount, we noticed that Frazier was hunched over on the opposite side of the floor, and that's when we kind of went over to -- well that's when we went over to see if he was okay, and realized that he had been struck in the head.

Q And you said you stepped back, where were you located at the time?

A I was on the opposite side, I was on stud side of the rig floor, and going to lift up the -- or the slips. Frazier was on the dummy side, which would be the mud tank side, I was on the doghouse side, driller's side.

Q And what position would you be in to lift the slips?

A You would be in a hunched over position, ready to lift them, positioned close to the drillstring, and bails, and elevators. Typically in the rotary danger zone.

Q Was the rotary table turning at the time that you're pulling the slips?

A No.

Q How quickly do you pull up the slips in the process?

A Once the drillstring, the weight has been lifted on to the bails, once you see it move.

Q What does it mean to let the slips ride?

A You don't lift the slips, you just let them ride on the pipe, or in the bushings, in the table.

Q Would there be a time where that was accepted practice?

A When you're laying down sideways set in casing where you have no possibility of getting stuck.

Q No possibility of?

A Getting stuck.

Q But ordinarily would be hunched over and ready to lift the slips?

A Correct.

Q In your past experience, tripping out, had you seen torque released when removing slips?

A Yes.

Q Do you recall when that was?

A No. Numerous times.

Q And you said you stepped back on hearing a sound, did you observe anything about the bails?

A I saw them spin.

Q And what did you hear?

A The -- the sound of something going fast.

Q Had you observed torque like you saw on December 12th, had you seen that type of torque previously?

A No.

Q What type of torque would you ordinarily see?

A I would see it when it was feathered out instead of lifted right up.

Q So you would still have torque, even if it had been feathered out?

A Not necessarily, no.

Q But on occasion?

A On the occasion, yeah, but for the most part, ninety -- 99 percent of the time once it's feathered out, it's released, there's nothing left in there.

- Q And when would you see the most torque, removing the kelly from -
- A Off bottom.
- Q - the top strand?
- A Off bottom.
- Q Off bottom. And what does it mean to be off bottom?
- A When you are removing either the kelly, when you're making your bottom hole connection, when you reverse out the drillstring through the rotary table instead of the kelly.
- Q Do you need to use the kelly to make a connection while you are tripping out, or is it just --
- A No, once we are tripping out, we get rid of the kelly in total, and -- and all.
- Q What do you use to remove other strands of pipe?
- A We have a pipe spinner.
- Q And what does --
- A It's run by -- it's run by hydraulics, it connects onto the top joint of pipe, it clamps down, and it has a chain drive that spins around and back screws -- or screws the -- the stand of pipe out.
- Q And then how is it lifted out?
- A Through the elevators and the blocks.
- Q In the same manner as you would rack the kelly?
- A It's a totally different -- the kelly is going down into a sock, the stands of pipe are going into the derrick.
- Q Okay. But in terms of going up the mast, is it the same process?
- A The driller would hoist it, it is already -- the stand is already up the mast, or the derrick as you call it -- or mast as you call it, but the derrick, he would just lift it up an extra couple of inches to get it out of the actual sock itself, and then the roughnecks would then proceed to push it back into the bird baths, and the derrickhand would unlatch the elevators and pull it back into the monkey board.
- Q Ordinarily how many men would be required to lift the slips?
- A Two.

Q Where was the other floorhand at the time?

A I -- I believe he was back in the bird bath, or back by the catwalk skate operators, or controls.

Q Okay.

THE COURT: I'm sorry, bird bath or?

A The catwalk controls.

THE COURT: Thanks.

MS. MAGILL: What communication did you have with the driller before going into the area to pull the slips?

A What -- can you repeat that?

Q What communication, if any, did you have with the driller before you went in to pull the slips?

A Didn't really have any. Can't really remember to be honest.

Q What communication did you have with Frazier Peterson before you both went in to grab the slips?

A I can't remember.

Q Did you observe any communication between the driller and Mr. Peterson before going in for the slips?

A I can't remember. There's communication between all workers, we're -- we're working, talking to -- you're talking to each other, but the exact words, I can't remember.

Q Was there a designated signaller to communicate with the driller about torque?

A No.

Q Was there a specific phrasing that would be used?

A No. Typically the driller would just release the torque right after, right after the torque was set in place by back-screwing the bottom of the drillstring.

Q Do you recall on December 12th if you had a safety meeting about tripping out?

A I believe so, but I can't remember 100 percent sure. We have three different safety meetings, three, four different safety meetings a day, and four years is a long time, with a lot of safety meetings.

Q No, that's fair enough.

MS. MAGILL: Sir, if I may, just to grab a couple binders here.

THE COURT: Sure.

MS. MAGILL: Madam clerk, Exhibit 2.

Q Mr. Brookes, your safety meetings, if they occurred, would be documented; is that right?

A Correct.

Q I will ask you to -- there's a number of tabs in that binder, if you want to go to tab 13--

MR. MYROL: Are we in Exhibit 2 now?

THE COURT: Yes.

MS. MAGILL: Exhibit 2, yes.

MR. MYROL: Thank you.

Q MS. MAGILL: And you have that before you?

A Yeah.

Q Page 34, is the very last page.

A Okay.

Q Who would be responsible for writing out the safety meeting minutes?

A Everybody.

Q And the JSAs would be the JSAs at the rig site?

A Correct.

Q And if a JSA is reviewed, it would be noted on the safety sheet?

A I believe so, yes.

Q Do you recall if a safety meeting took place before the Kelly was disconnected, or afterwards?

A I can't remember.

Q Do you recall, Mr. Brookes, how far you were bent over?

A I don't remember.

Q Now I see in the meeting report that JSAs two and three were reviewed, I would like to take you to a couple of other JSAs that are under tab ten. Do you have that in front of you?

A Yeah.

Q Okay.

A Depending on what page though.

Q Now I would ask you to go to page 19. And right at the bottom there's a task of pulling slips, and it appears that trapped torque, spinning slips, is identified.

A Yeah.

Q What would -- what hazard would spinning slips pose?

A If your hands are on them, they could either come around, hit the back your hand, break your knuckles, or if you're grabbing onto it strong enough, it could pull you in towards the bails and elevators.

Q And how would -- was there any other way, except visual confirmation by the person, yourself or another floorhand, when you're pulling the slips, any other confirmation that you can rely on other than visual to know when the weight is off the string?

A You could see it -- no, you would see it moving, that's about it. Now when you said the weight is off the string, the string always has weight on it, did you mean the weight is off of the slips, or --

Q That's what I meant, sorry.

A Okay.

THE COURT: And what was your answer?

A The only way that you would be able to tell is visual. You would see the weight indicator move, you would see the slips move, you would see the drillstring move, bails, the elevators, everything. Everything is visual.

MS. MAGILL: And where is the weight indicator located?

A Behind the dummy roughneck.

Q And sorry, were you on the dummy side, or --

A I was on the stud side.

Q So on the dummy side it would be behind the worker in that position?

A Correct.

Q Now from what you observed on the 12th, and your prior experience in the patch, is there anything else that could cause the drillstring to spin the way that it did during hoisting, except trapped torque?

A No. Not with anything connected to it like that.

Q The JSA number two, which was page 19 on tab ten, do you still have that in front of you?

A Yeah.

Q Sorry, the JSA is at page 16. Do you have that before you?

A Yeah.

Q Do you recognize that JSA?

A No, I can't remember.

Q Have you tripped out pipe with Trevor Haviland before?

A I can't remember.

Q Who -- who picks the JSAs to review before a task is undertaken?

A Anyone of us.

Q Why were you going for the slips instead of Mr. Finlay?

A He was busy doing something else at the moment.

Q Where was he located?

A Like I said, bird bath or the catwalk controls.

Q Where is the bird bath in relation to the --

A V-door, the right-hand side of the rig floor if you're coming from the doghouse.

Q Was that usual for workers to be doing different things at the time?

A When you're starting to pull out of the hole, yes. Once you get into the routine of things of actually pulling out each near the drillstring, and breaking stands off, then it's usual for just two people to work the floor with -- or with the driller.

Q I may have asked you this, Mr. Brookes, and if I did, I apologize, but how long had this crew worked together before this incident occurred?

A Not very long, but I can't remember exact days.

Q I'll just ask you, Mr. Findlay -- or Mr. Brookes, sorry, I will refer you to Exhibit 10. Under tab four there are number of pictures there, do you recognize yourself in those photographs?

A Yeah.

Q Of these photographs, what would have been the positioning of Mr. Peterson?

A Mr. Peterson would have been in my positioning. Yeah.

Q And what I'm looking at in the circular table, those are the slips?

A Yes.

Q And in photograph four and five, and six --

THE COURT: They're numbered at the bottom right.

A Yeah, I know.

MS. MAGILL: Can you explain to us what you and another person in blue are doing there?

A We're breaking off the kelly, running our tongs to break off the kelly.

Q And that would be the positioning of the workers during the tripping out process, removing the kelly?

A When we were just pulling -- or when we're removing the kelly, yes, that would be the positioning.

Q Would it be similar positioning when reattaching the kelly?

A Correct.

Q After this incident did you receive any instructions with respect to pulling the slips?

A I can't remember.

Q Were there any changes to the work process after Mr. Peterson's accident?

A Explain more, what do you mean? Like in general, right after, I -- I don't understand your question.

Q We'll start with right after.

A I can't remember.

Q You had mentioned that there was nothing to indicate to workers on the rig floor that there would be trapped torque, or could be trapped torque, are you aware of changes that were made?

A Now, yes.

Q And what was that?

A They set up a table brake hoist - table brake hoisting alarm.

Q And what does that do?

A If your table brake is engaged, it -- when you go to hoist it, it sends an alarm off, which doesn't allow you to hoist the drillstring until you have released the table brake. So that way there -- if there is any trapped torque in there, it would either be released before lifting up on the bails and the elevators so that there would be no trapped torque.

Q Have you worked on rigs with that installation?

A Now, yes.

Q Have you ever heard that alarm go off?

A Yes.

Q And in the times that you've heard the alarm go off, what happens?

A Nothing, you have to release the table brake in order for you to lift up there, the driller will either say stuff back, I've got to release the table brake, or -- that's the only thing that can happen.

Q Mr. Brookes, going back to the Exhibit 2 binder, and back to tab ten, and once you're at tab ten, if you could go to page 68. I'll just give you a second to look at that document. It's a JSA, pulling slips with mud motor in hole?

A (NO AUDIBLE RESPONSE)

Q This JSA, did it relate to breaking off the kelly and tripping out?

A Yes.

Q And in the control, or recommendation to eliminate hazard, it says, make sure and double check his control panel prior to lifting string, would that be a floorhand or motorman's job, or would that be the driller?

A That would be the driller.

Q Did you ever receive training on the driller's console for double checking?

A Not at the time, no.

Q Have you since?

A I do have my first line, so yes, I have worked the controls.